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Errata

p.vi, para 2, line 4: replace 'conversions' with 'conversations'

p.29, para 1, line 5: replace 'Institute' with 'Institutes'

p.50, para 4, line 6: replace 'HIV-infected' with 'AIDS-infected'

p.53, para 2, line 2: omit 'reactionary'

p.146, para 1, line 3: insert 'albeit rarely' after 'into the 1990s'

p.170, para 1, line 12: replace 'causal' with 'casual'

p.214, para 3, fifth sentence, should read: 'This is of crucial significance, as psychiatrist Laurence Tancredi and lawyer Nora Volkow argue, because "metaphor essentially creates the framework for the individual's experience of the disease" and influences how a person will deal psychologically and physically with their illness.'

p.267, para 1, line 13: replace 'extremely infectious' with 'infectious'

**Learning to Trust:
A History of Australian Responses to AIDS**

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A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy
in the School of Historical Studies, Faculty of Arts, Monash University, Victoria,
Australia.

September 2001

for

John and Cheryl

and

Katrina

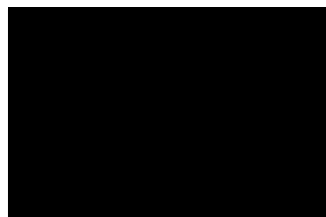
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Statement

This thesis contains no material that has been accepted for the award of any other degree or diploma at any university. It does not contain material previously published or written by another person, except where due reference is made in the text of the thesis.

Signed:

A solid black rectangular box used to redact the signature of Paul Sendziuk.

Paul Sendziuk

Acknowledgments

Nearly two years into this project, and after a semester of full-time teaching in the Department of History at Monash University, I took the opportunity to tour around Europe for twelve weeks. The trip caused no end of disruption to my research, both in terms of time away and the fact that I became determined to change the scope of my thesis once I returned. Yet while removed from the archives and the books, and the excitement and emotional exhaustion of speaking to people with, and about, AIDS, I learned to appreciate the art of academic research and writing. Staring at the magnificent mosaic floor of St Mark's Basilica in Venice, the essence of academic enterprise was laid out before me. This intricate and beautiful tile tapestry, which stretches from the porch to the altar, was the product of many artisans working in unison, the whole being much less but for the patient labours of each individual.

And so a doctoral dissertation takes shape, the product of many contributions provided by people and organisations who for a short time, or their entire adult lives, have shared my passion for understanding the social, political and cultural dimensions of the most devastating epidemic of our time. The tiles with which I have worked were largely quarried from the National AIDS Archive Collection, held at the Noel Butlin Archive Centre, Australian National University, Canberra. I am grateful to Phil Carswell, Bill Bowtell, Scarlet Alliance, ACT UP, AFAO, the IV League, Haemophilia Foundation Australia and the Commonwealth Department of Health and Human Services for granting me permission to access their files. I have also drawn on primary source material provided by the National Gallery of Australia, the AIDS Councils of Victoria, New South Wales and Western Australia, the Australian Socio-Graphic AIDS Project, the State Library of New South Wales, the Australian Gay and Lesbian Archives, and the Travers and Goller Collections at Monash University. I particularly appreciate the help provided by the librarians at the National Library of Australia who administer the 'Australian Responses to AIDS' oral history project.

The pattern of this mosaic has been subtly guided by my supervisor, Dr Mark Peel, who welcomed me to Melbourne with a meal at his home and has been a generous friend and colleague ever since. Mark teaches his students by praising what they do well rather than criticising their errors, a principle I have both benefited from and have been careful to

adopt. He listened patiently to what I hoped to achieve and has enthusiastically encouraged me to realise and articulate the wider public policy implications of my work.

I am also indebted to my three very good friends, Gerard Calnin, Chris Straford and Drew Carter, who, upon my completion of laying tiles, told me if they were straight or out of order. Their enthusiasm for hunting down misplaced commas and typing errors is matched only by their appetite for late-night conversation and solving the problems of the world, AIDS-related or otherwise. My thanks also to the McKitterick family in EchUCA, the Knowles family in Canberra and Pauline Gilbert in Warragul who provided magnificent food, a warm bed, a means of transport and space to write during research trips and times of reflection.

In one sense, this thesis attempts to explain how many Australians learned to trust and love unconditionally in the face of terror. I learned to recognise these two virtues from my parents, Cheryl and John, who never wavered in extending them to me. My mother still has a ceramic mat – fashioned from a piece of wood and eight beige tiles – that I glued together in kindergarten. She brings it to the table every time we have guests for a meal and proudly displays it. Perhaps it will now be replaced by this new thing that I have built. With trepidation that my dissertation shall be scalded by a casserole, I dedicate it my mother and father.

It is also for the fabulous Miss Katrina Stats who has waited patiently for me to finish and assisted in every way possible so that she could whisk me away to Europe once again. Writing this thesis and constantly thinking about people living with, and dying from, AIDS has been painful at times, but I have yet to encounter an evil too horrible, a burden too heavy, or a problem so difficult that it could not be eased away by lying beside her and listening to her breathing.

Abstract

This dissertation chronicles the history of Australian responses to AIDS in the first decade of the epidemic. It outlines the impact of AIDS on gay men, people with haemophilia, sex workers, and injecting drug users, and examines the range of measures proposed and enacted to prevent the spread of HIV in each of these populations. It also explains the reactions of these groups to the threat of infection and stigmatisation, and the way in which they established community-based AIDS organisations committed to fighting the social, political and physiological consequences of HIV infection.

Thematically, my dissertation explores the way in which pre-existing cultural understandings framed the production of new knowledge about, and responses to, AIDS. That is, I demonstrate how pre-existing narratives and myths about homosexuality, injecting drug use, sex work, and the nature of 'infectious' disease informed and shaped public, political and medical responses to AIDS. Rather than responding to AIDS as a physiological disorder caused by a viral agent that is difficult to transmit, Australians were guided by their preconceptions of the type of people likely to become infected with HIV and the probability that these people would transmit the disease to others. Individuals who were imagined to be irresponsible and selfish, such as homosexuals and injecting drug users, or historically deemed to be 'pools of infection' and 'vectors of disease transmission', such as prostitutes, were believed by some to pose the greatest threat and thus were in need of surveillance and control. Accordingly, a number of influential doctors and legislators, and a large section of the Australian public, called for the mandatory HIV-antibody testing of 'high risk' individuals and the isolation or quarantine of those found to be infected. They also demanded that drug use and prostitution be more tightly policed, and called for the closure of gay sex-on-premises venues.

The communities most affected by AIDS vigorously opposed this 'traditional' approach to infectious disease control. They claimed that AIDS posed an exceptional challenge for society and government as it primarily affected marginalised communities who had a historical distrust of medical authorities and who had demonstrated an unwillingness to modify their behaviour to conform with existing laws and regulations. A regime of widespread testing, the implementation of coercive public health laws, and the policing of sexual activity and drug use would thus prove ineffective. Indeed, they asserted, it would

prove counterproductive as it was likely to drive gay men, prostitutes and drug users 'underground', thus making it impossible for peer-educators to provide information about AIDS prevention.

Accepting these arguments, the Commonwealth and most Australian state governments sought to incorporate representatives of the most affected communities into a partnership with public health departments and medical experts in order to employ their expertise in communicating with, and educating, people at risk. The result was an approach to AIDS prevention that stressed the need for community participation and education rather than the identification of infected individuals through widespread testing and the curtailment of their activities through coercive laws. Instead of promoting abstinence and relying on prohibition, Australian public health authorities and community-based organisations sought to inculcate a sense that everybody was at risk for AIDS, but that this risk could be minimised – regardless of the lifestyle that one led – by the adoption of safe sexual and drug use practices.

Thus by the beginning of 1987, the Commonwealth and state governments – with the exception of Queensland and Tasmania – were funding gay men, sex worker collectives and drug user groups to provide sterile needle and syringe exchange services, and produce and distribute educational materials which extolled the virtues of sex with condoms. Their success in preventing the 'second wave' of HIV infection among heterosexuals, and facilitating a marked decline in new infections among gay men, has seen Australia's pragmatic approach to the control of AIDS hailed as a 'model' for other nations to emulate.

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Introduction

In November 1982, Professor Ron Penny, an immunologist at St Vincent's Hospital in Darlinghurst, Sydney, diagnosed the first case of AIDS in Australia. It took him nearly a month to be sure. The patient, a 27-year-old New York City resident who was visiting Sydney on a working holiday, was referred to the hospital suffering respiratory distress and likely pneumonia. He was a gay man who averaged six new sexual contacts per month, frequently inhaled amyl nitrate ('poppers') during sexual activity and had previously been exposed to a range of sexually transmitted infections such as hepatitis A and B, herpes and amoebiasis.¹ He thus presented with many of the 'risk factors' for AIDS that had been established by that time. Penny and his colleagues had never encountered a case of AIDS, however, and in the absence of a diagnostic test it took numerous telephone conversations with experts at the United States Centers for Disease Control for them to be convinced.² Writing up the case in the *Medical Journal of Australia* nearly six months later, they admitted that the cause of AIDS was still unknown, but suggested that it might be a new infectious agent.³ Others suspected that its origins lay in aspects of the homosexual lifestyle. None of the doctors could have suspected the effect that AIDS would have on their lives and the nature of their work in the coming decade.

Penny's initial diagnosis was soon followed by a report of the first Australian to develop AIDS. This news was announced in a tone that bordered on hysteria. 'Mystery Gay Disease Hits Here' proclaimed the *Truth*, while the *Daily Mirror* prophesised: 'AIDS: The Killer Disease That's Expected To Sweep Australia'.⁴ Other newspapers were only slightly more circumspect: 'AIDS - A New Killer At Large'.⁵ The public was left in no doubt about who was harbouring the fugitive, as the media reports emphasised that all of the cases involved homosexual males and that this group in America was in the midst of an

¹Ronald Penny, *et al.*, 'Acquired Immune Deficiency Syndrome', *Medical Journal of Australia*, 11 June 1983, pp.554-7.

²Ronald Penny interviewed by Diana Ritch, 28 June 1993, 'The Australian Response to AIDS', Oral History Project, National Library of Australia, TRC-2815/39, pp.19-20.

³Penny, *et al.*, 'Acquired Immune Deficiency Syndrome', pp.554-7.

⁴*Truth*, 9 April 1983, p.5; and *Daily Mirror*, 27 May 1983, p.8.

⁵*Herald*, 25 May 1983, p.5.

epidemic. Following the announcement of the fourth case of AIDS in Australia, Professor Penny warned: "The reality of the moment is that within Sydney there may be many people incubating the disease because of the enormous exchange between gay communities here and in America."⁶ He thus unwittingly lent support to the emerging opinion that gays were responsible for exposing Australians to a malicious new killer.

As had been the case during other disease epidemics that were deemed to be caused by deviant 'outsiders', the public's anxiety about AIDS was soon manifested in persecution and discrimination against homosexuals. Some people joked that the acronym 'G.A.Y.' actually meant 'got AIDS yet', while others believed that all gay men were infected, or would soon become so.⁷ Such beliefs led a Sydney dentist to ban homosexual patients from his surgery in August 1983, and saw numerous gay men evicted from their homes or denied accommodation.⁸ Sydney Telecom engineers refused to carry out repairs at the Pitt Street mail exchange because, they claimed, it was staffed by a large number of homosexual telephone operators "who probably had AIDS",⁹ and plumbers who feared "catching AIDS" refused to fix pipes in restaurants where gay men might have eaten or cooked.¹⁰ When it was announced that three Queensland babies had died from AIDS as a result of receiving HIV-contaminated blood donated by a homosexual, a gang of men roamed Sydney's gay strip looking for poofers to punish.

Such responses, based on an ignorance of homosexuality and the nature of AIDS, remained common even after the viral origin of AIDS had been discovered. In November 1984, for example, New South Wales police called for a halt on random breath testing, and then insisted on being issued with plastic gloves, because they believed that HIV could be

⁶S. Downie, 'AIDS: The Killer Disease That's Expected to Sweep Australia', *Daily Mirror*, 27 May 1983, p.8.

⁷Randy Shilts, in his journalistic account of the AIDS epidemic, notes that a gay man travelling to Perth in August 1983 saw the words 'GAYS - Got AIDS Yet Sucker?' scrawled above the urinal in the bathroom at Perth International Airport. See Shilts, *And the Band Played On: Politics, People and the AIDS Epidemic*, New York: St Martin's Press, 1987, p.363.

⁸NSW Anti-Discrimination Board, 'Accommodation Discrimination', *Campaign*, vol.100, April 1984, p.16.

⁹*Ibid.*

¹⁰Jenny Ross (member of the National Advisory Committee on AIDS) interviewed by Heather Rusden, 11 February 1993, 'The Australian Response to AIDS' Oral History Project, National Library of Australia, TRC-2815/18, p.46.

transmitted via the saliva of motorists. (This occasioned one commentator to ponder which part of the policeman's apparatus the subject was required to blow!)"¹¹ Seven months later, Ansett and TAA airlines banned HIV-positive individuals from travelling on their planes as a means of protecting their staff. Fortunately, the Australian Flight Attendants' Association had a better understanding of HIV and its modes of transmission and rejected the bans, describing them as "ludicrous".¹² A spokesman for the Association wryly noted that if anyone managed to have mid-flight sex with an HIV-positive passenger – one of the few ways of transmitting the virus – they should be given "points for enterprise".¹³ No one was laughing, however, when a three-year-old Gosford girl was banned from attending a pre-school centre in July 1985 after parents, fearing contagion, threatened to withdraw their children from her class.¹⁴ Australians may not have experienced the rage and hysteria that led residents of a small American town to burn down the home of haemophilic boy after he contracted HIV from contaminated blood products, but they were certainly exhibiting symptoms of acute paranoia.

Given the hostility expressed towards homosexuals, and the public's fear of those afflicted by the syndrome, it seemed likely that Australian federal and state governments would be persuaded to enact a range of coercive public health measures in an effort to contain the spread of AIDS. The quarantine of infected individuals and the universal screening of the entire population for HIV-antibodies was not out of the question; indeed, various public opinion polls conducted in 1986 and 1987 suggested that approximately 25% and 50% of the population favoured these respective options.¹⁵ An even greater number of people

¹¹Larry Galbraith, 'It Won't Just Go Away', *Campaign*, 1985, p.5.

¹²Mark Metherell and Tony Harrington, 'TAA to Ban Passengers with HIV Antibodies', *Age*, 23 July 1985, p.12; and Susan Peak, 'Airlines Review on AIDS', *Sun*, 24 July 1985, p.11.

¹³Mark Metherell, Anthony Nagy and Prue Innes, 'Airlines to Drop AIDS Bans', *Age*, 24 July 1985, p.3.

¹⁴'AIDS Baby – Little Eve Banned From A Play Centre', *Daily Mirror*, 19 July 1985, p.1; 'AIDS Tot Shunned By Kindy Mothers', *Daily Sun*, 5 September 1985, p.1; and 'Forty Children Withdrawn As AIDS Toddler Returns', *Newcastle Herald*, 30 September 1985, p.1.

¹⁵For example, a 1986 Australian Market Research survey of 1500 adults aged between 16 and 60 found that 47% of respondents were in favour of universal screening, and 24% supported isolation of HIV-positive people from the workplace or the community at large. (Bill Taylor, 'The AIDS Campaign: Three Months On', unpublished paper prepared by the Commonwealth Communicable Disease Branch, 1987, p.7, AIDS Council of New South Wales archive, id: G6079 [folder: campaigns]). A survey of 2000 people conducted in April 1987 suggested that 42% of those interviewed wanted all people over the age of 16 to be tested, while 63% and 68% wanted the compulsory testing of injecting drug users and prostitutes respectively. (Peter

supported mandatory testing of 'high risk' groups, such as gay men, injecting drug users and sex workers. Advocates of this 'traditional' approach to the control of infectious disease also called on the government to close gay bathhouses and other venues where disease might be spread, as the public health authorities of San Francisco had done in October 1984. They also asked for funds to be channelled into medical research institutions and clinical facilities in the hope that a cure for AIDS might be found and widespread HIV-antibody testing programmes implemented.

Gay AIDS organisations, which emerged spontaneously within Australia's largest gay communities in order to educate their members about the means of AIDS prevention and to care for the sick, also asked to receive funding and be incorporated into the policy-making process. This looked unlikely, however, while medical experts dismissed their claims for legitimacy and while homosexuals were still perceived to be the cause of the problem. Australian governments, which were looking to the United States for guidance, would have also noticed that most federal and state authorities in that country were refusing to fund gay community-based organisations, and preferred that local public health authorities devise education programmes instead. Facing the prospect of mandatory testing, the destruction of community institutions, and the possible identification and isolation as HIV-positive individuals, gay men thus prepared themselves for a fight to retain the rights and public acceptance that they had slowly but steadily gained during the previous twenty years.

The expected backlash against homosexuality did not occur, however, and with the exception of the conservative states of Queensland and Tasmania, Australian state and federal governments deviated from the American model and privileged the role of community-based organisations over that of doctors, researchers and legislators. Indeed, they proved themselves to be remarkably unreceptive to the claims made by proponents of the 'traditional' model of infectious disease control, and moralists who conflated homosexuality with disease. They accepted that HIV/AIDS posed an exceptional challenge for society and government as it primarily affected marginalised communities who had a historical distrust of medical authorities and who had demonstrated an unwillingness to

Stephens, 'Fear of AIDS Has Forced Changes to Sexual Attitudes, Survey Finds', *Age*, 4 May 1987, p.5.) I discuss the results of these and other opinion surveys in Chapter 4.

modify their behaviour to conform with laws and regulations. Australian health ministers thus sought to incorporate representatives of these communities into a partnership with government and medical experts in order to seek their advice and expertise in communicating with, and educating, people at risk. The result was an approach to AIDS prevention that stressed the need for community participation and education rather than the identification of infected individuals through widespread testing and the curtailment of their activities through coercive laws. Instead of promoting abstinence and relying on prohibition, Australian public health authorities and community-based organisations sought to inculcate a sense that everybody was at risk from AIDS, but that this risk could be minimised – regardless of the lifestyle that one led – by the adoption of safe sexual and drug use practices.

Thus by the end of 1987, Australian state and Commonwealth governments were funding targeted education campaigns that extolled the virtues of (safe) anal intercourse in glossy posters and pamphlets and supported the promotion of condom use on prime-time television. Comprehensive sex-and-AIDS education courses were introduced in state (and most private) secondary schools, and nearly all of the Australian states established needle and syringe exchange outlets, some of which were staffed by sex workers and drug users. Exactly how this was achieved, when it looked likely that the public's fears of AIDS would see the prohibition of drug use and prostitution more tightly enforced and the rights of gay men and 'AIDS carriers' severely diminished, is the central concern of my thesis.

Thematically, I explore the way in which pre-existing cultural understandings framed the production of knowledge about, and responses to, AIDS. That is, I demonstrate how pre-existing narratives and myths about sex work, injecting drug use, homosexuality and the nature of 'infectious' disease informed and shaped public, political and medical responses to AIDS and the communities most affected by the epidemic. Rather than responding to AIDS as a physiological disorder caused by a viral agent, many Australians were guided by their preconceptions of the type of people likely to become infected with HIV and the probability that these people would transmit the disease to others. Individuals who were imagined to be irresponsible and selfish, such as homosexuals and injecting drug users, or historically deemed to be 'pools of infection' and 'vectors of disease transmission', such as prostitutes, were believed by some to pose the greatest threat and thus were in need of surveillance and control. Hence the calls for the implementation of coercive public health

laws and widespread HIV-antibody testing that I outlined above and which I discuss in detail in Chapter 4.

Drawing upon different memories and personal experiences, other Australians – not least the communities most affected by HIV – conceptualised the virus and individuals ‘at risk’ in a different way. Rather than viewing HIV as a highly ‘infectious’ or ‘contagious’ disease, and grouping it with typhoid and tuberculosis, they classified HIV as a blood-borne virus that was extremely difficult to transmit. Its prevention lay in the use of condoms and the provision of sterile needles and syringes, they argued, rather than punitive or coercive measures. They also conceptualised gay men, prostitutes and injecting drug users in a contrasting manner. Instead of imagining them as wilful creatures seeking pleasure and thoughtlessly spreading AIDS to unsuspecting victims, they considered them to be willing and able to modify their behaviour given access to information and the means to act upon it.

The way in which AIDS and the communities most at risk were ‘constructed’ or represented is not of idle interest. As Susan Sontag, Douglas Crimp and Paula Treichler have suggested with reference to the United States, and I demonstrate throughout my thesis, these representations had very real effects in terms of public policy and public attitudes.¹⁶ They determined whether gay men, prostitutes and injecting drug users would be feared and loathed, or trusted and incorporated into the public health response, and whether they would be kept under surveillance and controlled or provided with funds and resources to protect themselves. Accordingly, the ‘social construction’ of AIDS and gay men, prostitutes and injecting drug users underpinned the different approaches that were suggested to prevent the spread of HIV and inevitably affected the number of lives lost to AIDS.

Australia’s approach to AIDS prevention became recognised as one of the most innovative and successful in the world because politicians and, I think one can argue, doctors and the public, came to consider gay men, prostitutes and injecting drug users as they, and their

¹⁶Susan Sontag, *Illness as Metaphor and AIDS and its Metaphors*, London: Penguin, 1991; Douglas Crimp, ‘AIDS: Cultural Analysis/Cultural Activism’, in Douglas Crimp (ed.), *AIDS: Cultural Analysis/Cultural Activism*, Cambridge: MIT Press, 1988, pp.3-16; and Paula A. Treichler, ‘AIDS, Homophobia and Bio-medical Discourse: An Epidemic of Signification’, in *ibid.*, pp.31-70.

supporters, imagined themselves: as trustworthy. They were persuaded to do so because these often maligned social groups proved themselves to be responsible and committed to the fight against AIDS by mobilising quickly and adopting their own innovative strategies aimed at preventing the transmission of HIV among their members. They raised funds, devised educational materials, held forums and workshops and sought alliances with sympathetic medical professionals and politicians. They angrily refuted the notion that they were recklessly spreading disease and deliberately poisoning the blood supply, and proved themselves to be caring and committed lovers and friends by tending to the sick and frightened. Their actions defied the stereotypical representation of them as hedonistic, selfish and irresponsible pleasure seekers.

In comparison to their American counterparts, the communities most affected by AIDS in Australia were more successful in mobilising and proving their commitment to their own health and the well-being of others, in part because the epidemic in this country effectively began eighteen months after that in the United States. This crucial period gave gay men and sex worker organisations time to understand what was required of them, and to plan strategies to counter the expected community backlash. Governments also benefited from this window of opportunity, through which they observed the mistakes made by civic leaders in America. During a research trip to the United States in January 1985, for example, Neal Blewett, the Commonwealth Minister for Health between 1983 and 1990, was able to witness the effect of the Reagan administration's reluctance to speak frankly about safe sex or finance AIDS prevention initiatives within the homosexual community. Touring an AIDS ward of a public hospital, and speaking with frustrated doctors and community-based AIDS workers, he glimpsed the consequences of HIV prevention policies constrained by moralism. Similarly, Australian AIDS advisory committees were able to read reports of HIV spreading rapidly through injecting drug using populations in America and Scotland before they had to deal with this reality in Australia. They thus became convinced that an innovative approach to HIV prevention, which utilised the communication skills and energy of community-based organisations, would be required to combat AIDS.

There was also an element of pragmatism in the approach taken by politicians and public health authorities. They were eventually convinced that HIV posed an exceptional problem as it predominantly affected marginalised individuals and communities – especially gay

men – who were historically distrustful of doctors and legislators, and who had demonstrated a reluctance to alter their behaviour regardless of laws requiring them to do so. As High Court Justice Michael Kirby stated: “Law and the risk of punishment are usually the last things on the minds of people in the critical moment of pleasure.”¹⁷ Politicians and public health authorities also came to accept that there was little incentive for ‘high risk’ individuals to contact doctors because medical researchers could not offer a cure for AIDS and, until the late 1980s, could not provide drug therapy to delay the onset of the syndrome. Conversely, there was a significant disincentive to be identified as ‘at risk’ or ‘infected’ as it carried the possibility of discrimination and ostracism. Thus, as Neal Blewett acknowledged, an approach to AIDS control that relied on testing was likely to drive individuals away from health services.¹⁸ Instead, government had to build a partnership of trust with medical professionals and the communities most affected by AIDS, and empower gay men, drug user groups and sex worker organisations to become the vanguard in the fight against AIDS.

By the end of the 1980s, Australia’s approach to AIDS prevention was being hailed as a ‘model’ for other countries to emulate by Dr Jonathan Mann, Director of the World Health Organisation’s Global Program on AIDS.¹⁹ Australia certainly proved to be more successful than most countries in preventing the spread of HIV. For instance, AIDS has remained relatively confined to the homosexual communities of Australia’s large cities where it first appeared. As Table 1.1 indicates, men-who-have-sex-with-men have accounted for over 80% of HIV infections and AIDS deaths throughout the epidemic, while in most other industrialised countries this figure has rapidly decreased as greater numbers of heterosexuals have become infected.²⁰ In effect, the so-called ‘second wave’ of HIV infection, which has devastated injecting drug users, their sexual partners and their children in countries such as Scotland, Spain, Italy and the United States, has been

¹⁷Justice Kirby quote in New South Wales Department of Health AIDS Bureau, ‘HIV Prevention in New South Wales: Status Report on AIDS Health Promotion’, unpublished report, 1991, Noel Butlin Archives Centre, National AIDS Archive Collection, Australian National University, H5/5(7).

¹⁸Neal Blewett, ‘Valuing the Past...Investing in the Future’, *Australian and New Zealand Journal of Public Health*, vol.20, no.4, 1996, p.344.

¹⁹Philip McIntosh, ‘Australia’s Response to AIDS Epidemic: A Model for Others’, *Age*, 21 July 1987, p.9.

²⁰National Centre in HIV Epidemiology and Clinical Research, *HIV/AIDS, Hepatitis C and Sexually Transmissible Infections in Australia Annual Surveillance Report 2000*, Sydney: NCHECR and the University of New South Wales, 2000, p.29, 34, 36.

prevented in this country. There have also been relatively few cases of HIV acquired through heterosexual intercourse, and none during commercial sex transactions. People with haemophilia in Australia have been severely affected by AIDS, however, with nearly 30% of those who treated their blood coagulation disorders with blood products between 1980 and the end of 1984 developing AIDS. A further 228 people acquired HIV from contaminated blood transfusions and organ transplants during surgery in this period. But only one person has been infected in this manner since the end of April 1985, when Australia became the first country in the world to screen its blood supply and all blood donations.

Considering the overall epidemiological picture of AIDS in Australia (Figure A), then, it is apparent that the number of new HIV infections per year dropped rapidly after 1984, and has remained steady at around 480 new infections per year during the last decade.²¹ Whereas Australia ranked third or fourth out of twenty-four OECD countries in terms of the number of AIDS cases per capita in the early 1980s, by 1991 its efforts towards AIDS prevention had seen it drop to eighth.²²

A comprehensive assessment of Australia's response to AIDS, and an explanation of how these results were achieved, should thus prove illuminating to those public policy-makers and community leaders in Australia who are still reluctant to trust and empower marginalised communities to care for themselves. My narrative should also prove informative for those who scorn 'harm minimisation' approaches to social and health problems such as drug use.²³ The history of Australia's response to AIDS also offers

²¹*Ibid.*; and Commonwealth Department of Health and Family Services, *Building on Success 1: A Review of Gay and Other Homosexually Active Men's HIV/AIDS Education in Australia*, Canberra: Commonwealth Department of Health and Family Services, 1998, p.29.

²²Alex Wodak, 'The Epidemic That Australia Does Not Have To Have', *Today's Life Science*, 1992, vol.4, pp.26-30; and National Evaluation Steering Committee, *Report of the Evaluation of the National HIV/AIDS Strategy*, Canberra: AGPS, 1992, cited in David Hawks and Simon Lenton, 'Harm Reduction in Australia - Has it Worked?: A Review', *Drug and Alcohol Review*, vol.14, 1995, p.296.

²³Elsewhere I have suggested how proponents of supervised injecting rooms, which aim to prevent the deaths of drug users who overdose while injecting heroin, might draw on the success of Australia's needle and exchange programme to demonstrate the way in which drug use can be made safer without leading to social catastrophe. The provision of free sterile needles and syringes, for example, did not result in an increase in drug use, nor represent the sanctioning of such activity, as opponents of the scheme proclaimed in 1986 and 1987. Yet these arguments are still used today to prevent the implementation of other 'harm reduction' initiatives. See Paul Sendziuk, 'Diving Under the "Second Wave": Harm Minimisation Approaches to Drug Use and HIV Prevention in Australia', *Health and History*, forthcoming, September 2001 (a revised version of Chapter 7).

Table 1.1: Characteristics of cases of newly diagnosed HIV infection 1985-1990 by year, exposure category and proportion of total cases.

Risk Category	1985	1986	1987	1988	1989	1990
Homosexual/bisexual contact	83.5	84.0	86.0	83.3	80.7	79.3
Homosexual/bisexual contact and IDU	2.1	2.7	3.2	2.0	3.1	3.0
Injecting Drug Use	2.5	5.0	4.9	7.4	6.7	6.5
Heterosexual contact	1.3	2.0	3.0	5.1	7.2	9.5
Haemophilia	7.8	4.2	1.5	0.6	0.3	0.1
Receipt of blood transfusion or tissue	2.6	2.0	1.3	1.5	1.6	1.4
Mother to child	0.2	0.1	0.1	0.1	0.4	0.2

Note: HIV-antibody testing was not available before 1985. Cases of HIV infection are denoted by year of diagnosis and have not been back-dated to the year of actual infection. The exposure category of a number of cases was undetermined. These cases have been excluded from the calculation of percentages.

Source: National Centre in HIV Epidemiology and Clinical Research, *Australian HIV Surveillance Report*, vol.10, no.2, April 1994, p.8.

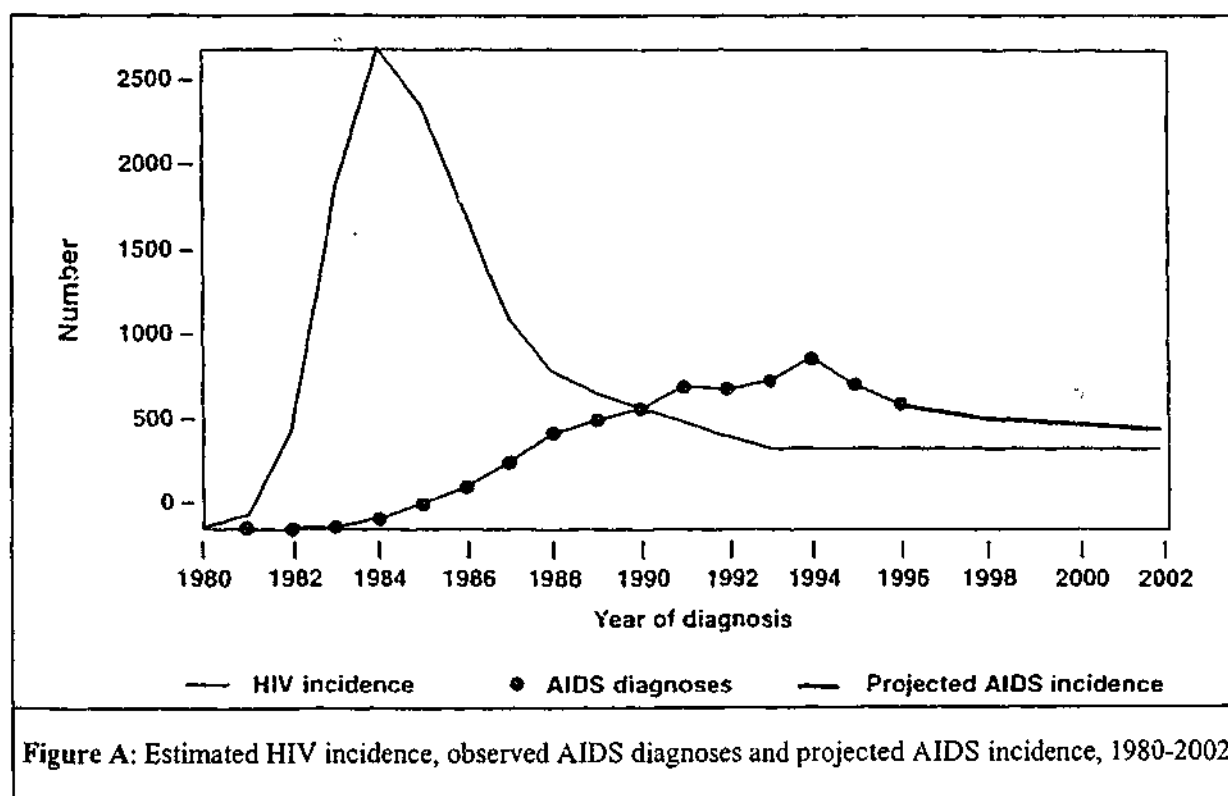


Figure A: Estimated HIV incidence, observed AIDS diagnoses and projected AIDS incidence, 1980-2002.

Note: HIV and projected AIDS incidence estimated by back-projection. Observed AIDS diagnoses adjusted for reporting delay.

Source: Commonwealth Department of Health and Family Services, *Building on Success 1: A Review of Gay and Other Homosexually Active Men's HIV/AIDS Education in Australia*, Canberra: Commonwealth Department of Health and Family Services, 1988, p.29.

valuable lessons for health authorities in other countries that are struggling to contain the spread of HIV infection. Although limited access to resources and fear of sacrificing crucial details about Australia's approach has prohibited me from undertaking a comprehensive comparative study, I have highlighted points where Australia's approach to AIDS in the 1980s differed from that of other countries. Overseas readers who are familiar with their own government's response to AIDS will also instantly recognise Australia's points of departure. I offer this dissertation therefore as a case study of an effective and, eventually, enlightened response to AIDS that complements existing national histories of the epidemic provided by Virginia Berridge and Simon Garfield (Britain), Theo Sandfort *et al.* (the Netherlands), and Ronald Bayer, Elinor Burkett and John-Manuel Andriote (the United States of America).²⁴

Of these national histories, Berridge's *AIDS in the UK* is the most thorough chronicle of political responses to the epidemic. She categorises AIDS policy-making in Britain into four periods: the first, a period of inaction and low-level funding; the second, a phase of "war-like" mobilisation that began at the end of 1986 and was characterised by extensive funding for AIDS education; the third, a "normalisation" stage in which HIV/AIDS became positioned as a chronic illness and lost the media's attention; and finally the current period of uncertainty in which Britain's pragmatic and consensual approach to AIDS is threatened by conservative forces. Australian politicians responded in a similar manner, although they were roused into action almost two years earlier than their British counterparts for reasons that I explain in Chapter 3. Berridge also claims that AIDS policy-making in Britain was guided by an existing social policy agenda, and thus cannot be characterised as particularly exceptional. For example, she notes that 'harm minimisation' strategies aimed at combating health problems associated with drug use were already accepted in *principle* by government and were awaiting implementation. Politicians and health authorities were finding it difficult to sell these ideas to the public, however, until the threat of AIDS provided them with a mandate to turn innovative policy into practice.

²⁴Virginia Berridge, *AIDS in the UK: The Making of Policy, 1984-1994*, Oxford: Oxford University Press, 1996; Simon Garfield, *The End of Innocence: Britain in the Time of AIDS*, London: Faber and Faber, 1994; Theo Sandfort (ed.), *The Dutch Response to AIDS: Pragmatism and Consensus*, London: UCL Press, 1998; Ronald Bayer, *Private Acts, Social Consequences: AIDS and the Politics of Public Health*, New York: Free Press, 1989, Elinor Burkett, *The Gravest Show on Earth: America in the Age of AIDS*, Boston: Houghton Mifflin Company, 1995, and John-Manuel Andriote, *Victory Deferred: How AIDS Changed Gay Life in America*, Chicago: University of Chicago Press, 1999.

As I argue in Chapter 5, Australia's approach to AIDS certainly benefited from the Labor Party's long-standing ideological commitment to community participation and community health centres, but in most other aspects Australian AIDS policy-making was clearly exceptional. Throughout my account, for instance, I stress that Australia may well have followed the example of the United States or reacted favourably to the public's frightened call for sanctions against 'high risk groups' and people with AIDS. Most Australian governments refused to do so because of the unique nature of the virus, the difficulty of securing the trust and co-operation of affected communities, and the extraordinary work of community-based groups, activists and individual politicians and bureaucrats who refused to treat AIDS as just another health problem.

In comparison to Simon Garfield's account, Berridge diminishes the significance of the role played by activists and affected communities in shaping the nature of AIDS policy and the epidemic in Britain. Despite occasionally peeking from the meeting rooms of advisory committees, her focus remains on politicians and bureaucrats. In contrast, I emphasise the centrality of community-based organisations, and pay less attention to the minute workings of government, because I believe it was primarily their contribution that enabled Australia to limit the spread of HIV. In comparison to both Berridge and Garfield, I also develop a more sustained discussion of Australian cultural responses to AIDS and the way in which people with AIDS were represented in public discourse and education campaigns. As I have suggested already, analysis of these representations is crucial to understanding why Australians responded in the manner that they did. A close reading of the 'texts' – produced by doctors, politicians, journalists, activists and artists – which imaginatively constructed people with AIDS therefore underpins my account.

Although arranged chronologically to tell the story of AIDS in Australia in the 1980s, each of my chapters examine a contentious issue or debate that captured the public's attention. Generally these discussions are centred on the possibility of containing the spread of HIV within a particular group such as gay men, people with haemophilia (Chapter 2), heterosexually active Australians (Chapter 6), injecting drug users (Chapter 7) and sex workers (Chapter 8). Theo Sandfort's edited collection of essays on the Dutch response to AIDS is structured in a similar way but lacks an overarching chronological narrative due to its multi-authored nature.

John-Manuel Andriote's recent book also addresses the difficulties of curtailing the spread of AIDS in different 'high risk' populations. The author's main purpose, however, is to chronicle the impact of AIDS on gay life in America. A similar book is yet to be written in Australia, although Graham Willett and Dennis Altman have provided useful chapter-length studies of the way in which AIDS has changed the lives of gay men and gay community institutions in this country.²⁵ Andriote describes the way in which American homosexuals and their supporters quickly mobilised to lobby their reluctant federal government and raise money for the education and support services that they established. He recalls, for example, the founding and evolution of New York's Gay Men's Health Crisis, the first of a series of gay-community based AIDS organisations which became models for health care provision and information exchange in America and other countries such as Australia. Throughout his account, Andriote maintains that gay men were fighting against two forces: a deadly disease and the ignorance, indifference and homophobia which delayed the federal government's response and inhibited the implementation of effective AIDS-prevention initiatives. He thus counters the approach of Elinor Burkett who misunderstands the claims of AIDS activists when asserting that "AIDS is not caused by avarice, indifference, opportunism, careerism or homophobia. As best we know, it is caused by a virus."²⁶ While this may be literally true, one's likelihood of HIV infection – and thus the *incidence* of disease – largely depends upon the political will to provide information about safe sexual and drug injection practices as well as the means to act upon it. In some cities this political will has been sadly lacking among politicians who failed to see beyond the stereotypes of 'poofers, junkies and whores' as selfish, reckless and untrustworthy, or who solicited the votes of moral and religious conservatives by denouncing explicit sex education and needle and syringe exchange programmes. Thus, while the HIV molecule is not a 'social construct', the incidence of HIV infection and the extent of the AIDS epidemic is clearly the product of values, community prejudices and competing agendas.

²⁵Graham Willett, *Living Out Loud: A History of Gay and Lesbian Activism in Australia*, Sydney: Allen and Unwin, 2000, particularly pp.166-95; Dennis Altman, 'Legitimation Through Disaster: AIDS and the Gay Movement', in Elizabeth Fee and Daniel M. Fox (eds), *AIDS: The Burdens of History*, Berkeley: University of California Press, 1988, pp.301-15; and Altman, 'AIDS and the Reconceptualization of Homosexuality', in Allan Klusacek and Ken Morrison (eds), *A Leap in the Dark: AIDS, Art and Contemporary Cultures*, Montreal: Vehicule Press, 1992, pp.32-43.

²⁶Elinor Burkett, *The Gravest Show on Earth: America in the Age of AIDS*, Boston: Houghton Mifflin Company, 1995, p.16.

Andriote's book complements Ronald Bayer's earlier study of AIDS and the politics of public health in the United States. Although written before the commercial release of AZT (sections of the book, which was published in 1989, first appeared in 1985), it remains one of the most perceptive analyses of the philosophical issues raised by the epidemic. Bayer understands the arguments about HIV prevention in America to be underpinned by the fundamental tension between protecting the rights of the individual and safeguarding the health of the wider community.²⁷ The rhetoric of AIDS activists, doctors, public health officials and conservative community leaders was certainly cast in these terms as they clashed over proposals to implement compulsory HIV-antibody testing, the closure of gay bathhouses in San Francisco and New York City, and the exclusion of 'high risk' blood donors. As I explain in Chapters 2 and 4, similar measures were proposed and contested in Australia, with gay activists initially appearing keen to mimic the arguments of their American counterparts by demanding protection of their civil rights. After being banned from donating blood in May 1983 and learning more about the virus, however, they changed their strategy and set about proving that the dichotomy between protecting individual rights and safeguarding the public's health was illusory. For instance, gay activists and community-based organisations opposed legislation that sought to make HIV infection notifiable by name and address by claiming that such a law would deter individuals from taking the HIV-antibody test, thus keeping them out of reach of health services. Conversely, they claimed, notification of HIV status by code, strict confidentiality agreements and anti-discrimination laws, which protected one's right to privacy, encouraged individuals to come forward for testing and counselling.

Ronald Bayer clearly recognised the value of providing national case studies for comparison (and perhaps, national conscious-raising) as he co-edited two other books in the 1990s which detailed the responses to AIDS by different countries.²⁸ John Ballard, a political scientist at the Australian National University, provided the chapter-length case studies of Australia's response to AIDS in each of these volumes and I am indebted to his

²⁷See, for example, Ronald Bayer, 'AIDS and the Gay Community: Between the Spectre and the Promise of Medicine', *Social Research*, vol.52, no.3, 1985, pp.581-606.

²⁸David L. Kirp and Ronald Bayer (eds), *AIDS in the Industrialized Democracies: Passions, Politics and Policies*, New Brunswick: Rutgers University Press, 1992; and Eric A. Feldman and Ronald Bayer (eds), *Blood Feuds: AIDS, Blood and the Politics of Medical Disaster*, New York: Oxford University Press, 1999.

pioneering work.²⁹ Along with Dennis Altman and Deborah Lupton, he remains the only author to chronicle Australia's response to AIDS in more than a cursory manner.³⁰ Drawing on archival collections of AIDS documents and ephemera, and interviews collected by the National Library of Australia for the 'Australian Responses to AIDS' oral history project – both of which were largely unavailable to Ballard – I have substantially expanded on the issues he raises and revised some of his conclusions. I have also discussed topics and events which Ballard overlooks, such as the impact of HIV on the everyday lives of people with haemophilia, the battle to implement needle and syringe exchange programmes and the response to AIDS by Australian artists and sex worker organisations.

My account of the impact of AIDS on the haemophilia community is drawn largely from primary sources, as this group has yet to attract the attention of scholars in Australia. Despite having a claim to be the community most affected by AIDS – nearly 22% of people with haemophilia were infected with HIV in the early 1980s – Australia is still waiting for an equivalent of Susan Resnik's wide-ranging, if somewhat partial, history of AIDS and haemophilia in the United States.³¹ Best-selling novelist Bryce Courtenay, whose son Damon died of AIDS in 1991, has written a long account of his son's battle with haemophilia and HIV, but it is an impressionistic tale prone to exaggeration and factual error.³² Written soon after Damon's death, Courtenay's anger, and his own sense of failure as a father, transformed what might have been a provocative insight into a community beset by tragedy into a bitter denouncement of Australia's medical system and

²⁹John Ballard, 'Australia: Participation and Innovation in a Federal System', in Kirp and Bayer (eds), *AIDS in the Industrialized Democracies*, pp.134-67; and Ballard, 'HIV-Contaminated Blood and Australian Policy: The Limits of Success', in Feldman and Bayer (eds), *Blood Feuds*, pp.243-70.

³⁰In addition to his writings on AIDS and its impact upon the homosexual community, Altman has published two full-length books about the AIDS epidemic. The first was published in 1986, and mainly chronicles the response to AIDS by the public, the press and health authorities in the United States. The second book details the response to AIDS by community-based organisations, although it has little to say about such groups in Australia during the period that I am writing about. (Dennis Altman, *AIDS in the Mind of America*, New York: Doubleday Books, 1986; and Altman, *Power and Community: Organizational and Cultural Responses to AIDS*, London: Taylor and Francis, 1994.) Deborah Lupton has analysed the way in which discourse about AIDS was framed in the Australian press, and has also examined the construction of 'risk' in mainstream AIDS education campaigns. I critique Lupton's work in relation to the second of these themes in Chapter 6. (Deborah Lupton, *Moral Threats and Dangerous Desires: AIDS in the News Media*, London: Taylor and Francis, 1994; and John Tulloch and Deborah Lupton, *Television, AIDS and Risk: A Cultural Studies Approach to Health Communication*, Sydney: Allen and Unwin, 1997.)

³¹Susan Resnik, *Hemophilia, AIDS and the Survival of a Community*, Berkeley: University of California Press, 1999.

³²Bryce Courtenay, *April Fool's Day* [1993], Melbourne: Mandarin, 1994.

a treatise on parenting. The author, for example, remains a brooding central character throughout the book, but has little to say about the experience of Damon's mother, Benita. Yet my research suggests that it is women such as Benita who have the most profound stories to tell. For it is mothers who have traditionally accepted the responsibility of treating their sons' bleeding episodes, and who thus live with the almost unbearable knowledge that they administered the contaminated blood products that infected their sons. This burden weighs most heavily on women who, as asymptomatic carriers of the haemophilia gene, experience an existing sense of guilt for transferring the disease to their sons. In telling the stories of these women, I have largely relied upon the observations and personal experience of Jennifer Ross who, as President of Haemophilia Foundation Australia for over twenty years, chronicled the everyday struggles of people with haemophilia in her monthly newsletter. I am also grateful to Mrs Ross for granting me an interview and allowing me to access her personal papers and the files of the Haemophilia Foundation.

My accounts of the battle to implement needle and syringe exchange programmes in Australia, and the response to AIDS by Australian artists and sex worker organisations, are also largely drawn from primary sources and interviews which the National Library and I have undertaken. Dr Alex Wodak, Director of the Drug and Alcohol Service at St Vincent's Hospital in Sydney, and Ted Gott, former curator at the National Gallery of Australia, are the only other authors to chronicle the response to AIDS by drug authorities and Australian artists in any detail. Until now, Professor Marcia Neave, former member of the National Advisory Committee on AIDS, has been the only scholar to explore thoroughly issues relating to AIDS in the sex industry.³³ Of these authors, only Neave employs what might be termed a historiographical approach, in which she considers the social, political and historical context of events she describes, and identifies the pre-existing discourses and representations that underpinned the public and political responses to the threat of AIDS in the sex industry. Wodak and Gott, on the other hand, write from

³³See, for example, Alex Wodak and Peter Lurie, 'A Tale of Two Countries: Attempts to Control HIV Among Injecting Drug Users in Australia and the United States', *Journal of Drug Issues*, vol.27, no.1, 1996, pp.117-34; Ted Gott, 'Agony Down Under: Australian Artists Addressing AIDS', in Ted Gott (ed.), *Don't Leave Me This Way: Art in the Age of AIDS*, Canberra: National Gallery of Australia, 1994, pp.1-35; Gott, 'Sex and the Single T-Cell: The Taboo of HIV-Positive Sexuality', in Jill Julius Matthews (ed.), *Sex in Public: Australian Sexual Cultures*, Sydney: Allen and Unwin, 1997, pp.139-46; and Marcia Neave, 'AIDS and Women in the Sex Industry - Legal Approaches to Public Health', *Community Health Studies*, vol.13, no.4, 1989, pp.423-30.

the perspective of participants and chronicle events that they helped to bring about. Their contributions tend to be descriptive rather than analytical, a perspective that my work brings.

Although I originally intended to extend my study of Australian responses to AIDS until the present day, the complexity of the issues which I describe has led me to confine my discussion to the first decade of the epidemic. This was certainly the most crucial period in determining Australia's overall response to AIDS, as the principles established during this time became enshrined in the first, and subsequent, national HIV/AIDS strategies. The fact that these strategy documents, first released in August 1989 and thereafter at three yearly intervals, closely resemble each other reflects the importance of ascertaining how these principles were forged. My focus on the 1980s, however, prevents me from discussing a number of interesting issues that were only beginning to emerge at the end of this period. Regretfully, therefore, I do not comment on the controversies surrounding the introduction and availability of drug therapies, the emergence of a powerful People Living With AIDS movement, or the repositioning of HIV/AIDS as a chronic illness in the 1990s. Also worthy of note is the fact that community-based AIDS organisations began to transform their structure and philosophy at the start of the 1990s.³⁴ Their relationship with government also changed once the Labor Party lost power at a national and state level in the mid-1990s. These are important events and issues to which I hope to turn at another time.

As a means of concluding my examination of the representation of AIDS and individuals at 'high risk', I have extended the chronological scope of my dissertation in the final chapter to discuss the way in which Australian artists and cultural producers responded to AIDS. Australian artists became involved in the epidemic at the end of 1980s and in the early 1990s after making contact with the communities most at risk and personally experiencing the tragedy of AIDS. They were also responding to opinion polls which suggested that many members of the public still imagined people with AIDS to be dangerous, the

³⁴Dennis Altman and Nancy Stoller, for example, argue that the need to win the confidence of government led community-based organisations to become 'bureaucratized' and less responsive to the needs of the communities from which they derive and predominantly serve. This has resulted in tension between volunteers and management staff. See Altman, *Power and Community: Organizational and Cultural Responses to AIDS*, London: Taylor and Francis, 1994; and Stoller, *Lessons from the Damned: Queers, Whores and Junkies Respond to AIDS*, New York: Routledge, 1998.

epidemic to be a threat to others rather than themselves, and gay men, sex workers and drug users to be diseased and deserving. These myths and stereotypes undermined the level of public sympathy and support for Australia's innovative and humane response to AIDS, and artists understood that Australia's successful approach to HIV prevention remained under threat whilst these inaccurate representations went unchallenged. Chapter 9 therefore examines how artists addressed the problems of representation that underpinned Australian responses to AIDS.

Chapter 1.

"Anally Injected Death Sentence": The 'Homosexual Lifestyle' Hypothesis and the Social Construction of Knowledge about AIDS

The deceptively simple and common-sensical notion that a virus, the Human Immunodeficiency Virus, was the causative agent for AIDS has been with us for so long now – standing relatively impervious to challenge – that it belies the intense uncertainty and debate concerning the origins of AIDS which gripped the public after the syndrome was discovered in 1981. Before the virus hypothesis was established and accepted in 1983 and 1984, scientists, medical reporters and members of the communities most affected by AIDS were frantic in their efforts to find and explain the transmissible agent or behavioural pattern which caused the deadly new syndrome. Some theories were more credible than others. The American public, for example, was told that AIDS was created by biomedical scientists at the Centers for Disease Control in an effort to generate funding for their activities; that AIDS was part of a capitalist scheme to create new markets for pharmaceutical products; that AIDS was the result of genetic mutations caused by "mixed marriages"; and that AIDS was actually an ancient plague stored in King Tutankhamen's tomb which was unleashed in America when the Tutankhamen exhibit toured the United States in 1976.¹ Australians, like the American public, also heard the old chestnut: that AIDS was the Wrath of God, punishment for the depraved activities of homosexuals (here, the acronym 'WOG' – a euphemism for illness – seemed fitting). They also heard its New Age equivalent: that AIDS was a subconsciously-triggered immunosuppression stimulated by intense feelings of guilt about the present or past sexual lives of people with AIDS.²

In August 1983, an officially sanctioned Chinese newspaper described AIDS as a "capitalist disease" which represented "the decay, decadence and moral degeneracy of the

¹Paula A. Treichler, 'AIDS, Homophobia and Biomedical Discourse: An Epidemic of Signification', in Douglas Crimp (ed.), *AIDS: Cultural Analysis/Cultural Activism*, Cambridge: MIT Press, 1988, pp.32-3. Other early theories about the origins of AIDS are recounted in Douglas A. Feldman and Julia Wang (eds), *The AIDS Crisis: A Documentary History*, Westport: Greenwood Press, 1998, pp.1-5; and Edward Hooper, *The River: A Journey Back to the Source of HIV and AIDS*, London: Penguin, 2000, pp.151-69.

²See, for example, Louise L. Hay, *You Can Heal Your Life*, Santa Monica: Hay House, 1984.

West".³ The report implied that Western capitalism inevitably led to selfishness, personal gratification and indulgence – the cult of the individual of which homosexuality was the highest expression, and AIDS the inevitable end point.

The world's other great Communist power, the Soviet Union, viewed the origins of AIDS in a different but no less antagonistic way. A cartoon taken from an article in the official Soviet newspaper, *Pravda*, in November 1986, reveals that the Soviets viewed AIDS to be an American biological weapon gone wrong: a virus manufactured by biological warfare specialists at Fort Detrick, Maryland, which had escaped from its laboratory confines to destroy its creator (see Figure 1.1). The cartoon depicts an American General paying for a test-tube of AIDS virus supplied to him by a venal-looking scientist. Swimming about in the test-tube, representing the Marxist-Leninist equation of America with fascism, are a multitude of tiny swastikas; the dead, the victims of AIDS, are represented as bare feet, echoing the photographs of concentration camp victims.⁴

I recount these theories not because they were particularly prevalent, or had much impact on thinking about AIDS in Australia, but because they embody, in a simple manner, the way in which the construction of new knowledge is constrained and shaped by ideological imperatives and pre-existing arguments and narratives – about the corrupt nature of scientists, the repercussions of permissive sexual and racial attitudes, the inherent evil of capitalism and the degenerate nature of homosexuality – all of which had little to do with AIDS itself. Moreover, they reveal a need to locate the origins or cause of AIDS in ways which lay the blame for its devastating consequences on *someone else*: something other, corrupt or unnatural, which could be tainted further or discredited by its link with AIDS. The debates in Australia concerning the origins of AIDS embodied both of these aspects of knowledge production.

³Cited in 'News Brief', *Campaign*, vol.94, October 1983, p.17.

⁴Sander L. Gilman, *Disease and Representation: Images of Illness from Madness to AIDS*, Ithaca: Cornell University Press, 1988, p.264. The *Pravda* article relied on the findings of a British-based American scientist, Dr John Seale, and an East German biologist, Professor Jakob Segal, who claimed that AIDS was manufactured in a US military research laboratory. Two Australian newspapers also published their findings ('AIDS Blamed On Lab Test That Went Wrong', *Age*, 28 October 1986, p.9; and Bryan Boswell, 'AIDS Virus "Made in US Laboratory"', *Australian*, 27 October 1986, p.5).



Figure 1.1: A Soviet Construction of the Origins of AIDS, *Pravda*, 1 November 1986.

Australians generally relied on scientists, doctors and medical reporters to inform them about AIDS and, on the whole, ignored the more unusual conspiracy theories about the origins of the syndrome to focus on two key hypotheses: that AIDS was caused by the 'homosexual lifestyle', and, later, that AIDS was caused by a virus which originated in Africa. While these theories emanated from more credible sources that were amenable to public and professional scrutiny, they were produced by a process of knowledge construction which differed little from that employed by the conspiracy theorists. Sections of Melbourne and Sydney's gay communities were not immune from this process and, while concerned with learning more about AIDS in order to save lives, they were often driven by other agendas, and political battles within the gay community, to suggest that the 'gay lifestyle' was the cause of AIDS.

The first medically documented cases of the condition later to be known as AIDS were published in the *Morbidity and Mortality Weekly Report* of the US Centers for Disease Control (CDC) during June and July 1981. These reports described how previously healthy men had developed Kaposi's sarcoma cancer (KS) or *Pneumocystis carinii* pneumonia (PCP), both of which were considered rare in the United States and seldom fatal.⁵ In 1981 they were devastating the patients under observation. The men also developed other symptoms and illnesses that, like the cancer and pneumonia, resulted from the breakdown of the body's immune system. As each of the men was homosexual, their condition was quickly dubbed GRID, or Gay-Related Immune Deficiency, although medical practitioners generally favoured the term CAID (Community Acquired Immune Deficiency). Here the term 'community' was a thinly veiled allusion to homosexuality, but if the practitioners were attempting to avoid the exclusive identification of the disease with homosexuality, they failed. Both terms became popular and contributed to the coining of the phrase 'the gay plague', which became the most prevalent identifier of the syndrome in the first few years of the epidemic even though the term AIDS was officially adopted in July 1982 (by

⁵CDC, '*Pneumocystis carinii* pneumonia - Los Angeles', *Morbidity and Mortality Weekly Report*, no.30, 5 June 1981, pp.250-2; and CDC, 'Kaposi's Sarcoma and *Pneumocystis* Pneumonia Among Homosexual Men - New York City and California', *Morbidity and Mortality Weekly Report*, no.30, 3 July 1981, pp.305-8. A gay newspaper, the *Sydney Star*, summarised the contents of these articles and became the first Australian newspaper to publish a report about AIDS in July 1981.

which time injecting drug users, women and recipients of blood products had died from AIDS).⁶

AIDS was thus clearly positioned as a disease of gay men and, as the first *Morbidity and Mortality Weekly Report* stated, it was thought to be caused by aspects of the homosexual lifestyle. This report, and the initial sequence of reported cases which centred on the homosexual community, framed the way in which the mainstream and gay press would write about AIDS in the first years of the epidemic, and set the paradigm within which medical researchers would work. It was not long before the 'homosexual lifestyle' hypothesis was being 'proved' with cohort studies and reported in the mainstream and gay press in Australia. Key researchers at the Centers for Disease Control had discounted this theory by the end of 1982, although other medical researchers, some doctors and the journalists who simplified their findings continued to perpetuate the idea that aspects of the 'homosexual lifestyle' caused AIDS until 1984.

There were variations on what constituted the 'homosexual lifestyle' hypothesis, with some proponents including or emphasising particular characteristics at the expense of others. In general, it was believed that homosexuals developed AIDS because they used 'poppers' (drugs such as amyl and butyl nitrate which served as sexual stimulants), suffered multiple exposures to sexually-transmitted diseases and their antibiotic remedies which weakened the body's immune system, and frequently had anal and oral sex.⁷ Semen, once ingested or absorbed into the body, was considered to be an immuno-suppressant.⁸

⁶The US Public Health Service decided upon the term 'AIDS' in July 1982. It was first used by the CDC in September ('Update on Acquired Immune Deficiency Syndrome (AIDS) - United States', *Morbidity and Mortality Weekly Report*, no.31, 24 September 1982, pp.507-8, 513-14).

⁷See, for example, David T. Durack, 'Opportunistic Infections and Kaposi's Sarcoma in Homosexual Men', *New England Journal of Medicine*, vol.305, 1981, pp.1465-7; J.J. Goedert, *et al.*, 'Amyl Nitrate May Alter T Lymphocytes in Homosexual Men', *Lancet*, no.1, 1982, pp.412-6; K.A. Jorgensen, 'Amyl Nitrate and Kaposi's Sarcoma in Homosexual Men', *New England Journal of Medicine*, vol.307, 1982, pp.893-4; M. Marmor, *et al.*, 'Risk Factors for Kaposi's Sarcoma in Homosexual Men', *Lancet*, no.1, 1982, pp.1083-7; Jay A. Levy and John L. Ziegler, 'Acquired Immunodeficiency Syndrome is an Opportunistic Infection and Kaposi's Sarcoma Results from Secondary Immune Stimulation', *Lancet*, 9 July 1983, pp.78-81; and Shyuan Hsia, *et al.*, 'Unregulated Production of Virus and/or Sperm Anti-Idiotypic Antibodies as a Cause of AIDS', *Lancet*, 2 June 1984, pp.1212-4.

⁸Carlos Navarro and Jack W.C. Hagstrom, 'Opportunistic Infections and Kaposi's Sarcoma in Homosexual Men', *New England Journal of Medicine*, vol.306, no.15, 1982, p.933. The authors asserted that human semen was "an antigenic nightmare" and a "potent immunosuppressor". Medical researchers also posited that

Some researchers were willing to recognise that a "transmissible agent" might be the underlying cause of AIDS and the reason for its spread, but asserted that immunosuppression and the onset of KS and PCP was precipitated by the effects of the 'gay lifestyle'.⁹

As Adam Carr pointed out in June 1983, in one of the first feature articles to be published about AIDS in an Australian gay magazine, the hypothesis completely ignored the fact that people who did not conform to the 'gay lifestyle' were also developing AIDS: "Heterosexual women from Zaire, elderly hemophiliacs in Alabama, ten-week old babies, [and] whole families of Haitians, certainly did not contract AIDS through the backroom bars of Manhattan or from using too many poppers".¹⁰ Moreover, the social habits of many heterosexual men and women were similar to the 'fast-track' lifestyle identified as deadly by the doctors, yet they were not developing the symptoms of AIDS in vast numbers. STDs and drug use were not uncommon amongst the heterosexual population, and a NACAIDS survey of 1986 indicated that 5% of heterosexual men and 4% of women had incorporated anal sexual intercourse into their love-making during the previous month. These figures are in aggregate more significant than the number of gay men having anal

AIDS might be caused by 'feminising practices' in which gay men engaged, such as the use of steroid and oestrogen creams. See Hans H. Neumann, 'Use of Steroid Creams as Possible Cause of Immunosuppression in Homosexuals', *New England Journal of Medicine*, vol.306, no.15, 1982, p.935; and Elismar M. Cortinho, 'Kaposi's Sarcoma and the Use of Oestrogen by Male Homosexuals', *Lancet*, vol.1, 1982, p.1362.

⁹This is known as the 'co-factor' theory, and was popularised by Dr Joseph Sonnabend and the influential *Journal of the American Medical Association*. See, for example, Joseph Sonnabend, Steven S. Witkin and David T. Purtilo, 'Acquired Immunodeficiency Syndrome, Opportunistic Infections, and Malignancies in Male Homosexuals: A Hypothesis of Etiologic Factors in Pathogenesis', *Journal of the American Medical Association*, vol.249, 6 May 1983, pp.2370-4; and Gene M. Shearer, 'Allogeneic Leukocytes as a Possible Factor in Induction of AIDS in Homosexual Men', *New England Journal of Medicine*, vol.308, 1983, pp.223-4.

¹⁰Adam Carr, 'The AIDS Epidemic', *Outrage*, vol.3, June 1983, p.16. On 11 June and 16 July 1982, the CDC reported cases of PCP and KS among injecting drug users and people with haemophilia respectively; and in December 1982 it reported cases of AIDS among people receiving blood transfusions, as well as infants and female sexual partners of men with AIDS. See CDC, 'Update on Kaposi's Sarcoma and Opportunistic Infections in Previously Healthy Persons - United States', *Morbidity and Mortality Weekly Report*, no.31, 11 June 1982, pp.294-301; CDC, 'Pneumocystis carinii Pneumonia Among Persons with Hemophilia A', *Morbidity and Mortality Weekly Report*, no.31, 16 July 1982, pp.365-7; CDC, 'Possible Transfusion-Associated Acquired Immune Deficiency Syndrome (AIDS) - California', *Morbidity and Mortality Weekly Report*, no.31, 10 December 1982, pp.652-4; CDC, 'Unexpected Immunodeficiency and Opportunistic Infections in Infants - New York, New Jersey, California', *Morbidity and Mortality Weekly Report*, no.31, 17 December 1982, pp.665-7; and CDC, 'Immunodeficiency Among Female Sexual Partners of Males with Acquired Immune Deficiency Syndrome (AIDS) - New York', *Morbidity and Mortality Weekly Report*, no.31, 7 January 1983, pp.697-8.

intercourse when one considers the size of the heterosexual population.¹¹ It should have also been apparent to doctors and journalists that the very notion of a 'gay lifestyle' was based on a misconception, as studies and anecdotal evidence strongly indicated that gay men varied considerably in their living habits and sexual practices. They certainly did not all have sex with vegetables, household appliances and family pets, as one article about AIDS in the *Bulletin* implied,¹² and only a tiny minority of homosexual men frequented bathhouses or had over "one thousand sexual partners per year" as was typically reported.¹³ Even before AIDS was medically documented, many gay men abstained from sex or preferred non-penetrative sex. AIDS never was a 'gay plague', nor was there any evidence, apart from the circumstances of the first reported cases, that it was caused by the 'homosexual lifestyle'.

Given the logical evidence against the 'homosexual lifestyle' hypothesis, one has to ask: why did gay men and their alleged lifestyles become and remain the focus of doctors and medical researchers, journalists, and sections of the gay community for so long? It is perhaps understandable that they equated the first *reported* cases of AIDS with the first cases to *occur*, thus locating the origins of AIDS in the homosexual populations of New York and Los Angeles, but why did the practices of gay men remain under such close scrutiny until 1984? As the doctors' condemnation of anal sex with multiple partners and the use of 'poppers' effectively amounted to a demand that gay men behave more like 'normal' heterosexuals, some commentators have been quick to explain the 'gay lifestyle' hypothesis as a manifestation of homophobia,¹⁴ or an attempt to subjugate gay sexuality to

¹¹Bill Taylor, 'The AIDS Campaign: Three Months On', unpublished report by the NSW Communicable Diseases Branch, Department of Health, 1988, p.6, AIDS Council of New South Wales archive, id: G6079.

¹²Glennys Bell, 'Disorders Peculiar to Homosexuals', *Bulletin*, 10 May 1983, p.23.

¹³See, for example, Michael Daly, 'New York: A City That Lives In Fear', *Weekend Australian Magazine*, 25-26 June 1982, p.1.

¹⁴See, for example, Randy Shilts, *And the Band Played On: Politics, People and the AIDS Epidemic*, New York: Penguin, 1988; and Treichler, 'AIDS, Homophobia, and Biomedical Discourse', pp.31-70. More recently, in a essay titled 'Trapped in a Woman's Body? The Persistence of Feminine Pathology in Biomedical Discourse Around HIV/AIDS', the Australian historian Spongberg has continued this line of thought (Mary Spongberg, *Feminizing Venereal Disease: The Body of the Prostitute in Nineteenth-Century Medical Discourse*, Basingstoke: Macmillan, 1997, especially pp.189-91).

the moral superiority of (healthy) heterosexual desire.¹⁵ Such interpretations do not explain, however, why gay doctors were propagating the 'homosexual lifestyle' hypothesis, nor why this theory was being vigorously supported by sections of the gay community. Other commentators have accused scientists, doctors and the media of being 'erotophobic' or 'sexphobic' (that is, of fearing the continuation of the kind of sexual permissiveness which characterised the late 1960s and the 1970s), and of being sexist (and thus misunderstanding the nature of women's bodies, which prevented medical researchers from recognising that women, as well as gay men, could contract and transmit HIV).¹⁶ While cases can be made for each of these factors, they fail to consider the kinds of constraints, specific to the early 1980s, under which medical researchers and doctors were working. One gains the impression from reading the accounts of Patton, Treichler and Donovan, that the response to AIDS would have differed little had the syndrome emerged at the end of the 1990s instead of 1981. This is clearly not the case. In being called upon to make a rapid diagnosis of a new and deadly illness of unknown origin, the Centers for Disease Control and epidemiologists in the United States, from whom Australian doctors and journalists were taking their lead, were constrained by methodological imperatives and predisposed to certain outcomes due to the research that they had undertaken at the end of the 1970s into the spread of sexually transmissible diseases and the behaviour of gay men. They were clearly influenced by a range of existing discourses, but these discourses were particular to the beginning of the 1980s and were not necessarily homophobic, erotophobic or sexist in nature.

It was not by accident that the CDC, and epidemiologists working within it, were the first to respond to the seemingly inexplicable cases of KS and PCP and establish a 'lifestyle' model of disease aetiology. The CDC was, and still is, responsible for monitoring morbidity and mortality trends in the United States and for responding to acute outbreaks of disease. In the absence of a putative causative agent of disease, epidemiologists are

¹⁵Raymond Donovan, 'The Plaguing of a Faggot, the Leperising of a Whore: Criminally Cultured AIDS Bodies and "Carrier" Laws', *Journal of Australian Studies*, vol.43, 1995, pp.110-24; and Treichler, 'AIDS, Homophobia, and Biomedical Discourse', p.49.

¹⁶See, for example, Cindy Patton, *Sex and Germs: The Politics of AIDS*, Boston: South End Press, 1985, pp.103-18; and Paula A. Treichler, 'AIDS, Gender, and Biomedical Discourse: Current Contests for Meaning', in Elizabeth Fee and Daniel M. Fox (eds), *AIDS: The Burdens of History*, Berkeley: University of California Press, 1988, pp.190-266.

called upon to identify sick people and the common links between them and their social and physical environments in the hope of isolating a causal factor or factors. Thus it was the CDC that Dr Michael Gottlieb contacted once he came across the first few cases of PCP amongst homosexual patients in Los Angeles. His paper to the CDC's *Morbidity and Mortality Weekly Report* was forwarded in May 1981 by Dr Mary Guinan to Dr James Curran, head of the CDC's venereal disease division, who returned it to her with the note: "Hot stuff, Hot stuff."¹⁷ Gottlieb's paper was published in the June edition of the *MMWR*, alongside an editorial note which suggested a link between the new diseases and "aspects of the homosexual lifestyle". This was an premature statement to make, given that only five cases within the homosexual population had been identified.¹⁸

The CDC's tenuous pronouncement did not originate from an epistemological vacuum, however. As I have pointed out, it was logical for epidemiologists, by virtue of their methodology, to look for, and suggest, common lifestyle factors between the men who were developing the fatal illnesses. Moreover, as Gerald Oppenheimer has explained, the CDC's decision to emphasise the association between disease and "aspects of the homosexual lifestyle" was likely to have been influenced by research that it had recently completed into risk factors for hepatitis B, a disease that can be sexually transmitted and whose prevalence was reaching epidemic proportions among gay men.¹⁹ The multi-year study involved the cooperation of a number of gay community health clinics in the United States, and found that blood markers for the disease were significantly associated with, among other factors, a high number of male sexual partners and sexual practices that involved anal contact. This cooperative study took place against a background of other

¹⁷Shilts, *And the Band Played On*, p.67.

¹⁸Steven Epstein claims that in a country with an expensive and inequitable health care system, gay men with KS and PCP were the first to come to the attention of doctors because they were relatively affluent and could afford to consult physicians and attend the major teaching hospitals. (Steven Epstein, *Impure Science: AIDS, Activism, and the Politics of Knowledge*, Berkeley: University of California Press, 1996, p.49.) In New York City, if not elsewhere, it appears likely that there were at least as many cases of PCP among injecting drug users as among gay men at the time of the discovery of the syndrome. (Cindy Patton, *Inventing AIDS*, New York: Routledge, 1990, pp.27-8.) Living in gay ghettos around Castro in San Francisco and Greenwich Village/ Chelsea in New York, homosexuals also generally consulted the same doctors and talked about their ailments among themselves, thus drawing attention to their unusual illnesses.

¹⁹Gerald M. Oppenheimer, 'In the Eye of the Storm: The Epidemiological Construction of AIDS', in Elizabeth Fee and Daniel M. Fox (eds), *AIDS: The Burdens of History*, Berkeley: University of California Press, 1988, pp.271-2.

investigations that suggested an increase in the incidence as well as the types of STDs in homosexual men. It would appear, therefore, that the combination of the CDC's recent work on risk factors for hepatitis B transmission, and its understanding of the prevalence of STDs among the gay population, directed epidemiologists to focus on elements of the 'homosexual lifestyle' in explaining the emergence of 'new' diseases afflicting gay men.²⁰ The CDC was also predisposed to suggesting, and exhaustively testing, a 'multifactorial' lifestyle hypothesis rather than searching for a virus in 1981 after it had been severely criticised for committing itself too quickly to a microbial hypothesis during the outbreak of Legionnaires' disease in 1976.²¹

The CDC's research into the risk factors for STDs and hepatitis B also accounts for the misleading generalisations and exaggerations inherent in the 'homosexual lifestyle' hypothesis. The CDC's cooperative studies were clearly unrepresentative of the gay population, as they relied on data supplied by STD clinics and gay community health centres in the United States. These clinics were more likely to be attended by young gay men living the 'fast-track' lifestyle of anonymous sex and drugs than men who were in steady monogamous relationships or who were not having anal sex at all.²² Indeed, while researchers at the CDC may have felt that they had increased their understanding of gay sexuality, evidence suggests that they remained ignorant about the way in which most gay men lived their lives at the start of the 1980s. As a National Academy of Sciences panel pointed out in 1986, no *comprehensive* research into the sexual practices of gay men had been undertaken since Kinsey's studies in America and Westwood's studies in Britain in the 1950s.²³ To the naive medical researcher, unfamiliar with homosexual sexual practices,

²⁰Oppenheimer, 'The Epidemiological Construction of AIDS', p.271.

²¹See House Subcommittee on Consumer Protection and Finance Committee on Interstate and Foreign Commerce, *Hearings on Legionnaires' Disease*, 23-24 November 1976, 94th Congress, cited in Oppenheimer, 'The Epidemiological Construction of AIDS', p.272.

²²Oppenheimer, 'The Epidemiological Construction of AIDS', p.271.

²³Institute of Medicine and National Academy of Sciences, *Confronting AIDS: Directions for Public Health, Health Care, and Research*, Washington D.C.: National Academy Press, 1986. It is interesting to note that Westwood found that only 32% of male homosexuals, whom he surveyed in his extensive study, regularly had anal intercourse. He remarked that "a large proportion of the sample do not like anal intercourse at all". See Gordon Westwood, *A Minority: A Report on the Life of the Male Homosexual in Great Britain*, London: Longmans, 1960, p.131. Research into the sexual practice of Australian gay men in the first half of the 1980s

it was not beyond the realm of possibility that all gay men did have over one thousand sexual partners per year, and suppressed their immune systems with strange drugs such as 'poppers'.²⁴ Equally, medical researchers clearly did not have a reasonable understanding of heterosexual sexual practices; they were aware of the prevalence of sexually transmitted diseases in this population but demonstrated little knowledge of the prevalence of anal sexual practices. Having little experience of these matters, doctors and researchers simply did not think to ask different questions of their data, such as: if many heterosexuals are participating in the 'gay lifestyle', why were they not getting AIDS as well?

Having proposed a hypothesis to explain the manifestation of diseases in previously healthy young men, the CDC set about supporting its argument with cohort studies. Unfortunately, its efforts were corrupted by biased, or unrepresentative, samples of clinic patients, similar to those which characterised the studies into hepatitis B. Searching for other cases of disease caused by immunosuppression after the first reports of PCP and KS were published in the *MMWR*, for example, the CDC surveyed 420 males attending STD clinics in San Francisco, New York and Atlanta. (The fact that only males were surveyed eliminated the possibility that women with immunosuppression might also be identified.) It found thirty-five cases in the sample (which was, of course, already biased towards men who were likely to be more sexually active than the general population by virtue of the fact that they were attending a STD clinic). In investigating the behaviour of these patients, all of whom were homosexual, two patterns predictably emerged: the men had enjoyed sex with many different partners in the previous year (the median number of partners was eighty-seven) and had frequently used marijuana, cocaine, and amyl or butyl nitrate.²⁵ This

by a team at Macquarie University produced similar findings. See Gary Dowsett, *Practicing Desire: Homosexual Sex in the Era of AIDS*, Stanford: Stanford University Press, 1996, p.80.

²⁴The alternative scenario was also true in some instances. According to Dr James W. Curran, head of the CDC's venereal disease division, many scientists, ignorant about the mechanics of anal sex, rejected the possibility that AIDS was an infectious disease with a viral origin because they could not conceive how a man could transmit an infectious agent to another man. See Sandra Panem, *AIDS: Public Policy and Biomedical Research*, *Hasting Centre Report*, Special Supplement, vol.15, no.4, August 1985, p.24.

²⁵House Subcommittee on Health and the Environment, Committee on Energy and Commerce, *Hearings on Kaposi's Sarcoma and Related Opportunistic Infections*, 13 April 1982, p.10; and Centers for Disease Control Task Force on Kaposi's Sarcoma and Opportunistic Infections, 'Epidemiologic Aspects of the Current Outbreak of Kaposi's Sarcoma and Opportunistic Infections', *New England Journal of Medicine*, vol.302, 1982, p.252, cited in Oppenheimer, 'The Epidemiological Construction of AIDS', p.273.

appeared to support the CDC's 'gay lifestyle' hypothesis and encouraged more research to be done on gay men specifically. The fact that 14.9% of male heterosexuals in the original sample of 420 men admitted to using nitrate in the previous five years, and had histories of STDs and numerous sexual partners, was overlooked. They had not developed opportunistic infections or diseases caused by immuno-suppression.²⁶

Yet non-homosexuals clearly were developing AIDS. By June 1982 the CDC reported that 22% of patients with KS and/or PCP were heterosexual, the majority of whom were injecting drug users. Almost one-third of the heterosexual patients were women, some of whom did not use injecting drugs.²⁷ Despite this fact, epidemiological studies of these groups were significantly under-represented in the medical literature prior to 1984.²⁸ It was gay men who remained the focus of researchers' attention, and it was their lives and illnesses that were reported in medical journals. These articles, in turn, were summarised and published by the gay and mainstream press, creating the false impression that America and Australia were witnessing a 'gay plague'. Once again, this preoccupation with gay men and the implicit condemnation of their 'lifestyles' should not be seen as a simple manifestation of homophobia or sexism on the part of medical researchers and journalists. As interviews with a number of directors and key personnel within AIDS-research institutes and the CDC reveal, there were practical and organisational reasons for this.

Heterosexual drug users were initially ignored in studies undertaken by the CDC because it lacked experience and expertise in dealing with this population and thus shied away from studying them.²⁹ At a federal level in the United States, the National Institute of Drug Abuse (NIDA) had principal responsibility for investigating issues related to injecting drug

²⁶*Ibid.*

²⁷CDC, 'Update on Kaposi's Sarcoma and Opportunistic Infections in Previously Healthy Persons - United States', *Morbidity and Mortality Weekly Report*, no.31, 11 June 1982, pp.294-301.

²⁸Don C. Des Jarlais, *et al.*, 'Heterosexual Partners: A Large Risk Group for AIDS', *Lancet*, vol.2, 1984, pp.1346-7. Only four articles about women with AIDS were published prior to 1984. See Mary Guinan and Ann Hardy, 'Epidemiology of AIDS in Women in the United States: 1981 through 1986', *Journal of the American Medical Association*, no.257, 1987, pp.2039-42.

²⁹Dr Stephen Schultz, personal communication with Gerald Oppenheimer, 22 July 1987, cited in Oppenheimer, 'The Epidemiological Construction of AIDS', p.280.

use and had a staff of epidemiologists solely for that purpose. NIDA's traditional focus, however, was only on drug abuse and diseases, such as hepatitis B and endocarditis, that were endemic in its target population. The directors of NIDA thus decided that AIDS should be treated like any other disease, thereby leaving the research initiative to other centres at the National Institute for Health or the CDC.³⁰ Researchers were also hampered by the fact that drug users were disinclined to cooperate in studies which required them to reveal information about their illegal drug using habits because they did not trust the researchers' assurances that the data would remain confidential. The injecting-drug using population has also always been relatively transient by nature, thus making unviable some of the longitudinal research projects that required follow-up interviews.

The relatively small number of heterosexual subjects available for researchers to study was another reason that gay men tended to dominate cohort studies of people with AIDS. This situation was no more evident than in Australia in July and August 1983 when Professor Ron Penny and his Sydney AIDS Research Group were calling for volunteers to participate in the first longitudinal study into social behaviour and AIDS to be conducted in Australia. At the time, Australia had reported only a handful of AIDS cases – all of whom were homosexuals – and Penny could rely on recruiting an enthusiastic cohort of gay men (who were exhibiting the most concern about AIDS at the time) for his project.³¹ The first cases of blood transfusion recipients acquiring HIV did not emerge in Australia until July 1984 and, at the time of Penny's initial call for volunteers, data on AIDS in these groups were not yet conclusive. This left Penny with little choice but to survey gay men if he wanted to conduct a meaningful longitudinal study.

Australian doctors in general faced a unique problem in their efforts to construct and disseminate knowledge about the cause of AIDS as they relied on the United States to provide the latest updates about developments in the AIDS epidemic. As the first case of

³⁰Don C. Des Jarlais, coordinator for AIDS Research at New York State Division of Substance Abuse Services, personal communication with Gerald Oppenheimer, 15 January 1988, cited in Oppenheimer, 'The Epidemiological Construction of AIDS', p.297. In 1985 NIDA reversed its decision and began to fund AIDS research extensively.

³¹Professor Ron Penny interviewed by Diana Ritch, 28 June 1993, 'The Australian Response to AIDS' Oral History Project, National Library of Australia, TRC-2815/39, transcript p.23 (henceforth Penny, NLA, TRC-2815/39).

AIDS in Australia was not reported until March 1983, Australian doctors could not conduct their own trials to validate the American data, and, owing to the low public health priority of the yet-to-eventuate epidemic, the National Health and Medical Research Council Working Party on AIDS, headed by Professor David Penington, and Penny's Sydney AIDS Research Group, were the only recognised medical authorities on AIDS in Australia.³² Their method of information collection and knowledge construction was highly questionable given these constraints, and because the doctors working for these groups could only conduct very brief and occasional visits to the United States to witness the developments in AIDS research first hand. As Penny recalls, during the first meetings of his group it became obvious that:

No-one knew anything about [the cause of AIDS]. It was a complete black hole, other than theories. There's certainly no question that the fact it may have been a new virus was not excluded and was probably held by many because it [was] thought to resemble hepatitis B in its transmission mode.³³

Neal Blewett, however, received a different opinion from the experts in his department upon being appointed Commonwealth Minister for Health:

Item 35 on my initial ministerial briefing in March 1983 referred to a mysterious disease known as GRID affecting mainly homosexual males in the United States. No cases had been confirmed in Australia [and] the aetiology of the disease was unknown, though it was suspected by some that it might be a viral disease. My officials tended to discount that, thinking it more likely that it derived from environmental aspects of the homosexual lifestyle.³⁴

³²The National Health and Medical Research Council established the Working Party on AIDS in June 1983, at which time Penny was assembling his Sydney AIDS Study Group. (Penny was a member of both groups.) The Working Party was later absorbed into the National AIDS Task Force, the state governments' chief scientific advisory body on AIDS.

³³Penny, NLA, TRC-2815/39, p.22.

³⁴Neal Blewett, 'AIDS: How We Got Where We Are', the Keith Harbour Memorial Lecture, Victorian AIDS Council/Gay Men's Community Health Centre, Melbourne, 26 September 1993, p.5, cited in Michael Bartos, 'The Queer Excess of Public Health Policy', *Meanjin*, vol.55, no.1, 1996, pp.123-4.

Penny's group and the NH&MRC Working Party on AIDS were unwilling to discount either possibility. They suspected that a viral agent was the cause of AIDS, but believed that its transmission was related exclusively to the 'homosexual lifestyle'. Throughout 1983, for example, both Penny and Penington were adamant that women with AIDS were likely to have contracted the condition as a result of anal intercourse with infected men. This theory was discussed at the inaugural meeting of the Working Party on AIDS and then repeated during an address given by Penny to a small meeting at St Margaret's Hospital the following month.³⁵ When Dr David Cooper, an AIDS expert on the Working Party was quoted in *Cleo* as saying, "most of the women in the USA who have been diagnosed as having AIDS admit to freely engaging in rectal intercourse. This seems to indicate that our theory of the rectal transmission of AIDS is correct", *Campaign's* news editor, John Cozijn, rang a member of the Working Party to inquire about the source of the information. He was told that Penington had heard it mentioned at a meeting while on a visit to New York, but that the information had not been published or tested. The informant then admitted that, due to the lack of evidence to the contrary, most American women still fell into the category of being injecting drug users.³⁶ This situation indicates how difficult it was for Australian doctors and 'AIDS experts' to construct knowledge about AIDS while they remained geographically removed from the epidemic.

Randy Shilts was not prepared to consider the constraints of time, distance and research opportunities that hampered Australian doctors when he accused the *Medical Journal of Australia* of inspiring panic and perpetuating homophobia with its June 1983 front cover which announced: "The Black Plague of the Eighties...Perhaps We've Needed A Situation Like This To Show Us What We Have Already Known All Along -- Depravity Kills".³⁷ As is often evident in his work, Shilts might have benefited from asking a few more questions instead of jumping to the most obvious conclusion before making this assertion. The editor

³⁵National Health and Medical Research Council Working Party on Acquired Immune Deficiency Syndrome, 'Report of Inaugural Meeting', 25 July 1983, NBAC/NAAC, ANU, H7/22.

³⁶John Cozijn (news editor), 'One Step Forward, Two Steps Back', *Campaign*, vol.95, November 1983, p.16.

³⁷*Medical Journal of Australia*, vol.1, no.2, 11 June 1983, front cover; Shilts, *And the Band Played On*, p.343. The *MJA* also drew criticism from the Commonwealth Minister for Health, Dr Neal Blewett ('Blewett Hits "Irresponsible" Media Over AIDS Reports', *Australian*, 29 June 1983).

of the *MJA* explained that, rather than inflaming homophobia, the cover was actually satirising the sensationalist and often ignorant AIDS coverage appearing in the media. The front cover quote had been taken from an *Weekend Australian Magazine* article that was itself syndicated from the *New York Times Magazine*.³⁸ As Raymond Donovan acknowledges, the irony was lost on the mainstream media and many members of the public, including some religious leaders, who reproduced the depravity collage and evoked the notion that AIDS was caused by the 'homosexual lifestyle' to pursue their own political purposes.

While homophobia does not explain the medical construction of knowledge about the cause of AIDS, it goes some way to explaining why the 'homosexual lifestyle' hypothesis gained such a firm hold on the minds of Australians and continued to be reproduced in the print and electronic media long after the theory had been epidemiologically discredited. The idea that 'gays cause AIDS' was used by various conservative politicians, members of the public, and church groups, such as Fred Nile's Festival of Light and the Anglican Diocese of Sydney, to legitimate their efforts to block homosexual law reform (which gay lobbyists were trying to see reintroduced into the New South Wales parliament), and to justify their calls for continued discrimination against homosexuals in employment and other areas. J.C. Grover from Seaforth NSW, for example, wrote a letter to the editor of the *Australian* in June 1983, criticising the proposed amendments to the NSW Anti-Discrimination Act which would make it unlawful to discriminate against homosexual teachers for the first time. He opposed the amendments, claiming that:

with the greater appreciation of the horror of the disease A.I.D.S., the origin of which medical expertise lays squarely on the unnatural homosexuality practices, one can appreciate why natural people have discriminated against them for thousands of years...All that is being achieved by the anti-

³⁸Raymond Donovan, 'Vile and Viral Bodies: Bioscientific Truths and Mediatized Realities, 1981-1985', in Robert Aldrich and Garry Wotherspoon (eds), *Gay and Lesbian Perspectives IV: Studies in Australian Culture*, Sydney: University of Sydney, 1988, p.245. The article in question was by R.M. Henig, 'The Black Plague of the Eighties', *Weekend Australian Magazine*, 5-6 March 1983, p.4.

discrimination hooha is to discriminate against normal and wholesome families in favor [*sic*] of the sordid destructive elements.³⁹

Mrs Lesley Hicks, in an earlier letter to the *Sydney Morning Herald* concerning the same issue, asserted that "this fatal disease syndrome affecting male homosexuals is...yet another of the good reasons for the social control of homosexuality".⁴⁰ The views of J.C. Grover and Mrs Hicks were disturbing, given that they were expressed in a seemingly rational and lucid manner, and not framed in the language of a religious zealot. The same cannot be said for Mr I. Blaskow, whose letter to Sydney's *Sunday Telegraph* was simply titled 'Bible can cure gay plague'.⁴¹

In other instances, the 'fact' that gays cause AIDS was used to justify sheer prejudice and violence towards homosexuals. It was not uncommon to find the slogan 'AIDS=Anally Injected Death Sentence' graffitied on a toilet door with the words 'Die, Poofter, Die' inscribed below. In a similar vein, John Campbell wrote a letter to the editor of the *Sun-Herald* in September 1984 to campaign against homosexuals attending the National Lesbian and Gay Conference which was to be held in Brisbane. He suggested that "justice would be served if [the homosexuals] were all assembled as fuel for a large bonfire – especially if it is true that AIDS is a product of their casual connections".⁴² It is interesting, of course, that the *Sun-Herald* found this kind of statement appropriate to print.⁴³

Yet, as I have suggested already, it was not only medical researchers, mainstream journalists and conservative members of the public who were keen to equate the 'homosexual lifestyle' with the cause of AIDS. A fervent debate concerning this very topic

³⁹Letter to the Editor (J.C. Grover), *Australian*, 6 June 1983, p.8.

⁴⁰Letter to the Editor (Lesley Hicks), *Sydney Morning Herald*, 30 October 1982, p.12.

⁴¹Letter to the Editor (I. Blaskow), *Sunday Telegraph*, 10 October 1982, p.166.

⁴²Letter to the Editor (John Campbell), *Sun-Herald*, September 1984, cited in Larry Galbraith, 'Mediawatch', *Campaign*, vol.106, October 1984, p.4.

⁴³For further discussion of the way in which the Australian mainstream media treated the story of the origins of AIDS, and its heterosexual bias, see Deborah Lupton, *Moral Threats and Dangerous Desires: AIDS in the News Media*, London: Taylor and Francis, 1994; and Donovan, 'Vile and Viral Bodies', pp.223-62.

had broken out within the gay communities of New York and San Francisco in the final months of 1982 after Michael Callen and Richard Berkowitz published their now famous article, 'We Know Who We Are: Two Gay Men Declare War On Promiscuity', in the *New York Native*. In Australia the article was given full-page prominence and discussed in *Outrage* and *Campaign* during the first months of 1983.⁴⁴ Callen and Berkowitz had recently been diagnosed with AIDS and took up the cause of their doctor, Dr Joseph Sonnabend, by arguing that repeated exposure to venereal diseases, the overuse of antibiotics to treat these infections, the use of 'poppers', sexual practices involving faeces and urine, and the over-absorption and ingestion of semen were causing "immune overload and therefore AIDS". They also went further than most of the mainstream journalists to ask:

Can researchers really comprehend the dynamics of urban gay male promiscuity? Can they understand the health implications for a 27-year old who has had 2,000 sexual partners? ... We veterans of the circuit must accept that we have overloaded our immune systems with common viruses and other sexually transmitted infections. Our lifestyle has created the present epidemic of AIDS among gay men ... There is no mutant virus, and there will be no vaccine.⁴⁵

Larry Kramer, the outspoken New York author and gay activist, was making similar claims.

While it would be callous and incorrect to suggest that Callen and Berkowitz, and the gay men who accepted their argument, did not always have the goal of saving their brothers' lives as their primary objective, one needs to point out that this theory about the cause of AIDS fitted neatly into an existing debate within the gay community concerning homosexual identity and the contested notions of 'community' and 'difference'. Gay men were struggling to find ways to define themselves and to understand the role that sex, and

⁴⁴See, for example, Adam Carr, 'The AIDS Epidemic', *Outrage*, vol.3, June 1983, p.16.

⁴⁵Michael Callen and Richard Berkowitz, 'We Know Who We Are: Two Gay Men Declare War On Promiscuity', *New York Native*, 8 November 1982, p.29, cited in *ibid.*

promiscuous sex in particular, should play in this process of self-definition and community identification. Larry Kramer was at the forefront of this debate, and had been acclaimed by some for his 1978 novel, *Faggots*, which chastised gay men for coming out of the closet only to escape into a self-imposed hedonistic world where drugs and sex overwhelmed love. Others, however, accused him of 'gay homophobia' and 'anti-eroticism'.⁴⁶ *The Body Politic* (a Toronto based gay magazine that was frequently cited in the Australian gay press), for example, opposed Kramer, Berkowitz and Callen by proclaiming promiscuity to be one of the gay community's most "cherished institutions", "the foundation of our identity" and "what knits our community together"⁴⁷. AIDS had entered American and Australian homosexual communities at a time in which contention over the notions of 'homosexual identity', 'community' and 'difference' had reached a peak, and it was almost inevitable that protagonists on one side of this debate would be predisposed to accept, and then employ, the 'gay lifestyle' hypothesis concerning the cause of AIDS to support their argument about the sins of homosexual hedonism.

In April 1983 the editor of *Campaign*, Barry Lowe, took a neo-Marxist slant on this issue, by linking capitalism and the commodification of homosexual identity to the cause of AIDS. In the first of many editorials that would be devoted to AIDS in the magazine, Lowe, a prominent playwright and community leader, mourned a sexual revolution that had lost its direction:

Many thought Stonewall was the beginning of a "sexual revolution" that would touch the most intimate parts of our lives. But as lesbians and gay men all over the world came out of their closets some people saw the beginnings of a very different "revolution". They saw in that movement the embryo of what would be called the "gay dollar". Enter "gay capitalism". What followed was an unprecedented explosion of establishments such as bars, backrooms, sex shops, saunas and clubs. They were to become the centre for what is now known as the "gay (male) community". We were to witness the genesis of what

⁴⁶For a summary of the criticism of Kramer's position, see Shilts, *And the Band Played On*, pp.108-9.

⁴⁷Cited in Barry Lowe, 'Editorial', *Campaign*, vol.88, April 1983, p.4.

community leaders would dub "gay (male) lifestyle". In fact, what we really saw was the commercialisation of promiscuity among urban gay men.⁴⁸

He concluded by warning that "the role of the saunas, bars, and other institutions similarly needs to be discussed in light of recent information on AIDS in the US and Australia". AIDS, seen as a product of "gay capitalism" or the "promiscuous gay lifestyle" which gay business establishments encouraged and catered for, was thus used as an instrument to challenge this construction and commodification of homosexual identity. In the first editorial about AIDS to appear in an Australian gay magazine, this issue, rather than the disease itself or the number of gay men who were dying, assumed primary importance.

Such debates within the homosexual community concerning the cause of AIDS further illustrate how a range of existing discourses, specific to the start of the 1980s, constrained and shaped the knowledge that was produced and propagated about the deadly new syndrome. Clearly the acceptance that AIDS was caused by the 'homosexual lifestyle' cannot be viewed in isolation from other debates that were going on in Australia at the time concerning the liberalisation of laws affecting homosexuals, and arguments within the gay community about the nature of 'homosexual identity' and the commercialisation of promiscuity. Moreover, in colluding with the doctors' implicit condemnation of the 'homosexual lifestyle', the response of sections of the gay community indicates that homophobia was not the only driving force behind the construction of the 'homosexual lifestyle' hypothesis, as some commentators have suggested. While it is true that the association of homosexuality with disease led to the persecution of gay men – not to mention calls for the cancellation of Mardi Gras, the closure of gay discos and bathhouses, and for gay men to be banned from entering the country⁴⁹ – one should not conflate the *outcome* of the public's understanding of the 'gay lifestyle' hypothesis with the *motives* for its production. Rather than being driven by homophobia, medical researchers (particularly

⁴⁸*Ibid.*

⁴⁹Dr Julian Gold and Professor Penington were two of the most vocal proponents of cancelling the Gay Mardi Gras in Sydney although Penington claims he was misinterpreted ('Gays Risk AIDS at Mardi Gras', *Daily Sun*, 1 February 1985, p.8). The populist mainstream press and Reverend Fred Nile, among others, called for American gay men to be banned from entering Australia and for gay establishments to be closed. See John Campbell, 'Reverend Fred Raises Gay Hackles Over AIDS March', *Weekend Australian*, 25-26 June 1983, p.11.

epidemiologists at the Centers for Disease Control) and doctors were hampered by methodological constraints and the philosophical underpinning of their discipline, and were predisposed to constructing an inaccurate conception of the 'homosexual lifestyle' (and to associate it with disease), because of the crude understanding about the activities of gay men and sexually transmissible diseases that they had formulated in the years immediately prior to the first case of AIDS being reported.

To this point, I have emphasised the complicity of gay men with the prevailing biomedical discourse, but this degree of compliance is contrary to that remembered by many gay men reflecting on the early 1980s. Indeed, since the emergence of activist organisations such as ACT UP and a powerful People Living With AIDS movement, which developed a rigorous critique of the construction of biomedical knowledge during the late 1980s in an attempt to reclaim control of information about the epidemic from medical professionals, it has become common for gay men to recall their opposition to doctors in the first years of the AIDS crisis. To substantiate their memories, these men can point to letters and the odd editorial published in *Campaign*, *Outrage* and *Gay Information* which cautioned gay men to remain suspicious of the doctors' motives.⁵⁰ As was frequently the case, these letters and editorials were provoked by articles that had appeared in North American gay periodicals in the preceding months, and were influenced by writers such as Michael Lynch, who, in the November 1982 issue of *Body Politic*, warned:

Another crisis exists with the medical one. It has gone largely unexamined, even by the gay press. Like helpless mice we have peremptorily, almost inexplicably, relinquished the one power we so long fought for in constructing our modern gay community: the power to determine our own identity. And to whom have we relinquished it? The very authority we wrested it from in a struggle that occupied us for more than a hundred years: the medical profession.⁵¹

⁵⁰See, for example, John Cozijn, 'Editorial', *Campaign*, vol.90, June 1983, p.4; John Cozijn, 'One Step Forward, Two Steps Back', *Campaign*, vol.95, November 1983, p.16; and L. Hutton-Williams, 'Deconstructing a Syndrome: AIDS', *Gay Information*, no.13, Autumn 1983, pp.30-8.

⁵¹Michael Lynch, 'Living With Kaposi's', *Body Politic*, no.88, November 1982, p.31.

The struggle to which Lynch referred was the battle against doctors (and psychiatrists in particular) who, at the end of the nineteenth century, had replaced the Church's construction and condemnation of homosexuals as 'morally depraved' with the diagnosis that they were 'pathologically ill'. Such categorisation underpinned the laws that criminalised homosexual activity in most Western countries, including Australia, laws which were only now beginning to be repealed as medical professionals and moralists softened their stance.⁵² Gay men, who were taking their first tentative steps as 'normal' people in the wake of Stonewall and the victories of 'liberation', now faced being pushed back into the closet by a casual link between the 'homosexual lifestyle' and AIDS which would prove, once and for all, that gay men were indeed 'sick'. It was not surprising that they should resist the biomedical discourse which categorised their lifestyles as dangerous.

On the whole, however, they did not. For every article or letter urging gay men not to trust doctors or their theories, there were literally hundreds describing doctors and medical researchers in reverent tones. With few exceptions, doctors were portrayed by the gay press as experts to be relied upon and turned to, their comments dutifully reported and their findings and hypotheses quoted without editorial comment.⁵³ In one of the first articles about AIDS to be published in *Campaign*, for example, AIDS researchers were introduced in heroic terms usually reserved for military commanders in the time of war:

⁵²The categorisation of homosexuality as a "sociopathic personality disorder" was removed from the internationally consulted psychiatric textbook, *Diagnostic and Statistical Manual of Mental Disorder*, as late as 1973. Many practitioners greeted this deletion with ambivalence; a survey of 2,500 psychiatrists taken almost ten years after the official change revealed that 69% still defined homosexuality as a 'pathological illness'. (Edward Albert, 'Acquired Immune Deficiency Syndrome: The Victim and the Press', *Studies in Communication*, no.3, 1986, p.140. Also see Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis*, New York: Basic Books, 1981.) The Australian Medical Association only agreed to remove 'homosexuality' from its list of disorders and illnesses in March 1984.

⁵³See, for example, 'Rare Viral Cancer Rouses Fear and Hope', *Campaign*, vol.70, October 1981, p.14; 'Parasitic Pneumonia A New Killer in U.S.', *Campaign*, vol.68, August 1981, p.10; 'Cancer/Pneumonia - New Findings', *Campaign*, vol.78, June 1982, p.13; 'Link Found in Kaposi Sarcoma', *Campaign*, vol.82, October 1982, p.8; and '2.7 mil for KS', *Campaign*, vol.82, October 1982, p.8. Even authors who disputed the 'gay lifestyle' hypothesis stopped short of criticising biomedical practices. Although one of the first to debunk the 'lifestyle' theory, Adam Carr had no hesitation in adopting immunological jargon and citing the most recent gay-cohort research published in the medical literature. His comments frequently expressed a trust in medical researchers to find a solution if only recalcitrant politicians would give them enough money. See, for example, Adam Carr, 'The AIDS Epidemic', *Outrage*, June 1983, pp.4-6, 15-18.

In the U.S. ... research into AIDS is being co-ordinated by the Atlanta headquarters of the Federal Centre [sic] for Disease Control (CDC). There, 20 full-time physicians and more than 80 professionals working part-time are trying to find answers to the mysterious AIDS disease.⁵⁴

All of this in an article introduced with a byline – obviously written by a sub-editor rather than the author – which denounced “homophobic medicos and journalists who originally dubbed AIDS ‘the gay plague’”! In a densely-spaced two-page article that exalted the efforts of medical researchers and recounted the latest scientific theories about AIDS, this certainly did not constitute a rigorous critique of the construction of biomedical knowledge.⁵⁵ It would thus seem that gay men’s current memories of opposition and resistance to biomedical discourse are coloured by the experience of radicalism at the end, rather than the start, of the 1980s.

This conclusion, drawn from documentary sources, is supported by events that transpired at a public AIDS Forum organised by the NSW AIDS Action Committee and held at the Paddington Town Hall on 15 August 1983. The forum was a significant event because of its size – it was by far the largest public meeting about AIDS to be held in Australia up till that point in time – and the status of the speakers, who included the five leading medical experts on AIDS in Australia: Professor David Penington (flown in from Melbourne especially for the event), Dr Trevor King, Dr David Cooper, Dr Julian Gold and Professor Ron Penny.⁵⁶ The entire forum, lasting over two hours, was captured in perfect clarity on a remarkable roll of videotape that reveals the response of the audience to the information

⁵⁴Paul Harris, ‘Acquired Immune Deficiency – First Victim Here’, *Campaign*, vol.88, April 1983, pp.14-15.

⁵⁵It is interesting to note that *Campaign* printed a small article a few issues later that criticised the *Australian* for including the “offensive term ‘the gay plague’” in three articles that it published during June 1983. *Campaign* had only given up the practice itself the month before, nearly one year after the term ‘AIDS’ was officially coined. See Jamie Gardiner, ‘Sez Who’ [monthly media watch column], *Outrage*, vol.4, July 1983, p.7.

⁵⁶Gay community leaders including Lex Watson, Lou McCallum and Fred Miller, the Federal Member of Parliament for Bligh, also addressed the audience. Craig Johnston and Robert French of the AIDS Action Committee chaired the forum.

put forward by the doctors.⁵⁷ Given that the forum was situated in the heart of Oxford Street, and that homosexuals were exhibiting the most concern about AIDS at the time, one can assume that the audience, which numbered about six hundred, predominantly consisted of gay men and women. They listened intently, nodding and applauding, as each of the doctors related the latest medical research which indicated that while the epidemiology of AIDS transmission suggested a viral origin, aspects of the homosexual lifestyle were likely co-factors in determining whether a person would develop AIDS. The men in the audience were clearly desperate to learn from someone with authority about how they could save their lives.

Professor Penny used the occasion to launch his gay-cohort research project, claiming that the aim of his study was to investigate the link between the behaviour of gay men and the onset of immune-deficiency. In an effort to recruit volunteers, Penny distributed a questionnaire to each member of the audience, asking them to reveal confidentially their sexual and recreational activities. Those who volunteered for the project were then tested for immuno-suppression and required to submit to on-going testing and surveys. Despite a few members of the audience articulating fears about the confidentiality of the questionnaires (sexual intercourse between consenting homosexual men was still illegal in New South Wales at the time and most of the respondents would have compromised themselves), the audience complied and Penny had no difficulty in recruiting subjects.⁵⁸ Rather than resisting the doctors' efforts to construct links between homosexual practices and disease, gay men were clearly willing to offer themselves up for medical surveillance and to be categorised under the medical gaze.

Indeed, during question-time which lasted for more than one hour, only two audience members dared to challenge the doctors' motives. Conspicuously, both were women. The first stood up and expressed disappointment that no one had addressed the way that AIDS, as defined by doctors and scientists, could be used as an instrument of social control.

⁵⁷The videotape is now in the possession of the AIDS Council of New South Wales and can be accessed through its library. See 'AAC Forum, 18/6/83', amateur video, colour, unedited, 131 mins.

⁵⁸Penny recalls that 'he recruited over one thousand men for his study very easily, and that his research team received "good interactive support" from Sydney's gay community. (Penny, NLA, TRC-2815/39, p.23, 25.)

Worried that the doctors on the panel had used words like "contain" and "moderate", and had pleaded for gay men to "be reasonable", she remarked: "we all know what this means in real terms!" Medical scientists, she claimed, were using AIDS to curtail the sexual freedoms of homosexuals as they had done in the past, and she urged the audience to read an article recently published in *Gay Information* (cited above) that developed this idea. The only other woman to speak during question time echoed the first, and expressed her concern that "people [would] walk away from this forum and fill out the questionnaire...without really thinking about what that means". It meant, she insisted, surveillance and control, and a loss of privacy for homosexuals which was disproportionate to the impact that AIDS was having in Australia, considering that only four cases had been officially confirmed in this country.

Gay men did more than offer themselves up for medical surveillance. In Foucauldian terms, they also put themselves under self-surveillance, and in the privacy of their own bedrooms altered their sexual habits. As submissions to Australian gay magazines, and the Social Aspects of the Prevention of AIDS (SAPA) study of homosexual sexual behaviour indicate, gay men were prepared to discipline their sexual proclivities and avoid the 'aspects of the homosexual lifestyle' declared to be dangerous by doctors.⁵⁹ Garry Bennett, for example, wrote an article for *Campaign*, claiming that:

When AIDS first became an issue here I reacted with personal panic and paranoia. My sexual life was such that I knew I had to be a high risk for AIDS. With little information about, or support for, experimenting with alternative ways of exploring my sexuality I became almost celibate.⁶⁰

Rather than escaping into celibacy, the author suggested that gay men explore the possibilities of 'safe sex': talking dirty on the phone, voyeurism (looking but not touching), courtship (which entailed a 'getting to know him period' before deciding whether or not to

⁵⁹Five hundred and thirty-five men were interviewed at length concerning changes in their sexual behaviour for the Social Aspects of the Prevention of AIDS project (SAPA) conducted by a research team at Macquarie University. I discuss the findings of this project in Chapter 5. Also see Susan Kippax, *et al.*, *Sustaining Safe Sex: Gay Communities Respond to AIDS*, London: The Falmer Press, 1993, pp.79-91.

⁶⁰Garry Bennett, 'Safe Sex: Eroticism in the Eighties', *Campaign*, vol.94, October 1984, pp.10-11.

have sex), and 'circle jerks' and 'jack-off' parties (where mutual-masturbation was the order of the day).⁶¹ Australian gay men took up the offer and disciplined their sexual behaviour more or less to conform with the doctors' wishes, even if this only meant not having sex with American men (who were perceived to be at highest risk for 'carrying AIDS'). Witnessing a 1980s version of the Panopticon as Foucault might have had it, the two female interlocutors in the Paddington Town Hall audience would have been horrified at the way in which gay men colluded with the biomedical discourse that categorised them as diseased and dangerous, stripped them of their power of self-determination, and seemingly legitimated their vilification and persecution at the hands of the wider community.⁶²

Power was certainly involved here, but despite the Foucauldian analysis, gay men were not necessarily experiencing its detrimental effects. Faced with terrifying reports of hundreds of gay men dying in America of a mysterious illness of unknown origin and means of transmission, gay men took the most *powerful* option available to them: they clamoured to save their lives. Far from being the passive partner in the power-knowledge nexus, they astutely determined that if submitting to the various forms of surveillance would give them the best chance of survival, then they would be prepared to form an alliance with their traditional foe. Unlike the lesbians in the forum audience who were not implicated in the

⁶¹*Ibid.*

⁶²The 'Panopticon' refers to Jeremy Bentham's nineteenth-century prison design which encouraged those incarcerated to discipline their behaviour due to the ever-present possibility that they were being observed by an external agent. In his most accessible book, *Discipline and Punish*, Michel Foucault uses this design as an analogy to explain the way in which power operates in modern society. Foucault contends that power operates not so much through repression, violence, or blatant control (as in a typical prison), but instead through the creation of expert knowledges about human beings which serve to channel or constrain their thinking and actions. Through the construction of 'expertise' and knowledge about contagion, modes of transmission and methods of prevention, for example, doctors and public health authorities encourage individuals to 'survey' and discipline their own sexual behaviour, and that of their peers, without having to resort to visibly violent, coercive or repressive measures. See Michel Foucault, *Discipline and Punish: The Birth of the Prison*, trans. Alan Sheridan, London: Penguin, 1977, especially pp.200-28. Deborah Lupton and Alan Petersen apply Foucault's ideas to the realm of public health in *The New Public Health: Health and Self in the Age of Risk*, Sydney: Allen and Unwin, 1996; and Deborah Lupton, *The Imperative of Health: Public Health and the Regulated Body*, London: SAGE, 1995. Also see Denise Gastaldo, 'Is Health Education Good For You? Re-thinking Health Education Through the Concept of Bio-Power', in Alan Petersen and Robin Bunton (eds), *Foucault, Health and Medicine*, London: Routledge, 1997, pp.113-33; and Robert Castel, 'From Dangerousness to Risk', in Graham Burchell, Colin Gordon and Peter Miller (eds), *The Foucault Effect: Studies in Governmentality*, Hemel Hempstead: Harvester Wheatsheaf, 1991, pp.281-98.

epidemic to the same extent, gay men could not afford the luxury of distrusting biomedical practices.⁶³

Furthermore, far from signalling the end of sexual freedom, gay men sitting in the Paddington Town Hall saw an opportunity to use AIDS, and their alliance with doctors, as an instrument to liberate themselves further. While they did not question the agenda behind Professor Penny's questionnaire, at least three audience members pointed out that under the NSW Crimes Act they could be imprisoned for admitting to having sex with other men. They demanded that if Penny's team of doctors wanted the cooperation of the gay community, then "we require things back in return".⁶⁴ Specifically, they wanted Penny to put his name behind their push for the repeal of laws in New South Wales which criminalised sex between consenting men, and for him to argue their case for law reform on medical grounds. The gay press made similar demands in the months following the AIDS forum. While gay men were obviously arguing from a compromised position, their attempt to use biomedical discourse to liberate sexuality, rather than constrain it, was a powerful move, and one which would become a recurring theme in the history of the response to AIDS by minority communities in Australia. As my following chapters will show, throughout the next decade, drug users, sex workers, and homosexuals in Queensland, Western Australia and Tasmania attempted, with varying degrees of success, to repeal laws criminalising their activities by arguing that such laws prevented the effective implementation of research projects and education campaigns and programmes that aimed to halt the transmission of HIV.

⁶³Since the forum was organised by a gay organisation and located in the heart of Sydney's gay community, one can assume that most of the women in the audience would have been lesbians. The first woman who spoke against the doctors almost certainly was, given that she recommended that others read the article about the biomedical construction of AIDS and homosexuality in *Gay Information*.

⁶⁴'AAC Forum, 18/6/83', amateur video, colour, unedited, 131 mins, in the possession of the AIDS Council of New South Wales library.

Chapter 2.

Australia's Blood Supply and People with Haemophilia in Crisis

On 28 July 1999 news services throughout the country reported that a Victorian schoolgirl had tested HIV-positive after being transfused with contaminated blood during a routine operation at the Royal Children's Hospital in Melbourne. It was the first case of HIV to be acquired during a medical treatment since Australia became the first country in the world to adopt universal blood screening procedures for HIV in May 1985. The blood had been donated by an asymptomatic woman, described as "neither a prostitute nor an intravenous drug user", who had been unknowingly exposed to the virus only days before making her donation.¹ Insufficient time had elapsed since the woman's infection for her body to produce the required number of HIV-antibodies to register a 'positive' result on the screening test.

Predictably, the case of an 'innocent' schoolgirl contracting a deadly infection through a process deemed for so long to be infallible prompted a public outcry. There was also considerable panic, similar to that which accompanied the announcement, in July 1984, that a Melbourne man had developed Australia's first case of AIDS acquired through a blood transfusion. If one was to believe the media hyperbole, it was as if the black plague had returned after centuries of banishment to once again threaten human existence. The community's anxiety was tempered, however, by the Victorian Red Cross Blood Transfusion Service's (BTS) exhortations that the case was a "one-in-a-million chance"; in fact, of the 14 million blood transfusions since 1985 only one had led to infection.² The BTS was also careful to advertise that the infected donor was a woman, and not a gay man, thus avoiding a re-emergence of the kind of media-propelled homophobic vilification that accompanied the announcement of the initial cases of medically-acquired HIV in 1984. After the death of three Queensland babies infected with contaminated blood donated by a gay man, for example, the *Midweek Truth* printed a full-page headline which quoted the

¹Stephen Lunn, '45 Minutes to Condemn a Young Life', *Australian*, 28 July 1999, p.1.

²Dr Patrick Coghlan, Victorian BTS Director, quoted in Amanda Hodge, 'Blood Stocks Tainted', *Australian*, 28 July 1999, p.1.

father of one of the babies demanding "Die, You Deviate".³ In 1999, the media and the schoolgirl's father were more interested in blaming the hospital, which had refused the father's pre-operative request for a family member to donate the required blood, rather than the donor for the girl's infection.⁴

People with haemophilia, who are required to infuse themselves with a blood-clotting agent known as factor VIII to treat their blood coagulation disorder, accounted for the majority of cases of HIV acquired medically before 1985. Tragically, 30% of people with haemophilia who treated their condition between 1980 and 1984 received contaminated blood; most have since died. In total, 22% of all people with haemophilia in Australia acquired HIV, arguably making this community the most severely affected by AIDS.⁵ The stories of their infection, coming at a time when the 'AIDS virus' had only just been discovered and when the public still had little understanding of how the virus was transmitted, profoundly shaped the public's attitudes towards people with AIDS and especially towards homosexuals, who were seen as responsible for infecting the 'innocent victims'. Gay men were banned from donating blood and accused of donating infected blood "out of spite", to which they responded by organising public demonstrations and establishing AIDS Action Committees in Sydney and Melbourne – the first AIDS-orientated political organisations to be founded within the gay community. The lives of people with haemophilia thus became irrevocably linked with gay men at a time when the first manifestation of gay activism in response to AIDS was beginning to emerge in Australia.⁶

³'Die, You Deviate', *Midweek Truth*, 3 December 1984, p.1.

⁴See, for example, 'Our Worst Nightmare Came True', *Australian*, 28 July 1999, p.4; and Mary-Anne Toy, 'Blood Scare Inquiry', *Age*, 28 July 1999, p.1.

⁵Jenny Ross, 'AIDS – Have We Got It Right?', paper delivered to the Australian Doctors' Fund Summit, Sydney, 14-15 May 1992.

⁶Until now, John Ballard and Bryce Courtenay, in his biographical novel *April Fool's Day* (1993), have been the only authors to explore the implications of the infection of people with haemophilia in Australia. They do not, however, discuss or attempt to explain the response of the gay community to the contamination of the blood supply in any great detail. See John Ballard, 'HIV-Contaminated Blood and Australian Policy: The Limits of Success', in Eric A. Feldman and Ronald Bayer (eds), *Blood Feuds: AIDS, Blood and the Politics of Medical Disaster*, New York: Oxford University Press, 1999, pp.243-70.

The Sydney homosexuals' aggressive reaction to a seemingly rational request to desist from donating blood, and the public's petrified response to the disclosure that the blood supply was contaminated, suggests that more was at stake than a simple matter of collecting and transfusing a fluid-like scarlet substance of plasma, cells and platelets. Indeed, as Dorothy Nelkin suggests, in order to understand the anxiety surrounding the contamination of blood with HIV one must cease to view blood as a biological substance, and recognise that it exists as a cultural entity, invested with a range of social meanings and sometimes conflicting metaphors:

Blood is seen as a source of life and energy, but it is also a symbol of violence and danger. It is a metaphor for social solidarity and the connection between the individual and society, but it has also represented the biological distinctions between peoples and is linked to the politics of race and social class. Blood is a social fluid that calls for altruistic relationships, but blood plasma is an economic product that can be competitively bought and sold. Purity of blood is a clinical concept associated with physical health, but it is also a racist construct used to define ethnicity and to justify exclusion and discrimination. In its social meanings, blood can stand at once for purity and contamination, vitality and death, community and corruption, altruism and greed.⁷

As numerous cultural historians and theorists have commented in relation to the body, the social meanings invested in blood reflect political circumstances and social relationships within a particular culture at a specific point in time.⁸ In the minds of gay men in 1983,

⁷Dorothy Nelkin, 'Cultural Perspectives on Blood', in Eric A. Feldman and Ronald Bayer (eds), *Blood Feuds: AIDS, Blood, and the Politics of Medical Disaster*, New York: Oxford University Press, 1999, p.275. Other important analyses of the social construction of blood and blood donation include Thomas Murray, 'The Poisoned Gift: AIDS and Blood', in Dorothy Nelkin, Scott V. Parris and David P. Willis (eds), *A Disease of Society: Cultural and Institutional Responses to AIDS*, Cambridge: Cambridge University Press, 1991, pp.216-40; and Piero Camporesi, *The Juice of Life: The Symbolic and Magic Significance of Blood*, New York: Continuum Publications, 1995.

⁸See, for example, Sally Shuttleworth, 'Female Circulation: Medical Discourse and Popular Advertising in the Mid-Victorian Era', in Mary Jacobus, Evelyn Fox Keller and Sally Shuttleworth (eds), *Body/Politics: Women and the Discourses of Science*, New York: Routledge, 1990, pp.47-68; Susan Bordo, 'Reading the Slender Body', in *ibid.*, pp.83-112; Mary Douglas, *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo*, London: Routledge and Kegan Paul, 1966; Sander L. Gilman, *Disease and Representation: Images of Illness from Madness to AIDS*, Ithaca: Cornell University Press, 1988; Michel Feher, with Romona Nadoff and Nadia Tazi (eds), *Fragments for a History of the Human Body*, vols 1-3,

denial of the right to exercise their citizenship and participate in a community of blood donors signified a threat to – and perhaps the end of – gay liberation and severely jeopardised the possibility of homosexual law reform in New South Wales. As I demonstrate in the first part of this chapter, such issues ensured that a ban on gay blood to safeguard the public's health was significantly more complex and problematic than would first appear.

In the second half of this chapter I turn my attention towards people with haemophilia, and explore the way in which HIV infection changed their lives, and the nature of the 'haemophilia community'. Haemophilia is a hereditary disorder of the blood which, due to the inactivity of an essential protein known as clotting factor VIII, does not coagulate when necessary.⁹ It occurs in approximately one in 6,500 males; females with the haemophilia 'gene' are usually asymptomatic but have a 50% chance of passing it on to a son who would develop haemophilia. A person with mild or moderate haemophilia begins slowly to bleed internally into a joint or muscle after a minor bump or trauma to the body. People with severe forms of haemophilia, in which factor VIII is completely inactive, often begin to bleed for no apparent reason. This spontaneous bleeding can occur two or three times per week. Most people with haemophilia suffer severe arthritic joint damage and long-term pain as a result of this bleeding. For much of the twentieth century, they were forced to treat their bleeding episodes by lying in hospital for hours at a time in order to be infused with fresh frozen blood plasma. The development of blood fractionation technology and factor concentrates, such as cryoprecipitate and Anti Haemophilic Factor (AHF) in the 1960s and 1970s, however, changed the nature of this treatment dramatically. AHF, the most popular option, is a concentrated form of clotting agent which is extracted from blood plasma and converted to a powder. It can be reconstituted with distilled water and transfused by means of a simple syringe, thus making it easy to store, transport and administer at home, work or school. In the words of Jenny Ross, a mother of a son with

New York: Zone, 1989; Bryan S. Turner, *The Body and Society: Explorations in Social Theory* [1984], 2nd edition, London: SAGE, 1996; Thomas Laqueur, *Making Sex: The Body and Gender from the Greeks to Freud*, Cambridge: Harvard University Press, 1990; Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity*, New York: Routledge, 1990, especially pp.128-41; and Elizabeth Grosz, *Volatile Bodies: Toward a Corporeal Feminism*, Bloomington: Indiana University Press, 1994.

⁹A rarer form of haemophilia, often called Christmas Disease, is linked to a deficiency of factor IX.

haemophilia and President/Executive Director of Haemophilia Foundation Australia since its inception: "Everybody learned a new independence from the hospital. It seemed like God's blessing, a medical miracle in the 1970s."¹⁰ It was, however, a blessing from God which became the Devil's curse when it was discovered in the early 1980s that viruses such as hepatitis and HIV had infected the product. People who had been injecting themselves with AHF faced a much greater probability of being exposed to contaminated blood than those who chose to treat their bleeds in hospital with frozen blood plasma or cryoprecipitate, because their product was manufactured from the blood of between 2,000 and 3,000 donors. Cryoprecipitate, by comparison, is constituted from the blood of less than twenty people.

An awareness that people infusing blood products could be infected with HIV came slowly to the medical profession. The U.S. Centers for Disease Control's (CDC) *Morbidity and Mortality Weekly Report* first alerted its readers that patients with haemophilia, but no other underlying disease, had contracted AIDS-related pneumonia in July 1982. Inquiries concerning the patients' sexual activities, drug usage, travel patterns, and place of residence offered no evidence that the cases were in contact with each other, or with homosexuals and intravenous drug users; nor was there any evidence that they were suffering the effects of lifestyle-induced immune overload. The haemophilia patients did, however, share a dependence on factor VIII concentrate.¹¹ Commenting on the report, an editorial note in the *MMWR* stated that "although the cause of severe immune dysfunction is unknown, the occurrence among the three hemophiliac cases suggests the possible transmission of an agent through blood products".¹² In response, James Curran, head of the

¹⁰Jenny Ross interviewed by Heather Rusden, 11 February 1993, 'The Australian Response to AIDS' Oral History Project, National Library of Australia, TRC-2815/18, transcript p.5 (henceforth as Ross, NLA, TRC-2815/18). Haemophilia Foundation Australia began as the Australian Federation of Haemophilia Societies in 1979 and operated under this name until 1986. I have adopted its current nomenclature throughout this chapter.

¹¹CDC, 'Pneumocystis carinii Pneumonia Among Persons with Hemophilia A', *Morbidity and Mortality Weekly Report*, vol.31, 16 July 1982, pp.365-7. The response of the CDC and the American blood collecting agencies to these cases is discussed in Ronald Bayer, 'Blood and AIDS in America: The Making of a Catastrophe', in Eric A. Feldman and Ronald Bayer (eds), *Blood Feuds: AIDS, Blood, and the Politics of Medical Disaster*, New York: Oxford University Press, 1999, pp.21-2.

¹²CDC, 'Pneumocystis carinii Pneumonia Among Persons with Hemophilia A', *Morbidity and Mortality Weekly Report*, vol.31, 16 July 1982, p.366.

CDC's AIDS unit, urged homosexuals to refrain from giving blood, thus echoing a call issued by a gay physician in the United States in August 1982.¹³

The possibility that blood could be a vector for AIDS was heightened by a case, reported by the CDC in December 1982, of unexplained immunodeficiency and opportunistic infection in a 20-month-old infant who had received multiple transfusions, including platelets, from a donor subsequently diagnosed with AIDS.¹⁴ The sibling of the infant was in good health and his parents were described as "heterosexual non-Haitians" without a history of intravenous drug use, thus removing them from any of the 'high risk' groups that had been established. The blood supply, it seemed, was contaminated. Soon after this case had been reported, in January 1983, the three largest blood-collecting agencies in the United States called for donor education about the symptoms of AIDS and contemplated a system of self-deferral. They also recommended that people at 'high risk' – gay men, Haitians and intravenous drug users – not be targeted for donor-recruitment drives. Significantly, however, these agencies stopped short of questioning donors about their sexual orientation or practices and did not directly ban gay men from donating blood.¹⁵

Finally, in March 1983, the US Public Health Service recommended that members of groups at increased risk for AIDS should refrain from donating blood. Most of the major blood collecting agencies complied with these recommendations.¹⁶ For a time, lesbians were also rejected as donors in some locales – an incredible proposition given that no cases of AIDS had been reported among the lesbian population.¹⁷ Despite these recommendations, Dr Joseph Bove, chairman of the American Association of Blood Banks' Committee on Transfusion Transmitted Disease, remained unconvinced that AIDS

¹³Murray, 'The Poisoned Gift', p.228.

¹⁴CDC, 'Update on Acquired Immune Deficiency Syndrome (AIDS) Among Patients with Hemophilia A', *Morbidity and Mortality Weekly Report*, vol.31, 10 December 1982, pp.644-52; and 'Possible Transfusion-Associated Acquired Immune Deficiency Syndrome (AIDS) – California', *ibid.*, pp.652-4.

¹⁵'AIDS Leading the Way for Blood Bank Ban', *Campaign*, vol.87, March 1983, p.13.

¹⁶U.S. Public Health Service, 'Prevention of Acquired Immune Deficiency Syndrome (AIDS): Report of Inter-agency Recommendations', *Morbidity and Mortality Weekly Report*, vol.32, 4 March 1983, pp.101-4.

¹⁷J. H. Downton, 'Should Lesbians Give Blood?', *Lancet*, vol.2, 16 August 1986, p.298.

was being spread via blood transfusions: "In two years since AIDS was first identified, 20 million people have been transfused and some must have gotten blood from donors with AIDS. But we don't see an epidemic."¹⁸ As Dr Bruce L. Evatt of the CDC pointed out, however, in the first article about contaminated blood to appear in an Australian newspaper, Dr Bove was not taking into account the incubation period of AIDS, knowledge of which had been firmly established.¹⁹

It was in this newspaper article, published in March 1983, that the Australian public first became aware of the possibility that the blood supply might be infected with AIDS. On 2 May 1983 the *Australian* further reported:

British health authorities are becoming increasingly concerned about the threat of the fatal disease AIDS being imported in contaminated blood products from the United States ... neither the Department [of Health], nor the Communicable Disease Surveillance Centre was able to confirm a report that two [people with haemophilia] were suspected of contracting the disease in this way in Britain.²⁰

Australia, with a proud tradition of supplying all of its own blood requirements, was considered to be immune from this problem; at least, this is what BTS officials told frightened people with haemophilia when they inquired about the safety of their blood service. They also pointed to Australia's system of voluntary blood donation, established and enshrined in state law in 1929, which, unlike the United States, did not provide an incentive for potentially HIV-infected drug abusers to deposit blood for cash. One anxious mother of a haemophilic child was even ushered into a BTS lounge and told, "Look at all these good clean people. These are our donors. You don't think that these people would have HIV?"²¹ Such self-assurances convinced the BTS to remain non-committed to the

¹⁸Robin Marantz Henig, 'The Black Plague of the Eighties...', *Weekend Australian Magazine*, 5-6 March 1983, p.4.

¹⁹*Ibid.*

²⁰'Sexually Transmitted Disease May Be Imported In Blood Transfusion Products', *Australian*, 2 May 1983, p.8.

²¹Ross, NLA, TRC-2815/18, p.15. Ross is obviously paraphrasing here, as the term AIDS rather than HIV would have been used at the time.

Haemophilia Society's suggestion for a donor screening system to be established, despite the growing evidence overseas that AIDS was caused by a blood-borne virus and was now killing people with haemophilia.

The BTS's outward assurances concealed an inner anxiety, a facade that cracked when Dr Gordon Archer, Director of the Sydney BTS, publicly called for "promiscuous homosexuals" to desist from donating blood on 9 May 1983; his plea made the front page of newspapers the following morning.²² During a television interview that evening, Archer also stunned his BTS colleagues in other states by proclaiming that it was "a virtual certainty that AIDS was in the blood supply". While the National Red Cross Blood Transfusion Committee (NBTC), headed by Professor David Penington, had decided to wait for firm Red Cross guidelines from the United States, Archer had taken the advice of a visiting Oklahoma blood bank director who was implementing the US Public Health Service recommendation of voluntary donor deferral, despite the absence of detected cases of AIDS in Oklahoma.²³ The *Australian* article which had appeared less than a week before may have also influenced Archer.

Archer's announcement, made without the consultation of gay community leaders, incensed a group of homosexual activists in Sydney. Members of Gay Solidarity Group were particularly angry at the way in which the ban stigmatised gay men by equating them with disease and defining them as potential killers. John Cozijn, journalist for the gay news-magazine *Campaign* and a leading member of Gay Solidarity Group, went to see Archer the following day and requested that he meet with a delegation from the gay community who were in favour of surrogate blood testing for hepatitis B instead of a blanket ban on 'promiscuous homosexuals'.²⁴ Archer flatly refused. The issue was then discussed at a Gay Rights Lobby meeting where it was decided to organise a picket outside

²²See, for example, Sue Cook, 'Disease Fears Lead Cross to Ban Gays as Donors', *Australian*, 10 May 1983, pp.1-2.

²³'Blood Bank Gets It Wrong', *Campaign*, vol.90, June 1983, p.5; Ballard, 'HIV-Contaminated Blood and Australian Policy', p.249.

²⁴At the time, many people with AIDS also presented with other infections such as hepatitis B, and it was believed that the presence of this virus – which could be detected – was a good indicator that the donor may have AIDS and should thus be excluded.

Red Cross House in Clarence Street.²⁵ The picket went ahead on 13 May 1983 with a small group of protesters chanting and distributing leaflets which demanded "Ban the Bigots not the Blood" and called for surrogate blood testing. The leaflets also claimed that in a state where male homosexual acts were illegal and in a society where oppression of gays was rife, the blood ban was likely to be counter-productive because "[m]any homosexual men feel they must now give blood, irregardless [*sic*] of their particular risk factors, to show to their friends and colleagues that they are not gay."²⁶

By portraying gay men as closeted and willing to risk the lives of others in order to preserve their secret identities, the protest was a public relations disaster and left gay men looking irresponsible and selfish. Dissatisfied with the outcome of the picket, gay groups including the Gay Counselling Service, Gay Rights Lobby and Gay Solidarity Group met on 15 May 1983 to discuss the ramifications of the ill-conceived public action and the threat of further stigmatisation. They established an AIDS Action Committee – the first of a breed of gay-run state-based AIDS committees that would mature into state AIDS Councils within the next two years – with the purpose of disseminating accurate information about AIDS and forming a consultative relationship with government. Indeed, in its first weeks of existence the AAC persuaded the NSW Minister for Health to establish an AIDS Consultative Committee, with membership drawn from the Department of Health, medical specialists and the AAC.²⁷ Yet gay men remained tainted by accusations of irresponsibility and selfishness which, in the following years, made the public even more susceptible to believing that gay men were donating blood "out of spite" and killing 'innocent victims'.²⁸ It is therefore important to understand what propelled gay men to

²⁵Alison Thorne, 'Bad Blood and Bad Politics', *Outrage*, vol.3, June 1983, p.3.

²⁶Leaflet quoted in *ibid.*

²⁷John Ballard, 'Australia: Participation and Innovation in a Federal System', in David L. Kirp and Ronald Bayer (eds), *AIDS in the Industrialized Democracies: Passions, Politics and Policies*, New Brunswick: Rutgers University Press, 1992, pp.138-9.

²⁸See, for example, accusations made in a Network Ten documentary titled *The Truth About A.I.D.S. in Australia* which went to air on 28 October 1985 and comments made by Queensland BTS Director, Dr Peter Harden; the Chief Medical Officer of New South Wales, Dr Tony Adams; and radio station 2GB's popular breakfast programme host, Mike Carlton (Glen Turner, 'New Fear On Spread of AIDS', *West Australian*, 19 November 1984, p.5; 'Gays Accused of Giving Blood "Out of Spite"', *Daily Telegraph*, 17 November 1984, p.2; and 'The Gay Crisis', *National Times*, 23-29 November 1984, p.12).

reject a seemingly sensible public health measure, picket outside the Red Cross headquarters, and write scathing letters criticising the blood ban to the gay and mainstream press.

It is seductive to suggest that the gay protest was a simple and misguided case of Sydney homosexuals mimicking the reactionary position adopted by American gay groups to bans on their blood earlier in the year. After all, the Sydney gay community had already proven itself willing to mimic the response of US homosexuals in organising fund-raising events and health and home care provision for people with AIDS, despite the absence of any Australian cases of the syndrome. To support this argument, one can point to the rhetoric employed by the Sydney gay activists, which was almost identical to the statements issued (and reprinted in the Australian gay press) by their American counterparts during the months preceding Archer's announcement.²⁹ Compare, for example, the argument expounded in the Red Cross picket leaflet with a statement made by the U.S. National Gay Task Force in January 1983 in response to calls by the National Haemophilia Foundation for blood agencies to stop collecting gay blood:

If you were a worker on the assembly line at a Ford Motor Company plant and your blood collecting unit had a big sign on it that said 'No Gay Blood!' – you'd be the first one to roll up your sleeve and give, just to prove to your colleagues that you are not gay.³⁰

In many instances, this rhetoric was inappropriate. Australia did not have a tradition of mobile blood banks travelling to workplaces (although this did occur), and had a system that allowed donors to forego giving blood by citing illness, history of disease infection, or the current use of medication. Donors could also privately contact the BTS immediately after making a donation to request that the blood not be used.³¹

²⁹See, for example, 'U.S. In Summary' and 'AIDS Leading the Way for Blood Bank Ban', *Campaign*, vol.87, March 1983, pp.12-13.

³⁰'U.S. In Summary', *Campaign*, vol.87, March 1983, p.12.

³¹Dr Gordon Archer, cited in 'Evidence Confirms That Gay Men Have Ceased Blood Donation', *Campaign*, vol.108, December 1984, p.20.

While there is little doubt that the gay activists took their lead from America, the vehemence with which Sydney homosexuals took up the protest against the BTS suggests that a more profound, and culturally specific, motivation underpinned their actions. Indeed, statements made in the gay press, at the Red Cross picket, and during late-night meetings of the Gay Rights Lobby and Gay Solidarity Group, indicate that they were primarily concerned with how the explicit association of AIDS with gays, and the separation of gay men from 'normal' and 'healthy' donors, would affect public attitudes towards homosexuals. As Craig Johnston wrote in *Campaign* in June 1983:

When blood collection agencies announce that they don't want any gay donors because of the appearance of AIDS in some gay men, I interpret that announcement as 'all gay blood is bad blood'. And that is not on. That offends my dignity.³²

Johnston and his friends were, of course, aware of the wider consequences of this association, and of their segregation from a community of blood donors. On the page adjacent to which his column appeared, *Campaign* carried a frightening story from Joplin, Missouri, which reported that the town's inhabitants had taken to picketing a local gay bar and wearing T-shirts that read "Queers have bad blood", in an attempt to drive their gay neighbours out of town.³³ As Ronald Bayer has written, gay men clearly recognised what was stake in losing their civic right to give blood:

Just as the threat to blood – symbolic of life itself – galvanized communal anxiety, the threat of exclusion from the blood donor pool represented a profound threat to the social standing of those who would be classed as a danger to public health ... The debate over the blood supply thus placed into question the gay struggle for social integration.³⁴

³²Craig Johnston, 'Comment' [column], *Campaign*, vol.90, June 1983, p.11.

³³'Sex Crackdown', *Campaign*, vol.90, June 1983, p.10.

³⁴Ronald Bayer, *Private Acts, Social Consequences: AIDS and the Politics of Public Health*, New York: Free Press, 1989, p.73.

Coming at a time when Sydney homosexuals were trying to extend their freedoms and participation in society by seeking the repeal and reform of laws affecting homosexuals in New South Wales (sexual intercourse between consenting male adults was illegal in NSW until June 1984 and homosexuals were not protected by anti-discrimination legislation before this time), this new curtailment of their civic rights was keenly felt.

Given that the Sydney BTS did not ban other 'high risk' groups in May 1983 – a step which should have seemed logical yet was delayed until June – gay men could have also been forgiven for suspecting that the ban on their blood was motivated by homophobia rather than concerns for the public's health. The gay community was well aware that clients of the BTS had complained about having to receive the blood of 'poofers', and a number of blood banks in the United States had already proven that they were not above pandering to the homophobic prejudices of their customers by taking advantage of the 'gay plague' hysteria to ban lesbians as well as gay men from donating blood.³⁵ The suspicions of gay men in Sydney were exacerbated when Archer tersely refused to meet with gay community leaders following his announcement, and after it was made known that BTSs in other states were consulting gay groups before committing themselves to a course of action.³⁶

It is also clear that gay men in Sydney were confused by the timing of Archer's announcement and the contradictory statements they had read in the gay press, emanating from medical experts and blood bank officials in the United States, regarding the threat posed by AIDS to the blood supply. In the first instance, the BTS ban seemed overly cautious and premature, given that a second Australian case of AIDS had not yet been reported and given that the US Red Cross and Penington's NBTC had not yet issued firm guidelines. Moreover, gay men in Sydney could cite statements made by Dr Bove and the assurances of the American Association of Blood Banks that AIDS had not affected the US blood supply (assurances which had been retracted by the time that *Campaign* quoted the

³⁵Downton, 'Should Lesbians Give Blood?', p.298.

³⁶'Blood Bank Gets It Wrong On AIDS', *Campaign*, vol.90, June 1983, p.5.

material).³⁷ They could also cite the comments of Dr David Cooper, an epidemiologist recently returned from the United States, who claimed in an issue of the *Medical Journal of Australia* that "[a]voidance of blood donation by high-risk groups is predicted to be ineffective and inappropriate".³⁸ It is this kind of confusion and contradiction in the minds of gay men, not to mention their justifiable anxiety that their march towards gay liberation was coming to a halt, that one must take into consideration when assessing the claims that gay men were 'selfish' and 'irrational' in their protestations against the Sydney Blood Transfusion Service.³⁹

While gay men were mobilising swiftly in Darlinghurst, the pace was no less frantic at the headquarters of the National Red Cross Blood Transfusion Committee. Despite immediately supporting Archer's initiative in New South Wales, Penington's NBTC was quick to assert publicly that there was no risk of contracting AIDS from blood in Australia because of this country's self-sufficiency in blood supplied by voluntary donors. He sent a cable to BTS Directors which indicated that since NSW was the only state to register a case of AIDS, and this man's sexual partners had been traced and warned against giving blood, "it is considered that there is no cause for alarm at present and it is not felt necessary to request any particular group in the community outside NSW to refrain from donating their blood".⁴⁰ It was an extremely naive statement given Penington's understanding of the incubation period for AIDS and the likely cases of asymptomatic infection that existed in Australia. The Victorian BTS did, however, change its method of blood collection two days after Penington's communiqué, when the first confirmed case of AIDS in Melbourne

³⁷John Cozijn, 'AIDS: Fact and Fiction', *Campaign*, vol.92, August 1983, p.14.

³⁸David Cooper, 'The Acquired Immune Deficiency Syndrome: Conference Report', *Medical Journal of Australia*, vol.128, 11 June 1983, pp.564-6; also quoted in 'Minister Favours Funding', *Campaign*, vol.91, July 1983, p.13.

³⁹Such an accusation was made by Jack Rush, a barrister who represented the first person with haemophilia to sue for compensation (PQ vs Australian Red Cross Society and Ors, Victorian Supreme Court, September 1990). Moreover, he argued that the gay protest persuaded the various BTSs to delay the implementation of nation-wide and universal blood bans on gay men and other high risk groups, which might have prevented hundreds of people from becoming infected with HIV in the following year. See John T. Rush, 'AIDS - Have We Got It Right?', in Australian Doctors' Fund, *AIDS - Have We Got It Right?*, unpublished collection of papers delivered to the Australian Doctors' Fund Summit, 15 May 1992, Travers Collection (uncatalogued), Monash University Rare Book Collection.

⁴⁰Internal communiqué to the Red Cross BTS Executive Director and BTS Directors, 'Statement on Acquired Immune Deficiency Syndrome (A.I.D.S.)', 10 May 1983, NBAC/NAAC, ANU, H7/46.

was announced. It instructed all of its regional BTSs to discontinue mobile collections from prisoners, and prepared brochures for prospective donors, which identified people at high risk of AIDS, so that they might be able to assess their own suitability for donation.⁴¹ Finally, after the Director of the South Australian BTS returned from the United States with an American Red Cross leaflet warning of the risks of donating AIDS-infected blood, the NBTC shifted its position and recommended, on 1 June 1983, that Red Cross donation centres ask for "sexually active homosexual or bisexual men with multiple partners", injecting drug users and partners of these people to abstain from donating blood.⁴² The implementation of the NBTC guidelines was left to each BTS and none of them proceeded to introduce screening measures beyond the distribution of pamphlets to donors. They thus relied on a process of voluntary self-education and exclusion rather than risk losing "sensitive-minded" heterosexual blood donors who might have been deterred from donating if directly questioned about their sexual or drug using practices.

In carefully choosing to widen the group deemed 'at risk', thus diminishing – to an extent – the stigmatisation of gay men caused by exclusively linking them with AIDS, the NBTC demonstrated that it had learnt a lesson from the Sydney BTS fiasco. Despite this new emphasis, however, the media continued to focus on the ban of homosexuals in their headlines, and frequently evoked the term "promiscuous", as Archer had done, instead of the more cautiously phrased "sexually active homosexual and bisexual men with multiple partners".⁴³ This choice of word came to have dire consequences in the following year as a few gay men with multiple partners, taking their lead from the media rather than the BTS pamphlets, continued to donate blood because they did not consider themselves "promiscuous" (a category laden with connotations of immorality, and with which, understandably, few men wished to identify).

⁴¹Internal communiqué to the Red Cross BTS Executive Director and BTS Directors, 12 May 1983, NBAC/NAAC, ANU, H7/46.

⁴²Ballard, 'HIV-Contaminated Blood and Australian Policy', p.249. As I shall discuss later in the chapter, the timing of each of these developments and the speed with which the Australian Red Cross accepted US medical evidence and recommendations was to become incredibly important in subsequent years, as people with medically-acquired HIV sought to sue the BTS and hospitals for negligence in failing to act with more determination to secure the blood supply. Each measure stalled or half taken, they claimed, resulted in another life lost.

⁴³See, for example, 'Move to Stop Homosexuals Giving Blood', *Age*, 3 June 1983, p.5.

For the time being, however, it appeared as if Australia had avoided the blood contamination crisis that was emerging in the United States. Indeed, when the National Health and Medical Research Council met in October 1983 to accept recommendations from its Working Party on AIDS, it issued public advice that "[t]here is no evidence that blood products in Australia are at risk of transmitting AIDS, following precautions already undertaken by the Australian Red Cross Society".⁴⁴ But the precautions taken thus far had only amounted to half measures and Australia had not avoided tragedy; at least, this was the story to unfold in July 1984 when a Melbourne man, Bruce Loker, became the first person in Australia to develop AIDS after receiving a transfusion of contaminated blood.

Loker, who did not belong to any of the groups recognised to be at 'high risk', had been admitted to hospital and diagnosed with AIDS late in June. The only risk factor that the hospital could identify was a blood transfusion, consisting of four units of blood taken from four different donors, which Loker had received one year earlier as treatment for Legionnaire's disease. The BTS traced the four donors and sent samples of their blood to Dr Jay Levy at the Cancer Research Institute in San Francisco, whose newly developed immunofluorescence assay confirmed that one of the donors had been exposed to HIV. The donor, a gay man, subsequently acknowledged that he was aware of the BTS warning on gay blood but ignored it as he did not consider himself to be "promiscuous".⁴⁵

Worse news was to come. On 26 July 1984, the *Age* reported that additional units of the donor's blood had been used in the manufacture of factor VIII. Twenty-eight children with haemophilia in Queensland had received the blood and were now being tested for AIDS while hospitals in three states went in frantic search for batches of the man's blood which had not been accounted for.⁴⁶ It was in news reports such as this that many people with haemophilia learned that they were at risk from, or may well have, HIV infection.

⁴⁴NH&MRC, 'Acquired Immune Deficiency Syndrome (AIDS)', *Medical Journal of Australia*, vol.141, 1984, p.562, cited in Ballard, 'HIV-Contaminated Blood and Australian Policy', p.250.

⁴⁵Anthony I. Adams, 'AIDS and Blood Donors', *Medical Journal of Australia*, vol.141, 27 October 1984, 1984, p.558.

⁴⁶'AIDS in Transfusion Sparks Three-State Blood Search', *Age*, 26 July 1984, p.5.

The news media, which since June 1983 had been relatively quiet on AIDS, now embraced the 'epidemic' with relish. It speculated about the number of "secret AIDS carriers" in Australia, described the BTS's frantic hunt for contaminated blood, and suggested that gay men with AIDS were donating blood "out of spite" for a society which had rejected them (claims which I shall explore in my next chapter). *Campaign* reported that "the AIDS panic is now in full swing. As radio stations, newspapers and television vie with each other for the final word, ignorance, prejudice and lies are being spread about a very real threat."⁴⁷ Barry Lowe, *Campaign*'s editor, suggested that AIDS had only now become a front page news story, and aroused the government's interest, because mainstream heterosexual society had been visibly implicated in the epidemic:

AIDS research has not been given much priority because it has, until now, [only] affected the 'underbelly' of society ... Homosexual health, alas, is a very low priority for government unless it's a vote winner or else the problem spills over into the heterosexual community.⁴⁸

His comments were without foundation and inappropriate, however. The media, the NH&MRC and state health departments had been taking an interest in AIDS since its arrival in Australia, and the news media, in an effort to sell its product, could also be forgiven for '(over) exposing' a health issue which now clearly concerned the majority, rather than a small minority, of its audience. Ironically, the title of Lowe's editorial, 'AIDS & US', alluded to the reason for his over-sensitivity. Rather than referring to 'Us' (Australian homosexuals) as the editorial purported, Lowe merely encapsulated the situation that he had read about in the United States, and simply plagiarised the criticisms of the American media and politicians that had been published by the North American gay press.

⁴⁷Editorial, 'AIDS & US', *Campaign*, vol.104, August 1984, p.16.

⁴⁸*Ibid.*

In addition to the dramatic rise in the news media's output, the disclosure of the first medically-acquired HIV case saw the BTS intensify its efforts to prevent the spread of AIDS through the blood service. In Sydney, Dr Gordon Archer spoke at a public meeting of gay men to explain the need for those with multiple partners to refrain from donating blood, and his BTS, with support from the AAC, began to require donors to declare on a form that they were not members of a high risk group. Despite objections from the NSW Privacy Committee, the BTS maintained the use of the form. Having heard that some US blood agencies were introducing surrogate testing, Archer also arranged to import Belgian hepatitis B antibody test kits and began surrogate testing in October as a further means of identifying donors at 'high risk' for AIDS.⁴⁹ Sydney gay groups had, of course, advocated this course of action in May 1983. In October 1984, after several more cases of medically-acquired HIV had been revealed in Sydney, staff at the Melbourne BTS began to question its donors in confidence about their possible exposure to AIDS, and excluded those deemed to be at risk.⁵⁰ In November 1984, donor declaration forms were introduced by each of the state Blood Transfusion Services.

Australia had obviously not avoided the blood contamination crisis unfolding in the United States and Professor Penington, as head of the NBTC, was asked to explain why it had failed to do so. The root of the problem, he claimed, was clear and simple: gay men with multiple partners had not desisted from donating blood after May 1983. He cited two main reasons for their recalcitrance. First, homosexuals, exhibiting classic symptoms of denial, wanted to convince themselves that they were neither sick nor at risk. Second, as the BTS carried out routine tests for syphilis and hepatitis, the process of donating blood provided gay men with a convenient and pleasant way of having their blood screened for these diseases, a practice they were not willing to forego.⁵¹ Perhaps influenced by his contact with gay men during the May 1983 Red Cross protest, Penington clearly believed gay men to be irresponsible and unwilling to consider the health of others. In December 1984, he

⁴⁹Ballard, 'HIV-Contaminated Blood and Australian Policy', p.251.

⁵⁰Mark Metherell, 'Blood Bank Bans Donations From AIDS Risk Groups', *Age*, 6 September 1984, p.1. Also see, Open letter to blood donors from Dr J.P. Morris, Director of the Red Cross Blood Bank of Victoria, dated October 1984, NBAC/NAAC, ANU, H7/22. Approximately 150,000 of these letters were sent to prospective donors.

⁵¹Andrew Biggs, 'Learning to Live with AIDS', *Courier Mail*, 8 January 1985, p.5.

would use this explanation to justify his call for criminal penalties to be attached to making false declarations about sexual or drug use practices on blood donor forms. The head of the NBTC obviously did not accept that gay men might have been confused by the contradictory messages regarding blood donation disseminated by the American and Australian blood banks and the *Medical Journal of Australia*, and the conflation of "multiple partners" with "promiscuity" by Dr Archer and the mainstream press. Nor did he accept that the arbitrary nature of his own guidelines, and the delay in the introduction of donor declaration forms and face-to-face interviews, might have been partially responsible for the contamination of some blood products. Indeed, Penington's insistence that the blame lay with gay men ignored the fact that there was a rapid decline in donations from homosexuals once firm guidelines and proper education were provided after July 1984. There was, in fact, a 7% drop in donations in New South Wales after July 1984, which was estimated to correlate exactly with the proportion of gay men donating to the blood supply before this time.⁵²

The isolation of the Human Immunodeficiency Virus and the development of rudimentary HIV-antibody tests, such as that produced by Jay Levy in the United States, provided an opportunity for Professor Ian Gust, an immunologist at Melbourne's Fairfield Hospital, to estimate the extent of HIV infection in the haemophilic population. Gust sent a laboratory specialist to the CDC and the US National Institute of Health in August 1984 to learn how to perform the test. By 16 September he had returned with a jar of antigen, enabling Fairfield to test a limited number of blood samples.⁵³ Gust gained permission to test the stored sera of people with blood coagulation disorders who were using AHF. His initial testing found that one-third of the sample were HIV-antibody positive.⁵⁴ Gust's next task was to inform the Haemophilia Treatment Centre at the Alfred Hospital, who then contacted the President of the Australian Federation of Haemophilia Societies, Jenny Ross. Ross remembers the telephone conversation vividly:

⁵²Figure supplied by Dr Gordon Archer and cited in AAC/ Lex Watson, *Proposals for Government Action and Strategies in Response to AIDS*, unpublished report prepared for a meeting with the Minister for Health, Neal Blewett, Melbourne, 18 November 1984, NBAC/NAAC, ANU, H19/25.

⁵³Ballard, 'HIV-Contaminated Blood and Australian Policy', p.251.

⁵⁴Jenny Ross, 'Report of Special Committee Meeting of Haemophilia Society of Victoria held on 30 October 1984', NBAC/NAAC, ANU, H7/46.

This was the most shattering phone call in anybody's life that you can imagine. It upsets me just talking about it. I can remember the day. It brings all the feelings back. I didn't know if my son would be one of them. It was correct that a third of the total group who used treatment in those five years were infected. But of the group who were severe – the ones who were treated twice a week – it was 60 per cent to 70 per cent. So from that day I, as the President of the national group, had been given this information.⁵⁵

Ross was also informed that the Commonwealth government would provide \$10,000 to allow Gust to test the blood of every person with haemophilia in Australia. The government's commitment was announced in the newspapers the following morning, denying Ross the opportunity to personally contact members of her community and compassionately deliver the devastating news: "The first [thing] people knew was that \$10,000 had been given, because a third of the people with haemophilia had been infected. Being the President, people rang me."⁵⁶

Such news, coming at a time when people with HIV were being ostracised like lepers by their neighbours and work-mates, and when few people distinguished HIV infection from 'full-blown' AIDS and death, caused great distress within the haemophilia community. It was not surprising, therefore, that one of Ross's first priorities was to secure counsellors to be based in the major haemophilia treatment hospitals in each state. One of their tasks was to counsel numerous people with haemophilia who only discovered the result of their blood tests when, in the words of another mother of a haemophilic son, "they rang the Blood Bank for supplies and were informed either they could have cryoprecipitate because their result was negative, or they would continue to use [the more dangerous] AHF as it didn't matter what they infused because their result was positive".⁵⁷

⁵⁵Ross, NLA, TRC-2815/18, p.12.

⁵⁶*Ibid.*

⁵⁷Lynn Reid, mother of a son with haemophilia, contribution to 'Consumer Forum', *National Haemophilia*, no.23, October 1988, p.8.

Unlike the gay community, which had been following the development of AIDS in the United States for two years and thus had an opportunity to organise home-care, education and counselling services before having to deal with its first case, the haemophilia community had no time to prepare for the devastation of AIDS. The small size of its population – which numbered around 1,500 in 1984 – and its geographical dispersion, meant that resources for these people were scarce or non-existent. At the time, there was only one (part-time) social worker devoted to working with people with haemophilia in the entire country, and only three Australian states – Victoria, New South Wales and South Australia – had formally organised haemophilia societies which could offer support and information. In 1979-80, these groups had established the Australian Federation of Haemophilia Societies, with Jenny Ross as President, and it was Ross who took on the bulk of the responsibility for informing people with haemophilia about their options and providing information about AIDS.

People with haemophilia faced many other problems, unique to their group because of the nature of their condition, in dealing with HIV infection. These problems, related through the words of the people who experienced them, will be the focus of the remainder of this chapter. In particular, I rely on the testimony of Jenny Ross who, as President and then Executive Director of what is now called Haemophilia Foundation Australia (HFA), editor of the HFA newsletter, and committee member of NACAIDS and ANCA, was in constant communication with her constituency and shared many of their experiences. I trace their stories of coping with HIV infection until the early 1990s before returning, in my next chapter, to examine the political response to the contamination of the blood supply and the treatment of homosexual men who were branded (not for the first time) as murderers.

The hereditary nature of haemophilia and the way it fosters a relationship of dependence between mother and son, preconditioned, to an extent, the sense of guilt and grief that many mothers experienced after learning of their sons' infections. As Jenny Ross relates, a mother who carries the haemophilia gene and who had passed it on to her son had to deal with "the fact that she gave her son the haemophilia, which causes him all this pain and agony ... that then becomes the reason he got AIDS. On top of that, it was often her hand that pushed the syringe and the infected blood product into his veins. We've got a lot of

guilt and a lot of problems in dealing with that.”⁵⁸ This sense of guilt was encapsulated in the despair of another mother who claimed that “I’ve been putting poison into my child.”⁵⁹ Staff at Haemophilia Treatment Centres who had, in some cases, become much loved members of extended families after caring for people with haemophilia since birth, also experienced this sense of devastation and guilt once they became aware that the treatments they had been administering were, in numerous instances, deadly. Ross recalls that,

[t]he health carers went through enormous trauma, because, in the best of faith, they were doing what they thought was right. They loved these people. These people were a large part of their life. It’s different if you have someone come into hospital with cancer and you meet the person with a terminal illness. These were people that they’d known, some of them, since they were babies. Here they are at [age] thirty. So it was like family members. But instead of one family member, here in Victoria it was sixty or one hundred family members. It was the same in New South Wales. So you can imagine the trauma that that caused personally.⁶⁰

Parents of sons with haemophilia also faced the prospect of one child acquiring HIV while the other did not, despite the fact that they used similar blood products. As Ross relates: “We have families where two brothers used the same batch of concentrates out of the fridge. One got HIV and one didn’t. That happened in a number of instances. You sort of have a survivor guilt about why you could be so lucky.”⁶¹ Ross’s own son, who received 39 treatments during the ‘danger period’ between 1980 and 1984 but was not exposed to HIV, knew something of this ‘survivor guilt’. HIV-negative people with haemophilia were not, of course, the only ones to endure this new ‘syndrome’; many gay men also found themselves asking: ‘Why did I not get infected when I behaved in the same manner as my friend who did?’

⁵⁸Ross, NLA, TRC-2815/18, p.23.

⁵⁹Alison Bellamy, counsellor at Royal Prince Alfred Hospital, cited in Peter Smark and Jennie Curtin, ‘Johnny Can’t Play...He’s Got AIDS’, *Sydney Morning Herald*, 9 May 1985, p.5.

⁶⁰Ross, NLA, TRC-2815/18, pp.21-2.

⁶¹*Ibid.*, p.63.

The shock of infection also led to a kind of irrational anger on the part of some HIV-positive people towards those who tested negative. As Ross remembers: "Those that were positive didn't even want to speak with those with haemophilia who were lucky enough to be negative, which seemed very sad at the time, because everybody went through the same terrible trauma with the testing and the fear."⁶² Predictably they also directed anger towards the people who had unknowingly donated infected blood. Ross observed, however, that "people worked through that and came to terms with the fact that if people hadn't been donating blood all those years, they wouldn't have had treatment either and that nobody did it deliberately...But initially it is all feelings. It's nothing to do with being rational."⁶³ Their difficulty in overcoming their anger was not helped by irresponsible media reporting which opined that "Gay blood donors are the direct cause of the haemophilia community's anguish."⁶⁴

HIV did not only affect families who now nursed an infected father or son. All people with haemophilia were forced to come to terms with the new threat to their lives that their treatments entailed, and the stigmatisation that came with being newly identified as a "high risk group". It is difficult to convey the kind of terror that gripped each person with haemophilia once they started to bleed, aware of the fact that their treatment might result in a terminal illness. Many lost confidence in their blood products and the staff at the Haemophilia Treatment Centres, and refused to treat their injuries with factor concentrates, suffering increased pain, immobility and irreversible joint damage as a consequence. They were forced to take time off work and school, and, in an effort to avoid new injuries, withdraw from sporting commitments. In short, for people with haemophilia who decided to delay or reject treatment with blood products, HIV ushered a return to 'invalidity' and the fear of life-threatening bleeds.⁶⁵ The anxiety of being infected with contaminated blood

⁶²*Ibid.*, pp.17-18; 19-20.

⁶³*Ibid.*, p.18.

⁶⁴Peter Smark and Jennie Curtin, 'Johnny Can't Play...He's Got AIDS', *Sydney Morning Herald*, 9 May 1985, p.1.

⁶⁵Alison Bellamy, 'AIDS: Impact on People with Haemophilia', paper presented at the Second National Conference on AIDS, Sydney, 31 October 1986, reprinted in *National Haemophilia*, no.8, June 1987, p.11.

lingered even after the Commonwealth Serum Laboratories, which manufactured the factor concentrates, began to successfully destroy the HIV virus in November 1984 by applying heat to its products, and the BTS implemented universal screening tests for HIV in May 1985.⁶⁶

As it was generally necessary for boys and men with haemophilia to inform their classroom friends, team-mates and colleagues about their bleeding disorders, they suffered, perhaps more than other groups, the stigma of being classified as at 'high risk' for AIDS. While drug users who injected in private and innocuous-looking gay men defied detection, it was difficult for people with haemophilia to escape the public's suspicious gaze. Their situation was not helped by the fact that, proportionally, the haemophilia community was the most severely afflicted by HIV, nor inaccurate media reports which stated that "experts say that between 60 per cent and 70 per cent of Australian haemophiliacs will test positively to AIDS antibodies in their blood".⁶⁷ Fearing persecution and discrimination because of their haemophilia and its association with AIDS, some members of the Haemophilia Society of Victoria requested that their newsletter not be sent in an envelope marked 'Haemophilia Society', "because the postman might see it and might think we've got AIDS in our house".⁶⁸ This anxiety was particularly prevalent in rural areas, where people with haemophilia faced the prospect of trying to keep their blood disorder a secret in small and often uninformed communities.

Exacerbating these problems was the financial hardship that many people with haemophilia now faced in living with HIV infection. While accustomed to taking time off work to treat a bleed or nurse a sick son, men with haemophilia and HIV who had to quit work, and mothers who took leave to look after their children, now found themselves having to pay the extra medical and travel costs associated with HIV infection on a reduced income.

⁶⁶The application of heat to kill viruses in blood products was not unknown before this time, but had proved inefficient, reducing the yield of the product by almost 50% - an unacceptable result: given the shortage of blood donations. CSL achieved acceptable yields and success in destroying HIV by heating AHF at 80 degrees for 72 hours.

⁶⁷Peter Smark and Jennie Curtin, 'Johnny Can't Play...He's Got AIDS', *Sydney Morning Herald*, 9 May 1985, p.1.

⁶⁸Letter quoted by Ross, NLA, TRC-2815/18, p.23.

These families were already financially incapacitated by the burden of having to treat the haemophilia and its side-effects: arthritis, swollen joints, viral infections such as hepatitis (which was often also transmitted via blood transfusion), and liver damage. This circumstance, and the fact that their health care providers had failed them, convinced the HFA that its members living with HIV were worthy, above other groups, of financial assistance to be provided by the Commonwealth government in the form of 'no-fault' compensation. Jenny Ross raised this issue at the first meeting of NACAIDS in December 1984, linking the plight of her community with that of farmers who received 'no-fault' compensation when their livelihood is destroyed by natural disaster. On 12 December she sent a letter to Neal Blewett outlining how her community was suffering because of the medical service over which he now presided, and requesting compensation "similar to that given to road accident victims (even if they have contributed towards their own injury or death)."⁶⁹ She also asked for comprehensive haemophilia treatment centres (staffed with medical professionals and a counsellor skilled in dealing with people with haemophilia) to be established in the major metropolitan hospitals, and requested funds to enable the HFA to produce and distribute a monthly newsletter that would communicate the rapidly changing information about AIDS to its members. Blewett acquiesced to all of these demands, but balked at the request for compensation.⁷⁰

The HFA continued to push for compensation in a submission to the Australian Health Services Committee, which, on the advice of Blewett, had convened a Working Party to consider the issue of 'no-fault' compensation in February 1985. The Working Party reported in September, however, that "at the present time it is not feasible to introduce a no fault compensation scheme" due to the fact that there were no precedents for providing compensation to people afflicted by a specific disease, and because the government already

⁶⁹Letter to Neal Blewett from Jenny Ross, 12 December 1984, NBAC/NAAC, ANU, H7/46.

⁷⁰Blewett's department allocated \$20,200 to the HFA to assist the production of a monthly newsletter and the provision of education and support. The Haemophilia Society of Victoria also received a grant from the Victorian Health Commission for a secretary, a social worker and an office, which it shared with the HFA. When the HFA headquarters finally moved out of Jenny Ross's house, its newsletter remarked that "the Ross household has returned to some semblance of normality, even discovering a dining room table and buffet not sighted for many months!" (*AIDS News Bulletin*, no.7, March 1986, p.1). The newsletter changed its name to *National Haemophilia* in 1986, when the Australian Federation of Haemophilia Societies became Haemophilia Foundation Australia.

provided welfare payments to which people with medically-acquired HIV were entitled. The Working Party was also concerned that the HFA could not provide exact data about the number of people infected with HIV via blood products, nor suggest how these persons, who varied in age, earning capacity, physical impairment and number of dependents, should be paid.⁷¹

Ross was undeterred, however, and the following year chaired a NACAIDS Working Party that examined the issue of compensation. It presented its recommendations to NACAIDS in November 1986, which unanimously endorsed the proposal for people with medically-acquired HIV to receive 'no-fault' compensation. "But the following year", Ross recalls, "the report disappeared in the [Commonwealth Health] Department. It didn't get any further and was never acted upon. It was the only working party report that was produced by NACAIDS that was never acted upon."⁷²

On behalf of the HFA, Ross then argued the case with Blewett personally in November 1987 and October 1988. The minister listened compassionately on both occasions but was swayed by the concern within the gay community, and the gay-dominated AIDS Councils, that an offer of financial assistance to one group of 'innocent victims' would portray other people with AIDS as 'guilty' by association. Phil Carsvell, past-president of the Victorian AIDS Council and project officer with the Health Department of Victoria's AIDS Unit, had written to one of Blewett's chief advisors in May 1988 to express this very opinion:

I would be most reluctant to institutionalise, in any way at all, the concept that some people with HIV are innocent and therefore deserving of support, whilst others do not deserve compassion because they have "got what they deserve". I understand the urgency of the needs expressed [by people with haemophilia], I also know of many other cases of hardship throughout the various populations currently experiencing the full brunt of the AIDS epidemic. If a Trust Fund is

⁷¹*AIDS News Bulletin*, no.4, October 1985, pp.3-4.

⁷²Ross, NLA, TRC-2815/18, p.69.

to be established, and it is needed, then it needs to be accessible to all those with a genuine need.”⁷³

As Carswell's letter indicated, while Blewett's department was reluctant to pay compensation, it had been considering Ross's suggestion that an Endowment Fund be established for people with medically-acquired HIV. Ross hoped that such a Fund might be modelled on the Macfarlane Trust which had been established in Britain with a ten million pound government grant. Blewett asked the HFA to prepare a needs assessment and to submit a proposal which estimated the funds required and outlined how such a Trust Fund might be administered. The HFA worked tirelessly and produced a comprehensive document, but its proposal was rejected.

HFA then sought permission from its members to “go public” – as the British Haemophilia Society of Great Britain had done before winning the Macfarlane Trust money – in an effort to place pressure on the government to recognise the needs of people with medically-acquired HIV infection. It was an extremely courageous decision for the HFA to make, and for the majority of its members to endorse, given the increased exposure and stigmatisation of their group that was likely to result from headlines linking haemophilia to AIDS. Indeed, the HFA received letters from some of its members that pleaded for the HFA to cease its action. One parent claimed that “no amount of money will take this virus away from my son. Let him live in peace without public exposure.” A few others, fearing stigmatisation or the moment that previously unsuspecting acquaintances would suddenly make the link between their haemophilia and HIV, threatened the HFA with litigation if it continued to publicly lobby the government.⁷⁴ The HFA remained resolved, however, and launched its campaign with a press conference on 7 August 1989. The subsequent publicity resulted in the HFA's case coming to the attention of the Prime Minister, Bob Hawke, who granted Ross a fifteen minute interview. Ross presented a passionate argument and Hawke

⁷³Letter to Bill Taylor, Assistant Secretary of the Communicable Diseases Branch, Commonwealth Department of Community Services, from Phil Carswell, AIDS Unit, Health Department of Victoria, 12 May 1988, NBAC/NAAC, ANU, H9/31.

⁷⁴Comments quoted in Jenny Ross, ‘Haemophilia Foundation Endowment Fund – Evolution’, document distributed to HFA members, 30 March 1989, NBAC/NAAC, ANU, H7/58. Also see Stephanie Buckle, ‘Perspectives of People with Haemophilia Infected By Blood Products’, *National Haemophilia*, no.44, August 1990, p.6.

returned to cabinet with a request that it reconsider the HFA's proposal. The HFA believed that \$11.7 million would be needed to establish the Endowment Fund. On 7 November 1989 the Commonwealth government announced that it would provide a seeding grant of \$13.2 million to found what became known as the Mark Fitzpatrick Trust. It was named after a haemophilic boy from northern Tasmania who had died aged 10 years after receiving contaminated blood products.

To be eligible for financial assistance from the Trust, people with HIV or AIDS had to show that they had become infected as a consequence of medical procedures prior to the protection of the blood supply and blood products in May 1985. An initial payment of \$2,000 was made to living persons as soon as their registration was accepted while payments of \$10,000 (if single) or \$30,000 (if with spouse or dependents) were made in respect of those who were deceased at the time of registration. Upon death, a final payment of \$8,000 or \$23,000 was made to the estate. Living registrants were grouped into one of three categories, defined by level of physical impairment and determined by medical examination. Those who were very sick and thus incurred greater medical and travel costs, received higher annual payments. Until 2 July 1999 (and with accumulation of interest), 425 registrations had been accepted and payments totalling over \$14.5 million distributed.⁷⁵

Both the HFA and the Trustees took great pains to emphasise that the Mark Fitzpatrick Trust would only provide financial assistance for medical and travel costs associated with medically-acquired HIV infection, and was not a form of compensation. Those people seeking compensation were directed to sue their health care providers – the BTS, CSL, hospitals and individual doctors – if they believed they could prove a case of negligence. In order to prove their cases, people who acquired HIV through medical procedures had to determine the exact date of their infection, and demonstrate that the treating hospital and the BTS had enough information about the possibility of HIV transmission to warrant warning against the treatment. It was assumed that, given the option, most people with haemophilia would have reverted to traditional methods – such as rest, ice and elevation –

⁷⁵Jenny Ross interviewed by Paul Sendziuk, 24 November 1999, notes in possession of the author. Ross pointed out that the structure of the payments was based on HIV-positive individuals living for 10-12 years after the date of infection. New anti-viral treatments have allowed people with HIV/AIDS to remain healthy for much longer, and thus the Trust's funds were due to be extinguished by May 2001.

to treat their bleeds, rather than continue to use factor concentrates. In some cases, plaintiffs were also required to prove that the health care providers knew enough about the efficacy of heat treatment, surrogate testing and donor declaration forms to warrant the adoption of these procedures before November 1984. Cases were also brought against hospitals and individual doctors who continued to administer AHF instead of cryoprecipitate, despite being aware of the greater probability that AHF was contaminated, and who, in an effort to use up existing stocks, continued to distribute untreated factor concentrates after heat-treated products became available.

The government and the health care providers clearly believed that people with haemophilia had little chance of winning their cases in court. Brian Howe, Blewett's successor, for example, wrote to the HFA in April 1991 to urge that it resist its push for compensation. He stated that

The bringing to court of cases which must be known to have little or no prospect of success can only benefit members of the legal profession at the cost of additional stress and anguish to litigants who have their expectations unrealistically raised.⁷⁶

People with haemophilia and their lawyers believed otherwise. They maintained that the CDC and the medical literature of mid 1982 and early 1983 (cited at the beginning of this chapter) had informed Australian blood transfusion institutions of the likelihood that AIDS was caused by a blood borne virus, capable of being transmitted through the transfusion of blood products, by March 1983. Indeed, Dr Sawers from the Alfred Hospital had cited this literature and suggested this very possibility in January 1983 at a meeting of the Haemophilia Society of Victoria.⁷⁷ Despite this information, the BTS, CSL and the hospitals had not moved quickly to communicate the threat of AIDS or introduce measures to secure the blood supply. The BTS, for example, ignored the Haemophilia Society's

⁷⁶Letter to Michael Barry, President HFA, from Brian Howe, Minister for Community Services and Health, 17 April 1991, NBAC/NAAC, ANU, H7/58.

⁷⁷Haemophilia Society of Victoria, 'Minutes of Meeting held 10 January 1983', Melbourne, NBAC/NAAC, ANU, H7/2; and Ross, NLA, TRC-2815/18, p.14.

request for the introduction of donor declaration forms in favour of disseminating pamphlets which relied on donors at 'high risk' for AIDS to educate and exclude themselves – a process that was precarious at best. The plaintiffs were not convinced by the Red Cross's argument that such declaration forms would have posed a greater risk to the *supply* of blood by deterring 'sensitive-minded' people from donating. Such justification, they claimed, amounted to little more than blackmail.⁷⁸ Overseas experts who eventually gave evidence on behalf of the first person with haemophilia to sue for compensation also noted that donor declaration forms had been introduced in Hong Kong in May 1983, while all potential Red Cross blood donors in Britain, Germany and Switzerland were required to undergo a medical examination which checked for early signs of AIDS.⁷⁹

People with haemophilia and HIV who sought compensation through the courts were also critical of the time it took the BTS to introduce surrogate testing for hepatitis B and/or immune deficiency as a means of identifying donors at "high risk" for AIDS. Gay groups in Sydney had called for surrogate testing in May 1983, yet it was not introduced until October 1984 when Archer's BTS became the first to do so. Plaintiffs claimed that the CSL had been similarly tardy in applying heat treatment to its factor concentrates, noting that the CSL had been experimenting with this technology throughout 1983 yet delayed its universal application until November 1984. Moreover, they believed that the hospitals were negligent in not immediately making this heat-treated product available to people with haemophilia. As Michael Barry testified in July 1991:

When the first batches of [heat-treated] factor VIII were supplied [to the hospitals], they were identified with coloured dots and there were instructions to the staff of the hospitals. One: they were to use all of the untreated factor VIII first before they would use the heat treated factor VIII. There were also decisions made about who should receive heat treated factor VIII and who

⁷⁸As Jenny Ross recalls: "We were virtually blackmailed by their saying, 'If you want to do something about this, you'll end up with no treatment for your child or for you.'" (Ross, NLA, TRC-2815/18, p.15).

⁷⁹Evidence given by Dr Leong, Dr Z. Seidle and Professor Hassig, PQ vs Australian Red Cross Society and Ors, Victorian Supreme Court, September 1990, cited in John T. Rush, 'AIDS – Have We Got It Right?', in Australian Doctors' Fund, *AIDS – Have We Got It Right?*, unpublished collection of papers delivered to the Australian Doctors' Fund Summit, 15 May 1992, Travers Collection (uncatalogued), Monash University Rare Book Collection.

should not. During this time the patients knew what was going on and that was incredibly distressing and it was very distressing for the staff who had to make these sort of decisions.⁸⁰

Despite the strength of their case, many people living with haemophilia, like Mike Barry's son, remained reluctant to sue the institutions that had provided their lifeline for so many years. In some cases, it was practically impossible for them successfully to do so; they had received so many transfusions of factor VIII that they were unable to determine the exact date on which they were infected. This situation angered the HFA, who demanded that the government provide compensation to these people on moral grounds, rather than see them take their worthy, but impossible to determine, cases to court.⁸¹ More often, however, they were reluctant to sue in order to avoid generating any more stress for the staff at the Haemophilia Treatment Centres, who had become much loved members of the extended haemophilia family, and to reduce the risk of any further complications occurring in the delivery of their health care. As Jenny Ross related in a letter to the state and Commonwealth health ministers, the Red Cross, and CSL, in January 1991:

Those who seek compensation do not want to sue people providing their ongoing treatment. Others need compensation, but are not willing to sue much loved health providers they or their children must depend upon. All of the haemophilia group is concerned about the effects these actions are having on Haemophilia Treatment Centres. Concerned they well may be, as staff at Haemophilia Treatment Centres, already under-resourced and over-worked by the patient needs and demands associated with haemophilia and HIV, are traumatised by court actions, both by the physical demands [i.e. the legal

⁸⁰Transcript of evidence provided by Michael Barry, President of the HFA and parent of a child with haemophilia and HIV infection, to the NSW Legislative Council Standing Committee on Social Issues Inquiry into Medically Acquired HIV Infection, 19 July 1991, p.3, NBAC/NAAC, ANU, H7/58.

⁸¹Michael Barry, 'Supplementary submission to the NSW Inquiry to Medically Acquired HIV Infection', 18 July 1991, transcript pp.4-5, NBAC/NAAC, ANU, H7/58.

paperwork and time devoted to legal proceedings], and by the emotional aspects such litigation brings.⁸²

The HFA was also clearly concerned that the obstructionist stance adopted by some hospitals towards people with haemophilia would continue if they persisted in lodging their claims. One hospital, for example, informed the parents of a haemophilic boy that it would not perform an operation on their son's elbow because "people with haemophilia go to the bottom of the waiting list" due to the legal action they were mounting against the hospital.⁸³ The boy was not HIV-positive nor were his parents involved in any litigation against the hospital.

In an effort to avoid these distressing consequences, HFA and the various state Haemophilia Foundations lobbied state governments and the Commonwealth to provide compensation to people with medically-acquired HIV in the form of *ex gratia* payments. (The state health ministers had agreed, in May 1985, to indemnify the Red Cross BTSs for uninsured costs and damages resulting from compensation claims. In July 1990, the Commonwealth, which was fully responsible for the CSL, agreed to cover 40% of the Red Cross indemnity, while the states, responsible together with insurance companies for the hospitals, covered the Red Cross for the remainder.)⁸⁴ It took the first successful case of a man with medically-acquired HIV suing his hospital to convince the governments to come to the negotiation table. The 'PQ' case, as it became known, was the longest civil jury trial in Australian legal history, extending over eighty-seven days between August and December 1990. During that time, the plaintiff proved that staff at the Alfred Hospital were negligent in changing his haemophilia treatment from cryoprecipitate to AHF in September 1984 without informing him of the extra risk of HIV infection that this entailed. The jury

⁸²Letter to State and Commonwealth Health Ministers, BTS, Hospitals and CSL, from Jenny Ross, 23 January 1991, NBAC/NAAC, ANU, H7/11. Ross's concerns were informed by communication with staff members at the Alfred Hospital. See, for example, Letter from W.A. Kricker, Group Chief Executive Alfred Hospital, to Mike Barry and Jenny Ross, 12 March 1991, NBAC/NAAC, ANU, H7/58; and Dr Alison Street, 'The Impact of HIV Infection on Haemophilia Treatment Centres', *National Haemophilia*, no.58, November 1991, p.3.

⁸³Michael Barry, 'Evidence given before NSW Inquiry into Medically Acquired HIV Infection', hearing date 15 April 1991, p.18, transcript at NBAC/NAAC, ANU, H7/58.

⁸⁴Ballard, 'HIV-Contaminated Blood and Australian Policy', p.255, 259.

found that neither the Red Cross nor the CSL was liable because they had manufactured and distributed the product before there was sufficient evidence to prove that their products might be infected with AIDS. The Alfred Hospital was, however, required to pay \$870,000 damages, and close to \$10 million in legal fees for all parties.⁸⁵

The extent of the pay-out and, in particular, the extraordinary legal costs incurred by the hospital – the consequence of running such a long case in the courts and flying medical experts in from around the world – irrevocably changed the nature of the discussions between claimants, their health care providers and the Commonwealth and state governments. The Haemophilia Foundations and the mainstream media, which readily adopted the cause of the “innocent” victims of the medical system, now intensified their efforts to see the government provide *ex gratia* compensation payments rather than force all of the parties to endure the painful and expensive process of going to court. Indeed, after a second case (‘BC’) was settled mid-trial in early 1991, resulting in the Red Cross agreeing to pay compensation and the considerable legal costs of the plaintiff, John Slee, a columnist with the *Sydney Morning Herald* stated:

The amounts eventually spent on these cases [‘PQ’ and ‘BC’] may conceivably come close to the amount that would have been necessary to make reasonable settlements of the claims of all haemophiliacs who have contracted AIDS through medical treatment – without the need to prove negligence on anyone’s part, without the trauma of court proceedings, and without the delay that, in many of these cases, is the cruellest blow of all.⁸⁶

⁸⁵Editorial, ‘Just Compensation for AIDS Victims’, *Age*, 19 March 1991, p.13. In this case and the others that followed, the Red Cross Blood Transfusion Service and the CSL were found to have acted honourably. This is in contrast to a number of senior government officials, key AIDS advisors and pharmaceutical companies in France, Germany and Japan, who became embroiled in public scandals during the 1990s when it was discovered that they had continued to produce and distribute unheated products which they knew were likely to be contaminated with HIV. For a discussion of the blood contamination crisis in these countries, see Monika Steffen, ‘The Nation’s Blood: Medicine, Justice and the State in France’, in Eric A. Feldman and Ronald Bayer (eds), *Blood Feuds: AIDS, Blood, and the Politics of Medical Disaster*, New York: Oxford University Press, 1999, pp.95-126; Eric A. Feldman, ‘HIV and Blood in Japan: Private Conflict into Public Scandal’, in *ibid.*, pp.59-93; and Stephen Dressler, ‘Blood “Scandal” and AIDS in Germany’, in *ibid.*, pp.191-212.

⁸⁶John Slee, ‘The Cost of Judicial Inquiries’, *Sydney Morning Herald*, 25 January 1991, p.12.

Accepting this argument, and anxious to prove that they were not completely heartless, a number of state governments agreed to provide compensation in 1991. The Western Australian government became the first to settle on 20 May 1991 after negotiating a \$5.4 million package with 22 claimants, who each received between \$102,000 and \$301,000.⁸⁷ The South Australian government (incorporating the Northern Territory) settled under slightly different conditions in November 1991, with claimants receiving between \$150,000 and \$600,000 each, plus a guarantee of continuing free medical care.⁸⁸ Meanwhile, the Victorian government, anxious to resolve the issue before a state election, met with a team of Commonwealth, Red Cross and insurance lawyers to devise a model by which to assess and settle the claims of 109 Victorians with medically-acquired HIV/AIDS. On 23 December 1991 it announced that each claimant would receive a payment ranging between \$100,000 and \$650,000, to be determined by each individual's common law rights and the likelihood of success of his or her litigation. It was deemed that health care providers were only nominally liable for HIV infection acquired before December 1982, when scientific evidence about the transmission of HIV via blood products was inconclusive. A greater degree of liability was admitted for failing to warn about the possible transmission of HIV in 1983, and this level of liability increased for the period between December 1983 and July 1984. The highest measure of liability was admitted for cases of transmission occurring between July 1984 and the implementation of HIV screening in May 1985, on the basis of a combination of the health care providers' failure to warn and screen and, in concentrate cases, to heat. Traditional damages for the individual's loss of earnings, pain and suffering, and costs, were also factored into the equation, while future medical expenses were assumed to be covered by Medicare.⁸⁹ No liability was accepted for the failure to begin surrogate testing of donors' blood for hepatitis B and/or immune deficiency, after the jury in the 'PQ' case accepted the testimony of Ian Gust and a number of international experts that neither the hepatitis B nor the T4/T8 ratio test was particularly effective in screening for HIV.⁹⁰

⁸⁷Christine Rau, 'WA to Pay \$5.4m in AIDS Cases Settlement', *Age*, 21 May 1991, p.9.

⁸⁸Jenny Ross, 'SA/NT Financial Settlements', *National Haemophilia*, no.58, November 1991, p.4.

⁸⁹Ballard, 'HIV-Contaminated Blood and Australian Policy', p.260.

⁹⁰*Ibid.*, n.21, p.268.

During the Victorian negotiations, Slater and Gordon, the legal firm representing people with medically-acquired HIV/AIDS, discovered a precedent for covering claims by relatives of deceased patients for shock, distress and nursing costs. The Victorian settlement thus also included retrospective payments of between \$25,000 and \$50,000 to the families of people who had already died. One could cynically suggest that the lower cost in compensating families mourning the death of people with AIDS was the reason that the New South Wales government prolonged its negotiations with people who had medically-acquired HIV, using every political and legal means available – including a parliamentary inquiry – to stall the process. Existing evidence indicates, however, that there were other more pressing factors influencing its response.

In the first instance, New South Wales overwhelmingly faced the greatest financial burden in settling its cases, which numbered 224. While Victoria settled for approximately \$22.5 million, the New South Wales government looked likely to have to pay two or three times this sum. It was thus predisposed to accepting the argument vehemently advanced by the AIDS Council of New South Wales, which claimed that granting compensation to one group of “innocent victims” would only serve to institutionalise and legitimate the innocent/guilty dichotomy, and diminish the funds available to provide for all people with AIDS (90% of whom were gay men). This latter fear was unfounded; rather than being subtracted from the total ‘AIDS budget’, the compensation money would effectively be drawn from a ‘legal fund’ – money which would have normally covered the legal costs of cases that went to court.⁹¹

The New South Wales Legislative Council Standing Committee on Social Issues Inquiry into Medically-Acquired HIV Infection considered these various positions in 1990 and 1991 before eventually recommending, in a split decision 5-4, to make payments of between \$0 and \$50,000 to people who had acquired HIV through medical procedures or treatment for haemophilia. Jenny Ross was livid; in the course of compiling her submission to the Inquiry, she had come across a newspaper article which detailed how a woman was

⁹¹Ross, NLA, TRC-2815/18, p.73.

awarded more than \$11,000 compensation for back pain and embarrassment in 1990 after being hit in the back by a flying tuna during a tuna-throwing competition.⁹² Surely, she thought, the lives of people with haemophilia were worth more than injuries suffered to one's pride from being hit by a flying fish. The Haemophilia Foundation of NSW echoed Ross in expressing its incredulity at the sums determined by the Inquiry:

In Victoria police are being awarded up to \$20,000 from the Crimes Compensation Tribunal merely for the pain and suffering caused by the fear of HIV when handling clients. Some of our families will be offered a lesser amount for their real pain and suffering, their costs, loss of income and loss of relationships and life expectancy, together with the social isolation brought by HIV.⁹³

The Foundation understated the circumstances of the policemen's case, but still made a valid point. In response to the Inquiry's decision, people with medically-acquired HIV/AIDS in New South Wales refused to sign away their rights to sue and took up the government's effective challenge to 'fight every case to the death'.

The awarding of financial assistance, after six years of lobbying, to people who acquired HIV through medical procedures and haemophilia treatment does not, of course, provide a satisfying end to the story of their struggle with HIV. In many respects, the words of the mother who wrote to the HFA to argue against pushing for compensation remained perfectly and poignantly true throughout the entire ordeal: "No amount of money will take the virus away from my son". While the Mark Fitzpatrick Trust and the *ex gratia* payments helped ease the financial stress on families – which threatened to cause the relationships within to fissure – they could not alleviate the sense of guilt that mothers of sons with haemophilia experienced, nor diminish the anger of a young man brought closer to a terrifying death by way of a procedure which was supposed to enable and enrich his life.

⁹²'Real Tuna Thrown Out', *Age*, 28 January 1991; see Ross' personal files at NBAC/NAAC, ANU.

⁹³Haemophilia Society of NSW, 'Adding Insult to Injury' [press release], 24 September 1991, NBAC/NAAC, ANU, H7/58.

Families affected by haemophilia still grimly face each new day and watch with despair as their sons, husbands and fathers become ill and die.

Chapter 3.

Beyond Blame: Queensland Babies and the Construction of Homosexual Guilt

It's a real witch-hunt
this time, what better excuse
for a burning.¹

The discovery that Australia's blood supply had been contaminated in July 1984, while causing considerable public consternation, attracted little interest from politicians other than Neal Blewett who was periodically forced to censure scare-mongering sections of the media and call for calm in the face of rising hysteria. This situation changed in November 1984, in the middle of a Federal election campaign, when the Queensland Minister for Health, Brian Austin, announced that four babies at Brisbane's Mater Hospital had been transfused with HIV-contaminated blood donated by a homosexual man. The ensuing public and political outcry encapsulated a theme which I introduced in my previous chapter, namely the construction of homosexual 'guilt' as opposed to the 'innocence' of people they were deemed to have infected. I return to this theme here to find parallels between the designation of blame which accompanied the 'spread' of AIDS from homosexuals to the wider community and earlier attempts in Australia's past to find and condemn 'deviant' individuals and groups, such as prostitutes and the Chinese, for spreading infectious disease. The existing historiography of public responses to AIDS explains the construction of homosexual 'guilt' by referring to society's efforts to maintain traditional values and norms, such as the 'decent living' nuclear family, in the face of an emerging 'deviant' homosexual visibility. While this was certainly the case in Australia, it does not entirely account for the level of public hysteria about AIDS and the compulsion to vilify people other than gay men for the catastrophe it promised. For there was something different about the process of scapegoating in the 1980s, a time in which Australian society – fortified by the towers of medical science and technology – had begun to feel impervious to disease and disaster. Australia's compulsion to blame, I argue, sprung from the

¹From Margaret Bradstock, 'Not So Gay Now' (poem), *Gay Information: Journal of Gay Studies*, no.17-18, 1985, p.33; reprinted in Margaret Bradstock, *Flight of Koalas*, Sydney: Blackwattle Press, 1992.

modernist illusion of social perfectibility and immortality fostered by doctors who had recently cured polio and eradicated smallpox and who could now painlessly peer inside our brains. It was an illusion that demanded the public condemn those who 'wilfully' transgressed the bounds of good health designated by medical science and considered to be achievable for all. Moreover, it expressed a need to extract retribution for exposing the general public to disease and death, and to warn other people who might refuse to behave in a 'rational' and 'responsible' manner of the social constraints – on sympathy, health care and opportunities – that a community could impose on those who transgressed.

AIDS became an issue in the 1984 Federal election on 15 November when Brian Austin, Minister for Health and member of the ruling National Party in Queensland, prematurely announced that three babies had died after they were transfused with blood contaminated with AIDS.² A fourth baby was reported as being seriously ill in Brisbane's Mater Hospital and subsequently died one month later. The blood had been donated by a 27-year-old Brisbane homosexual who had made fifteen donations to the Red Cross Blood Transfusion Service since 1981. The link between the man's blood and the unexpected death of the babies was not confirmed until the day preceding Austin's announcement, when a paediatrician who attended two of the babies concluded that their unexpected wasting and unusual physical symptoms must have been caused by a common factor. Ensuing investigations found that these babies, and two more, had received transfusions of blood donated in February 1984 by the same man. He was contacted and tested and found to be antibody-positive to the virus which causes AIDS.³

The first of the babies had died in February, very shortly after receiving the infected blood, and it is thus unlikely that the contaminated transfusion was related to the cause of death.⁴ Austin did not wait for confirmation that the deaths were AIDS related before going to the news media, however, for reasons which soon became apparent. Within twenty-four hours,

²'Gay Blood Fear As 3 Babies Die', *Sun*, 16 November 1984, p.1.

³'A Father Tells of the Agony', *Sun*, 3 December 1984, p.1; and 'The Parent's Plight - By AIDS Baby's Father', *Courier-Mail*, 3 December 1984, p.1.

⁴Larry Galbraith, 'Is It Safe to Drink the Water? AIDS Hysteria Downunder', *Campaign*, vol.108, December 1984, p.19.

the Federal leader of the National Party, Ian Sinclair, was appearing at a campaign launch in Melbourne to link the death of the babies with the Australian Labor Party and its "promotion of homosexuality". He asserted:

If it wasn't for the promotion of homosexuality as a norm by Labor, I am quite confident that the very tragic and sad passing on of the AIDS disease through the blood transfusion to those three poor babies would not have occurred...There is no doubt that the lack of concern by the Hawke government for the traditional family is encouraging the extent to which the community regards homosexual relationships as normal. As far as we are concerned the traditional family is not only the family which is good for the nation, it will be good for the health of the individuals of the nation.⁵

The following evening, a gang of angry men roamed Oxford Street, assaulting homosexual men and kicking in the doors of gay bars.⁶

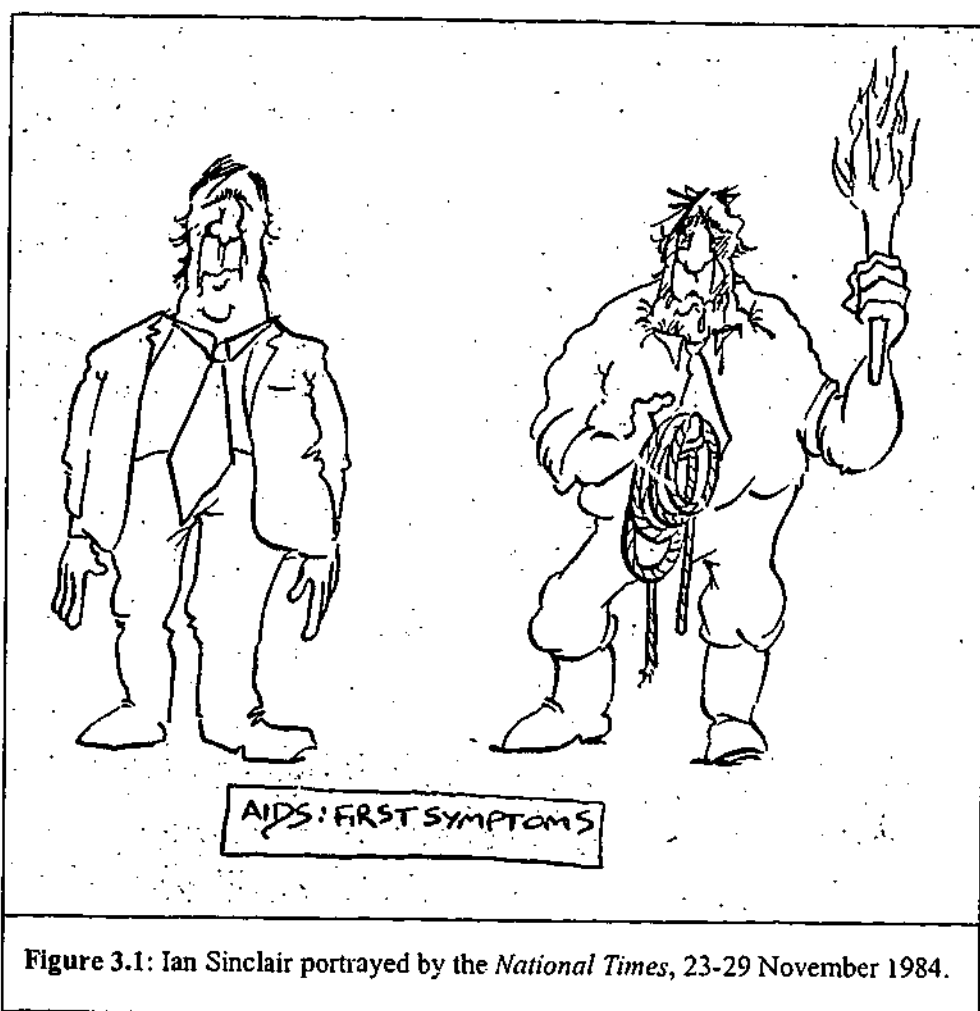
Drawing on the imagery of a lynching mob, a cartoonist for the *National Times* captured the voracity of Sinclair's scapegoating of homosexuals with great verve (see Figure 3.1). As a Moir cartoon (Figure 3.2) illustrated, however, Sinclair's remarks were not immediately well received by the Party faithful who had gathered to hear him speak, and were reported to have been greeted with a solitary 'Hear, Hear'.⁷ For his part, the Prime Minister, Bob Hawke, responded disdainfully, stating that "There is no politician in Australia who is lower in public esteem than the Leader of the National Party, and [his] observation is so contemptible it is beneath me to comment on it."⁸

⁵'Sinclair Blames Labor', *Sun*, 17 November 1984, p.11; 'Hawke Blamed', *West Australian*, 17 November 1984, p.2; and Galbraith, 'Is It Safe to Drink the Water?', p.19.

⁶Mark Metherell, 'Ministers Act On AIDS Scare', *Age*, 19 November 1984, p.3.

⁷Galbraith, 'Is It Safe to Drink the Water?', p.19.

⁸'Sinclair Blames Labor', *Sun*, 17 November 1984, p.11; 'Hawke Blamed', *West Australian*, 17 November 1984, p.2.



Queensland-based leaders of the National Party in the 1980s were difficult to deter once they took the high moral ground and had a poofter in their sights, however, as Sir Joh Bjelke-Petersen demonstrated in the week following Sinclair's statement. Speaking before a crowd of about one thousand people at a National Party rally, the Queensland Premier argued that homosexuals indulged in dirty, despicable acts that were beneath the level of animals. Ignoring the numerous instances of same-sex attraction in the animal kingdom, and of oral and anal sexual practices in the heterosexual population, Sir Joh said "You can't get any beast or animal that is so depraved it will do what these people do".⁹

The Very Reverend Lance Shilton, Anglican Dean of the Sydney Diocese, also failed to be deterred by Hawke's rebuke as he accused AIDS carriers of having blood on their hands and asserted that politicians who voted for homosexual decriminalisation shared the blame for the AIDS crisis. Homosexuals, he said, had flaunted God's laws and the consequences were inevitable for them and their innocent victims.¹⁰ The Reverend Fred Nile, puritan campaigner against abortion, homosexuality and pornography, and leader of the Christian fundamentalist Call To Australia Party which was contesting several seats in the Federal election, simply declared: "the man who gave the blood which killed the three babies was as guilty of their manslaughter as if he had run over their pram with his car".¹¹

⁹"Homosexuals Feel the Wrath of Sir Joh", *West Australian*, 23 November 1984, p.3. Sir Joh did not elaborate on what homosexuals actually did because "to talk about it would be degrading".

¹⁰"Attitude Too Soft", *West Australian*, 19 November 1984, p.4; and 'Blood On Their Hands', *Daily Telegraph*, 19 November 1984, p.3. The notion that a relaxation in laws concerning homosexuality facilitated the spread of AIDS remained a persistent myth throughout the 1980s and was periodically expressed in public debates. During a televised forum on AIDS in 1988, an audience member suggested that the spread of AIDS throughout Australia proved this very point, citing the 'fact' that AIDS had spread from Victoria - where the first AIDS death was recorded and which had repealed laws against homosexuality in 1980 - to NSW after this state had legalised consensual homosexual sex between adults in 1984. His comments demonstrated, of course, an ignorance of the epidemiology of AIDS and the occurrence of homosexual sex before law reform. Dennis Altman, a panelist during the discussion, also noted that for the case to be true in 1988, South Australia - the first state to legalise homosexuality in 1975 - should have the highest incidence of HIV per capita (it had one of the lowest), and Queensland - where homosexuals faced criminal charges for engaging in sexual acts - should have the lowest incidence of HIV per capita (yet it had one of the highest). See *Four Corners*, ABC TV, televised community forum held at the Hurstville Community Centre, mediated by Andrew Ollie, directed by Glyn Patrick, 12 March 1988.

¹¹P. Totaro, P. Bailey and A. Buckley, 'States Move On AIDS Peril', *Sydney Morning Herald*, 17 November 1984, pp.1-2.

The major metropolitan newspapers (all of which carried the Queensland babies story on their front page) failed to distinguish themselves during this exchange. The *Sydney Morning Herald* gave prominence to the comments of Sinclair, Nile and Shilton, as well as the State President of the Queensland branch of the United Graziar's Association who opined that homosexual blood donors should be indicted for murder. The newspaper declined to offer a counter view from the homosexual community or the AIDS Action Committee. Brisbane's *Daily Sun* printed a headline which declared 'Donor Walks Free', clearly implying that he should have been locked up.¹² It then joined the *Courier Mail* in providing a mouthpiece for the inflammatory comments of an obviously distressed and bitter father of one of the dead babies, whose open letter was published on the front page of both newspapers. The man's vitriolic attack on homosexuals encapsulated many of the opinions that were expressed at the time:

[My baby's] life was wasted because some thoughtless person – namely, our poor distraught homosexual friend – had a misdirected sex drive. As an easy-going couple – although we didn't agree with homosexuality and the like – we believed that as long as they kept to themselves, it was OK. Oh, what fools we were. Even though we attempt to accept the idiosyncrasies of others, here we are staring something in the face that could destroy mankind...This individual has committed one of the greatest crimes anyone could inflict on society and his fellows. Politicians should make laws that come down heavily on people who engage in acts that spread such disease. A penalty of up to \$10,000 fine, or two years' jail, is ludicrous. Perhaps jail terms similar to war criminals, e.g. capital punishment, would be more appropriate. I realise homosexuals and their cohorts are quite numerous. But what do you do with something that is contaminated? You destroy it.¹³

Given that the Australian public was unlikely to sanction this option, the father suggested:

¹²For further examples, see John O'Hara, 'The Media Coverage of AIDS', *Metro*, vol.71, Spring 1986, p.17.

¹³'A Father Tells of the Agony', *Sun*, 3 December 1984, p.1; and 'The Parents Plight – By AIDS Baby's Father', *Courier-Mail*, 3 December 1984, p.1.

As the parents of this baby, we feel that the only honorable [*sic*] thing for the murderer of our son to do is commit suicide if he feels as bad about his action as we are led to believe...Unfortunately, if this degenerate trend in society is allowed to continue, it could be your child that suffers.¹⁴

While expressing sorrow for the babies and their families, Sydney's gay press, *Campaign* and the *Sydney Star*, were the only publications to sympathetically reflect on the plight of the homosexual donor who had less than three days to deal with his own seropositive status before being urged to commit suicide for the common good. Due to the donor's anonymity, which the Red Cross Blood Transfusion Service respected, *Campaign* was unable to interview the man. It did, however, extensively quote the Queensland BTS Director, Dr Peter Harden, who reported that the donor was "a person with a civic conscience who has been upset by the revelation and is now suffering extreme regret...He has taken up the suggestion to become part of a special project to provide blood for investigation and culture of the AIDS virus to try to find a cure. He has indicated he would be more than willing to take part in any investigation or procedure that might help to develop a beneficial result."¹⁵ Few mainstream newspapers picked up Harden's comments, and none printed them in full.

The mainstream news media displayed more interest three days later when the blood bank director attempted to use the anxiety fostered by the death of the Queensland babies to publicly lobby for funds to purchase computer equipment which could be used to trace the distribution of potentially dangerous blood products. He did so by claiming that Australia's blood supply was in peril as it was likely that homosexuals were deliberately spreading AIDS in an attempt "to get back at the world".¹⁶ Homosexuals felt isolated and persecuted in the community, he said, and some of them might try to get their revenge by unleashing AIDS on mankind. He substantiated his claim by confiding: "I have heard there is evidence in America where there are militant gay-rights activists and it's certainly possible in

¹⁴*Ibid.*

¹⁵Galbraith, 'Is It Safe to Drink the Water?', p.19.

¹⁶Glen Turner, 'New Fear On Spread of AIDS', *West Australian*, 19 November 1984, p.5.

Sydney".¹⁷ In suggesting such, Harden echoed the comments of Dr Tony Adams, the Chief Medical Officer of New South Wales, that had been reported under the banner headline 'Gays Accused of Giving Blood "Out of Spite"' in the *Daily Telegraph* on 17 November.¹⁸

The *West Australian*, which printed the article from which I quote, published an editorial the following day that rejected Harden's speculation:

The AIDS-related deaths of three babies understandably aroused strong feelings, and it was inevitable that people would look for someone to blame. However, the last thing we want is for the community's fears about AIDS to be translated into a witch-hunt against homosexuals. It is inconceivable that homosexuals would knowingly donate contaminated blood to a blood-transfusion service. Homosexuals are victims of the AIDS problem, yet they have been labelled as its creators.¹⁹

The newspaper did not acknowledge that by publishing such unfounded speculation it, and other media outlets which disseminated similar claims, were complicit in heightening the community's fear and loathing of homosexuals and contributed to the process of assigning blame. Moreover, while the editor's plea for a witch-hunt to be averted was commendable, it probably fell on deaf ears as it failed to catch the eye; unlike the prominently displayed quarter-page original article, the editorial lacked a 17-point headline, a first paragraph in bold font or a photograph.

In any case, the witch-hunt was already in full swing as radio station 2GB's popular breakfast programme host, Mike Carlton, joined Harden and Adams in suggesting that gays were intentionally donating contaminated blood out of spite:

¹⁷*Ibid.*

¹⁸Adams claimed that while "the majority of homosexual men are acting very responsibly and co-operating in not giving blood...we believe a certain proportion of homosexuals – and it only takes one – are giving blood out of spite. These men feel alienated from society and are giving blood as a form of protest." He added that it might be the case of a gay man thinking: "If I'm going to die of AIDS, I might as well take a few people with me."

¹⁹Editorial, 'AIDS Reaction', *West Australian*, 20 November 1984, p.8.

I have a feeling, I may be totally wrong about this and you may disagree but I have the feeling that there is a fringe group of homosexuals somewhere who out of a warped sense of revenge perhaps donated blood over recent months, knowing perhaps that they have AIDS or [were] at least at risk of having AIDS.²⁰

Then, in October 1985, television station Network Ten aired a special one-hour report titled *The Truth About A.I.D.S. in Australia* which investigated, and lent support to, accusations that gay men were purposefully spreading AIDS.²¹ The charge was made in an anonymous letter that was sent to a New South Wales parliamentary committee inquiring into prostitution. Its author suggested that heterosexuals who had been infected via blood transfusions were innocent victims of an "evil conspiracy" in which homosexual activists deliberately contaminated the blood supply so that their calls for government funding to fight AIDS would be acted upon. Furthermore, gays were knowingly infecting other men in their community to "get even" with old boyfriends because "the gay community is notoriously bitchy". The letter's author, a "Kings Cross homosexual", was also angry that a "fringe group of radical homosexuals" – the NSW AIDS Action Committee led by Sydney academic Lex Watson – was claiming to speak on behalf of the entire gay community. "They are establishing paper empires to get government funds and couldn't care a stuff about their gay brothers and sisters", he wrote. While the programme accepted that it was impossible to prove these claims, it remarkably stated that it could "prove that the AIDS blood plan was seriously considered" because homosexuals in America had contemplated such an act of political terrorism and "the intimate links across the Pacific ensured that the American plan became pillow talk down under". The report did not reveal how most American gay men regarded this terrorist action, nor explain why Australian homosexuals would contemplate such a plan when the Commonwealth and state governments were already responding to AIDS with more urgency than politicians in the United States had exhibited during the first three years of the AIDS epidemic.

²⁰Cited in Larry Galbraith, 'Mediawatch', *Campaign*, vol.108, December 1984, p.4. Carlton's comments were also reprinted in 'The Gay Crisis', *National Times*, 23-29 November 1984, p.12.

²¹*The Truth About A.I.D.S. in Australia*, Network Ten, 28 October 1985.

The claims made in the letter were extraordinarily similar to those expressed in other submissions to the mainstream and gay press by Paul Dexter, self-proclaimed leader of the Gay Army, which, as far as the gay men I interviewed could tell, consisted only of himself.²² Those who knew of his antagonism towards the AAC, and who had already begun to view the programme cynically, would not have been surprised to soon see Dexter introduced as a "spokesman for the gay community" to confirm that a fringe group of radical gays were, indeed, deliberately spreading AIDS. As an 'unbiased' member of the gay community, he supposedly served the purpose of demonstrating that homophobia was not the basis for the programme's investigation into the "evil conspiracy". To many Darlinghurst gay men in the audience, however, his presence only confirmed their doubts about the authenticity of the letter.

It is interesting to note that when a man, considered by Jenny Ross to be an "inappropriate representative" of the haemophilia community, was interviewed by another television station, his comments were omitted from the programme that went to air at the request of the Haemophilia Foundation.²³ Despite the complaints of the AIDS Action Committee that Paul Dexter did not represent the general view of the homosexual community, and that he was predisposed to making spiteful comments about some of its members, no such courtesy was extended to it. Rather, Network Ten neglected to examine Dexter's personal and political motives for accusing radical homosexuals of donating blood infected with HIV, just as the press had failed to challenge the factual basis of the doctors' claims. One can be sure that the print and electronic media would have been more thorough in their research and selection of witnesses if they were to accuse National Party politicians or religious leaders of spiteful murder. Moreover, one can be certain that a public outcry would immediately follow if such accusations were ever made. As it was, the scapegoating of gay men continued unabated and (the *West Australian's* hesitant censure aside) members

²²See, for example, 'Some Gays Don't Give A Damn' [letter], *Sydney Morning Herald*, 13 February 1985, p.10. He also wrote a number of letters to David Penington which urged the NH&MRC Working Party on AIDS not to co-operate with the AAC. See 'Letter to S. McGuinness, secretary of the NH&MRC Working Party on AIDS, from P.D. Dexter, The Gay Army, 2 October 1984', NBAC/NAAC, ANU, H7/22.

²³Jenny Ross interviewed by Paul Sendziuk, 24 November 1999, notes in possession of the author. Also see Jenny Ross interviewed by Heather Rusden, 11 February 1993, 'The Australian Response to AIDS' Oral History Project, National Library of Australia, TRC-2815/18, transcript p.40.

of the community and the print and electronic media were complicit with it occurring. Indeed, 38% of people surveyed by Spectrum Research for the *Sunday Telegraph* in August 1985 said that they were "less sympathetic" towards homosexuals since the AIDS crisis had arisen, a fact frequently expressed in letters-to-the-editor (some of which I quote in my first chapter). Despite the misery that gay men were facing, a further 51% of those surveyed claimed to be neither more or less sympathetic.²⁴ The question thus remains: why were conservative politicians and the media so keen to construct gay men as guilty, either by explicitly stating so or by virtue of the fact that, unlike babies and people with haemophilia who acquired AIDS, homosexuals were never labelled 'innocent'? And why wasn't the public moved to reject this dichotomy?

The response of the media can be partially explained by the fact that news editors in the 1980s, like those who came before and after them, were driven by an imperative to sell their product. Attention-grabbing headlines and stories of victims and villains – a simplistic narrative upon which the ninety-second news report and the two-column article rely – provided a means of doing so. Journalists understood that stories about dying babies and grieving fathers provided their audience with a sense of intimacy and poignancy that it craved, as opposed to stories about healthy-looking homosexual blood donors or perishing gay men, with whom the audience was unfamiliar and thus unconnected. They strategically sought well-known and controversial 'talking heads', such as Reverends Fred Nile and Lance Shilton, to articulate these narratives in order to appeal to an existing audience that these public figures attracted. The provocations of Sinclair and Nile also guaranteed an attractive headline and promised a follow-up story as the targets of their accusations, such as Bob Hawke, were compelled to defend themselves. Any incentive to balance these stories or, at least, problematise their factual basis, was diminished because the imagined audience, from which the news media in Australia extracts its profit, was a heterosexual one.

²⁴Telephone survey of 300 people cited in 'Parents Say No To Rules On AIDS', *Sunday Telegraph*, 18 August 1985, p.4. A later study of 1,626 randomly selected adults conducted by the National Centre for Epidemiology and Population Health in 1991 indicated that two-thirds of the public had "no sympathy" for homosexuals with AIDS, while almost everyone felt sorry for people who had acquired HIV from a blood transfusion ('No Sympathy on AIDS', *Age*, 30 September 1991, p.10).

Of course, one cannot accuse Doctors Harden and Adams, nor Nile and Shilton, of deriving their homosexual bogey-man from a heightened sense of opportunity to accumulate profit (although Harden, for one, clearly evoked the 'dangerous homosexual' to solicit more money for his facility, just as Nile and Shilton employed him in an effort to manufacture a wider constituency for their ideas). Nor did the media always utilise inflammatory headlines, controversial public figures and visible villains in their stories about AIDS. Rather, their construction of homosexual guilt was underpinned by two further factors; namely, the belief that AIDS was caused by gays and was originally contained within their ranks, and the conviction that AIDS confirmed that homosexuals were indeed deviant and sick and lived lifestyles that should rightly be avoided. Each of these arguments can be revealed through a close analysis of the language that was used by politicians, journalists, doctors and members of the public in articulating concerns about AIDS.

The guilty homosexual was not visibly present in seemingly innocuous narratives that forecast the spread of AIDS, for example, such as those disseminated by Penington's AIDS Task Force and published in the press:

The government AIDS Task Force estimates that 50,000 Sydney homosexual and bisexual men are carriers of the disease [AIDS]...It asked bisexual men to reduce the likelihood of spreading the disease outside the male homosexual community...by chang[ing] their lifestyle and avoid[ing] practices likely to transmit disease."²⁵

He lurked in the shadows of the text, however, identified by words such as 'spread' and 'the general public' which referred to his status as outsider and his position at the start of the epidemiological chain of destruction. As I explained in my opening chapter, the 'gay lifestyle' was believed to have caused AIDS, a thesis which was later revised to assume that homosexuals must have been one of the first groups to contract the HIV virus. AIDS was thus popularly seen as a 'disease' which was initially 'contained', confined to identifiable 'risk groups' that were distinct from the 'general population'. The word

²⁵ 'Fears of 100 AIDS Deaths This Year', *West Australian*, 31 January 1985, p.10.

'spread' therefore suggested an insidious movement of the disease out from its natural limits.²⁶ As I have explained, this was not true, although a hazy epidemiological picture and the overt political agendas of some of the commentators conspired to present it as such. As a consequence, the notion that gays were to blame for spreading AIDS was implicitly expressed whenever the contamination of the blood supply, or the infection of heterosexuals, was mentioned.

Of course, population groups who were first associated with particular diseases have always been blamed for their origin and spread. Their stigma was often inscribed in the names given by layman to the disease or infection which they were alleged to have brought: the 'Chinese' smallpox epidemic of 1881-2 and the Asian Flu pandemic, which killed 234 people in Australia in 1890-1, are two examples. The Chinese were initially targeted during the first of these epidemics because a Chinese child, the son of one of Sydney's leading merchants, happened to present as the first *reported* case of smallpox. Public speculation about the nature of the epidemic then implied that the disease had arrived aboard a ship carrying Chinese immigrants, thus provoking calls for the expulsion of Chinese and an end to their migration or, at the very least, their forcible detention and vaccination.²⁷

The Chinese were also blamed for spreading disease at various times in Australian history because of their 'foreign' ways, which upset traditional Anglo-Australian notions of what to eat and how to behave in a family, a home and in a workplace. During the bubonic plague epidemic which affected Sydney in 1900, for example, public health and government authorities, supported by the press, considered that the Chinese were more susceptible to plague than Europeans because of their vegetable-based diet, and due to the alleged filth and over-crowdedness of their living conditions. When the predicted high number of plague cases did not emerge in the Chinese community, a city council alderman explained the lack of corpses by stating: "the Chinese do not bury their dead - they pickle

²⁶For further discussion of this point, see Jan Zita Grover, 'AIDS: Keywords', in Douglas Crimp (ed.), *AIDS: Cultural Analysis/ Cultural Activism*, Cambridge: MIT Press, 1989, p.28.

²⁷For details of the public response to these epidemics, see Peter Curson, *Times of Crisis: Epidemics in Sydney, 1788-1900*, Sydney: University of Sydney Press, 1985, particularly pp.112-118.

them and send them home to their ancestors."²⁸ Predictably, the city council spared no mercy in fumigating and, in many cases, demolishing Chinese dwellings and businesses under the pretext of removing a health hazard. Equally harsh treatment was meted out with respect to quarantine.²⁹ The non-conformist lifestyle of Chinese people, regarded as unnatural or deviant, thus clearly underpinned the public's suspicions that they were to blame for spreading disease, just as women who did not conform with contemporary notions of femininity or sexuality were often viewed to be responsible for epidemics of sexually transmitted disease and required to submit to draconian public health laws such as the Contagious Diseases Acts.³⁰

Commentators such as Simon Watney and John O'Hara have suggested that the media's demonising of gay men in response to AIDS was underpinned by a similar anxiety about the increasing visibility of 'deviant' homosexuals and the threat they posed to the traditional nuclear family.³¹ Their analyses are also applicable to the response of the public, which was conspicuous (and complicit) in its silence as gay men were designated guilty, and the beliefs which informed comments made by a number of doctors and conservative public figures. Ian Sinclair, for example, clearly articulated the notion that AIDS proved that homosexuals fell short of fulfilling healthy and honest citizenship as he blamed gays

²⁸Alderman John Norton quoted in the *Daily Telegraph*, 10 April 1900, p.7, cited in Peter Curson and Kevin McCracken, *Plague in Sydney: The Anatomy of an Epidemic*, Sydney: University of New South Wales Press, 1988, p.173.

²⁹Curson and McCracken, *Plague in Sydney*, pp.174-5.

³⁰I discuss this point further in Chapter 8. Also see Julie Tisdale, 'Venereal Disease and the Policing of the Amateur in Melbourne During World War I', *Lilith*, vol.9, 1996, pp.33-50; Roger Davidson, 'Venereal Disease, Public Health and Social Control: The Scottish Experience in a Comparative Perspective', *Dynamis*, vol.17, 1997, pp.341-68; and Michael Sturma, 'Public Health and Sexual Morality: Venereal Disease in World War II', *Signs*, vol.13, no.4, 1988, pp.725-40.

³¹Simon Watney, *Policing Desire: Pornography, AIDS and the Media*, London: Comedia, 1987, and *Practices of Freedom: Selected Writings on HIV/AIDS*, London: Rivers Oram Press, 1994; and John O'Hara, 'The Media Coverage of AIDS', *Metro*, no.71, 1986, pp.14-17. The literature in this area is abundant; see, for example, Deborah Lupton, 'Discourse Analysis: A New Methodology for Understanding the Ideologies of Health and Illness', *Australian Journal of Public Health*, vol.16, no.2, 1992, pp.145-50; Andrea A. Baker, 'The Portrayal of AIDS in the Media: An Analysis of Articles in the *New York Times*', in Douglas A. Feldman and Thomas M. Johnson (eds), *The Social Dimensions of AIDS: Method and Theory*, New York: Praeger, 1986, pp.179-94; Edward Albert, 'Illness and Deviance: The Response of the Press to AIDS', in *ibid.*, pp.163-78; and Julian Meldrum, 'The Role of the Media and the Reporting of AIDS', in Brenda Almond (ed.), *AIDS - A Moral Issue: The Ethical, Legal and Social Aspects*, London: Macmillan, 1990, pp.85-98.

and the Labor Party for the death of the Queensland babies and declared: "as far as we are concerned the traditional family is not only the family which is good for the nation, it will be good for the health of individuals of the nation".³² AIDS was also used as a weapon to condemn homosexual lifestyles, and uphold those of "ordinary, decent folk", in a Brisbane *Daily Sun* editorial which commented on the case of a haemophilic father in the United States who had transmitted the HIV virus to his wife, and thus to their newborn son, after the man was transfused with contaminated blood. "What makes this case even sadder", the *Sun* opined, "is that the mother and father are ordinary, decent folk. They did not contract the disease through the kind of sexual lifestyle most people rightly avoid."³³ Two years earlier, the *Sunday Mirror* pronounced that "Melbourne is rapidly becoming the national capital of the homosexual killer plague disease AIDS – no longer confined to 'gays' but spreading world-wide to normal, innocent people",³⁴ thus conflating two of the discourses – about the homosexual origins of AIDS and abnormality – which informed the construction of homosexual guilt.

The idea that "ordinary, decent folk" with AIDS deserved our sympathy, while homosexuals were to blame for AIDS, was generally not cast in such explicit terms. Rather it was evoked by denying gay men the right to speak or have stories framed from their point of view. For example, a story that appeared in Perth's *Daily News* about Sammy Kushnick, a 3-year-old boy whose body was not accepted for preparation and burial by a funeral parlour, was sympathetically written from the perspective of the dead boy or, more precisely, his grieving parents.³⁵ The journalist's emphasis on the discrimination and injustice of the situation was well placed, yet this sympathy and indignation was lacking in a *West Australian* article which considered the burial of gay men with AIDS. This article was written from the point of view of the funeral parlour proprietor who expressed fears for the safety of his staff:

³²'Sinclair Blames Labor', *Sun*, 17 November 1984, p.11; and Galbraith, 'Is It Safe to Drink the Water?', p.19.

³³Editorial, 'Tragic Family', *Sun*, 13 May 1985, p.8, original emphasis retained.

³⁴*Sunday Mirror*, 26 June 1983, p.5.

³⁵'World Fear Over AIDS', *Daily News*, 30 August 1985, p.8.

I gather that [HIV] can be transmitted in a number of ways. You can't ask them if they are homosexual if they're dead. I can't see why we have not been warned by the Public Health Department.³⁶

While ignoring the fact that the funeral parlour director equated homosexuality with HIV infection, the journalist persuaded the reader to consider sympathetically the circumstance of the funeral director (and the potential 'innocent victims' – his staff), instead of allowing the reader to ponder, as in the case of the 3-year-old boy, what will happen to the body of a man with AIDS once his sexual or HIV serostatus is disclosed.

Indeed, while there were numerous reports of discrimination against HIV-positive people with haemophilia and children with AIDS such as Eve van Grafhorst, who was banned from her kindergarten and driven from her town in northern New South Wales by frightened neighbours after her HIV status was disclosed, there was an absence of stories written from the perspective of homosexuals.³⁷ Rarely did the Australian public hear about gay men with AIDS who lost their jobs or were evicted from their homes because they had contracted the virus (or, worse, because they were suspected of being HIV-positive by virtue of the fact that they were gay).³⁸ There were, however, a plethora of stories about gay men returning to their parents' homes and the compassion of the strong nuclear family which, the reader was led to believe, could handle AIDS, unlike the fickle homosexual community. To accentuate this notion, 'innocent' people with AIDS were often photographed in their homes, surrounded by their loving family, or, at least, their spouse (see Figure 3.3); gay men with AIDS who did not return 'home' were generally

³⁶'AIDS Fear In Funeral Parlour', *West Australian*, 11 December 1984. p.53.

³⁷'Little Eve's' story was related over several months in the middle of 1985. See 'AIDS Baby - Little Eve Banned From A Play Centre', *Daily Mirror*, 19 July 1985, p.1; 'Children Boycott School Row Over AIDS Pupil', *Australian*, 11 September 1985, p.4; 'Forty Children Withdrawn As AIDS Toddler Returns', *Newcastle Herald*, 30 September 1985, p.1; 'AIDS Fear Leaves Eve With A Handful Of Friends', *Australian*, 1 October 1985, p.1; and *All About Eve* [documentary video], directed by Monique Oomen. Top Shelf Productions, 44 minutes, 1994.

³⁸The *Age* provided the only notable early exception to this rule. See, for example, Olga Fernely, 'Gays Are Always Thought Of As Guilty', *Age*, 3 September 1983, Saturday Extra p.6; and Peter Roberts, 'AIDS Sets the Clock Back For Homosexuals', *Age*, 3 September 1983, Saturday Extra p.6.

photographed alone and isolated in a workplace environment (see Figure 3.4).³⁹ It was heterosexual couples and families who were threatened by AIDS, and it was the loss of men and women, boys and girls, within these community-sanctioned bonds that was to be mourned.

It is clear, therefore, that in public discourse about AIDS, people with HIV infection were categorised as innocent or blameworthy by virtue of their sexual identity and their relationship to the 'normal' (read heterosexual) family.⁴⁰ Simon Watney, applying a Foucauldian reading of this discourse, argues that the construction of homosexual guilt cannot be considered innocent of a social and political agenda:

AIDS has been mobilised to embody a variety of perceived threats to individual and social stability, organised around the spectacle of illicit sex and physical corruption. It has been used to stabilise the figure of the heterosexual family unit which remains the central image in our society which individuals are endlessly invited to identify their collective interests and their very core of being. As Foucault and others have argued, we need to recognise that the image of the threatened and vulnerable family is a central motif in a society like ours for which the family is not simply a given object, but is rather an instrument of social policy.⁴¹

The construction of heterosexual innocence and homosexual guilt thus sanctifies heterosexual relationships and justifies the privileged position of the traditional nuclear

³⁹Sander Gilman was the first to make this observation in his brief analysis of the American press and while this visual representation was not always consistent in the Australian press, it was certainly manifest. See Sander L. Gilman, *Disease and Representation: Images of Illness from Madness to AIDS*, Ithaca: Cornell University Press, 1988, pp.258-62.

⁴⁰It is important to note that in the public discourse about AIDS, gay men were not designated blameworthy because of their lifestyle *per se*, but because of their sexual identity. Gay men who did not experiment with drugs and had, on average, fewer sexual partners than heterosexual men were still never referred to as 'innocent' or unlucky and thus worthy of the public's sympathy.

⁴¹Simon Watney, *Practices of Freedom: Selected Writing on HIV/AIDS*, London: Rivers Oram Press, 1994, p.10; also see Michel Foucault, 'On Governmentality', *Ideology and Consciousness*, no.6, 1979, pp.5-21.



Figure 3.3: Frederick Davis, a person living with haemophilia and AIDS, and his wife, Pearl (*Age*, 29 October 1984).



Figure 3.4: Ron Sheppard, a gay man living with HIV/AIDS (*West Australian*, 1 February 1985).

family, whilst encouraging a form of self-surveillance, or self-censorship, by threatening to condemn those who might deviate from it.

While this reading has merit, and was almost certainly the motivation for a number of statements made about AIDS, the notion that homophobia completely explains the designation of innocence and blame fails to recognise that gay men were not the only people cast as guilty. Injecting drug users were also blamed for their own infection, just as Haitians were held responsible for 'causing' AIDS and condemned for spreading it to America. Indeed, some gay men were, themselves, culpable of casting blame by supporting the theory that AIDS was caused by Haitian voodoo practices, during which Haitian men drank pigs' blood that allegedly contained a mutated strain of African swine virus.⁴² This suggests that before the HIV virus had been discovered and its pathways of transmission fully identified, gay men, injecting drug users and Haitians were targeted for blame because of their 'Otherness', as well as their 'deviancy'; to an uninformed observer the exotic nature of their behaviour provided a cover to invest anxiety about the new and deadly syndrome. As Sander Gilman argues, this served the additional purpose of reinforcing in the minds of those who were not Other, that their behaviour or lifestyle was proper or superior.⁴³

Heterosexuals who contracted HIV after medical science had unlocked the secrets of HIV and its mode of transmission were also cast into the role of 'innocent victim' or 'perpetrator' depending on how they acquired the virus. Women who 'unknowingly' contracted AIDS from their bisexual husbands, for example, were clearly worthy of the public's sympathy while women who contracted HIV during unprotected sexual intercourse with a recent acquaintance were not.⁴⁴ They were deemed complicit in their infection because, if one is to follow the logic, they were aware of the risks of unprotected

⁴²Alexander Moore and Ronald D. Le Baron, 'The Case for a Haitian Origin of the AIDS Epidemic', in Douglas A. Feldman and Thomas M. Johnson (eds), *The Social Dimension of AIDS: Method and Theory*, New York: Praeger, 1986, pp.77-93.

⁴³Gilman, *Disease and Representation*, pp.271-2.

⁴⁴For sympathetic accounts of innocent female partners of bisexual or promiscuous males, see Katharine Hadley, 'Brave Victim Fights To Live', *Daily News*, 2 April 1987, p.8; and 'She's Dying Of AIDS: But It Wasn't Her Fault She Fell For the Wrong Guy', *Sunday Territorian*, 27 July 1986, p.14.

sexual intercourse with a stranger and thus did not 'unknowingly' contract the virus. Gay men remained 'guilty' whilst they did not heed warnings about anal sex and, in the words of Hiram Caton who wrote a particularly spiteful article for *Quadrant*, "betrayed no signs of shame or repentance for the wreckage they wrought...[nor made] appeals for counselling services to help them return to the straight life".⁴⁵ The stigma of these people denoted a new form of deviancy, one which defied the new scientific knowledge about 'risk behaviours' for HIV transmission.

It was not by accident that this new discourse about 'risk' and the consequences of transgression arose in the 1980s. Susan Sontag noted in 1977 that as biomedical science continued its claims for mastery over the macrobiotic world, and as bacteria was decreasingly accounting for illness, lifestyle – over which individual control was viewed as possible – was coming under increasing scrutiny as a possible cause for disease. During the 1970s, for example, when smallpox was joining polio and tuberculosis on the list of life-threatening diseases recently eradicated from the developed world by biomedical technology, cancer was declared to be a lifestyle disease caused by smoking, working conditions and burnt toast, among other things.⁴⁶ Human beings were thus asked to take responsibility for their own health by monitoring their lifestyle and avoiding behaviours that medical science had designated as risky. Those who ignored the doctors' warnings and transgressed the bounds of healthy behaviour were deemed to be complicit in their own demise and lost the claims they might have had on the public's sympathy. If their disease was infectious, they were more explicitly condemned for endangering the health of others.

The notion that human beings had, by the 1980s, acquired a level of knowledge that empowered them to designate risks and prevent misadventure was, of course, not confined to the field of health and medicine. The language of risk and personal responsibility was also articulated in legal discourse, as evidenced by the number of instances in which people who left their doors unlocked were blamed almost to the same extent as the burglars who intruded under the cover of darkness to steal their radios and televisions. It was also

⁴⁵Hiram Caton, 'The AIDS Apocalypse', *Quadrant*, vol.29, no.11, November 1985, p.28.

⁴⁶ for further examples, see Susan Sontag, *Illness as Metaphor and AIDS and its Metaphors*, London:enguin, 1991. *Illness as Metaphor* was originally published separately in 1977.

inscribed in the neo-liberal political philosophies of governments which came to power at the end of the 1970s and early 1980s in Western Europe, North America and Australia. Neo-liberalism reinstated the notion that individual citizens were atomistic, rational agents who were responsible for their own behaviour, and who had a duty to ensure that they would not impinge on the autonomy of other individuals.⁴⁷ It emerged as a consequence of the New Right's attacks on welfare provision (and the idea that human beings had innate social rights, including the right to an adequate income, regardless of their behaviour or merits), and was influenced by feminist and ecological critiques of the concept of rights (such as the right of one country to pollute the atmosphere which is shared by another).⁴⁸ Neo-liberalism thus ushered in a 'duties discourse' in which *individual rights implied a duty to others*. This 'duties discourse' was dependent on boundaries of risk being established by 'experts' such as doctors, scientists, and government bureaucrats. Once established, individuals were compelled to consider their duty to themselves and others, and were condemned if they ignored the risks and their responsibilities. In terms of AIDS, it meant that those people who contracted HIV by 'knowingly' defying the risks could be blamed for their own infection and denied the claims that 'innocent victims' had on the public's sympathy and care. Gordon, Rose and Miller suggest that it was fear of these consequences which caused citizens to regulate and discipline their own behaviour, thus dispensing with the need for the State to enact more traditional instruments of coercion. The 'risk discourse' which underpinned the 'duties discourse' thus functioned in a Foucauldian sense as a means for achieving 'government at a distance'.⁴⁹

⁴⁷Other dominant characteristics of neo-liberalism, as defined by Gordon, Rose and Miller, include scepticism about the capacities of political authorities to properly govern, and its emphasis on markets over planning as regulators of economic activity. See Colin Gordon, 'Governmental Rationality: An Introduction', in Graham Burchell, Colin Gordon and Peter Miller (eds), *The Foucault Effect: Studies in Governmentality*, Hamel Hempstead: Harvester Wheatsheaf, 1991, pp.1-51; Nikolas Rose and Peter Miller, 'Political Power Beyond the State: Problematics of Government', *British Journal of Sociology*, vol.43, no.2, 1992, pp.173-205; and Nikolas Rose, 'Government, Authority and Expertise in Advanced Liberalism', *Economy and Society*, vol.22, no.3, 1993, pp.283-99.

⁴⁸Maurice Roche, *Rethinking Citizenship: Welfare, Ideology and Change in Modern Society*, Cambridge: Polity Press, 1992, particularly pp.39-54, 71-89. Also see Bryan Turner, 'Outline of a Theory of Citizenship', *Sociology*, vol.24, no.2, 1990, pp.189-217; and Deborah Lupton and Alan Petersen, *The New Public Health: Health and Self in the Age of Risk*, Sydney: Allen and Unwin, 1996, particularly pp.10-13.

⁴⁹Gordon, 'Governmental Rationality: An Introduction', pp.1-51; Rose and Miller, 'Political Power Beyond the State: Problematics of Government', pp.173-205; and Rose, 'Government, Authority and Expertise in Advanced Liberalism', pp.283-99. Also see Petersen and Lupton, *The New Public Health*; and Robin Bunton, 'More Than A Woolly Jumper: Health Promotion As Social Regulation', *Critical Public Health*, vol.3, no.2, 1992, pp.4-11.

A belief that experts could – without bias – identify risky situations, and that human subjects could rationally negotiate them, underpinned the neo-liberal discourse of risk. Indeed, confidence in the rational and autonomous human subject was expressed every time a public health official condemned ‘irresponsible’ people for the increasing number of AIDS cases, and whenever the press valorised ‘innocent AIDS victims’ and blamed HIV-positive gay men, drug users and ‘promiscuous’ heterosexuals for their own infection. Such confidence was misplaced, however, for two reasons. In the first instance, the discourse of risk produced by experts was neither value-free nor impartial. As I demonstrated in my first chapter about the ways in which epidemiologists and the press constructed knowledge about AIDS, experts who identified risky behaviours and propagated warnings about them were not free from ideological bias and prejudice, nor the constraints of time and institutional traditions. Similarly, the debates which occurred in the mid-to-late 1980s about the safety of condoms and the risks associated with oral sex (which I discuss in Chapters 5 and 8) were driven by personal agendas and obscured by an absence of firm evidence to support either side. Indeed, the fact that working as a prostitute, or employing one, was declared to be a ‘very high risk’ for HIV transmission in the 1980s – despite the absence of any confirmed instances of HIV transmission in the sex industry in Australia during this period – indicates that the risk discourse disseminated by experts was far from transparent.⁵⁰

Second, and more importantly, the belief that all individuals are rational autonomous agents who are equally capable of making healthy lifestyle choices ignores the different circumstances under which human beings live their lives. In blaming particular people with AIDS for their own infection, many Australians simply failed to acknowledge that factors such as class, gender, ethnicity and sexuality significantly affect life opportunities and ensure that decision-making is considerably more complex than it might first appear.⁵¹

⁵⁰I discuss this point at length in Chapter 8. For similar critiques of the positivist nature of risk discourse, see Petersen and Lupton, *The New Public Health*, pp.27-60; and Catherine Waldby, Susan Kippax and June Crawford, ‘Epidemiological Knowledge and Discriminatory Practice: AIDS and the Social Relations of Biomedicine’, *Australian and New Zealand Journal of Sociology*, vol.31, no.1, 1995, pp.1-14.

⁵¹Here I am recalling the established socialist and feminist critiques of health and illness. See, for example, Robert Crawford, ‘You Are Dangerous To Your Health: The Ideology and Politics of Victim Blaming’, *International Journal of Health Sciences*, vol.7, 1977, pp.663-80; and Robert Crawford, ‘The Boundaries of

Injecting drug users, who were often miserable and addicted and trying to escape from problems which at any given moment seemed far more urgent than the remote probability of contracting a deadly infection, were thus blamed for ignoring the warnings against using drugs and sharing needles.⁵² Gay men who acquired HIV after they continued to have frequent sexual encounters with different partners were blamed by a society which, in the 1980s, disallowed gay men to marry, to adopt children, and to claim *de facto* status for social security benefits – incentives which might have encouraged them to adopt the model of safer long-term monogamous relationships.⁵³ Young gay men who refused to wear condoms were condemned for their own infection, without consideration of the self-loathing which might contribute to a young person making such a decision – self-loathing which had its origins in being persecuted at school, bashed in the street, vilified in church, labelled ‘animal’ by conservative politicians such as Sir Joh, and ignored by the mainstream media and popular culture that portrayed heterosexuality as the only true and proper expression of sexuality.⁵⁴ Indeed, the few tragic young gay men at the beginning of the twenty-first century who actively seek to become infected with HIV so that they may join an ‘AIDS community’ – which has a fixed identity and receives the recognition of its needs, care and support so sadly lacking in the lives of young gays when they ‘come out’ to their families or their school-mates – are never deemed to be innocent victims.⁵⁵ Yet surely they are not guilty. And what of those women who, fearing rejection, abandonment and perhaps violence, refuse to raise the question of condom use with partners upon whom

the Self and the Unhealthy Other: Reflections on Health, Culture and AIDS’, *Social Science and Medicine*, vol.38, no.10, 1994, pp.1347-65.

⁵²Loxley discusses other factors such as peer pressure and inequitable (gendered) relationships which militate against safe drug use and sexual practices. See Wendy Loxley, *Young Injecting Drug Users and the Risk of HIV/AIDS: Psycho-social and Environmental Constraints on Safer Drug Using and Sexual Behaviour*, PhD thesis published by the National Centre for Research into the Prevention of Drug Abuse, Curtin University of Technology, Perth, 1988, pp.217-25.

⁵³Terry Goulden, director of the Gay Counselling Service and one of the founders of the NSW AAC, made this very point at the time of the Queensland babies crisis when gay men came under attack.

⁵⁴Information gathered during counselling sessions and interviews with young gay men and homosexuals who had recently seroconverted consistently suggests that this situation was a powerful mitigating factor in the adoption of unsafe sexual behaviour. I am indebted to Jamie Dunbar, Education Officer with the AIDS Council of New South Wales, and Kenton Miller, Peer Educator with the Victorian AIDS Council, for this insight. Also see Victorian AIDS Council (James McKenzie), *When You Say Yes*, Melbourne: Victorian AIDS Council, 1992, pp.3-5.

⁵⁵Jenny Ross interviewed by Paul Sendziuk, 24 November 1999, notes in possession of the author.

they are economically or emotionally dependent?⁵⁶ All of these people *were* and *are* making rational decisions based on the options available to them and the future that they foresee for themselves, but their decisions were different from those arrived at by individuals with vastly contrasting life histories.⁵⁷

The idea that *all* people with AIDS might be innocent, of course, served little purpose for conservative politicians and members of the public, sections of the media and the small cohort of public health officials who did not trust that Australians would behave with the best intentions. They were comforted by the deterrent which blame occasioned and accepted the opportunity to criticise lifestyles that differed from their own or the norm. In reality, however, the horrors of AIDS provided its own deterrent, and the denigration of 'deviant' lifestyles that blame facilitated only served to further estrange a population whose existing alienation often drove it towards risky practices. In terms of AIDS, therefore, the construction of guilt and blame has been counterproductive – as, perhaps, it has always been.

Fortunately, in Australia, debates about AIDS and the design and implementation of health promotion messages ('risk discourse') have occurred with the involvement of community-based organisations, such as the gay-dominated AIDS Councils and drug user collectives, which have an intimate understanding of the complex life histories and the decision-making processes of their members. They have articulated a sophisticated risk discourse which identifies the factors leading to unsafe practices, rather than simply and judgmentally censuring the various risky behaviours. More importantly, in their role as primary health care providers, they have implemented programmes and education campaigns that address the problems of alienation, low self-esteem, ignorance and dependency which might lead members of their communities to adopt unsafe practices. By the end of the 1980s, for example, each of the state-based AIDS Councils offered on-going

⁵⁶Marvellous Mhboyi, 'Can A New Sex Culture Save the Next Generation?', *National AIDS Bulletin*, vol.7, no.6, July 1993, p.19.

⁵⁷For further discussion of this point from a theoretical perspective, see Susan Kippax and June Crawford, 'Flaws in the Theory of Reasoned Action', in Deborah J. Terry, Cynthia Gellois and Malcolm McCamish (eds), *The Theory of Reasoned Action: Its Application to AIDS-Preventive Behaviour*, Oxford: Pergamon Press, 1993, pp.253-69; and Loxley, *Young Injecting Drug Users and the Risk of HIV/AIDS*, pp.217-54.

workshops to young gay men that tendered a supportive environment for them to explore their sexuality and enhance their self-esteem. At various times, funding for these programmes has been threatened by conservative political and public opposition to their alleged 'promotion of homosexuality' or 'advocation of drug taking'. In July 1990, for instance, the Victorian AIDS Council (VAC) became embroiled in a controversy about a poster campaign titled 'When You Say Yes...' which was produced by the VAC's Youth Project Team (see Figure 3.5). The poster advertised VAC's peer support groups and provided a contact number to call, but also displayed two fully-clothed young men engaging in a kiss. The text advised:

Making the first move might be scary, but more guys than you think have sex with other guys. It's natural and if you're safe you'll have a great time. And what's safe? Kissing, cuddling, licking, stroking, wanking, oral sex (avoid cum in the mouth) vaginal and anal sex with condoms and water based lube.

The poster thus clearly targeted young gay men who were at risk of having unsafe sex due to low self-esteem caused by a sense of alienation and other people telling them that homosexuality is 'unnatural'. To reach this audience, the poster was widely distributed on university campuses and in gay venues and was intended to be inserted into publications that young gay men might read, such as the free street press and *TV Week*. On the day of its release, however, *TV Week* refused to publish the poster, claiming that its readership would be offended by its content,⁵⁸ and the Victorian Shadow Minister for Health, Marie Tehan, demanded that the Health Department withdraw funding to the VAC "if it continue[d] to place the irresponsible advertisements which blatantly promote homosexuality".⁵⁹ Furthermore, she suggested that "if the Victorian AIDS Council want to spend their money on AIDS advertisements it should be saying that you get AIDS from homosexual intercourse". On 9 August, a group of medical professionals as well as representatives from twenty-four churches and community organisations met in Bendigo to condemn unanimously the campaign and endorse the words of the Bishop of Sandhurst, Noel Daly,

⁵⁸Maree Curtis, 'AIDS Ad Row: "Blatant" Sex Poster Riles Bishops, MPs', *Sun*, 26 July 1990, pp.1-2.

⁵⁹Marie Tehan press release, 25 July 1990, cited in Victorian AIDS Council (James McKenzie), *When You Say Yes*, p.10.

When you say yes...



say yes to / safe sex.

Making the first move might be scary, but more guys than you think have sex with other guys. It's natural and if you're safe you'll have a great time.

And what's safe? Kissing, cuddling, licking, stroking, wanking, oral sex (avoid cum in the mouth) vaginal and anal sex with condoms and water based lube.*

For more information on safe sex and discussion groups for young gay and bisexual men, call 483 6700 or 419 9974.

Produced by the Victorian AIDS Council 1992. *Such as KY-gel



Figure 3.5: 'When You Say Yes...' (Victorian AIDS Council poster, 1990).

who described the poster as "revolting, offensive...[and] repugnant".⁶⁰ The group formally demanded that the Advertising Standards Council ban the poster from publications under its jurisdiction, which it did on 12 September. By this time, protagonists in the debate about the content and intention of the poster had appeared on ABC TV's *7:30 Report* and Network Ten's *Good Morning Australia*. This publicity, in addition to the thousands of 'When You Say Yes...' T-shirts and leaflets produced and distributed by VAC and ACT UP, meant that the message of the campaign was widely disseminated, resulting in over 250 'at risk' young gay men in Victoria becoming involved in VAC's 'Young and Gay' peer education programme. The campaign therefore achieved its aim, despite the efforts of its detractors who mistook a sophisticated approach to health promotion for gay propaganda because they were blinkered by an existing paradigm of guilt and blame.

Since their inception as AIDS Action Committees (AACs) in 1983, the AIDS Councils had been determined to problematise notions of risk and blame in an effort to ensure that a simplistic morality tale of innocence and guilt did not dictate Australia's political response to AIDS. Indeed, the gay men and women who formed the initial AACs understood the complex nature of homosexual lives and were thus keen to form organisations that could be incorporated into the policy-making process and offer this insight. Observing the difficulty that the gay community in the United States was experiencing in being recognised, the AACs also anticipated that the Australian government would be reluctant to spend money on gay men; they *knew* that the media would not want to tell their stories, or would tell them inaccurately. They therefore also saw their role as advocates and activists, and as an authoritative body representing the gay community which could liaise with news agencies.

Of course, these were not the only factors compelling gay men to mobilise. In 1983 the average Australian GP, who was not reading the American gay press, knew nothing about AIDS. Homosexuals thus realised that they had to organise and educate themselves, their brothers and their doctors if they were to survive. Within weeks of being formed, the NSW AAC had established a collection of AIDS literature for public use comprising over four

⁶⁰ 'Churches Slate AIDS Advertisement', *Bendigo Advertiser*, 10 August 1990, p.3.

hundred academic and scientific articles, handbooks on dealing with AIDS, and news clippings, much of which was produced or suggested by gay community-based AIDS organisations in the United States.⁶¹ In an effort to produce accessible scientific updates for the Victorian AAC and his readership, Adam Carr, a journalist for *Outrage* and one of the founders of the VAAC, purchased a copy of *Immunology Made Easy*, Macfarlane Burnet's *Natural History of Infectious Diseases* and a dictionary of medical terms, and set about translating complex and jargon-ridden medical literature concerning AIDS into layman's language.⁶²

The first AAC was established in Sydney on 15 May 1983 at a gay community meeting called in response to Archer's ban on gay blood and the public relations debacle of the subsequent picket outside the Red Cross centre. Representatives from over twenty existing gay organisations, including the Gay Rights Lobby, Gay Solidarity Group, the Gay Counselling Service, Radical Women, the Metropolitan Community Church and the Gay Business Association, were at the meeting and endorsed the establishment of the new organisation. In a letter introducing the AAC to the Commonwealth Minister for Health, its convenor, Lex Watson, stated that some of the AAC's aims were to monitor the available information on AIDS and provide non-alarmist information to both the gay community and the wider media in order to counter the political attacks on homosexuals that had become an adjunct to the AIDS debate. It also planned to organise support services for those who, in the future, would suffer from the syndrome.⁶³ The urgency of this final aim became apparent within the next year as rudimentary studies conducted by Australian researchers indicated a high incidence of infection in the homosexual population. Ron Penny's initial study of five hundred Sydney homosexual and bisexual men, for example, suggested that one-in-five were suffering from symptoms of immune deficiency and were thus potentially infected with the virus that causes AIDS (labelled HTLV-III at the time).⁶⁴ The validity of

⁶¹AAC, 'Introducing the AIDS Action Committee', June 1983, NBAC/NAAC, ANU, H7/22.

⁶²Adam Carr interviewed by Paul Sendziuk, 4 August 1999, notes of interview in possession of the author.

⁶³Letter to Neal Blewett from Lex Watson, 6 June 1983, NBAC/NAAC, ANU, H7/22.

⁶⁴Of this original sample, 289 men claimed to have two or more sexual partners per week and were deemed to be at much greater risk. Indeed, 47% of these men were exhibiting one or more signs of AIDS, such as swollen lymph nodes, immune deficiency, and had a history of ailments such as fever, night sweats, diarrhoea and weight loss. See Sydney AIDS Study Group, 'The Sydney AIDS Project', *Medical Journal of*

this result was disputed, however, because most of the men who volunteered for the study either were already exhibiting symptoms of AIDS or had indulged in many or all of the high-risk practices.⁶⁵ Nevertheless, researchers at Melbourne's Walter and Eliza Hall Institute for Medical Research reported a comparable level of infection in its cohort of gay men who were chosen because of their apparent good health. The study found that 24% of a cohort of 101 Victorian homosexuals were infected with HTLV-III.⁶⁶

The sense of urgency with which the Sydney gay men mobilised differed from that exhibited by most of the other gay communities in other capital cities and regional areas. This is because Sydney was home to the largest gay community in Australia, and was a popular holiday destination for homosexuals from San Francisco, Los Angeles and New York – the epicentres of the AIDS epidemic. Gay men in Sydney thus understood that they were at greater risk of coming into contact with the virus. The size of the Sydney homosexual population, and the established gay commercial district, gay press and gay political organisations which sustained it, also meant that Sydney homosexuals were in the best position to draw on existing social and political networks to respond to the AIDS crisis. Gay men in rural areas and smaller capital cities such as Hobart and Perth lacked such a network and, at the start of the 1980s, cannot be said to have constituted self-conscious 'gay communities'.

The experience of Sydney gay men was most closely reflected in Melbourne, which had a smaller homosexual population but its own gay press and institutions. Melbourne gay men began officially to respond to AIDS on 16 June 1983 when the health sub-committee of the ALSO Foundation called a public meeting at the Royal Dental Hospital to hear a panel of doctors provide information and answer questions about AIDS. A capacity crowd of 300 was left dissatisfied and pessimistic by the answers that were provided and agreed to meet

Australia, vol.141, 27 October 1984, pp.569-73; and Alan Tate, 'AIDS is Spreading, Gays Survey Finds', *Sydney Morning Herald*, 29 October 1984, p.3.

⁶⁵Penny admitted "it may well be that those who volunteered for this survey did so because they suspected or feared that they were already suffering from AIDS" (*ibid*). For criticism of the study, see Adam Carr, 'AIDS Risks' [letter], *Age*, 3 November 1984, p.12.

⁶⁶Mark Metherell, 'Serious Spread of AIDS Virus Among Gay Donors: Survey', *Age*, 20 November 1984, p.1.

the following month to establish an organisation which could undertake more research, provide information and lobby the government to take action. Thus on a cold night of 12 July 1983 about seventy people packed into a gay bar in Collingwood to debate and pass a motion to establish the Victorian AIDS Action Committee. Perhaps aware of the problems that the NSW AAC was experiencing in dealing with Paul Dexter and the Gay Army, the meeting also passed a motion that proclaimed the VAAC as "the sole representative of the Victorian gay community in all matters relating to AIDS".⁶⁷

The NSW AAC was also experiencing difficulty deciding upon its primary purpose, which resulted in a protracted argument between its leaders, Lex Watson and Terry Goulden. Watson, an experienced gay-rights campaigner and academic, wanted the organisation to be more politically aggressive, while Goulden, head of the Gay Counselling Service, argued that the AAC should avoid antagonising its potential allies and focus on organising care and support facilities for people with AIDS.⁶⁸ Watson's view prevailed until both groups became founding members of the AIDS Council of New South Wales in February 1985. Working separately, Goulden thus established the AIDS Support Group and AIDS Home Support in July and November 1983 respectively, with the aim of providing one-to-one emotional support and home care for people with AIDS.

The Melbourne gay community was not blessed with such a variety of existing organisations, and the VAAC was encouraged to assume responsibility for all issues concerning AIDS. It was governed by a well-balanced executive committee that represented a range of political, ideological and public health perspectives. Convenor Phil Carswell and Alison Thorne, for example, were affiliated with the Communist Party and had trade union links, while others, such as Adam Carr and Jamie Gardiner, were experienced campaigners for civil liberties. David Plummer, Ian Goller, Chris Carter and

⁶⁷Adam Carr, 'A Dangerous Decade: Ten Years of the Victorian AIDS Council, 1983-1993', in VAC, *Victorian AIDS Council Inc. Gay Men's Health Centre Inc. 1983-1993*, Melbourne: Victorian AIDS Council, 1983, pp.5-6. AACs were also formed in other Australian capital cities. In September 1983, they came together at the 9th National Conference of Lesbians and Homosexual Men to endorse the formation of an umbrella organisation, the Australian AIDS Action Committee, which became the gay community's representative in discussions concerning AIDS at the Federal level.

⁶⁸Don Baxter interviewed by James Waites, 26 July 1993 and 19 November 1993, 'The Australian Response to AIDS' Oral History Project, National Library of Australia, TRC-2815/79, transcript p.13.

Peter Knight were either medically trained or had an interest in treatment and care issues. Like the NSW AAC, nearly all of VAAC committee members knew each other from their past and present lives as student politicians, gay activists and union officials, and had links with the left wing of the Australian Labor Party. They thus were acquainted with many of the state and federal Labor politicians and civil servants, such as Bill Bowtell and Margaret Duckett, who in later years would assume policy-making positions in the state and Commonwealth health bureaucracies.⁶⁹ As I will argue in my next two chapters, these political links, and the trust which had already been established between gay leaders, the ALP and the people who would become key civil servants, was vital in allowing a public health partnership to be established to combat AIDS in the mid-1980s.

The AACs took as their model the gay-based AIDS organisations, such as Gay Men's Health Crisis in New York and the KS/AIDS Foundation in San Francisco, which had emerged in the United States during the previous eighteen months.⁷⁰ They quickly established sub-committees that co-ordinated education and fundraising initiatives, media and public speaking engagements, research, support for people with AIDS, legal advice for gay men and people with AIDS who had been discriminated against, and the volunteers who agreed to help in each of these areas.

The experience of the US organisations, in addition to the lessons learned during the Sydney Blood Bank fiasco, also suggested that the Australian AACs would need to be vigilant of the political ramifications of AIDS and seek incorporation into the policy-making process. Following Archer's ban on gay blood, the NSW AAC indeed sought, and

⁶⁹I am indebted to Ken Davis and Adam Carr who helped found the NSW AAC and the VAAC respectively, for these observations. Interview with Ken Davis conducted by Paul Sendziuk, 19 November 1999, notes in possession of the author. Interview with Adam Carr conducted by Paul Sendziuk, 4 August 1999, notes in possession of the author.

⁷⁰The history of the establishment and work of these organisations has been well documented. An enthusiastic appraisal of their contribution can be found in Suzanne C. Ouellette Kobasa, 'AIDS Volunteering: Links to the Past and Future', in Dorothy Nelkin, Scott V. Parris and David P. Willis (eds), *A Disease of Society: Cultural and Institutional Responses to AIDS*, Cambridge: Cambridge University Press, 1991, pp.172-88; Dennis Altman, 'Legitimation Through Disaster: AIDS and the Gay Movement', in Elizabeth Fee and Daniel M. Fox (eds), *AIDS: The Burdens of History*, Berkeley: University of California, 1988, pp.301-15; and John-Manuel Andriote, *Victory Deferred: How AIDS Changed Gay Life in America*, Chicago: University of Chicago Press, 1999, pp.83-122. An alternative, extremely critical, perspective is offered by Nancy E. Stoller, *Lessons from the Damned: Queers, Whores, and Junkies Respond to AIDS*, New York: Routledge, 1998, pp.33-62.

gained, representation on the Health Minister's co-ordinating committee on AIDS.⁷¹ The Victorian Health Minister, Tom Roper, however, rejected any contact with the VAAC for almost a year before granting it representation on a liaison committee that reported to his main advisory panel on AIDS. Through this body, the VAAC made formal submissions on education, research, contact tracing, the management of people with AIDS and blood donation policy.

The urgency with which the AACs sought political representation intensified as homosexuals came under public attack following news of the deaths of the Queensland babies in November 1984. Brian Austin's announcement also prompted the Queensland parliament to pass what seemed – to civil libertarians and gay men – to be draconian laws providing for jail terms of up to two years or a \$10,000 fine for anyone who donated blood without disclosing that they belonged to a 'high risk group'.⁷² The VAAC reacted strongly against this legislative approach to AIDS, considering it to be based on the expectation that gay men and others in 'high risk groups' could not be trusted to act responsibly. Adam Carr asserted:

All the experience in the US has shown that the only way the AIDS problem can be tackled is by the closest co-operation between the gay community, in particular, and the health authorities. This can't happen in an atmosphere of fear and paranoia.⁷³

Lex Watson, similarly, could not understand the need for the new punitive measures, noting that the AAC had told health authorities in August that it supported the banning of

⁷¹Letter to Neal Blewett from Lex Watson, 29 June 1983, NBAC/NAAC, ANU, H7/27.

⁷²Sally Gluyas and Penny DeBelle, 'Hawke AIDS Summit', *Herald*, 16 November 1984, p.1; and Damien Murphy and Mark Metherell, 'Queensland Will Fine, Jail Deliberate AIDS Donors', *Age*, 16 November 1984, p.1, 4. The legislation also made it compulsory for Queensland doctors to provide the names of people suspected of being infected with HIV to the state health authorities and criminalised the 'knowing' transmission of 'the AIDS virus' to another person. HIV-positive individuals were not to be held criminally liable if their partners were informed of the possibility of infection before transmission occurred, or if the HIV-positive individual and his/her partner were married, since the partner was deemed to have 'voluntarily run the risk of being...infected'. See Parliament of Queensland, *Transplantation and Anatomy Act Amendment Act (No.2) 1984*. I discuss the implications of this legislation further in Chapter 4.

⁷³Galbraith, 'Is It Safe to Drink the Water', p.20.

all homosexual and bisexual men from donating blood and that, to his knowledge, no gay men had since done so.⁷⁴

Despite their objections, health ministers in other states felt pressured to be seen by the public as proactive and to enact legislation similar to that introduced in Queensland. They were eventually persuaded to do so by David Penington, whose distrust of gay men was already known. He argued that the possibility of prosecution was critical to ensure that the donor declaration form would be honoured.⁷⁵

The bold steps taken by Queensland to take control of the AIDS epidemic (as it was now being called), and the public's anxious response to the contamination of the blood supply, also forced the Prime Minister to intervene. He publicly asked all men who had engaged in sexual intercourse with another man during the previous five years not to donate blood and issued a call for women to take their place in the Blood Bank lounge. New donors were also needed to compensate for the large number of people who had been deterred from making their regular blood deposits due to the irrational fear that they might contract AIDS from *giving* blood. Hawke's plea was perceptively captured in the context of the homophobia that pervaded at the time by a Tandberg cartoon published in the *Age* on 20 November (Figure 3.6). Never ones to miss a publicity opportunity during an election campaign, the wives of a number of prominent politicians, including Hazel Hawke and Margaret St George (wife of the Federal Opposition leader, Andrew Peacock), were photographed giving the gift of life for the good of the nation. Despite organising a

⁷⁴*Ibid.*

⁷⁵David Penington, 'The AIDS Epidemic in Australia: What Constitutes An Appropriate Response?', address to the Australian Institute of Political Science Seminar, 28 July 1987, NBAC/NAAC, ANU, H9/99. From April 1985 (when testing of all blood donations began) until December 1996, only 87 of over 11 million blood donations were found to contain the HIV antibody. Although several HIV-positive donors were found to be aware of their risk status, there were no prosecutions until 1993, when public evidence proved that a Victorian donor was aware of being HIV-positive. See National Centre in HIV Epidemiology and Clinical Research, *HIV/AIDS and Related Diseases in Australia: Annual Surveillance Report 1997*, Sydney: NCHECR, 1997, p.51; and John Ballard, 'HIV-Contaminated Blood and Australian Policy', in Eric A. Feldman and Ronald Bayer (eds), *Blood Feuds: AIDS, Blood and the Politics of Medical Disaster*, Oxford: Oxford University Press, 1999, pp.253-4.



Figure 3.6: Tandberg cartoon, *Age*, 20 November 1984.

television crew to capture her magnanimous effort, Lady Flo Bjelke-Petersen was turned away because, as a first-time donor, she was too old to give blood.⁷⁶

The Prime Minister and Neal Blewett also invited the health ministers from each state to an 'AIDS Summit', held in Melbourne on 19 November, in order to devise a national approach to combating AIDS. Representatives from the Sydney and Melbourne AACs were not invited to attend. Indeed, the Queensland Minister for Health made it clear that he would not participate if they were invited.⁷⁷ The AACs did, however, make written submissions to the Summit which suggested that gay men must be involved in designing policies and choosing advisory committees if these initiatives were to gain the confidence of gay men and thus be effective,⁷⁸ and there is evidence to suggest that a number of their proposals were incorporated into the final national approach. The ministers agreed to adopt a uniform blood policy, introduced a declaration form that prohibited people in 'high risk groups' from donating blood, and pledged funds for the screening of all blood donations as soon as a test became available. They also agreed to establish assessment, counselling and support services for people diagnosed with AIDS, and a nation-wide mass-media campaign to educate the public about the syndrome, both of which would be mostly funded and co-ordinated by the Commonwealth. Given that under the Constitution health policy and funding was a state concern, this level of national uniformity and Commonwealth control was exceptional. The states could see that the necessary measures would be expensive and that AIDS was political poison, however, and were happy for Blewett to assume responsibility.⁷⁹

Blewett also decided to reconstitute David Penington's NH&MRC Working Party on AIDS. It retained its chairperson, became the AIDS Task Force and was empowered to advise the state health ministers on matters relating to the aetiology of AIDS and its modes

⁷⁶'Top Women Rally To Donate Blood', *Age*, 21 November 1985, p.5.

⁷⁷Galbraith, 'Is It Safe to Drink the Water', p.20.

⁷⁸*Ibid.*

⁷⁹John Ballard, 'Australia: Participation and Innovation in a Federal System', in David L. Kirp and Ronald Bayer (eds), *AIDS in the Industrialized Democracies: Passions, Politics and Policies*, New Brunswick: New Jersey, 1992, p.134.

of transmission, as well as medical research and funding. On the recommendation of Bill Bowtell, Blewett's senior advisor, the Commonwealth Minister for Health also took the unusual step of establishing another advisory committee to be chaired by publishing and media personality Ita Buttrose. The National Advisory Committee on AIDS (NACAIDS), as it became known, comprised representatives from state health departments, the Australian Medical Association, the Red Cross, the AIDS Task Force, the ACTU, the Haemophilia Foundation, and the convenors of the Sydney and Melbourne AACs. It thus provided a forum for medical professionals, government and the communities most affected by AIDS to communicate with each other and advise Blewett on the 'social' and legal aspects of AIDS. The main role of NACAIDS was to develop a national 'AIDS-awareness' and education programme and it was expected that Buttrose's well-known face and proven ability to communicate in a direct and reassuring manner would help in this regard. With the assistance of the AIDS Task Force, by the end of 1984 NACAIDS had produced and distributed hundreds of thousands of information booklets and leaflets about AIDS aimed at the general community, homosexuals, and health care workers, as well as employers and union officials who were worried about AIDS in the workplace.

NACAIDS was also asked to devise a blood donor recruitment campaign and reassure the public that every effort was being made to safeguard the blood supply. To achieve this second goal, NACAIDS went to the extent of requesting that television news stations not use the Red Cross or BTS logo as a backdrop when reporting about AIDS.⁸⁰ Its recruitment drive, which quickly followed Hawke's plea for female donors to come forward, was initially successful but could not be sustained. On the Monday following Hawke's plea and Buttrose's appointment, for example, donations to most metropolitan BTSs across the country increased by approximately 110%, with women accounting, on average, for 80% of these donations.⁸¹ Within weeks, however, the number of people making donations had fallen below the pre-November 1984 level and, despite the publicity surrounding the introduction of universal blood screening procedures in April 1985, nearly 20% of two

⁸⁰ Action Sheet from National Advisory Committee on AIDS Meeting, 15 July 1985, reprinted in *AIDS News Bulletin*, no.3, August 1985, p.11.

⁸¹ Statistics compiled by the State Directors of the Blood Transfusion Services and contained in 'Briefing for Press Conference on AIDS Advisory Committee, Attachment 3', NBAC/NAAC, ANU, H19/25.

thousand people surveyed by Irving Saulwick for the *Age* newspaper in July believed that they would be at 'high risk' of contracting AIDS if they were admitted to hospital or received a blood transfusion.⁸² (In 1986, 57.4% of 371 people surveyed believed that HIV could be transmitted through donating blood.)⁸³ Rumours that gay men were deliberately contaminating the blood supply did nothing to alleviate the public's anxiety.

By the end of 1984, therefore, the future was looking bleak for gay men. The states and territories, led by Queensland and supported by Penington's Task Force, had indicated that they were willing to take a legislative approach to safeguard the public's health rather than rely on education and the co-operation of communities most at risk. Indeed, the level of public anxiety which still existed despite the efforts of NACAIDS might have been used as evidence that education would prove inadequate in countering the threat of AIDS. As members of the public fretted about the safety of the blood supply and reflected on the cause of their discontent, their anxiety often turned to anger which was directed towards homosexuals who were blamed for their own infection and the infection of others. As gay men, stigmatised by their association with AIDS, were discriminated against at work and home, and vigilante groups occasionally roamed Oxford Street looking for AIDS-ridden poofers to punish, it looked very much like Australia would experience the backlash against homosexuals that was witnessed in the United States, just as Australia's public health response was beginning to mirror that country's legislative and biomedical approach to disease control. Neither of these things eventuated, however, for reasons that I shall explain in the next two chapters.

⁸²'Australians Fear AIDS From Hospital: Poll', *Age*, 12 August 1985, p.3. Approximately 8% of respondents claimed that they would be at 'very high' risk and 11% rated their risk 'high'. A further 27% of respondents believed there was a 'moderate' risk that going to hospital or having a blood transfusion would give them AIDS. The survey recorded the responses of people throughout Australia from all socio-economic levels, genders and ethnic backgrounds.

⁸³Malcolm McCamish, 'Knowledge about AIDS', *Medical Journal of Australia*, vol.145, no.10, 1986, pp.177-8.

Chapter 4.

Challenges to the Traditional Model of Infectious Disease Control

At the time of the Queensland babies crisis, the NH&MRC Working Party on AIDS, which became the National AIDS Task Force, was the most influential medical body responding to AIDS in Australia. It was composed primarily of immunologists and epidemiologists such as Ron Penny and Julian Gold, who were involved in the Sydney AIDS Study Group which traced the arrival and spread of HIV in Sydney's gay community. The Task Force chairman, David Penington, was a respected haematologist and, as head of the National Red Cross Blood Transfusion Committee, had an existing stake in the control of AIDS. He had survived the contaminated blood disaster relatively unscathed and, unlike Dr Gordon Archer, was not required to front a national audience and an angry journalist on *60 Minutes* to explain why he had negotiated a compromise with a bunch of "homosexual radicals" and not immediately implemented stringent controls on the donation of blood by members of high risk groups.¹ Penington was wounded by the experience, however, and it shaped his relationship with gay-based AIDS organisations in the following years. He steadfastly refused to consult with the AAAC when it sought representation on his committee, for example.²

An intelligent and proud man – he had studied at Oxford and practised in Harley Street – Penington's capacity for quick and precise analysis and hard work earned him a place among Melbourne's medical establishment. He had been thrust into the public sphere as the foremost medical expert on AIDS because of these accomplishments, yet in spite of them Penington found himself in the unusual and frustrating position of trying to comfort an anxious public with an empty medical cabinet. Rather than a cure, the doctor on duty could dispense only hope. It was an ironic role given that Penington no longer worked in a clinical capacity and therefore had little actual contact with AIDS patients or the

¹Jana Wendt [reporter], 'AIDS – Out of the Closet' [report], *60 Minutes*, Nine Network, 2 September 1984.

²John Ballard, 'Australia: Participation and Innovation in a Federal System', in David L. Kirp and Ronald Bayer (eds), *AIDS in the Industrialized Democracies: Passions, Politics and Policies*, New Brunswick: Rutgers University Press, 1992, p.139.

marginalised communities from which they came. This soon led community-based AIDS organisations to accuse him of being distant and unable to understand their needs, something which was never said of fellow Task Force members Ron Penny and David Bradford, who worked respectively at St Vincent's Hospital in Darlinghurst, Sydney, and the Melbourne Communicable Diseases Centre. Indeed, the experience of Bradford and Penny in talking with gay men, injecting drug users and sex workers on a daily basis led the doctors to develop a greater respect for the communities at risk and their capacity to fight AIDS and change their practices if necessary – something which the Task Force chairman doubted.³ Penington's position among the medical elite, his intellect, his access to the media, and the fervour with which he pursued an end to the epidemic made him a formidable opponent, however, and the other members of the Task Force were reluctant to challenge him publicly throughout his tenure. In any case, the continued funding of their projects depended, in part, on his approval.⁴

While Penington and his fellow Task Force members could not offer a cure for AIDS, they did provide the Commonwealth and state health ministers with a strategy to contain its spread. Its strategy was at odds with the one proposed by the AIDS Councils and NACAIDS – the governments' other advisory committee – however, partially due to the background of its members and its terms of reference. The Task Force was composed entirely of medical professionals and one of its main objectives was to determine the extent, and probable future, of the AIDS 'epidemic' in order to advise the Commonwealth and state governments on how to best allocate funds for AIDS prevention programmes and treatment facilities. The doctors thus predictably drew upon the traditional 'test and contain' model of infectious disease control that they had learnt at medical school, and advocated widespread HIV-antibody testing and compulsory notification of serostatus to

³Bradford was homosexual himself and Penny had a gay brother, which perhaps allowed them to relate to the response of the gay community with greater sensitivity.

⁴One of the problems of David Plummer's otherwise compelling critique of the biomedical approach to AIDS control is his tendency to overlook the lack of consensus amongst members of 'the medical establishment', a term he uses to describe the Task Force, the Albion Street (AIDS) Clinic and other such groups. John Ballard provides a more accurate account of the tension between prominent AIDS doctors, such as Penington, Penny and John Dwyer, and the constraints placed upon them. See David Plummer, 'The Medical Establishment', in Eric Timewell, Victor Minichiello and David Plummer (eds), *AIDS in Australia*, Sydney: Prentice Hall, 1992, pp.73-86; and Ballard, 'Australia: Participation and Innovation', especially pp.156-7.

identify how many people were infected and where they lived.⁵ The Task Force believed that a face-to-face encounter between doctor and patient at an HIV-antibody testing site, and the shock of a 'positive' test result, provided an opportunity for the patient to be counselled on behavioural change which would help prevent the transmission of HIV via unsafe sexual or drug-using practices.

The identification of HIV-positive people through testing and compulsory notification also empowered the State to enact public health and criminal laws that permitted the incarceration of HIV-positive persons who 'knowingly' and 'recklessly' placed sexual partners at risk by failing to warn them of their infectious status. Persuaded by public pressure and led by Queensland and New South Wales, all of the state governments eventually passed such legislation, clearly believing that the State could force citizens to behave responsibly even if it did not trust them to do so. The Task Force expressed a similar inclination during its first weeks of existence by convincing the state governments to enact criminal sanctions against members of high risk groups – gay men, sex workers and injecting drug users – who, the Task Force believed, might make false declarations to the Blood Transfusion Service and continue to donate blood. Most members of the Task Force who worked in a clinical capacity opposed criminal penalties for 'knowing' and 'reckless' behaviour, however, as they feared that such penalties would discourage people from voluntarily taking the HIV-antibody test.

The 'test and contain' model of infectious disease control also called for restrictions to be placed on the movement and activities of infected individuals and people deemed to be at high risk. In the past, this had seen the establishment of quarantine or sanatorium facilities and the demolition of dwellings and places where disease might be spread. Such measures were inappropriate for HIV which was not casually transmissible. Nevertheless, some Task Force members, state health bureaucrats and community leaders called for the closure of gay bathhouses and other venues where men might have casual sexual encounters, and the abandonment of Gay Pride Week and the Sydney Gay and Lesbian Mardi Gras, in an effort

⁵I employ the label 'test and contain' to emphasise the central role that the identification and containment of infected individuals plays in this particular approach to the control of infectious disease. Other authors, such as Bayer and Kirp, prefer the label 'contain-and-control'. (Ronald Bayer and David L. Kirp, 'An Epidemic in Political and Policy Perspective', in Kirp and Bayer (eds), *AIDS in the Industrialized Democracies: Passions, Politics and Policies*, New Brunswick: Rutgers University Press, 1992, pp.4-5.

to eliminate activity that was at 'high risk' of transmitting HIV. When representatives of the homosexual community criticised such measures, and proposed that these venues and events be used as sites for education about safe sex and AIDS, they were accused of self-interest and criticised for ignoring 'proper' public health measures.

Proponents of the traditional 'test and contain' model of infectious disease control were thus characterised by the way in which they privileged the role of doctors and legislators in preventing the spread of AIDS, and by their distrust of the general public, and especially the communities most at risk from AIDS, to behave responsibly without the threat of legal penalty. Accordingly, they had little confidence in education programmes which promoted behavioural change, especially those that were not provided by medical professionals and were not accompanied by the 'shock' of an HIV-antibody test result. Seduced by the ability of biomedicine to find a 'magic bullet' for other infectious diseases and ignoring a more sophisticated understanding of the sociological determinants of sexual and injecting drug behaviours, they instead sought funding for HIV-antibody testing facilities, biomedical research and the quest for a cure.

NACAIDS and the AIDS Councils advocated a very different approach to the control of AIDS. More readily than many doctors (perhaps because few of their members were trained in the 'test and contain' model of infectious disease control), and certainly more quickly than some community leaders and newspaper columnists, they understood that AIDS posed exceptional challenges for public health authorities and the community that could not be dealt with in a traditional manner. In the first instance, they argued that while HIV was labelled 'infectious' and compared to tuberculosis and typhoid, the virus was actually very difficult to transmit and that this could only be done in specific circumstances. NACAIDS and the AIDS Councils thus steadfastly rejected calls for the quarantine and workplace dismissal of HIV-positive individuals, the closure of gay venues, and the denial of travel visas and immigration rights to people with AIDS. They also understood that AIDS overwhelmingly affected marginalised communities, especially gay men, who had an historical distrust of doctors and medical services. Familiar with the persecution which had resulted from doctors labelling them 'pathological' and 'mentally diseased', homosexuals would not be keen to co-operate with testing and notification

procedures that could identify them as 'AIDS carriers' and thus open up the possibility of renewed discrimination and persecution. Moreover, they argued that while doctors continued to advocate celibacy or monogamy and the avoidance of anal sexual intercourse, rather than 'safe sex', due to the 'scientifically proven' unreliability of condoms, any counselling and educational efforts that took place at HIV-antibody testing sites would be unlikely to produce sustained behavioural change in communities which were partially defined by promiscuous sexual activity. In the mind of the AIDS Councils, the doctors' retreat into 'theoretical probability' and the scientific literature that rejected condoms as a '100% effective barrier' to HIV infection, only served to prove how little they understood about the complicated lives of gay men, sex workers and drug users, and the emotional, psychological and economic needs that were satisfied by sex.

Rather than seeking to identify infected individuals by widespread HIV-antibody testing and 'disciplining' them through counselling and coercive public health and criminal laws, NACAIDS and the AIDS Councils (and, later, other community-based organisations such as the Australian Prostitutes' Collective which represented sex workers) proposed an education-based model of infectious disease control that targeted the entire community instead of the individual. They called for 'targeted' as well as 'broad-based' education campaigns which would encourage *all* Australians to consider themselves and their sexual partners potentially infected with HIV and urge them to take responsibility for preventing the transmission of the virus. They also outlined safe sexual and drug injection practices that could be adopted without demanding a drastic, and unrealistic, change in lifestyle. In short, they sought to implicate the entire community in the epidemic and advocated measures that minimised the risk of HIV transmission, such as sex with condoms and the exchange of 'dirty' needles and syringes for free sterile equipment (supplied by the government).

NACAIDS and the AIDS Councils understood the difficulty of achieving widespread behavioural change through education as decades worth of similar 'health promotion' campaigns aimed at smokers and drivers who sped, drank or failed to wear seatbelts had contributed only to a 10-20% drop in fatalities related to smoking and motor vehicle

accidents.⁶ The outcome would have been catastrophic if AIDS education programmes produced a comparable level of success. To facilitate the promotion and uptake of education, therefore, supporters of the 'education-based' model demanded that community-based groups, rather than public health departments, be funded to devise and deliver education to the people most at risk from AIDS. They argued that peer-educators knew where to find, and how to talk to, gay men, drug users and sex workers; the same could not necessarily be said for public health bureaucrats and doctors. They also suggested that the educational material aimed at gay men, sex workers and injecting drug users needed to be different in content and style from that produced for the rest of the community. Indeed, in order to popularise safe sex and explain the mechanism of safe drug injection, the material needed to be erotic and explicit and thus risk being construed by conservatives as pornography or promoting homosexuality and drug use.

It quickly became apparent, however, that information alone was inadequate to combat the way in which HIV was transmitted. Indeed, drawing upon the experience of other countries and, later, the work of sociologists at Macquarie University, Australian community-based AIDS organisations were soon suggesting that it was pointless to educate sex workers, gay men and injecting drug users about safe practices while these individuals did not have the power to realistically adopt them. How, for example, could poor and homeless prostitutes insist that their clients wear condoms when they were forced to work, without peer support and at the mercy of their customers, on the streets and from the back-seats of cars? What incentive did a depressed gay man have to 'choose life' and practise safe sex when he was being bashed at school, persecuted and vilified in the community or rejected by his family? And how could an addicted injecting drug user, without access to methadone or rehabilitation facilities, avoid sharing needles and syringes when they were in short supply and illegal to procure without a prescription? Proponents of the 'education-based' model of HIV prevention thus also sought the establishment of programmes which aimed to build the level of self-esteem within the gay community; and demanded legislative changes that would ensure the supply of low-cost sterile needles and syringes for drug users, and a safe regulated environment in which prostitutes could work (where they could enforce condom

⁶Bill Hart, 'Community Health Promotion Programs', in Heather Gardner (ed.), *The Politics of Health: The Australian Experience*, Melbourne: Churchill Livingstone, 1989, pp.426-30.

use and receive training in safe sex techniques and negotiation). This approach to disease prevention, which highlighted the complex psychological, economic, and legal determinants of health and illness, was much more sophisticated than the traditional 'test-and-contain' model that viewed disease prevention as a heroic fight against microbes in which only doctors and medical researchers could engage.

In a broad sense, these were the two approaches to controlling the spread of HIV that were presented to Neal Blewett and the state health ministers following the deaths of the Queensland babies and the introduction of an HIV-antibody test in early 1985. At the time, there were many reasons to suggest that the health ministers would accept the Task Force's version of the 'test and contain' model, and insist that doctors and medical researchers be funded at the expense of community-based organisations and education. The Task Force was, after all, the health ministers' expert medical advisory body and was merely proposing measures that had been enacted, with some success, during previous disease epidemics. And desperate measures, such as mandatory testing of 'high risk groups' and the closure of gay venues, seemed warranted – regardless of the consequences for civil liberties – given Australia now had one of the largest AIDS caseloads per capita in the world and evidence to suggest that perhaps 25% of gay men in Sydney were infected with HIV.⁷ The public and the mainstream media were certainly calling for swift and strong action to prevent the virus 'spreading' into the heterosexual community and expressed little sympathy for the rights of sex workers, injecting drug users and gay men, who were accused of 'murder' and donating infected blood 'out of spite'. It also seemed logical that Australia would continue to follow the lead of the United States, and the example of numerous European countries, including France, Italy and Spain, which were adopting traditional public health measures and investing in the scientific search for an 'AIDS cure' rather than community-based education, needle and syringe exchange programmes and law reform. Indeed, these kinds of 'radical' policy interventions and programmes were deemed politically unpalatable overseas and were bound to be unpopular with the electorate in Australia. Queensland, Tasmania and Western Australia had not yet decriminalised sexual

⁷Mark Metherell, 'Big Rise Likely in AIDS Cases, Researcher Fear', *Age*, 27 October 1984, p.3; and Sydney AIDS Study Group, 'The Sydney AIDS Project', *Medical Journal of Australia*, vol.141, 27 October 1984, pp.569-73.

intercourse between men, and were unlikely to sanction the funding of gay-based AIDS organisations to conduct 'self-esteem' workshops, never mind pay for the publication of erotic posters and pamphlets that extolled the virtues of safe (gay) sex. The states were also in the process of committing themselves to a popular 'offensive' on illicit drugs and were keenly promoting abstinence and the policing of drug laws; they thus risked contradicting themselves by agreeing to provide free sterile needles and syringes to drug users. Indeed, the idea of giving money to 'poofers, junkies and whores' – some of the most despised members of the community – to devise and provide peer-support programmes and education was anathema to many politicians and the constituencies they served. The notion of relying on them to be the frontline in the battle against the most serious health crisis that Australia had faced in the second half of the twentieth century was even less attractive.

Yet this is exactly what Neal Blewett did. He signalled his determination to deviate from the traditional public health model at the time of the Queensland babies crisis by constituting two advisory committees – the Task Force and NACAIDS, which represented community groups and had a wider terms of reference than Penington's group – and then encouraged the gay-based AIDS Action Committees to incorporate into AIDS Councils so that they could receive public funds to provide patient support services, advocacy and education. Both of these initiatives were prompted by Blewett's senior advisor, Bill Bowtell, a gay man who, as I shall explain in my next chapter, shared Blewett's distrust of doctors and the medical lobby. Blewett was then persuaded by NACAIDS and the AIDS Councils to invest in peer-provided education and 'community-building' programmes rather than allocating all of the AIDS budget to public health departments and medical researchers. He orchestrated a cost-sharing arrangement with the states which were ultimately responsible for distributing funds to medical institutions and community-based organisations. This stipulated, to the chagrin of doctors, that at least half of the money was to be spent on education and community programmes. Only Queensland refused to comply with the agreement which resulted in its money being withheld for a short time. The Commonwealth then devised a way to bypass the conservative state government and fund the fledgling Queensland AIDS Council 'directly' by co-opting the Sisters of Mercy to act as a 'baglady'.⁸

⁸Dennis Altman and Chris Healey, 'From Crisis to Condition', *Australian Society*, June 1990, p.22.

All of these decisions, made over an eighteen-month period, were remarkable in the circumstances and were crucial in Australia developing a national response to AIDS that was one of the most innovative and effective in the world. Yet during this time, the principles of 'community empowerment' and peer-based education were constantly being challenged by a medical lobby loosely aligned with Penington's Task Force, as well as religious leaders, conservative state politicians, and a number of respected journalists and social commentators. The Commonwealth's innovative approach was also undermined by some of the states that experimented with more coercive public health measures drawn from the 'test and contain' model. This chapter explains the attempts to implement such measures under the guise of 'proper' public health and reveals the way in which community groups resisted them. In doing so, it sustains the critique of the 'test and contain' model of infectious disease that I have outlined above. The following chapter then posits its alternative and discusses the fight to establish targeted education and community-building programmes based on the principles of community empowerment, participation and intersectoral public policy intervention. Together they encapsulate the key ideological differences and tensions that shaped Australia's response to AIDS, especially in relation to homosexuals who constituted the overwhelming majority of AIDS cases and were thus the primary object of debates about effective HIV prevention strategies. These two chapters also provide the conceptual framework for understanding the specific attempts to prevent the transmission of HIV among heterosexuals, injecting drug users and sex workers, which I discuss in Chapters 6, 7 and 8.

The two approaches to controlling the spread of HIV infection first came to a head in the aftermath of the Queensland babies crisis, when the NSW Health Commission (as the Department of Health was called at the time) considered a proposal to close gay bathhouses and suspected gay sex-on-premises venues in New South Wales.⁹ It was taking its lead from the Director of Public Health in San Francisco, Mervyn Silverman, who ordered the closure of that city's bathhouses on 9 October 1984, after first signposting the measure in

⁹'NSW May Shut Gay Baths', *Age*, 1 February 1985, p.3; 'Experts Clash on Numbers', *Sydney Morning Herald*, 1 February 1985, pp.1-2.

April.¹⁰ Silverman's actions, situated in a city that openly celebrated its homosexual citizens and gay sub-culture, shocked America's second largest and most visible gay community and prompted bitter reprisals. Activists accused Silverman of homophobia and short-sightedness and demanded that the City uphold the civil rights of law-abiding gay men to conduct their affairs in private and free from the intrusion of local government. They also correctly claimed that only a minority of gay men regularly used the baths and that there was no substantial evidence to suggest that closing the baths would decrease the spread of HIV.¹¹ Public health officials and medical 'AIDS experts' were compelled to come to Silverman's defence which brought them into conflict with the gay activists. The two warring factions were not clearly demarcated along the lines of sexuality and medical training, however. A number of prominent and influential gay men, such as Randy Shilts (reporter for the *San Francisco Chronicle*), championed the bathhouse closures by blaming the emergence of the AIDS epidemic on homosexual efforts to define their identity and 'community' through the bathhouse culture of promiscuous and anonymous sex.¹² Many doctors also switched allegiances by supporting the bathhouse owners' endeavours to provide AIDS education and condoms at their premises, recognising that this was one of the few ways to educate male bisexuals who enjoyed anonymous sex with men but did not identify as gay or participate in the gay community.¹³

The issue was of obvious interest to homosexual men in Australia, and the fight to keep the bathhouses open featured prominently in the Melbourne- and Sydney-based gay press. In contrast to their American counterparts, gay journalists in Australia – a number of whom were actively involved in the AIDS Action Committees – were united in criticising

¹⁰Larry Galbraith, 'Closing the San Francisco Bathhouses...The Echo of Jackboots', *Campaign*, vol.102, June 1984, pp.12-13; 'Ban Closes', *Campaign*, vol.103, July 1984, p.10; and 'Gay Clubs Defy Closure Order', *Sun*, 12 October 1984, p.27.

¹¹Robert A. Padgug, 'Gay Villian, Gay Hero: Homosexuality and the Social Construction of AIDS', in Kathy Peiss, Christina Simmons and Robert A. Padgug (eds), *Passion and Power: Sexuality in History*, Philadelphia: Temple University Press, 1989, p.305.

¹²Randy Shilts, *And the Band Played On: Politics, People and the AIDS Epidemic*, New York: Penguin, 1988.

¹³For further analysis and discussion, see Ronald Bayer, *Private Acts, Social Consequences: AIDS and the Politics of Public Health*, New Brunswick: Rutgers University Press, 1989, pp.53-67; and John-Manuel Andriote, *Victory Deferred: How AIDS Changed Gay Life in America*, Chicago: University of Chicago Press, 1999, pp.77-82.

Silverman's actions, and were wary of the ramifications that they might have in Australia. Pre-empting a strike on their own institutions, the AACs prepared a policy paper for Neal Blewett and the state health ministers which recommended the continued operation of bathhouses in Sydney and Melbourne. They based their argument on the need to reach and educate gay and bisexual men about safe sex, rather than civil rights (noting, no doubt, the failure of this approach to sway public health officials in San Francisco, and the fact that Australia's political culture – unlike that of the United States – was not forged in the fight for constitutional rights). In its submission to the health ministers, the Victorian AIDS Action Committee claimed that closing the bathhouses would "force gay men back into clandestine encounters on the beats [public toilets and parks] where they are unsafe and in fact where they expose a much larger and harder to trace group of people to [the virus]", while the saunas were "perfectly located as education centres" that were "already encouraging safe sex practices (use of condoms etc.) and displaying leaflets and posters".¹⁴

The AACs also sought alliances with medical professionals and communicable disease clinics that were providing outreach health services to the sex-on-premises venues. Thus, when NSW announced it was considering the closure of its bathhouses and community leaders in the other states expressed an interest in the proposal, a well-prepared and co-ordinated defence was put into action. Representatives of the National AIDS Task Force, the Victorian Health Commission, the VAAC, Gay Legal Rights Coalition, and the Melbourne Communicable Diseases Centre, for example, firmly warned against the closure of gay venues in Victoria. Dr David Bradford, chief venereologist to the Victorian Health Commission, who was working at the MCDC, suggested that it was "naive to think that by closing saunas people will stop sexual practices. Closures will just make it difficult to get information about sexual disease to those who need it most."¹⁵ His words were echoed by David Penington and Julian Gold who had initially supported the bathhouse closures but eventually conceded that bathhouses were an important outlet for AIDS educators and

¹⁴Victorian AIDS Action Committee, 'Submission to the Commonwealth Minister of Health, Dr Neal Blewett MHR, 18 November 1984', NBAC/NAAC, ANU, H19/25.

¹⁵Louise Bellamy, 'Health Officers Oppose Closure of Gay Saunas', *Age*, 2 February 1985, p.13.

clinical workers to provide outreach services to bisexual men who had little other contact with the gay community.¹⁶

Such arguments proved to be persuasive and the proposal to close the gay saunas was never acted upon in any of the states. Instead, educational efforts were intensified. The VAAC alone distributed nearly 20,000 AIDS-prevention brochures and 10,000 AIDS awareness posters in Melbourne sex-on-premises venues between November 1984 and February 1985, and outreach staff from the MCDC continued to make weekly visits to the two major sex-on-premises venues, Club 80 and Steamworks, to provide information and counselling (as well as blood testing for syphilis, hepatitis B and, later, HIV) to the men who frequented them.¹⁷ Politicised by the proposal to ban the bathhouses, the AIDS Council of New South Wales also chose an inner city Sydney sauna to launch 'Rubba Me', its first large-scale safe sex campaign, in February 1985. The NSW Health Commission initially pledged funds for this campaign but withdrew its support at the last minute as the content and context of the campaign became apparent. In its place the Gay Counselling Service and the Bobby Goldsmith Foundation, a gay-founded fundraising organisation, picked up the tab.¹⁸

The alliance between medical experts and the AIDS Action Committees, and the unwillingness of the state governments to force bathhouses to close, went some way towards restoring the relationship of trust between doctors, gay men and their governments that had been damaged during the blood bank disaster. This relationship was always tenuous, however, especially in Queensland where politicians were not afraid to express their disdain for homosexuals and where the government was keen to be seen acting

¹⁶Peter Hayes, 'Report on the AIDS Referral Clinic [MCDC]', unpublished report completed August 1987, p.3, NBAC/NAAC, ANU, H9/74.

¹⁷Louise Bellamy, 'Health Officers Oppose Closure of Gay Saunas', *Age*, 2 February 1985, p.13; Victorian AIDS Council, *Annual Report 1985*, Melbourne: VAC, November 1985, p.5; and Peter Hayes, 'Report on the AIDS Referral Clinic [MCDC]', unpublished report completed August 1987, NBAC/NAAC, ANU, H9/74.

¹⁸Ken Davis (peer educator with ACON in the mid-to-late 1980s) interviewed by Martyn Goddard, 6 July 1992, 'The Australian Response to AIDS' Oral History Project, National Library of Australia, TRC-2815/5, p.29 (henceforth Davis, NLA, TRC-2815/5). Also see Margaret Duckett, 'HIV/AIDS and Australia's Community-Based Sector: A Success Story in HIV Prevention', unpublished report prepared for AFAO, 1992, p.15, ACON archive, id: G2367.

decisively after the death of the Queensland babies. It is not surprising, therefore, that this state was reluctant to incorporate gay men and the ideology of education into its public health bureaucracy and instead relied on more traditional measures of infectious disease control such as testing, compulsory notification and criminal penalties for 'knowing' and 'reckless' transmission of the virus. On 27 November 1984 the Queensland government introduced a Bill to amend the state's Health Act, allowing AIDS and HIV-infection to be defined as a venereal disease and thus subject to notification laws and existing penalties for people who knowingly transmitted venereal disease. Until this point, only AIDS (NH&MRC Category 1) and lymphadenopathy syndrome (NH&MRC Category 2) were notifiable, thus requiring a doctor to inform the state health department only when a patient presented with opportunistic infections and severe immune deficiency that signified the onset of 'full-blown' AIDS. The Queensland legislation now required that doctors report all cases of HIV-antibody infection (NH&MRC Category 3) despite the fact that, at the time, it was expected that only 10% of these individuals would go on to develop 'full-blown' AIDS.¹⁹ This contradicted the stated purpose of such legislation, which was to allow public health authorities to track the course of the epidemic in order to facilitate the planning and distribution of treatment facilities and clinical services for the sick.

As for other venereal diseases, the legislation required that the Director-General of Health be notified in writing of the age, sex, occupation and marital status of the individual infected with HIV. Unlike other venereal diseases, however, doctors were also obliged to provide the patient's name and address. This information could be given to any government official or Department as considered necessary for the purposes of administering the Act.²⁰ Such a clause enabled the state to track down HIV-infected individuals and prosecute them for the 'knowing' transmission of the virus if it could be proved that they had transmitted the virus after learning of their infection. It was assumed that such legislation would force people living with HIV to behave responsibly and rationally. Civil libertarians and the AACs, on the other hand, were concerned with

¹⁹The NH&MRC categories were changed to A ('full-blown' AIDS), B (AIDS related complex) and C (asymptomatic HIV-infection) in 1986, thus bringing them into line with U.S. Centers for Disease Control definitions.

²⁰Peter J. North, *AIDS - Morality and Mortality: The Shaping of Preventive Strategies with Particular Reference to Queensland*, unpublished M.Soc.Wk thesis, University of Queensland, 1987, p.104.

protecting the rights of the overwhelming majority of people who *were* behaving responsibly, and questioned the need for personal details to be recorded. Breaches of confidentiality within the health bureaucracy were not unknown, they argued, and the names of people with AIDS might be leaked into the public domain.²¹ Moreover, at a time when politicians were talking about quarantining people with AIDS – and such proposals were receiving enthusiastic support in public opinion polls – they asked: who could be sure that the information would not be used at a later date to round up HIV-positive individuals and isolate them from the rest of the community?²²

When similar legislation was introduced in New South Wales in August 1985, these dissenting voices were joined by a number of prominent doctors who headed the very clinical and treatment facilities that the legislation was purportedly trying to assist.²³ They claimed that the compulsory notification requirements and laws against ‘reckless’ and ‘knowing’ transmission of the virus would deter ‘high risk’ individuals from coming forward to take the HIV-antibody test, thus defeating efforts to monitor the incidence of infection and to make contact with people potentially infected with the virus. Dr Julian Gold, director of the Albion St (AIDS) Clinic, argued that high risk groups would only continue to use his facility if there was “total confidentiality and privacy” and asserted that

²¹See, for example, Lex Watson (on behalf of the AIDS Action Committee), ‘Submission on AIDS Laws, Notification and Confidentiality’, 21 January 1985, discussed at a meeting of NACAIDS, NBAC/NAAC, ANU, H7/22; and Bob Hay, ‘Don’t Take the Test’, *Campaign*, vol.110, February 1985, p.17.

²²As Mark Counter, diagnosed HIV-positive in 1985 whilst living in Sydney, recalls: “Back in those days, most, including myself, were still fearful of disclosing their status. We were scared of losing jobs, getting kicked out of accommodation and of other rejections. In Sydney we had politicians talking about quarantining us on North Head. I still remember preparing an evacuation plan ready to get out of Sydney in a hurry just in case they began rounding us up.” (Mark Counter, ‘A History of the People Living with HIV/AIDS (PLWHA) Movement in Australia’, *Social Alternatives*, vol.15, no.4, October 1996, pp.25-6.

²³The amendments to the NSW *Public Health Act 1902*, introduced at the end of August 1985 and gazetted in April 1986, declared all categories of AIDS to be “proclaimed diseases” and required medical practitioners, under threat of penalty, to notify the Director General of the Department of Health of any case they detected. Cases were to be identified by code rather than by name and address, although the Act made provision for the Chief Health Officer to seek a District Court order requiring the medical practitioner to release the name and address of his or her patient. Any person found guilty of breaking these confidentiality arrangements faced a \$2000 fine. The legislation also made it an offence for an HIV-positive person to knowingly transmit the virus. A fine of \$5000 was imposed for those found guilty of committing such an offence. (See ‘Legislation on AIDS Carriers Approved’, *Canberra Times*, 21 August 1985, p.9; and John Godwin, Julie Hamblin and David Patterson, *Australian HIV/AIDS Legal Guide*, Sydney: The Federation Press, 1991, pp.2-3.) Other states introduced similar legislation, although Victoria and South Australia did not declare asymptomatic HIV-infection to be notifiable and, with the exception of Tasmania, none of the states required names and addresses to be forwarded to the health authorities.

his centre would not release its records without patient permission.²⁴ Dr Basil Donovan, Vice-President of the NSW Venereological Society and director of the Taylor Square Clinic (a private facility with the largest AIDS case-load and gay clientele in Sydney), defiantly declared that he would burn his records before the NSW Health Commission could examine them without his patients' consent.²⁵ The Federal President of the Doctors' Reform Society, Dr Peter Rowland, supported these statements while suggesting that something larger was at stake:

[Premier Neville Wran] has destroyed the painstaking efforts over four years of medical and community groups to build trust and mutual co-operation between medical authorities and homosexuals, intravenous drug users and prostitutes. These people, already vulnerable to government and community discrimination, must be protected or they will be afraid to co-operate. He has unnecessarily reinforced the worst fears of an already paranoid and frightened community.²⁶

For his part, the Premier was truculent and warned that doctors who did not comply with the new regulations faced a \$1000 fine for each offence and risked deregistration.²⁷ There was little he could do, however, when hundreds of patients lied about their identity and allegedly tested under the pseudonym 'Neville Wran'.²⁸ Nevertheless, as feared, other potential patients were deterred and in the first week of the legislation being passed Dr Gold's clinic experienced an average of nineteen cancellations per day.²⁹ The number of people requesting HIV-antibody tests for the first time at the Taylor Square Clinic also

²⁴Chris Thomas, 'Clinic to Defy New AIDS Law', *Daily Telegraph*, 29 August 1985, p.1.

²⁵*Ibid.*

²⁶Ross Dunn and Pilita Clark, 'AIDS Laws: Anger Grow', *Sydney Morning Herald*, 31 August 1985, p.15.

²⁷Ross Dunn, 'Doctors Face Axe in AIDS Battle', *Sydney Morning Herald*, 30 August 1985, p.1; also see John Miner and Michael Pelly, 'Doctors Who Defy AIDS Law Face Sack: Wran', *Australian*, 30 August 1985, p.3.

²⁸Bill Bowtell interviewed by Adam Carr, 19 May 1992, 'The Australian Response to AIDS' Oral History Project, National Library of Australia, TRC-2815/2, p.46. This information is actually provided by the interviewer.

²⁹Pilita Clark, 'Wran Bogeyman of the Empty Clinic', *Sydney Morning Herald*, 30 August 1985, p.1.

declined by 43% between August and September 1985. This downward trend continued until April 1987 when the 'Grim Reaper' AIDS advertisements scared men and women at 'high' and 'low' risk into taking the test.³⁰

It is important to stress that while both the AACs/AIDS Councils and medical experts opposed the legislation, they were doing so for different reasons. Gay men were concerned about their personal details and serostatus remaining confidential whereas the Albion St Clinic wished to protect the testing process and its ability to collect data on the epidemic. The two groups thus formed an alliance over this issue that lasted only as long as it took the Albion St Clinic, with the support of Penington's Task Force, to propose that HIV-antibody testing become the central component of the fight against AIDS and for funds to be distributed to medical facilities accordingly. The AIDS Councils wanted primacy to be given to education and a guarantee that funds would not be diverted from community-based educational initiatives. The issue of primacy and funding, and the merits of HIV-antibody testing – the third plank of the traditional 'test and contain' strategy to control infectious disease – thus became the next, and most prolonged, public controversy concerning Australia's public health response to AIDS.

The debate was ignited almost as soon as the first commercially viable HIV-antibody testing kits arrived in Australia in April 1985. The Albion St Clinic marked the arrival with a pamphlet entitled 'A Simple Blood Test Could Save Your Life', which outlined the benefits of taking the test. Gay men were quick to point out that it promised more than it could deliver. An 'AIDS test', they argued, was not like a pap smear or mammogram that offered diagnosis and the possibility of early intervention and treatment; it certainly was not going to "save your life". Rather, after proclaiming the diagnosis, all doctors could provide was advice about nutrition, the dangers of recreational drugs and the need for HIV-positive individuals to reduce their stress levels: lifestyle changes which could delay the onset of

³⁰Basil Donovan, *et al.*, 'HIV Infection in Sexually Transmissible Disease Practice in Sydney: The Effects of Legislation, Public Education and Changing Clinical Spectrum', *International Journal of STD and AIDS*, vol.1, 1990, pp.23-4.

'full-blown' AIDS. The trauma and anxiety associated with the knowledge of one's serostatus would, of course, militate against the possibility of this occurring.³¹

According to the Albion St Clinic and the AIDS Task Force, there were other benefits of the HIV-antibody test not outlined in the pamphlet. First, there was the possibility of tracking the course of the epidemic more accurately, which would help local and state governments plan AIDS education campaigns and distribute clinical and treatment facilities required by people living with AIDS. More importantly, they claimed, knowledge of one's serostatus would make messages about safe sexual and drug injection practices more meaningful to the individual and provide the surest means of promoting behavioural change. It also offered the possibility of counselling by a medical professional at an HIV-antibody testing site.³²

The benefits of HIV-antibody testing were such that some media commentators and members of the public were soon calling for universal screening procedures to be established along the lines of the compulsory chest X-Rays to which all Australians were subjected during the 1950s tuberculosis epidemic. Michael Barnard, for example, in an opinion piece for the *Age* newspaper, suggested that the community's acceptance of the compulsory chest X-Ray programme, and its continued tolerance of intrusive breathalyser tests for drivers, demonstrated that the public was ready for men and women to be coerced into taking the HIV-antibody test. He accepted that "the consequence of blood tests...would be to raise a question of consequent protective measures, such as quarantine, as operate in certain other areas of serious public health risk", but sarcastically shrugged off the outcry from civil libertarians which would inevitably come: "How terrible. And how terrible to

³¹Recollection of Ken Davis and Paul van Dyke, two gay men living in Sydney who worked for the AIDS Council of New South Wales and other community organisations in the mid-1980s, interviewed by Paul Sendziuk, 19 November 1999. Notes in possession of the author.

³²The position of Gold and Penington was manifest in most of the public statements these men made between 1985 and the end of 1987. These arguments were also fully articulated in a session at the Second National Conference on AIDS, held in Sydney at the end of October 1986, titled 'HIV-Antibody Screening: The Public Health Perspective'. (See Commonwealth of Australia, *AIDS: Australia's Response Examined, Report of the Second National Conference on AIDS*, Sydney, 31 October - 1 November 1986, Canberra: AGPS, 1988, p.105.) Once treatment prophylaxis became an option with the development of drugs such as AZT and ddI, doctors also offered the possibility of medical intervention to slow the onset of opportunistic infections as a reason for taking HIV-antibody testing. I discuss this development later in the chapter.

allow the continuation of the present stand-off while the threat to the community grows worse."³³

Barnard was not alone in his enthusiasm for compulsory testing, nor, for that matter, quarantine, as a series of public opinion polls conducted between 1986 and 1987 indicate. An Australian Market Research survey of 1500 adults aged between 16 and 60 conducted for NACAIDS in 1986, for example, found that 47% of respondents were in favour of universal HIV-antibody testing, and 24% supported isolation of HIV-positive people from the workplace or from the community at large.³⁴ A poll conducted during the last two weeks of April 1987 by Irving Saulwick in conjunction with the University of Melbourne for the *Age* also indicated that there was broad agreement for some form of compulsory testing for HIV. Of the 2000 people surveyed (drawn at random from the electoral roll to represent each of Australia's Federal electorates), 42% wanted testing for all people over 16 years of age, while 63% and 68% of those surveyed wanted the compulsory testing of people suspected of being injecting drug users by a doctor and prostitutes working in brothels respectively. Only 5% were against compulsory testing of any kind.³⁵ The *Age* poll coincided with Australia's first large-scale mass media AIDS education campaign that was supposed to calm the public's fears about the infectious nature of HIV. It was complemented by another poll in September 1987 which surveyed nearly 500 people, 44% of whom supported universal mandatory testing for HIV.³⁶

It is likely that the public's enthusiasm for compulsory testing stemmed from its conflation of HIV with other more highly infectious diseases such as tuberculosis and typhoid, and

³³Michael Barnard, 'AIDS: A Time to Get Tough?', *Age*, 19 March 1985, p.13.

³⁴Bill Taylor, 'The AIDS Campaign: Three Months On', unpublished paper prepared by the Commonwealth Communicable Diseases Branch, 1987, p.7, ACON archive, id: G6079 (campaigns).

³⁵Peter Stephens, 'Fear of AIDS Has Forced Changes to Sexual Attitudes, Survey Finds', *Age*, 4 May 1987, p.5.

³⁶Five hundred and twenty-five people over the age of 16 years were interviewed during the random door-knock survey. (K. Rigby, *et al.*, 'Shock Tactics to Counter AIDS: The Australian Experience', *Psychology and Health*, vol.3, 1989, p.155.) A subsequent review of 1987 Australian polls found continued widespread support for the mandatory testing of homosexuals (90%), immigrants (86%), prisoners (83%), and tourists entering Australia (57%). See '1987 Australian Election Survey Reported in Australia', *National AIDS Bulletin*, June 1988, p.9, cited in Raymond Donovan, 'The Plaguing of a Faggot, the Leperising of a Whore: Criminally Cultured AIDS Bodies and "Carrier" Laws', *Journal of Australian Studies*, vol.43, 1995, p.123.

their memories of the coercive public health measures which were used to stop the transmission of these diseases. This seems to be the case with Barnard's remarks and was certainly the rationale given by prison authorities in New South Wales when it became the first state to consider introducing mandatory HIV-antibody tests for all new and existing inmates of its correctional facilities in August 1985.³⁷ HIV was, of course, neither highly infectious nor casually transmissible and thus could not be compared to TB or typhoid, a fact that had been well established and was continually repeated by the various spokesmen for the AIDS Task Force. As I shall illustrate in further chapters, however, the 'highly infectious disease' paradigm and the coercive measures historically adopted to curb the spread of these diseases continued to influence Australian responses to HIV.

Since Barnard and the polls raised the possibility of quarantine, it is pertinent to note that Australian politicians never seriously considered this measure, despite the support it garnered in the community. In the aftermath of the Queensland babies disclosure, the Queensland Health Minister seemed to be the only one keen to pursue mass screening *and* quarantine as a legitimate option. His spokesman advised that such measures had been discussed and were "obviously going to be considered in the future". He also pointed out that compulsory screening had been carried out for tuberculosis from the early 1950s to 1972, and that Peel Island in Moreton Bay had been a compulsory isolation centre for lepers until its closure in 1959. The spokesman concluded his remarks by saying that Health Minister Austin did not want to get "too far down the track" with these measures at the present time.³⁸

³⁷Ray Turner, 'Compulsory AIDS Test In Jail Scheme', *Daily Mirror*, 26 August 1985, p.5.

³⁸Ken Blanch, 'Everyone Might Get AIDS Screening', *Courier Mail*, 15 December 1984, p.1, 3; and Peter J. North, *AIDS - Morality and Mortality: The Shaping of Preventive Strategies with Particular Reference to Queensland*, unpublished M.Soc.Wk thesis, University of Queensland, 1987, p.106. Cuba became the only country to forcibly quarantine its HIV-positive citizens from the rest of the population in 1985. They were condemned to live in prison-like environs where their movement was closely monitored. Scrutiny of the camps by international observers saw Cuba liberalise the treatment of those quarantined in the following years, and people living with HIV/AIDS are now permitted to leave the camps under the supervision of a 'sexual' chaperone - a senior medical student or intern - for periodic visits home. They may also receive visits from family members at any time. (See Marvin Leiner, *Sexual Politics in Cuba: Machismo, Homosexuality and AIDS*, Boulder: Westview Press, 1994, cited in Douglas A. Feldman and Julia Wang Miller (eds), *The AIDS Crisis: A Documentary History*, Westport, Connecticut: Greenwood Press, 1998, pp.131-2.) The issue of quarantine was also discussed in the United States. In November 1986 the citizens of California voted on a referendum proposition which demanded that public health authorities establish quarantine camps for people with 'full-blown' AIDS, and ban HIV-positive people from attending or teaching in a public school or holding a job which involved handling food. The referendum was held after

By the end of 1985 the interest generated in compulsory HIV-antibody testing had penetrated the state government in New South Wales and Premier Neville Wran asked Penington's Task Force for advice regarding the feasibility of screening the entire population of his state. Penington wrote back in a letter to the Acting Chief Health Officer of NSW and suggested that while the programme was logistically possible, it would prove to be enormously expensive. Indeed, he envisaged that it would cost at least \$310 million annually to screen the entire population of Australia which was close to 100 times the sum devoted to AIDS at the time. Testing would have to be on-going because of the 'window-period' between infection and the test's ability to detect HIV-antibodies and the possibility of infection occurring after the date of the initial test. Furthermore, Penington pointed out, people who did not appear on the electoral roll (some of whom would be involved in 'high risk' injecting drug use and male prostitution) would escape the net.³⁹

Penington believed very strongly in the benefits of testing, however, especially when people from 'high risk' groups were targeted. In his letter, he noted that a small expansion of the existing Commonwealth allocation for AIDS research "would permit sampling of community groups to permit more accurate assessment of the spread of the disease within the community".⁴⁰ In fact, by 1987, Penington was thinking of ways by which homosexuals, injecting drug users and sex workers could be forced to submit to blood testing without casting the net too widely and disrupting the lives of other members of the community. When Victoria moved to overhaul its antiquated infectious diseases legislation, he seized the opportunity to propose that "there be an obligation on those whose behaviour places them at risk to be tested to find out whether they have the infection".⁴¹ He was coy as to how this might actually occur but intimated that a person

683,000 Californian voters signed a petition requesting the ballot, which was sponsored by the right-wing Lyndon LaRouche organisation PANIC (Prevent AIDS Now Initiative Committee). The proposition was defeated 72% to 28% of the vote. (See Charles Petit, 'California to Vote on AIDS Proposition', *Science*, vol.234, 17 October 1986, pp.277-8; and North, *AIDS - Morality and Mortality*, p.54.)

³⁹Letter to Dr David Fox, Acting Chief Health Officer, NSW Department of Health, from David Penington, AIDS Task Force chairman, 10 December 1985, NBAC/NAAC, ANU, H19/8.

⁴⁰*Ibid.*

⁴¹David Penington interviewed by Greg Hunter, 'David Penington Interview', *Australian Penthouse*, vol.8, no.12, 1987, p.109. Also see Penington, 'The Community Needs Protection', *Age*, 5 May 1987, p.13.

who passed on the virus to another individual could be deemed to have 'knowingly' transmitted the virus (and thus be liable to face criminal charges) if he or she was found to be a member of a 'high risk' group or practising 'high risk' behaviours. The onus was thus on the individual to take the HIV-antibody test and, if found to be positive, withdraw from activities which might transmit the virus.⁴² Penington was confident that the other states would follow if the Victorian legislation went ahead. It all depended, he considered, on public opinion.⁴³ Such a statement suggests how crucial the public debate about the merits of HIV-antibody testing would be in shaping HIV/AIDS prevention policies and how important it was for opponents of widespread HIV-antibody testing to articulate their arguments forcefully.

Given the compulsory notification requirements of HIV-antibody positive test results, most of the AIDS Councils and the gay communities that opposed widespread or coerced testing programmes were initially motivated by the fear that an individual's serostatus would not remain confidential and could be used against them. In February 1985, for example, Bob Hay informed the readers of *Campaign* that: "There is no way we can stop lists of these people whose blood test results are positive from 'leaking' to security agencies and employment authorities, social welfare departments, insurance companies, [and] home loan bodies" all of which could limit the life opportunities of people with HIV/AIDS.⁴⁴ His fears were not unfounded: until 1988, none of the states had anti-discrimination laws that made provision for people living with HIV/AIDS, and HIV-antibody test results were often relayed over the phone by receptionists. Ken Davis, an education officer with the AIDS Council of New South Wales in 1985, remembers that his housemate received the result of

⁴²An equally, if not more, insidious method of compelling members of high risk groups to take the test was proposed by a delegate to the Second National Conference on AIDS held in Sydney at the end of October 1986. In a panel session on 'HIV-Antibody Screening', the gentleman suggested that only "those courageous enough" to submit to testing be offered the first use of vaccines and treatments once they became available. Unfortunately the delegate's name was not recorded in the minutes of the discussion, although the general disapproval of his suggestion was noted. (See Summary of panel session on 'HIV-Antibody Screening: The Public Health Perspective', in Commonwealth of Australia, *AIDS: Australia's Response Examined, Report of the Second National Conference on AIDS*, Sydney, 31 October - 1 November 1986, Canberra: AGPS, 1988, p.105.)

⁴³Hunter and Penington, 'David Penington Interview', p.109.

⁴⁴Hay, 'Don't Take the Test', *Campaign*, vol.110, February 1985, p.17.

his blood test over the phone, as had many of this gay friends and colleagues.⁴⁵ Even when confidentiality was not breached, the AIDS Councils understood that the burden of receiving a seropositive test result led many gay men to injudiciously, but understandably, disclose their status to friends, workmates and employers in search of support. A substantial number found themselves socially ostracised, and some were refused services or sacked, as a result.⁴⁶ Indeed, in the year ending 30 June 1986, the NSW Anti-Discrimination Board alone received 151 inquiries from gay men alleging AIDS-related discrimination.⁴⁷ The chairman of the AIDS Task Force was not unsympathetic to their plight and in August 1985 proved that he was at least listening to the concerns of the AIDS Councils:

The problems that people face when told that they have the virus are fairly formidable. Some of them face the problems of rejection by their family, loss of employment and difficulty with housing, all quite apart from the problems they face with the disease...It's a very alarming thing for people to find out that they have a positive test.⁴⁸

Penington's solution, however, was to offer counselling rather than allow non-compliance with testing procedures.

The issue of discrimination within the gay community – which was not, after all, immune from the irrational fear of people with AIDS that was being experienced by the rest of Australian society – also loomed large in the mind of the President of the Victorian AIDS Council, Phil Carswell, who became the chief spokesman for those opposing the HIV-antibody test. In March 1985 he warned that a situation of 'antibody apartheid' could

⁴⁵Davis, NLA, TRC-2815/5, p.37. Celeste Coucke, the lover of Bryce Courtenay's HIV-positive son Damon, also noted in an interview that her friends had related similar experiences. (Celeste Coucke interviewed by Diana Ritch, 24 August 1993, 'The Australian Response to AIDS' Oral History Project, National Library of Australia, TRC-2815/53, p.11.)

⁴⁶Adam Carr, 'Tests Alone Are Not the Answer', *Age*, 5 May 1987, p.13.

⁴⁷NSW Anti-Discrimination Board, *Annual Report 1985/86*, Sydney: NSW Anti-Discrimination Board, 1987, p.56.

⁴⁸Tony Harrington, 'AIDS Virus Carriers Commit Suicide', *Age*, 26 August 1985, p.3.

develop within the gay community, where 'positives' would be shunned by the 'negatives', if widespread testing was encouraged and enacted. Rather than submitting to the test, Carswell recommended that all gay men assume that they were positive and therefore adopt safe sexual practices. This advice became the central message of all of the AIDS awareness and AIDS prevention material produced by his organisation.⁴⁹

The concerns of the AIDS Councils grew as more information about the HIV-antibody test became available. Of greatest concern was the number of 'false positives' that the most widely used ELISA test returned. In the first month of blood donor screening in the United States, for example, 1% of all tests conducted produced a positive result, yet when these samples were retested, only 0.17% were found to be HIV-antibody positive. Upon subjecting these samples to a confirmatory test, only 0.038% proved to be actually positive.⁵⁰ In Australia, the early testing kits produced over 100 'false positives' for every true positive result due to the presence in many people of antibodies to lymphocyte antigens which contaminated the antigen used for ELISA testing.⁵¹ This was the case for people who had suffered, or were suffering from, malaria and liver or rheumatological diseases, and those who had given birth to several children, used intravenous drugs, or recently received vaccines for influenza or hepatitis B.⁵² It was for these reasons that even David Penington ruled out the possibility of mandatory screening of surgery patients in a letter to the Director of Medical Services at The Royal Melbourne Hospital in November 1985.⁵³

⁴⁹Phil Carswell, 'Homosexuals Active Against AIDS', *Age*, 24 March 1985, p.11.

⁵⁰Gerald J. Stine, *Acquired Immune Deficiency Syndrome: Biological, Medical, Social and Legal Issues*, 2nd edition, Englewood Cliffs: Prentice Hall, 1996, p.333.

⁵¹Letter to Dr D.G. Campbell, Director of Medical Services at The Royal Melbourne Hospital, from David Penington, AIDS Task Force Chairman, 19 November 1985, NBAC/NAAC, ANU, H19/41.

⁵²J.R. Carlson, *et al.*, 'AIDS Serology Testing in Low- and High-Risk Groups', *Journal of the American Medical Association*, vol.253, no.23, 1985, pp.3405-8; R. Biggar, *et al.*, 'ELISA HTLV Retrovirus Antibody Reactivity Associated with Malaria and Immune Complexes in Healthy Africans', *Lancet*, vol.2, 1986, pp.520-3; and K.B. Meyer and S.G. Parker, 'Screening for HIV: Can We Afford the False Positive Rate?', *New England Journal of Medicine*, vol.317, 1987, pp.238-41.

⁵³Letter to Dr D.G. Campbell, Director of Medical Services at The Royal Melbourne Hospital, from David Penington, AIDS Task Force Chairman, 19 November 1985, NBAC/NAAC, ANU, H19/41.

It is little wonder, then, that the AIDS Councils were unconvinced by the testing process, especially when the immediate consequences of testing positive could prove tragic. Cases of suicide after diagnosis were not unknown among gay men, and in August 1985 Penington reluctantly admitted that he could confirm at least two instances of patients suiciding after being informed of their serostatus.⁵⁴ An American study also suggested that 14% of those who tested positive had contemplated suicide.⁵⁵ Indeed, it had become clear that knowledge of one's HIV-positive status occasioned severe psychological reactions, of which thoughts of suicide was only one. Others, which the Australian Federation of AIDS Organisations (AFAO) outlined in a 1987 position paper criticising compulsory HIV-antibody testing, included anxiety, sleep disturbance and depression, the disruption of personal relations and feelings of rage, guilt and blame. None of these things, AFAO concluded, was conducive to maintaining one's immune system and fighting the virus.⁵⁶

As John Foster explained in his biographical account of his lover's battle with AIDS, a positive HIV diagnosis could also change the way in which one related to the future, one's partner and one's own body, all of which might prove detrimental to the task of maintaining a healthy immune system and personal support network. In *Take Me To Paris Johnny* he recounted the change which occurred in his lover, Juan, after he received the news of his infection at Fairfield Hospital in 1985 while waiting "in limbo" for his immigration status to be finalised:

Before the trip to Fairfield, however anxious he was, and however depressed he became because of the limbo in which he was having to spend this year, there was always the prospect of next year, and the one after that. And now? He felt dizzy, unbalanced, because suddenly there was no future to weigh against the present. He was like a man who had lost his shadow, weightless, insubstantial,

⁵⁴Tony Harrington, 'AIDS Virus Carriers Commit Suicide', *Age*, 26 August 1985, p.3.

⁵⁵Study cited in Shilts, *And the Band Played On*, p.540.

⁵⁶AFAO, 'Position Paper on HIV Antibody Testing', September 1987, unpublished paper, pp.3-4, NBAC/NAAC, ANU, H2/34. A similar point was made by Adam Carr, representing the Victorian AIDS Council, in 'Tests Alone Are Not the Answer', *Age*, 5 May 1987, p.13.

and when I tried to reassure him he said, 'Don't touch me, Johnny. Don't touch me.' He was terribly afraid...

The virus makes you obsessive. It settles in your head. It distorts your vision. In the first flow of knowing – or believing – it can make you regard your body with horror. The blood that is in you is lethal. It could drive you crazy if you dwelt on that knowledge, if you said to yourself, 'I am the embodiment of death'. Although those were not the words he used, it was clear that his thoughts were running in that direction. One morning he cut himself shaving. He wiped the blood off on a towel. 'Get the bleach!' he shouted to me in the next room. But there was no bleach, so he wrapped the towel in a newspaper and threw it in the garbage.⁵⁷

Before the events that Foster describes took place, Juan experienced few instances of ill health. Yet now, in some respects, he had become mentally 'disabled'. Foster was himself coming to grips with his own HIV-positive diagnosis as he wrote these words and thus knew very well the mental anguish that Juan was experiencing. It is because of stories like this that many other gay men refused to take the test, and AFAO and most of the AIDS Councils felt no compulsion to recommend that they do.

These concerns rarely looked like shaking Penington's faith in the desirability of widespread HIV-antibody testing, especially as he felt that knowledge of one's serostatus was a necessary requisite to sexual behaviour change. This proved in Penington's mind that traditional public health was 'proper' public health, a statement which he and other members of the Task Force became fond of repeating. In order to persuade the government and the public to reject coercive testing measures, the AIDS Councils had to prove that this assumption was incorrect. They went one step further, however, and proved that it was potentially dangerous. As Adam Carr argued in an opinion essay for the *Age* in May 1987:

⁵⁷John Foster, *Take Me To Paris Johnny: A Life Accomplished in the Era of AIDS*, Melbourne: Minerva, 1993, pp.124-7. Robert Ariss, an HIV-positive anthropologist who conducted over one hundred interviews with people with AIDS in his capacity as a researcher for the AIDS Council of New South Wales, recorded a number of similar testimonies in his PhD thesis, *Against Death: The Sydney Gay Community Responds to AIDS*, University of Sydney, 1992, pp.85-94.

There is no clear-cut proof, despite the rhetoric, that testing leads to sustained behaviour modification. In fact, some studies have shown that a [HIV-antibody] negative result (still the most common outcome of testing), can have the opposite effect, because the person decides that whatever they have been doing prior to the test must have been safe.⁵⁸

He was citing a U.S. Centers for Disease Control report, issued in February 1987, which found that "in cohort studies of self-selected homosexual or bisexual men, knowledge of seropositivity had little influence of behavior change, and knowledge of being seronegative was even reported to have had an adverse influence on behavior change for some".⁵⁹ The Victorian AIDS Council, of which Carr was Vice-President, had been observing this pattern in Melbourne gay men for some time. Ken Davis suspects that this might have been because gay men, since the 1970s, had "become accustomed to three-monthly or six-monthly checks of syphilis and other STDs and were used to testing negative and only seeking medical intervention or changing their behaviour once they tested positive".⁶⁰ They were thus putting themselves at risk by applying an earlier model of thinking to a new disease and assuming that they were immune or that their current practices were safe. Accordingly, Carr and Davis asserted, the HIV-antibody test could prove dangerous and undermine the AIDS Councils' advice for all gay men to practise safe sex. Indeed, Adam Carr concluded that there was no need for gay men to take the test as they did not need to be informed of their serostatus to know that they should always be practising safe sex: "The VAC policy has always been that gay men who have not been tested must assume that they are antibody-positive, and govern their sexual conduct accordingly."⁶¹

Despite the strong case put by the AIDS Councils of Victoria and New South Wales, and their umbrella organisation AFAO, they did not receive unanimous support from their

⁵⁸Adam Carr, 'Tests Alone Are Not the Answer', *Age*, 5 May 1987, p.13.

⁵⁹Cited in AFAO, 'Position Paper on HIV Antibody Testing', September 1987, unpublished paper, p.6, NBAC/NAAC, ANU, H2/34.

⁶⁰Davis, NLA, TRC-2815/5, p.25.

⁶¹Adam Carr, 'Tests Alone Are Not the Answer', *Age*, 5 May 1987, p.13.

membership. Most prominent among the dissenters was the Queensland AIDS Council and its President, Bill Rutkin. He wrote to his Victorian counterpart in July 1986, and bluntly stated:

If your argument succeeds in any way in reducing the force of effectiveness of certain current campaigns to stop AIDS, you will, with all the best intentions, be adding to the number of future AIDS patients. I cannot allow you to add my name to your list of supporters...I personally am firmly convinced that, at this time, widespread testing is the best means of stopping the AIDS epidemic in its tracks. I understand that the test is not perfect, but it seems to me to facilitate the only logical, reliable means of containing the epidemic available to public health authorities at this time.⁶²

NACAIDS, however, was agreeable and in its recommendations to the Commonwealth Health Minister sided with the Victorian and New South Wales AIDS Councils against the AIDS Task Force. The case of the Presidents of VAC and ACON was no doubt helped by their membership of NACAIDS and their ability to forcefully present their arguments during meetings. More important, however, was the fact that NACAIDS was already at odds with the Task Force after Penington's medical body had tried to assume control of the HIV-antibody testing issue, when NACAIDS clearly felt that it came within its terms of reference. NACAIDS had been empowered to deal with the social and legal aspects of AIDS, such as discrimination and the consequences of psychological trauma, and the AIDS Councils had successfully demonstrated to NACAIDS that these issues were inextricably linked with the question of testing. Thus at a meeting of NACAIDS on 7 May 1986, Dr Alan Wells, the Task Force representative on NACAIDS, was rebuked for trying to convince his colleagues that Penington's committee had the issue covered.⁶³ NACAIDS was also worried that an emphasis on testing might take funds away from educational

⁶²Letter to Phil Carswell from W.A. Rutkin, QuAC, 16 July 1986, NBAC/NAAC, ANU, H18/57.

⁶³'Report of the 9th Meeting of the National Advisory Committee on AIDS, Sydney, 7 May 1986', NBAC/NAAC, ANU, H9/82.

initiatives, which it was charged to oversee, and undermine the message that all gay men must practise safe sex.⁶⁴

With the government's two main advisory committees at odds and the issue threatening to become publicly inflamed as Carswell, Carr, Penington and Gold took every media opportunity to promote their case, Blewett's department called for a "summit" meeting with the protagonists. The meeting did not take place until July 1986, however, by which time Penington and the others had attended the Second International Conference on AIDS in Paris, where they heard that preventive education programmes were the only practical way to stem the transmission of HIV since an effective scientific response to AIDS was not foreseeable. Upon returning from Paris, Blewett gave assurances that these education programmes would be given primacy in the strategy to control the spread of AIDS and receive the appropriate funding. Penington was thus subdued at the summit meeting, and he, Buttrose and representatives of the AIDS Councils agreed that HIV-antibody testing should remain voluntary and take place only in the context of informed consent and counselling.⁶⁵ The agreement, of course, did not stop Penington from constantly pushing for the states to adopt legislation that would coerce members of 'high risk' groups to get tested, as his efforts in Victoria in 1987 illustrated.⁶⁶

⁶⁴NACAIDS' stance on voluntary and informed HIV-antibody testing was officially adopted in December 1985. See 'NACAIDS Report of 7th Meeting, 10 December 1985', NBAC/NAAC, ANU, H19/41.

⁶⁵Ballard, 'Australia: Participation and Innovation', p.144; and 'Agreed Statement - AIDS Antibody Testing, Sydney, 15 July 1986', press release from the Commonwealth Department of Health, NBAC/NAAC, ANU, H19/44.

⁶⁶As an aside, it is worth noting that there was considerable opposition to the use of the HIV-antibody test in the United States which, like Australia, was not restricted to gay groups. Both the U.S. Surgeon-General C. Everett Koop and a special committee established by the Institute of Medicine of the National Academy of Sciences rejected calls for coercive or mandatory screening in 1986. In his report on AIDS, Koop stated that such measures were "unnecessary, unmanageable, and cost prohibitive". (C. Everett Koop, *Surgeon General's Report on Acquired Immune Deficiency Syndrome*, October 1986, p.33.) Instead of compulsory screening, the National Academy of Sciences endorsed large-scale "voluntary, confidential testing (but with the provision for anonymous testing if desired)". (Institute of Medicine and National Academy of Sciences, *Confronting AIDS*, Washington D.C.: National Academy Press, 1986, p.125.) A number of U.S. states, however, took a vastly different approach and implemented mandatory HIV-antibody testing for sex workers and couples who applied for marriage licences. New York City's health commissioner, on the other hand, not only refused to establish testing sites but sought to impede the use of the test outside of blood banking. He was mainly responding to community fears of discrimination based on HIV-antibody status. Thus New York City, the epicentre of the AIDS epidemic, became the only major American city where voluntary, confidential, or anonymous testing was not readily available. For a discussion of this, and other issues relating to HIV-antibody testing in the United States, see Ronald Bayer and David L. Kirp, 'The United

Ironically, the fight over compulsory HIV-antibody testing for 'high risk' groups, and the debate concerning the emphasis that testing was given in Australia's strategy to combat AIDS, proved to be rather inconsequential, as it appears that a majority of gay men in Sydney and Melbourne voluntarily decided to take the test in any case. In May 1987 Penington announced that "well over 80,000 men at risk in Australia have behaved very responsibly and have come forward for testing", and data from Macquarie University's SAPA study of 535 Sydney gay men indicate that over 73% had agreed to be tested by the end of 1987.⁶⁷ This did not necessarily displease the AIDS Councils who were never critical of people who decided to discover their HIV-antibody status. They merely wanted the decision to remain in the hands of an individual who was fully aware of the consequences of testing positive and negative. In fact, in the mind of ACON, the high degree of compliance only went to prove its point that coercive compulsory testing was not required.⁶⁸

In any case, despite its reservations about the psychological and social consequences of testing, the AIDS Councils always maintained that they would change their stance on testing once drugs to slow the onset of AIDS became available. In 1985, for example, Adam Carr, speaking on behalf of the VAC, announced:

[R]esearch and medical practice in the AIDS field are progressing all the time, and the policies might need constant review and revision in the light of changing circumstances. Because of this, our policy on antibody testing is, like all our policies, a conditional one. If it needs modifying in the light of new information, we will modify it. However, we would have to be persuaded that any such new information had produced a real shift in the balance between

States: At the Centre of the Storm', in Kirp and Bayer (eds), *AIDS in the Industrialized Democracies: Passions, Politics and Policies*, New Brunswick: Rutgers University Press, 1992, particularly pp.24-6.

⁶⁷David Penington, 'The Community Needs Protection', *Age*, 5 May 1987, p.13; and S. Kippax, et al., *The Importance of Gay Community in the Prevention of HIV Transmission*, Social Aspects of the Prevention of AIDS Project, Study A, Report No.7, Sydney: Macquarie University AIDS Research Unit, 1990, cited in Ariss, *Against Death*, pp.78-9.

⁶⁸Paul van Reyk for ACON, 'AIDS: We've Got It Right - An ACON Perspective for the AIDS Summit', unpublished paper compiled for comment within ACON, May 1992.

potential benefit and potential risk...Nobody would be more pleased than VAC to hear that an advance in medical knowledge or practice had been made that would permit antibody-positive people to receive treatment or take other positive steps which would substantially reduce or eliminate their risk of progressing to AIDS or ARC.⁶⁹

Such advances did occur with the development of antiviral drugs such as AZT and AL7-21 and a range of prophylactic treatments against opportunistic infections that promised to improve the quality of life for people living with HIV and slow their progression to 'full-blown' AIDS. Carr and Phil Carswell thus publicly changed their position on HIV-antibody testing in August 1988.⁷⁰ ACON and AFAO reversed their stance the following year due to these developments in treatments and with the assurance that the Commonwealth and the states were considering comprehensive legislative amendments which would guarantee the confidentiality of HIV-antibody test results and protect HIV-positive individuals in cases of discrimination.⁷¹ While some doubts persisted as to whether the new legislation really did protect the rights of people living with HIV to privacy and freedom from discrimination, ACON and ANCA (the Australian National Council on AIDS which subsumed NACAIDS) were soon devising education campaigns that informed people living with HIV/AIDS, and those with risk factors who had not taken the HIV-antibody test, of the benefits and availability of early treatment.⁷²

⁶⁹Carr c.1985, cited in Adam Carr, 'A Testing Time for Gay Men', *Melbourne Star Observer*, 20 August 1988, p.3, held at the Australian Gay and Lesbian Archives, Melbourne.

⁷⁰*Ibid.*; and Phil Carswell, 'Gay Health and Politics', *Melbourne Star Observer*, 26 August 1988, pp.6-7.

⁷¹'HIV Testing', Memo to AFAO Committee Members from Peter Rowland, Bill Whittaker and Levinia Crooks, 20 September 1989, discussed at the AGM of AFAO on 7-8 October 1989, NBAC/NAAC, ANU, H5/1(15); and Bill Whittaker [President of ACON], 'Voluntary HIV Antibody Testing - Time for a More Proactive Approach', unpublished discussion paper for AFAO, 26 September 1989, NBAC/NAAC, ANU, H5/15.

⁷²By September 1989, four states (NSW, Victoria, SA and WA) afforded protection from discrimination to people with AIDS under impairment and disability provisions, although it remained unclear as to whether asymptomatic people living with HIV infection were covered. Discrimination based on HIV/AIDS status or perceived status did not become unlawful under the Federal Disability Discrimination Act until March 1993. For a discussion of the flaws in the anti-discrimination legislation see Bill Whittaker, 'Voluntary HIV Antibody Testing - Time for a More Proactive Approach', unpublished discussion paper for AFAO, 26 September 1989, NBAC/NAAC, ANU, H5/15.

The public disagreements about HIV-antibody testing procedures were by no means over, however, as the reactionary wing of the Australian Medical Association, led by NSW AMA President Dr Bruce Shepherd and Dr Bryce Phillips, sought to revive the issue of mandatory testing in April 1989 by calling for the screening of all elective surgery patients. Shepherd and Phillips also demanded that decisions regarding AIDS policy be "remedicalised" and taken out of the hands of the "gay lobby" and civil libertarians whom, they asserted, were controlling the way in which policy was formulated.⁷³ Such calls were not new. Surgeons had been proposing to deny treatment to 'high risk' individuals who refused to submit to an HIV-antibody test prior to surgery since 1985, at which time Penington and the Victorian Attorney-General was forced to intervene to prevent this from happening.⁷⁴ Now they were arguing that health care workers risked fatal infection if they accidentally jabbed themselves with bloodied needlesticks – injuries which were common in medical practice but might be avoided if a patient's HIV-status demanded that greater precautions be taken. They also noted the need to identify all of the potential hazards involved with a patient's surgery so as to choose the most appropriate form of treatment. As one doctor cautioned in an article to the *Australian and New Zealand Journal of Surgery*:

If an HIV patient has an altered immune status, he or she will have significantly increased risk of infection and wound breakdown after surgery. Hence one would be most loath to place a foreign body such as an orthopaedic prosthesis or heart valve in such a compromised patient.⁷⁵

Shepherd attempted to mobilise support for his position by organising an 'AIDS Summit' in 1989 at which he articulated his attack on the 'gay lobby' and the 'demedicalisation' of AIDS. Further criticisms were presented at the AMA's 1990 conference where Shepherd

⁷³AMA, 'AMA Releases AIDS Policy at AIDS Summit' [press release], 28 April 1989, NBAC/NAAC, ANU, H7/47.

⁷⁴Stuart Rosson, 'Surgery Dilemma on AIDS Patients', *Sun*, 14 June 1985, p.5; and Letter to Dr D.G. Campbell, Director of Medical Services at The Royal Melbourne Hospital, from David Penington, AIDS Task Force Chairman, 19 November 1985, NBAC/NAAC, ANU, H19/41.

⁷⁵Terence W. O'Connor, 'Do Patients Have the Right to Infect Their Doctor?', *Australian and New Zealand Journal of Surgery*, vol.60, 1990, p.160.

defeated a number of moderate candidates for the national presidency. His call for mandatory HIV-antibody testing for surgery patients was affirmed by the keynote speaker at this conference, David Penington. Obviously angered by the Commonwealth's support for the AIDS Council's education-driven model of AIDS prevention, Penington revised his earlier opinion on pre-operative blood screening:

In the AIDS debate, much has been driven by the social ethic on the basis of equity and civil rights. A high level of control of policy has been achieved by those suffering from the infection or likely to be infected, with inevitable distortion of the policies and their depiction to the community. The HIV epidemic is a public health issue and the principles of public health must take priority if spread of the infection is to be contained. As with any other epidemic, identification of those infected and strategies to minimise the risk of them infecting others must be the central issue rather than policy being driven by the image of the responsibility primarily resting with the uninfected community, an approach which has engendered fear and anxiety and achieved little to control the spread of the virus. Testing for HIV infection prior to major surgery must, on any grounds, be seen as logically mandatory in this day and age because of the very finite, tangible risk to health care workers when dealing with persons carrying the infection if this fact is unknown.⁷⁶

Neither Penington's comments, nor numerous letters from doctors to the *Medical Journal of Australia* in support of the mandatory testing of surgery patients, could persuade the Commonwealth government to change its mind on the issue, however, and through the Intergovernmental Committee on AIDS it encouraged the states not to consider such measures. In adopting this stance, the government was persuaded by the arguments presented by the AIDS Councils and various hospital and nursing groups who, in their submissions to the 1989 National HIV/AIDS Strategy Working Group on Testing, argued against mandatory HIV-antibody testing in favour of the implementation of universal infection control procedures in hospitals.⁷⁷ The Commonwealth and state governments

⁷⁶Cited in Ballard, 'Australia: Participation and Innovation', p.153.

⁷⁷*Ibid.*, p.149.

were also influenced by public opinion, which had been shaped, to some extent, by the popular ABC TV programme *GP*. A 1990 episode written by Greg Millin dramatised the possibility of discrimination resulting from the non-consensual blood screening of surgery patients and came down strongly against it.⁷⁸

Each of these opposition groups pointed out that while the potential for needlestick injuries in hospital settings was significant, the possibility of HIV transmission in these circumstances was extremely unlikely due to a number of factors. First, the nature of the virus made it difficult to transmit unless it was injected directly into a vein. The actual risk of transmission after receiving a needlestick injury from an HIV-positive patient was considered to be less than 1 in 200.⁷⁹ Second, the prevalence of HIV infection within the Australian community was very low and thus there were very few people with HIV attending Australian hospitals (which further reduced the likelihood of health care workers coming into contact with infected blood).⁸⁰ These two factors meant that, at the time of the AMA's policy statement, there were fewer than twenty confirmed cases of workplace HIV transmission world-wide, and only two possible cases in Australia (one of which involved a voluntary helper who was not a trained health care worker).⁸¹ The Intergovernmental Committee on AIDS also revealed that in approximately 86% of these cases, health care workers were already aware of their patients' HIV-status, thus undermining the claim that such knowledge would prevent infection occurring.⁸²

⁷⁸*GP*, 'Mates' [episode 46], written by Greg Millin, directed by Di Drew, ABC TV, 3 April 1990.

⁷⁹Terence W. O'Connor, 'Do Patients Have the Right to Infect Their Doctor?', *Australian and New Zealand Journal of Surgery*, vol.60, 1990, p.160.

⁸⁰J. Kaldor, *et al.*, 'Human Immunodeficiency Virus Antibodies in Sera of Australian Blood Donors: 1985-1990', *Medical Journal of Australia*, vol.155, 1991, pp.287-300; and Colin B.A. Reid, *et al.*, 'HIV Risk Factors and Seroprevalence in Surgical Patients', *Medical Journal of Australia*, vol.158, 4 January 1993, pp.21-3.

⁸¹M. Pirrie, 'Woman Health Care Worker Catches AIDS Virus From Patient', *Age*, 1 May 1989, p.1; and CDC, 'Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus and Other Blood-borne Pathogens in Health Care Settings', *Morbidity and Mortality Weekly Report*, vol.37, 24 June 1988, pp.277-88.

⁸²IGCA, 'Health Care Workers and the Risk of HIV Infection', unpublished discussion paper, April 1989, p.11, NBAC/NAAC, ANU, H7/47. The IGCA's data were drawn from reports published in 1988. Also see J.L. Gerberding, *et al.*, 'Risk of Exposure of Surgical Personnel to Patients' Blood During Surgery at San Francisco General Hospital', *New England Journal of Medicine*, vol.322, 1990, pp.1788-93.

A group of prominent doctors, led by Ron Penny, who campaigned against mandatory HIV-antibody testing for elective surgery patients also noted the inaccuracies of the ELISA test which continued to produce 'false positive' results into the 1990s despite fine-tuning. They were equally worried about patients who produced 'false negative' results due to being tested during the 'window-period' before their bodies could manufacture, and the test detect, HIV-antibodies. Such results might, they argued, give medical personnel a false sense of security that could lead them to becoming complacent regarding precautions.⁸³ A safer scenario was for health care workers to assume that all patients were infected and thus adopt universal infection control procedures to prevent the transmission of blood-borne viruses. Such precautions included the immediate disposal of used needles and syringes, and the cleansing of theatre and anaesthetic machines and instruments during and after surgery. While other doctors and surgeons argued that these procedures were expensive and time-consuming, such negative aspects were offset by the enormous cost savings associated with preventing the transmission of HIV and other blood-borne infections such as hepatitis B and C which were much more infectious than HIV.⁸⁴

These arguments proved decisive on every occasion that the reactionary wing of the AMA and the College of Surgeons tried to revive the issue. In April 1994, for example, after the *Medical Journal of Australia* reported the high incidence of medical personnel being stuck with needles and nicked by scalpels during surgery and the Royal Australasian College of Surgeons renewed its demand for the mandatory testing of surgery patients, the *Australian* newspaper, AFAO, the federal AMA (under the new leadership of Dr Brendan Nelson), and the Commonwealth government rejected implementing mandatory screening measures for the reasons cited above.⁸⁵ The AIDS Council of New South Wales, focusing on the issue of potential patient discrimination, responded to the revival of threats for mandatory

⁸³See Ron Penny, 'The Hippocratic Irrelevance Variable' [letter], *Medical Journal of Australia*, vol.152, 4 June 1990, p.614.

⁸⁴It was estimated that a health care worker who received a needlestick injury from a patient with hepatitis B faced a one-in-four chance of contracting this disease.

⁸⁵See *Medical Journal of Australia*, March 1994; Julie-Ann Davies, 'Virus Hits 6: Doctors Act on Risk', *Sunday Age*, 17 April 1994, p.1; and Editorial, 'HIV in the Operating Theatre', *Australian*, 7 April 1994, p.10.

testing with hard-edged humour. As a 1991 campaign poster (Figure 4.1) depicts, it suggested that if patients were to be tested for HIV, then surgeons should also submit to mandatory testing for the virus and a host of other infections.

It remained, then, that health care workers were to assume that all patients were infected so as to adopt universal infection control procedures, just as gay men and other members of the community were encouraged to imagine that they and their sexual partners were HIV-positive and modify their behaviour accordingly. The education-based approach to AIDS control that put responsibility on the community to prevent the transmission of HIV rather than doctors and legislators was thus clearly favoured over the traditional 'test and contain' model advocated by the AIDS Task Force.⁸⁶ Penington's irritation was palpable, as his speech to the 1990 AMA conference demonstrates. To understand exactly why he was so upset, one needs to consider the education-based model of 'community-empowerment' and the merits of 'safe sex' in greater detail.

⁸⁶The first National HIV/AIDS Strategy issued by the Commonwealth in August 1989 did, however, recommend mandatory testing for prisoners, immigrants, and defence force personnel, which suggests that the AIDS Councils did not have it all their own way.

BEFORE I LET YOU OPERATE ON ME YOU'LL HAVE TO BE TESTED
FOR H.I.V, C.M.V, HEP A B & C, E.B.V, HERPES, HOMOPHOBIA...



Figure 4.1: Poster and postcard produced by ACON for 'HIV Anti-Discrimination: It's Our Right' campaign, 1991.

Chapter 5.

"If it's not on, its not on": The Triumph of Safe Sex and Community-Based Education

By the end of 1984 it had been well established – within scientific circles at least – that AIDS was caused by a retrovirus-induced immune deficiency. Doctors were not certain how long the virus might exist within the body before attacking the immune system, nor what percentage of infected individuals would progress to develop 'full-blown' AIDS, but they were quite sure about the ways in which the virus could be transmitted. The exchange of contaminated blood and semen seemed to be the problem, although it was quickly determined that such occurrences could be avoided if blood donor screening procedures were introduced and sexual practices modified so as to avoid the exchange of semen or blood. Sexually active individuals were thus urged to use condoms or adopt non-penetrative forms of sexual activity, such as erotic talk, sensual massage, rubbing, licking and mutual masturbation. The term 'safe sex' was coined to denote these practices which, of course, had been familiar to heterosexual couples – although not necessarily gay men – for decades under the rubric of 'family planning'. Ironically, due to the initial pervasiveness of the 'gay lifestyle' hypothesis which posited the immunosuppressing qualities of semen, drugs and sexual promiscuity as the cause of AIDS, gay men in the larger cities of America and Australia had begun receiving training in the art of safe sex long before HIV had been identified. The cheeky gay group Sisters of Perpetual Indulgence, for example, began distributing leaflets on safe sex (with reference to protection from the 'gay cancer') in 1982 and the *Sydney Star* began publishing articles which recommended the use of condoms in May 1983.¹ Admittedly, some of the early 'safe sex' advice, such as the recommendation to avoid sexual relations with American men and

¹Ken Davis interviewed by Daniel Connell, 5 August 1993, 'The Australian Response to AIDS' Oral History Project, National Library of Australia, TRC-2815/45, p.19; and Margaret Duckett, 'HIV/AIDS and Australia's Community-Based Sector: A Success Story in HIV Prevention', unpublished report prepared for AFAO, 1992, p.14, ACON archive, id: G2367. The world's first safe sex brochure in response to AIDS was produced by the KS/AIDS Foundation of San Francisco in 1982. According to Peter North, one of the three founders of the Queensland AIDS Council, a second pamphlet entitled 'Can We Talk?', written by the Harvey Milk Gay Democratic Club of San Francisco, was used extensively as a model for American and Australian community-based safe sex education. See Peter J. North, *AIDS – Morality and Mortality: The Shaping of Preventive Strategies with Particular Reference to Queensland*, unpublished M.Soc.Wk thesis, University of Queensland, 1987, p.63.

to only choose partners who 'looked healthy', was probably ineffectual and possibly dangerous, but these maxims were soon replaced by the mantra 'always use condoms'. From the earliest days of the epidemic in Australia, then, concerned gay men invested their hopes in safe sex and education to save them from the fate of their American brothers, and came to favour this strategy above all others – including HIV-antibody testing – to contain the spread of HIV/AIDS.

David Penington was of a different mind, however. At the end of 1984, his AIDS Task Force developed a containment strategy based on the identification of infected individuals and the prohibition of their sexual relations. While some of his colleagues wavered from this line, Penington maintained this position throughout the 1980s, and this led him to try to undermine the discourse of safe sex. During an interview in 1987, he stated:

We have for two and a half years been saying publicly that in order to contain the spread of AIDS, those who carry the infection have a special responsibility to find out if they have the infection, and if they have, not to place anyone else at risk. We do not accept the doctrine of "safe sex" – that is, just the advocacy of the use of condoms for anal intercourse – is a sufficient strategy to control the epidemic. [This is for] two reasons: one is that there is objective evidence that a great many homosexuals will not follow those recommendations; secondly, even when they do there is a significant incidence of transmission because of ruptured condoms or slippage of condoms during anal intercourse. This occurs much more readily with anal intercourse than with vaginal intercourse. So we have called on members of those groups whose behaviour puts them at risk to come forward for testing.²

In an opinion essay for the *Age* newspaper published in May 1987, Penington reiterated this view and added "there is clear evidence that infection continues to spread in those fully conversant with the 'safe sex' guidelines and in large measure this is because the majority do not observe the rules much of the time and many never do. Sexual emotions are strong

²Greg Hunter with David Penington, 'David Penington Interview', *Australian Penthouse*, vol.8, no.12, 1987, pp.99-100.

and urgent and caution is often thrown to the wind when people believe, as most wish to, that they are not infected."³

Putting aside the Task Force chairman's narrow definition of safe sex (although I am reluctant to do so, given his repeated equation of safe sex with penetrative anal intercourse was deliberate, and surreptitiously aimed to heighten public fears that all sexually active, but unidentified, HIV-positive homosexual men were dangerous), Penington's claims warrant investigation. Were the Commonwealth and state governments duped into investing in 'safe sex' education when they might have been pushing for compulsory HIV-antibody testing and adopting more coercive measures to ensure that HIV-positive individuals did not infect others? How safe was 'safe sex'? And was it really possible for educators to counteract "strong and urgent" sexual desires and ensure that information about safe sex was acted upon?

David Penington was certainly not the first or only person to suggest that condoms were fallible. This question dominated discussion at a number of sessions of the Second National Conference on AIDS held in Sydney at the end of October 1986.⁴ It was also taken up by church leaders and, most publicly, by Nicholas Tonti-Filippini, Director of the Catholic Church's Bioethics Centre situated at St Vincent's Hospital in Melbourne. At the root of Penington's and Tonti-Filippini's concern was the often-quoted condom failure rate of 10%, which was attributed to condoms rupturing and slipping off during sexual intercourse.⁵ Their anxiety was not eased despite the publication of an article in the *Journal of the American Medical Association* that maintained there was no established data on condom breakage or slippage, and that noncompliance with condom usage recommendations and unprotected foreplay were the primary factors in the occasional

³David Penington, 'The Community Needs Protection', *Age*, 5 May 1987, p.13.

⁴See, for example, 'Summary of Panel Session on "Safe Sex"', Commonwealth of Australia, *AIDS: Australia's Response Examined, Report of the Second National Conference on AIDS, Sydney, 31 October 1986 - 1 November 1986*, Canberra: AGPS, 1988, pp.143-6.

⁵Letter to Phil Carswell, President Victorian AIDS Council, from David Penington, 16 June 1986, NBAC/NAAC, ANU, H18/4; and Nicholas Tonti-Filippini, 'Promoting Condoms for "Safe Sex" Irresponsible' [letter], *Age*, 23 September 1986, p.12.

'failure' of condoms to prevent pregnancy and disease transmission.⁶ Nor were the two men swayed by evidence presented at the Second International Conference on AIDS held in Paris during June 1986, which posited that the percentage of gay men being infected with HIV in San Francisco had declined from 15-17% per annum in 1983-4 to 4-8% per annum in 1985 – a decline that corresponded with the first extensive 'safe sex' campaign in that city.⁷ While condom usage might not have entirely accounted for this decline (abstinence was another explanation), Dr James Curren of the U.S Centers for Disease Control, who presented the information, also reported an 85% reduction in the rate of rectal gonorrhoea being diagnosed at STD Clinics in San Francisco during 1985.⁸ Rectal gonorrhoea, he noted, was transmitted in the same manner as HIV and could be prevented by the correct use of condoms. It was thus a reliable measure of the level of condom use and the effectiveness of these devices. In replying to Tonti-Filippini's tirade against the promotion of condoms in September 1986, Dr David Bradford of the Melbourne Communicable Diseases Centre, announced that statistics maintained by his clinic mirrored the San Francisco data, as the number of reported cases of anal gonorrhoea fell from 57 in 1983 to 37 in 1984, 22 in 1985, and to only 12 in 1986.⁹ (In June 1986, Penington himself remarked that the decline was even more pronounced in Sydney STD clinics where a ten to twenty fold reduction in cases of anal gonorrhoea was reported between 1983 and 1986.)¹⁰ Bradford added that this decline was witnessed in gay patients who, clinical interviews suggested, *continued* to practise anal intercourse with condoms.

⁶M.A. Conant, *et al.*, 'Condoms Prevent Transmission of AIDS-Associated Retrovirus', *Journal of the American Medical Association*, vol.255, no.13, 1986, p.1706. Findings from the most recent and comprehensive studies into the efficacy of condoms suggest a failure rate of between 3-4% when condoms are used during anal intercourse. The use of oil-based lubricant was generally found to be the most significant factor leading to condom breakage. For an overview of these studies, see Edward King, *Safety in Numbers: Safer Sex and Gay Men*, London: Cassell, 1993, pp.94-5.

⁷Cited in Letter to Nicholas Tonti-Filippini from Dr David Bradford, 30 September 1986, NBAC/NAAC, ANU, H9/16.

⁸*Ibid.*

⁹Letter to Nicholas Tonti-Filippini from Dr David Bradford, 30 September 1986, NBAC/NAAC, ANU, H9/16. Also see Adam Carr, 'Continued Fall in Victoria's Gay-Related STD Figures', *Gay Health Update* (Newsletter of the VAC/GMCHC), no.103, 7 August 1987, p.1.

¹⁰Letter to Phil Carswell from David Penington, 16 June 1986, NBAC/NAAC, ANU, H18/4.

A problem therefore existed. Representatives of the church were not willing to accept the implication of these trends and support the promotion of safe sex while, as Tonti-Filippini asserted, "the evidence is clear that genital sexual relationships are only safe from the spread of disease when neither partner is a carrier, and this can only be assured if neither has had another sexual partner".¹¹ Most doctors were also unwilling to promote the use of condoms above the HIV-antibody test while a statistical possibility remained that 'safe sex' might result in infection. Both parties thus adopted positions which respectively reinforced their long-held opinions on the need for celibacy before marriage and the medical control of public health initiatives. While undoubtedly concerned with saving lives, their arguments against safe sex were clearly aimed at enticing the public and decision-makers towards these positions. Gay men, too, had a significant interest in persuading the government and the public to endorse educational efforts and safe sex. The alternative, in their eyes, was a return to sexual puritanism – a 'heterosexualisation' of homosexual desire – and a regime of surveillance and discipline that the enactment of alternative, traditional public health measures promised.

We know little about the public's faith in condoms (except that condom sales soared once they started to be promoted as life-preservers).¹² The Commonwealth government, however, came to the firm opinion that in the absence of a vaccine or a fail-safe medical intervention to stop the spread of HIV, the community must be informed about safe sex and the correct use of condoms. Moreover, it insisted that the educational efforts within the gay community be supported by public funds. In 1985 it began financing these initiatives directly and then drew up a cost-share arrangement with each of the states to ensure that money would continue to be provided for safe sex education in communities at risk. I shall explain exactly why the Commonwealth government came to trust gay men and put its faith in education and safe sex at the end of this chapter (as it took more than the weight of argument and evidence to persuade politicians). At this point, it is necessary to explain how educators went about dealing with the second of Penington's concerns: namely, the unlikely adoption and continual practice of safe sex in the gay community which had little

¹¹Nicholas Tonti-Filippini, 'Promoting Condoms for "Safe Sex" Irresponsible' [letter], *Age*, 23 September 1986, p.12.

¹²'Condom Sales Up', *Daily Telegraph*, 15 February 1988, p.4.

need to use condoms in the past, and in which "strong and urgent" sexual desires were not unknown.

The task facing educators and gay community leaders was indeed immense. While they could take courage from the success of previous health promotion efforts aimed at smokers and drivers who drank, drove too fast or failed to wear seat-belts, they understood the level of success achieved by these campaigns in the 1970s and early 1980s would not be enough to prevent the loss of thousands of lives to AIDS.¹³ The AIDS Action Committees were unfazed, however, and devised a strategy that they believed would work. It depended on organisations such as theirs being empowered to devise and deliver information about AIDS and safe sex to their own communities which were unlikely to conform with the list of lifestyle taboos that the state health departments were beginning to compile. As the Victorian AIDS Action Committee wrote in a 1984 working paper on education:

It is important that the preparation of education material directed at the gay male community be undertaken by (or with the advice of) people familiar with that community, so that it is phrased in a way that is accessible and acceptable to gay male readers...Gay men are rightly wary of attempts by outsiders to dictate to them how they ought not to organize their lives and their sexuality.¹⁴

This report found its way on to the desk of Bill Bowtell, Neal Blewett's senior adviser, who persuaded the Health Minister to begin funding gay community organisations in order to provide education and support/care services. Some members of the AACs were happy enough to continue this kind of work without the assistance of government. In Sydney, however, Ken Davis and Lex Watson were adamant that such a situation would result in gay organisations struggling to cope once the AIDS case load increased, as was the

¹³As Don Baxter, Executive Director of the AIDS Council of New South Wales, recalled: "Anti-smoking campaigns rate a 2% decline in smoking per annum as a success. Road safety campaigns have reduced road deaths by 50% over ten years. If HIV prevention programmes had only been as successful as these the outcome would have been disastrous!" (Don Baxter, 'The Real Challenge in HIV/AIDS Policy - Not "Have We Got It Right" but "How Can We Do It Better?"', address to the Australian Doctors' Fund AIDS Summit - AIDS: *Have We Got It Right?*, Sydney, 14-15 May 1992.)

¹⁴VAAC, 'Education in the AIDS Phenomenon: A Working Paper Prepared by the Victorian AIDS Action Committee', 1984, NBAC/NAAC, ANU, H19/25.

situation in many states of America where the gay community's pleas for funding were ignored by government. The Commonwealth Department of Health recommended that the AACs and other gay-based AIDS organisations, such as the Bobby Goldsmith Foundation and the Community Support Network, incorporate themselves into AIDS Councils so that they could receive government funds. Once this was achieved in the first few months of 1985, the Commonwealth proceeded to provide the Victorian AIDS Council (VAC) and the AIDS Council of New South Wales (ACON) with starting grants of \$56,000 and \$74,000 respectively; Councils in other states received lesser amounts befitting the approximate size of their gay communities and general populations.¹⁵ All of the money was tied to specific education and support/care programs and no funds were made available for administration or advocacy work. Nor did the AIDS Councils receive state government funds until 1986. They thus continued to rely on income generated in the gay community through fundraisers, membership subscriptions and donations for the maintenance of their programmes.¹⁶

Underpinning all of their educational efforts was the idea, expressed in the VAAC working paper, that "[e]ducation needs to be sex-positive and gay affirmative, restructuring the gay male community towards positive and helpful expressions of sexuality".¹⁷ The AIDS Councils had learned from their counterparts in the United States that gay men were likely to disregard advice which they viewed to be moralistic or that demanded the curtailment of sexual pleasure and relationships which they had fought so long to have recognised. The VAC's first Education Working Group, led by Bruce Parnell and Marcus O'Donnell, thus set about convincing gay men that safe sex was not only possible but that it was fun and pleasurable. The result was two remarkably successful campaigns that spoke explicitly about different kinds of sexual practices and cast the condom in a new light.

¹⁵For a vivid portrayal of the formation of the ACON and the issues and internal arguments which dominated its first year of operation, see Don Baxter (former President of ACON) interviewed by James Waites, 26 July 1993, 'The Australian Response to AIDS' Oral History Project, National Library of Australia, TRC-2815/79, pp.21-36.

¹⁶Victorian AIDS Council, *Annual Report 1986*, November 1986, Melbourne: VAC, p.13.

¹⁷VAAC, 'Education in the AIDS Phenomenon: A Working Paper Prepared by the Victorian AIDS Action Committee', 1984, NBAC/NAAC, ANU, H19/25.

The *You'll Never Forget the Feeling of Safe Sex* poster and brochure (Figure 5.1), distributed in gay venues, saunas, bookshops and health centres in the final months of 1985, seems tame by the standards of future material, but provided a striking image around which to centre discussions about safe sex. Depicting a nude and well-toned man sprawling submissively between satin sheets, the image reworked a massive advertising campaign for Sheridan bed-linen that was plastered over Australian billboards at the time.¹⁸ *It's Black and White...Condomwise* (Figure 5.2), launched in 1986, was even more playful and used the image of six cuddly condom-clasping men arranged in a daisy-chain to ease anxiety about sex and condoms. Both campaigns concentrated on the kind of sex that gay men could continue to practise, and emphasised that only a small degree of change was required to make sex safe again. While the images became more explicit and colourful in later years in an effort to eroticise the condom even further (as Figures 5.3-5.5 illustrate), this remained the central message of all future safe sex campaigns.

If some people found these images confronting, the language used in the educational material might have also shocked them. The kind of language used in the posters and pamphlets was important because the discursive history of AIDS had proven that the use of vague or incorrect labels such as "high risk groups" and "promiscuity" could result in public misunderstandings about the nature of the epidemic. Community-based educators were keen to avoid making the same mistake.¹⁹ In speaking to their peers, they thus endeavoured to use language that was culturally specific and appropriate. While health department bureaucrats and doctors continued to use terms such as "making love" and "sexual intercourse", peer educators favoured the terms "fucking", "screwing" or (to add a particularly Australian flavour) "rooting". It was no use referring to "anal sex", they concluded, when some people did not know that an "anus" was. They used the term "arse" instead, or warned – as in the case of the *You'll Never Forget the Feeling of Safe Sex* brochure – "don't get cum up your bum". If they felt compelled to talk about celibacy and

¹⁸Ted Gott, 'Where the Streets Have New Aims: The Poster in the Age of AIDS', in Ted Gott (ed.), *Don't Leave Me This Way: Art in the Age of AIDS*, Canberra: National Gallery of Australia, 1994, p.202. Also see Andrew Stephens, "'Blatant' Poster for AIDS Battle', *Sun*, 19 December 1985, p.16.

¹⁹One AIDS educator recalled her conversation with a group of older adolescents from Sydney's western suburbs who believed that the word "homosexual" defined someone who had sex at home! See Judith Jones, 'The Role of Distinctive Language in AIDS Education', *Venereology*, vol.2, no.2, 1989, pp.44-5.

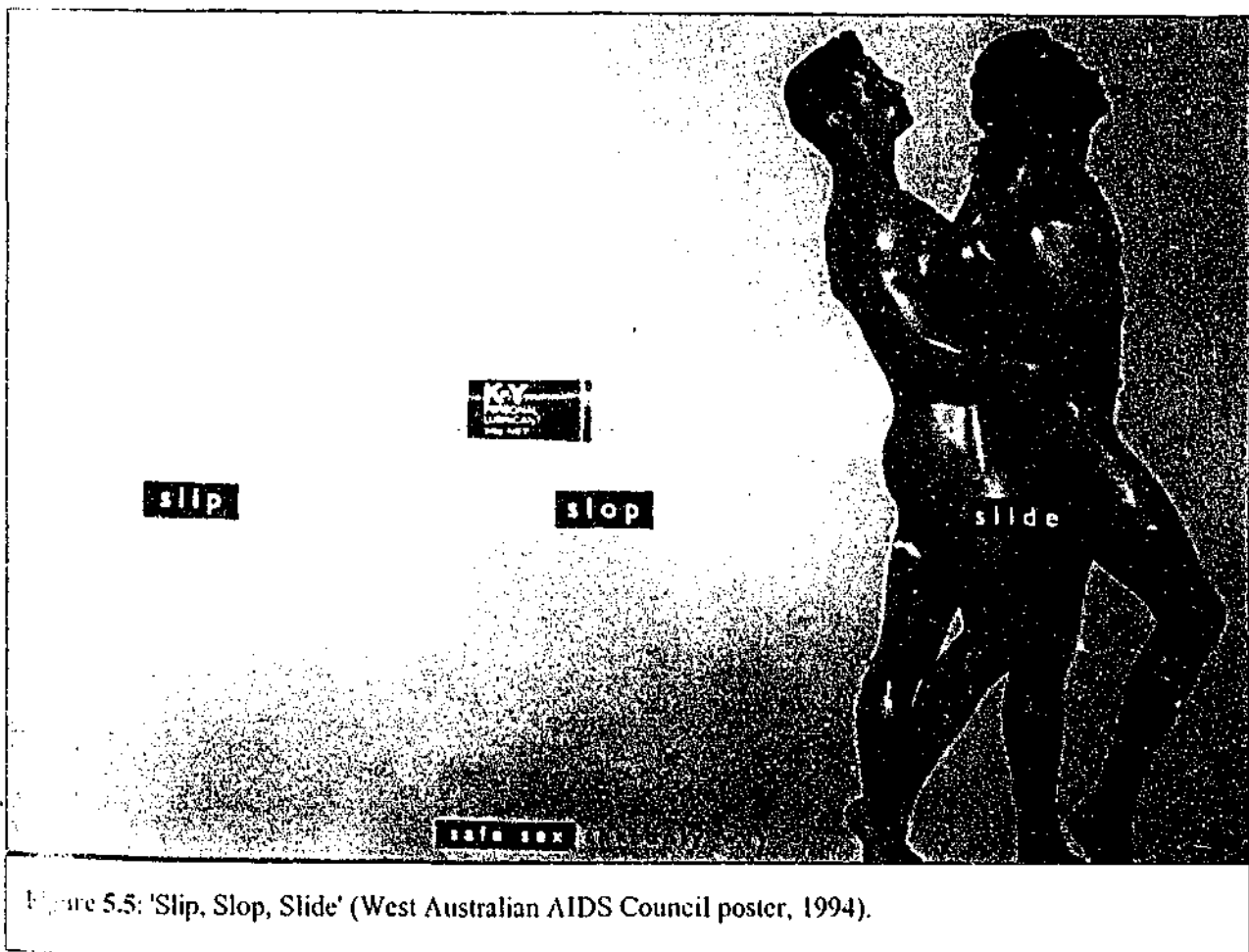


*You'll never
forget
the feeling
of safe sex*

Figure 5.1: 'You'll Never Forget the Feeling of Safe Sex' (detail of pamphlet cover, Victorian AIDS Council, 1985).



Figure 5.2: 'It's Black and White...Condomwise' (Victorian AIDS Council poster, 1986).



abstinence, they simply suggested "don't fuck anyone". Monogamy was also easily explained: "don't fuck anyone except your boyfriend". The purpose of such language was two-fold: explicit communication about the facts of AIDS and, in some cases, the eroticisation of safe sex by using terms associated with lust and subversion.

Jeffrey Weeks, a British historian of sexuality, has remarked that in a perverse kind of way, Western countries were fortunate that AIDS hit their homosexual communities first because gay men were in a better position to talk openly about sex and respond to the demands that AIDS placed on sexual practices:

One of the crucial things about the gay community is that it has been explicitly organised around sexuality, which makes it easier for it to talk about sexuality in relationship to the AIDS crisis. Other communities are not so explicitly organised around sexual issues and therefore have been more reluctant to discuss issues about unsafe sexual practices and changing sexual behaviour.²⁰

His point is certainly demonstrated by comparing the educational materials devised by gay community-based organisations and those produced by Australian state health bureaucracies which were distributed through schools, doctors' surgeries, health centres and mail-outs. The New South Wales Department of Health, for example, produced a pamphlet titled *A.I.D.S.* in 1985 that might have achieved its purpose by putting its intended audience to sleep before they could entertain any thoughts of sex, safe or otherwise. Its presentation of a complex array of epidemiological, immunological and venereological data and advice promised little more excitement or encouragement than the pamphlet's bland pink and blue cover (Figure 5.6).²¹ Four years later, its brochure (ironically) titled *Condoms Fun Sex: A Users [sic] Guide*, offered little more in the way of

²⁰Jeffrey Weeks, 'AIDS, Altruism and the New Right', in Erica Carter and Simon Watney (eds), *Taking Liberties: AIDS and Cultural Politics*, London: Serpent's Tail, 1989, pp.130-1. Also see Gary Dowsett, 'The Sociological Context', in Eric Timewell, Victor Minichiello and David Plummer (eds), *AIDS in Australia*, Sydney: Prentice Hall, 1992, p.99.

²¹The design of this pamphlet, among other materials produced by the NSW Department of Health, is discussed further in Leong K. Chan and Raymond Donovan, 'Difficences and Diversities: HIV/AIDS Public Health Campaigns in Australia', in *Proceedings of the Third European Academy of Design Conference*, Sheffield Hallam University, Sheffield, 20 March - 1 April 1999, pp.172-95.

linking condoms with eroticism. Forgoing photographs of alluring or lustful human beings, it depicted men and women as geometric shapes – a combination of circles, squares and triangles – arranged in stylised caricature to denote gender (Figure 5.7). Presumably the amorphous shapes were meant to appeal to a range of body types and ethnicities (who might not be addressed through the usual photographs of well-toned Anglo men and women).²² They did nothing, however, to suggest that safe sex and condoms were ‘fun’ as the title of the brochure promised.

The health departments’ campaigns fared better when they presented information about sex and condoms in the humorous style of cartoons. Ron Tandberg’s designs (Figures 5.8 and 5.9) were particularly popular and managed to communicate a simple but important idea about sex in a manner that was non-threatening and appropriate for display in public places. The AIDS Councils also adopted this graphic style, although, predictably, they did so with a sense of humour and degree of explicitness that was likely to offend the general public (Figures 5.10 and 5.11). While this meant they could not display their cartoons in mainstream public spaces, they were perhaps more effective in communicating to gay men because their celebration of sexuality offered the possibility of safe sexual fulfilment. In comparison, the message encoded in Tandberg’s designs (especially Figure 5.9) seems punitive. The South Australian AIDS Council found a happy medium in its 1988 poster devised to coincide with Adelaide’s Formula 1 Grand Prix (Figure 5.12). Depicting a hastily drawn Formula 1 driver and female companion, it advised locals and visitors to the city that ‘Racing is dangerous, drivers take precautions...Lay some rubber first big boy!’

It would be incorrect to suggest that the AIDS Councils focused exclusively on the print media to convey their messages. In their first year of incorporation, for example, ACON and VAC each established a Beats Project that entailed peer educators visiting well-known gay cruising areas and public sex spots such as toilets. Once on site, they passed condoms and sachets of lubricant under cubicle doors, pasted ‘safe sex’ stickers and spoke with loitering men. Many of these men did not identify as homosexual or attend established gay venues, and were thus unreachable through other mediums of education. In 1985, VAC

²²*Ibid.*, p.179.

AIDS
Acquired Immune Deficiency Syndrome

AIDS

AIDS

AIDS

Figure 5.6: 'A.I.D.S.' (front cover of pamphlet produced by the New South Wales Department of Health, 1985).



Figure 5.7: 'Condoms Fun Sex: A Users Guide' (front cover of pamphlet produced by the New South Wales Department of Health, 1989).

If it's not on , it's not on. 



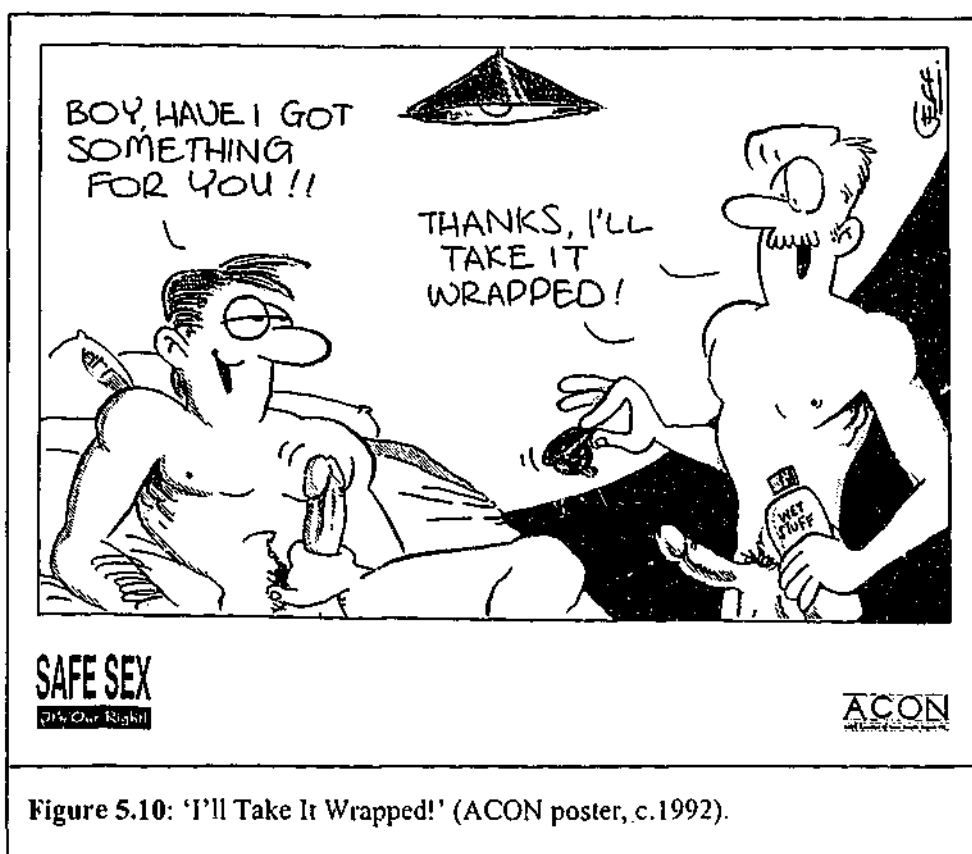
Figure 5.8: 'If it's not on, it's not on' (Ron Tandberg design for the Commonwealth Department of Human Services and Health, c.1988).



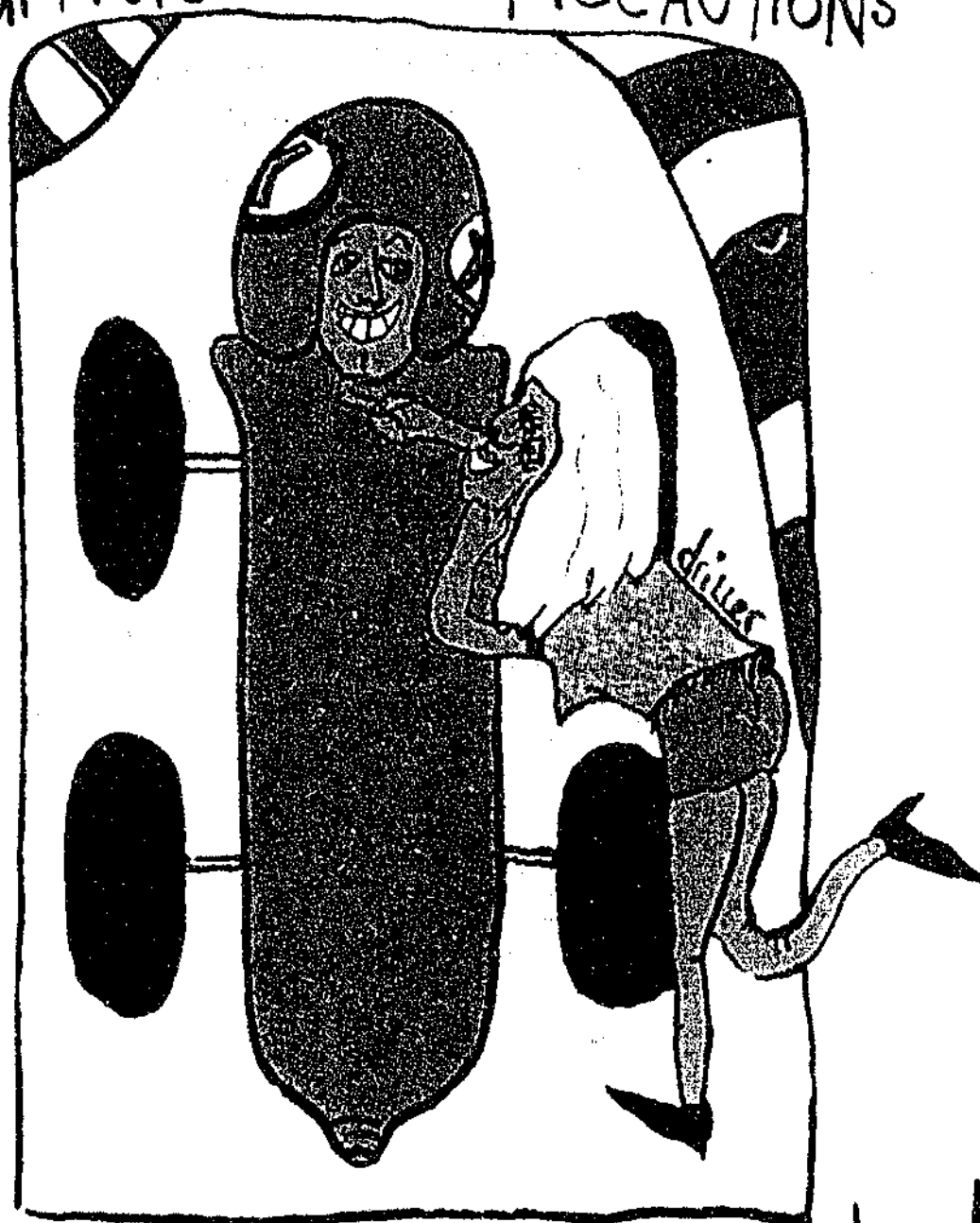
AIDS HOTLINE
(02) 11620

AIDS PREVENTION PROGRAM, DEPARTMENT OF HEALTH, N.S.W.

Figure 5.9: 'I wouldn't wear one if they were giving them away' (Ron Tandberg design for the New South Wales Department of Health, c.1988).



Racing is dangerous.
drivers TAKE precautions



Lay Some Rubber FIRST big boy!

Figure 5.12: 'Lay Some Rubber First Big Boy!' (cartoon poster, South Australian AIDS Council, 1988).

peer educators also held information evenings at gay saunas and nightclubs for similar reasons.²³ By 1986 the Education Group understood that these 'safe sex seminars' were waning in popularity, so they sent out the Fantom Frangers to provide a 15 minute 'show' at gay venues which emphasised the pleasures of condoms and the dangers of oil-based lubricants. The Safe Sex Sisters, a group which formed spontaneously within the Melbourne gay community and approached the VAC with an offer to help, also travelled to gay venues and parties where they distributed information and interviewed gay men about their sexual habits for use in future campaigns.²⁴ Figures 5.13 and 5.14 show the Fantom Frangers and the Safe Sex Sisters in action.

By 1992, 'Ken - the Safe Sex Character' was also doing the party circuit in a bid to encourage gay men to 'Fuck Safe' in a new and striking way. Commissioned by the VAC and designed by Sydney artist Brenton Heath-Kerr, Ken was a life-size walking safe sex advertisement composed of the body parts of two different male models which were photographed, fragmented and then combined with colourful pictograms and stark words such as Hot, Safe, Sweat, Fuck, and Condom (Figure 5.15). The images were sewn onto a black suit that was worn by an actor to dance parties, nightclubs and other community events. As Ted Gott, director of the *Art Against AIDS* exhibition that displayed Heath-Kerr's creation, remarked: "The outfit was designed to be immediately readable in the context of a crowded, dimly lit dance floor, as it flashed subliminal messages of responsible drug use and sexual safety to an audience naturally drawn to the universal allure of the piece."²⁵

²³At the end of the 1980s, researchers from Macquarie University who interpreted the data derived from the Social Aspects of the Prevention of AIDS study, suggested that the high levels of knowledge and behavioural modification relevant to AIDS demonstrated by non-gay identifying men-who-have-sex-with-men (MSM) was directly attributed to the Beats Project and education provided in saunas. See R.W. Connell, *et al.*, *Facing the Epidemic: Changes in the Sexual and Social Lives of Gay and Bisexual Men in Response to the AIDS Crisis, and their Implications for AIDS Prevention Strategies*, Social Aspects of the Prevention of AIDS Study A, Report No.3, Sydney, Macquarie University: School of Behavioural Sciences, 1988.

²⁴Victorian AIDS Council, *Annual Report 1986*, Melbourne: VAC, p.11.

²⁵Ted Gott, 'Agony Down Under: Australian Artists Addressing AIDS', in Ted Gott (ed.), *Don't Leave Me This Way: Art in the Age of AIDS*, Canberra: National Gallery of Australia, 1994, p.8. For a discussion of Heath-Kerr's other work and its visibility within Sydney's gay community party scene, see Paul Hayes, 'Brenton: The Man in the Irony Mask', *Outrage*, no.110, July 1992, pp.16-17.



Figures 5.13 and 5.14: The Fantom Frangers, demonstrating the finer points of condom use in a gay sauna, and the Safe Sex Sisters in action, c.1986.

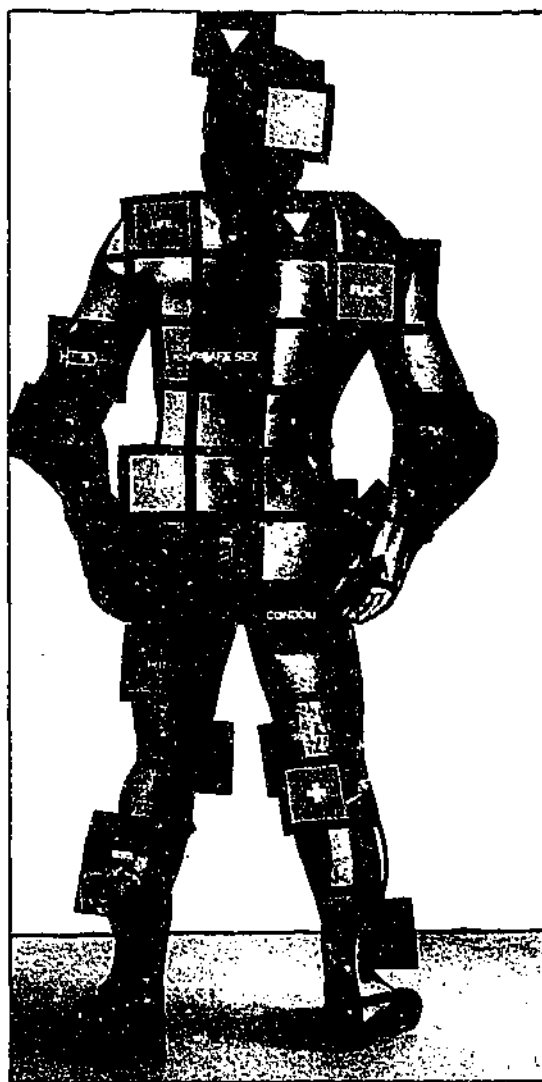


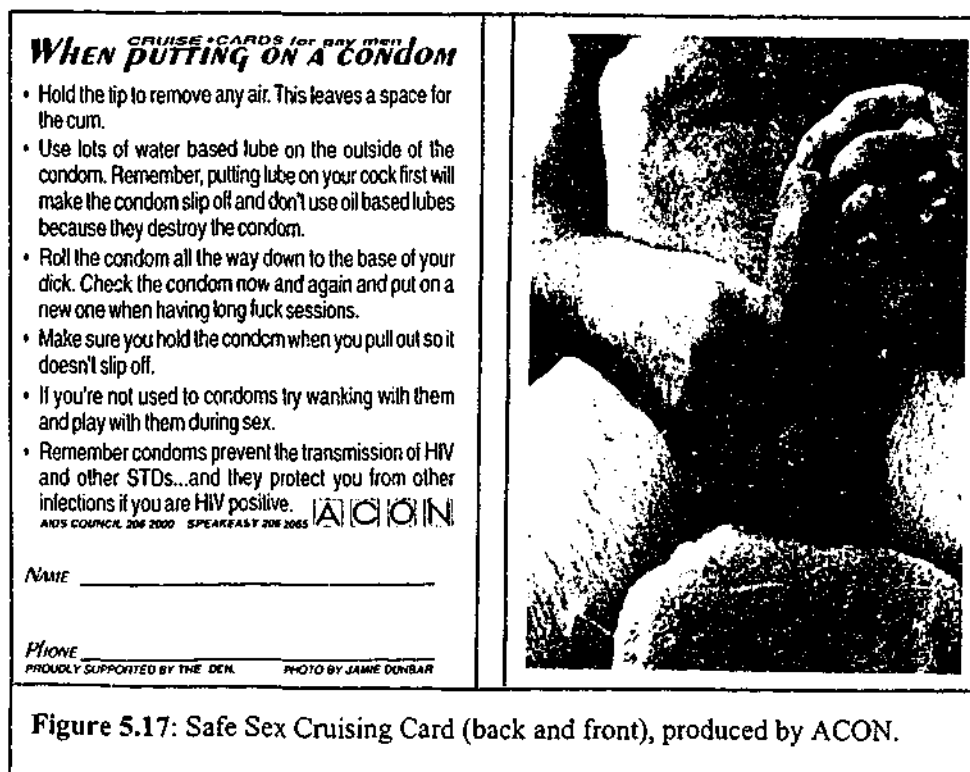
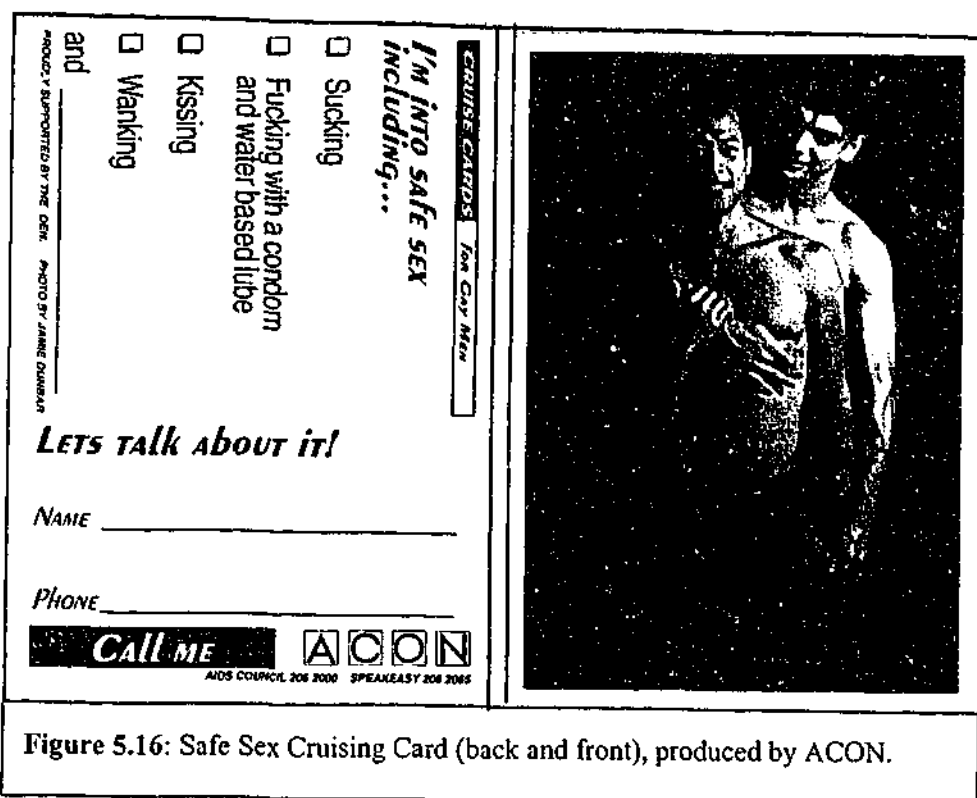
Figure 5.15: 'Ken - The Safe Sex Character' (full-body costume designed by Brenton Heath-Kerr, 1992). Original in colour.

In other innovative initiatives, the West Australian AIDS Council and ACON organised red-capped and G-string-clad 'lifeguards' to host safe sex parties – a variation on the tupperware theme suitable for the beach-culture of Perth and Sydney. Guests were served 'phallic hors-d'ourves' while their hosts demonstrated and sold safe sex products and erotic videos. (Most of the AIDS Councils tried to produce or import their own X-rated safe sex videos, with varying degrees of success.) ACON also experimented with a series of explicit but informative 'cruising cards' that were given to gay men to be distributed at bars and nightclubs in order to inform potential partners about the kind of (safe) sex they were willing to try (Figures 5.16 and 5.17). In the 1990s, the Queensland AIDS Council and the VAC went one step further and produced a range of safe sex swap cards which came in foil packets and could be traded like the basketball cards that were fashionable at the time (Figures 5.18 and 5.19). To the disappointment of many, they did not contain a stick of bubblegum. The 'bubble boy' cards were banned by the state censors in Queensland, though they proved to be so popular in Melbourne that they were soon being traded in San Francisco and New York.²⁶

Working groups were also established to produce educational materials for the deaf, an example of which was the 1988 VAC poster that spelled out the words 'safe sex' using sign language (Figure 5.20). Ethnic minorities within the gay community were also catered for, although most observers concur that they were ignored for too long.²⁷ ACON, for example, did not employ an ethnic gay men's project officer until 1989 at which time it became the first AIDS Council to do so. Once commissioned, the officer's task was to produce a range of materials for non-English speaking men-who-have-sex-with-men (MSM) who tended to avoid gay venues in favour of anonymous sex at beats. He translated existing information about AIDS into Chinese, Thai, Indonesian, Vietnamese and Tagalog

²⁶Greg Roberts, 'Righteous Indignation', *Bulletin*, 28 March 1995, p.22; Editorial, 'Query on AIDS Funds', *Sunday Mail*, 12 March 1995, p.62; and 'Think Again', *Male Out: A National Gay Men's Health Bulletin*, vol.2, December 1996, p.1.

²⁷Jamie Dunbar, ACON Educator Officer, interviewed by Paul Sendziuk, 14 July 1998, notes in possession of the author; and Peter Grant (convenor of the VAC Education working group), 'Education', in Victorian AIDS Council, *Together 1988: The Annual Report of the Victorian AIDS Council and the Gay Men's Community Health Centre for 1987/88*, Melbourne: VAC, 1988, p.10.





HIV won't ever happen to me.

You hear about AIDS all the time. But it's pretty rare really. A friend of a friend has got it, but I hardly see him. The guys that get it, well they're the sort who do stupid or dangerous things. I don't do that. HIV has been around for years, so if it was going to happen to me it would have happened already.

STANDARD OUTCOME!

A new infection happens in Melbourne nearly every day. Most guys who test positive for HIV are really surprised they got it. These aren't "stupid" or "dangerous" people. They're just guys like you who thought it couldn't happen to them. HIV will never happen to you if you only fuck using condoms and water based lube and never share injecting equipment.

Artist: Shane Heary

THE

1

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1 Chesham St South Yarra VIC 3141 Ph: (03) 9885 6700

YH



He's such a hunk I'll only get one chance to have sex with him.

He certainly was the cutest guy there. I'd been watching him for a while and then suddenly we were together, alone and getting naked. He didn't seem to want to use a condom and I didn't want to miss the chance of having sex with him by insisting. He fucked me and then he left.

STANDARD OUTCOME!

The sex was good, but afterwards I worried... What if I got HIV from him? If he was that cute, maybe he'd had lots of sex with lots of other guys. Maybe he hadn't used condoms with them either. The more I thought about it, the more I got sick up inside. I wish I could look back on that night without fear and regret. If I'd insisted he use a condom or done something else instead of letting him fuck me, I'd have happy memories to wank over instead of trying to forget about it. Now I don't even want to go back to that house in case I see him again.

Artist: Adam Little

GAY!

24

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1 Chesham St South Yarra VIC 3141 Ph: (03) 9885 6700

YH

Figures 5.18 and 5.19: AIDS prevention swap cards aimed at young gay men, Victorian AIDS Council, 1996.



STOP AIDS



Figure 5.20: 'Stop AIDS: Use Condoms. Don't Share Needles' (Victorian AIDS Council poster, 1988).

and helped to design images that were culturally sensitive.²⁸ Figures 5.21 and 5.22 illustrate two versions of a poster produced by ACON in 1991 that targeted Chinese-speaking gay men. They feature the photography of prominent Chinese-Australian artist, William Yang, whose work was used in a number of other campaigns.

Each of these initiatives targeted a different group within the diverse gay community: men who entertained at home, men who liked to cruise at bars and clubs, young men who were fascinated by anything novel and collectable, and men who had difficulty understanding spoken English. They thus aimed to communicate with groups of homosexuals and non-identifying MSM whom David Penington suggested could not be reached or encouraged to change their sexual behaviour. Given the sense of urgency and energy within the gay community, it is little wonder that they achieved their goal and, as I shall demonstrate later, lives were saved because of this.

What is remarkable, however, is that these educational materials were produced, in most cases, with the consent and funding of the Commonwealth and state governments, and the support of each of the major political parties in Australia. This was in stark contrast to the difficulty that community-based organisations in the United States experienced as they tried to produce and distribute explicit information about AIDS and safe sex. As Cindy Patton has explained, federal funding for US AIDS education was circumscribed from the outset; the first monies for community-based 'innovative projects' came in 1985 (some four years after the first case of AIDS was reported in America) and totalled less than \$500,000. The initial funding came with the provision that federally financed education materials must prominently promote the HIV-antibody test and be acceptable and accessible to "a broad spectrum of educated adults in society". In addition, visual images were to "communicate risk reduction methods by inference rather than through any display of the anogenital area or overt depiction of the performance of safe sex or unsafe sex".²⁹

²⁸ 'AIDS Education Across the Language Barrier', *OG Magazine* [an ACON publication], no.7, 1990, pp.69-70.

²⁹ Cindy Patton, *Inventing AIDS*, New York: Routledge, 1990, pp.55-6. Also see Ronald Bayer and David L. Kirp, 'The United States: At the Centre of the Storm', in David L. Kirp and Ronald Bayer (eds), *AIDS in the Industrialized Democracies: Passions, Politics and Policies*, New Brunswick: Rutgers University Press, 1992, p.20.

Such standards, if applied to Australia, would have required the AIDS Councils to produce brochures similar to that devised by the New South Wales Department of Health.

The small amount of money that US gay-based AIDS organisations did receive was threatened by a 1988 amendment to the federal AIDS Research and Education Funding Bill which prohibited federal funding for any form of education that was construed to "promote or encourage, directly or indirectly, homosexual sexual activities".³⁰ The amendment was proposed by the Republican Senator Jesse Helms who claimed he was "sickened" by a (safe) sexually explicit comic book produced by the Gay Men's Health Crisis of New York. He could not prove, however, that the comic was produced with government funds. (It was, in fact, financed by membership subscriptions, donations and fundraisers within the gay community.) The amendment was nevertheless passed by Congress, 94 votes to 2, although it was subsequently softened to reduce its impact on education funding.³¹

Despite the frequent opposition expressed by the Reverend Fred Nile in the New South Wales parliament and the occasional complaint by Federal and state politicians (such as Michael Cobbs' public criticism of ACON's 1988 pamphlet *Six Tips For Hard Cocks*), Australian state governments were generous in their funding of the AIDS Councils. The National Party-dominated government in Queensland was the only exception. The Queensland Minister for Health, Brian Austin, who was the first to use the tragedy of the deaths of the Queensland babies for political gain, refused to have any contact with the predominantly gay-based Queensland AIDS Council and also declined to use the more sedate educational materials designed by NACAIDS. This was despite entering into a cost-share arrangement with the Commonwealth in May 1985 and assenting to the National Health Strategy for AIDS Control, which highlighted the importance of education.³² When Neal Blewett tried to withhold Queensland's allocation of Commonwealth AIDS funds over this issue, Austin reiterated that the traditional medical approach was the most

³⁰Patton, *Inventing AIDS*, p.56.

³¹For further discussion of the impact of the Helms amendment, see Douglas Crimp, 'How to Have Promiscuity in an Epidemic', in Douglas Crimp (ed.), *AIDS: Cultural Analysis/Cultural Activism*, Cambridge: MIT Press, 1988, especially pp.259-64.

³²Queensland AIDS Committee, 'Briefing Notes for Delegates Attending the Second National Conference on AIDS, Sydney, 1986', NBAC/NAAC, ANU, H9/38.

appropriate model for dealing with AIDS and that his government would continue to invest in HIV-antibody testing and contact tracing programmes rather than "offensive" safe sex education.³³ (The Queensland government had already introduced other 'traditional' measures of disease control such as criminal penalties for 'high risk groups' who donated blood and for those who 'knowingly' transmitted HIV.) Blewett was thus forced to fund the fledgling Queensland AIDS Council (QuAC) with money channelled through NACAIDS and the Sisters of Mercy, whom he came to call "the most cheerful and altruistic of money launderers".³⁴

Throughout 1985, the only information about AIDS that was available from the Queensland Department of Health was a four-page leaflet called *AIDS: The Facts* (which was compiled by Penington's Task Force and featured a photograph of Brian Austin), and a booklet titled *AIDS: Acquired Immune Deficiency Syndrome - Information for Physicians*. No specific literature was produced to educate homosexuals or other 'high risk' groups concerning safe sex and the use of condoms. Austin frequently complained that such material simply promoted homosexual activities and "delude[d] those at risk of AIDS into believing that they can safely indulge in some types of deviant sexual behaviour with carriers of the disease".³⁵ Instead he preferred to accept "expert" advice which suggested "that if someone is at risk, the only way of not contracting the disease is abstinence".³⁶ In August 1985 Austin's department refused to distribute an AIDS brochure

³³Peter J. North, *AIDS - Morality and Mortality: The Shaping of Preventive Strategies with Particular Reference to Queensland*, unpublished M.Soc.Wk thesis, University of Queensland, 1987, pp.108-9.

³⁴Neal Blewett, 'Valuing the Past...Investing in the Future', *Australian and New Zealand Journal of Public Health*, vol.20, no.4, 1996, p.344. The QuAC was known as the Queensland AIDS Committee until September 1986 at which time it was informed that it must change its name in order to receive consideration for registration as a charitable organisation. The word 'Committee' apparently gave the impression that the QuAC was an arm of government. Its application for registration was eventually rejected. The QuAC was also identified as the QAC until its use of this acronym in a public education campaign brought the threat of legal action from the Principal of the Queensland Agricultural College, who claimed registration of QAC for exclusive use. Presumably his organisation did not want to be confused with a homosexual group as it permitted the Queensland Arts Council to continue using the acronym without acrimony. These issues concerning nomenclature indicate the kind of ingrained hostility and opposition that gay-based organisations in Queensland confronted every day. For further elaboration on this point, see North, *AIDS - Morality and Mortality*, especially pp.129-30, 140-4.

³⁵Ministerial Statement by Hon. B.D. Austin, Minister for Health and Environment, *Hansard, Proceedings of Queensland Legislative Assembly*, 16 September 1986, p.1355.

³⁶*Ibid.*

prepared by Melbourne's Royal Children Hospital (which could hardly be described as a subversive organisation) because, the Minister asserted, "the literature talks about kissing one another's anuses and urinating in one another's mouths. Quite frankly the Queensland Government is not going to be party to circulating that sort of literature."³⁷ When then called upon by the Queensland Nurses' Union to distribute educational material designed by NACAIDS, Austin emphatically replied: "We simply don't co-operate with the National Advisory Committee [on AIDS] because it is dominated by homosexual interest groups. We believe our other brochures and books on AIDS are second to none in Australia."³⁸ His government thus continued to take its advice from a state advisory committee composed entirely of doctors and treated HIV/AIDS as if it was any other infectious disease.³⁹

The belligerent stance of the Queensland government held until 1987, at which time Mike Ahern replaced Austin as Minister for Health. He immediately began to challenge Premier Joh Bjelke-Petersen's conservative views about sex education in schools, QuAC funding, and the introduction of condom vending machines in universities (the latter, the Premier memorably contended, would be like "letting everyone set up prostitution parlours so we can all be raped").⁴⁰ Ahern's determination ensured that AIDS became a focal point of division within the National Party – a division which eventually led to the health minister replacing Bjelke-Petersen as Premier in December 1987.⁴¹ While retaining the key features of the traditional 'test and contain' approach to AIDS control, Ahern's government, and the

³⁷Damien Murphy and Mark Metherell, 'Queensland Says No to National AIDS Brochures', *Age*, 14 August 1985, p.18.

³⁸*Sun*, 12 August 1985, cited in North, *AIDS – Morality and Mortality*, pp.113-14.

³⁹For a sample of the criticism that the Queensland government's approach attracted, see Sybil Nolan, 'Joh Attacked On AIDS Fight Inadequacy', *Australian*, 15 September 1986, p.3; Letter to the Editor (Roger Dawkins), *Sunday Sun*, 21 September 1986, Letter to the Editor (W.A. Rutkin and P.J. North), *Courier Mail*, 23 September 1986, p.4; and 'Open letter to Federal politicians from Greg Weir, Community and Media Liaison Officer, Queensland AIDS Committee', c. September 1986, NBAC/NAAC, ANU, H18/57.

⁴⁰*Sun*, 22 December 1986, cited in North, *AIDS – Morality and Mortality*, p.121.

⁴¹John Ballard, 'Australia: Participation and Innovation in a Federal System', in David L. Kirp and Ronald Bayer (eds), *AIDS in the Industrialized Democracies: Passions, Politics and Policies*, New Brunswick: Rutgers University Press, 1992, p.156.

Labor government that replaced it in 1989, worked more closely with NACAIDS and ANCA and agreed to fund the QuAC directly.

The Liberal Party in Victoria provided the only other significant source of antagonism for AIDS educators, as I indicated in my discussion of the controversy surrounding the VAC's *When You Say Yes* poster in 1990 (see Chapter 3). The poster was aimed at young gay men who were struggling or afraid to accept their sexual orientation and suggested: "more guys than you think have sex with other guys. It's natural and if you're safe you'll have a great time" (Figure 3.5, p.102). The Shadow Minister for Health, Marie Tehan, disagreed and called on the Victorian Department of Health to withdraw its funding of the VAC "if it continue[d] to place the irresponsible advertisements which blatantly promote homosexuality".⁴² In doing so, she missed the point of a new type of education campaign that the AIDS Councils were developing: a campaign which aimed to address the social context and determinants of risk-taking rather than just providing information about safe practices.

When You Say Yes was devised in response to numerous in-depth cohort studies involving gay men. These studies indicated that the decision of gay men to apply knowledge about AIDS and safe sex depended on a number of factors, including their level of gay community attachment, peer group support and self-esteem.⁴³ Isolated men, and those who believed the rhetoric – espoused by Queensland politicians among others – that they were dirty and depraved, were more likely to practise unsafe sex because they lacked the social support and positive peer-group pressure to do so, and because, in some cases, they felt that their lives were worthless. Ridiculed by strangers, bashed at school and abandoned by their families, some young gay men were simply deprived of the will, or the *power*, to make healthy life choices, despite all they might have learned about AIDS and condoms. The high rates of gay teen suicide and self-harm in Australia and overseas certainly confirmed

⁴²Marie Tehan press release, 25 July 1990, cited in Victorian AIDS Council (James McKenzie), *When You Say Yes*, Melbourne: VAC, p.10.

⁴³Susan Kippax, et al., *The Importance of Gay Community in the Prevention of HIV Transmission*, Social Aspects of the Prevention of AIDS Study A - Report 7, Sydney: Macquarie University, 1990; and Gary Dowsen, 'The Sociological Context', in Eric Timewell, Victor Minichiello and David Plummer (eds), *AIDS in Australia*, Sydney: Prentice Hall, 1992, especially pp.92-3, 96-7.

this conclusion. Research conducted in the 1980s by The London Gay Teenage Group, for example, found that 25% of young lesbians and gays felt isolated, 21% suffered verbal abuse, 12% had been bashed, and one in five had attempted suicide because of anguish, loneliness and despair.⁴⁴ The US Department of Health and Human Services suggested that lesbian and gay youth were two to three times more likely to attempt suicide than their heterosexual counterparts and that approximately 30% of successful teen suicides each year were by lesbian and gay teenagers.⁴⁵ A sample of more recent studies in Australia estimated that between 20% and 42% of gay and bisexual men had attempted suicide and that gay youth were three to four times more likely to attempt suicide than heterosexuals of the same age.⁴⁶ The VAC's 'When You Say Yes' campaign thus aimed to encourage young men that it is 'OK to be gay' and that same-sex attraction, and safe sex, entailed many wonderful possibilities.⁴⁷ ACON and the Australian Federation of AIDS Organisations (AFAO) – an umbrella organisation formed in October 1986 to represent community-based groups at the national level – used similar posters and literature to communicate this idea. Each of the AIDS Councils also offered support groups and courses such as 'Fun and Esteem' and 'Gay and Proud' to deal with the issues of isolation and depression.⁴⁸

There were, however, other ways to empower gay men and change the way in which they, and the wider community, viewed homosexuality. In the first place, high school teachers could be encouraged to tell the truth about homosexuality, or at least discuss gay sexual practices in health education classes without resorting to ridicule. Laws against

⁴⁴Cited in Stephen Jeffrey-Poulter, *Peers, Queers and Commons: The Struggle for Gay Law Reform from 1950 to the Present*, London: Routledge, 1991, p.222.

⁴⁵Kevin Jennings, *Becoming Visible: A Reader in Gay and Lesbian History for High School and College Students*, Boston: Alyson Publications, 1994, p.264, cited in Christopher Kendall and Sonia Walker, 'Teen Suicide, Sexuality and Silence', *Alternative Law Journal*, vol.23, no.5, 1998, p.217.

⁴⁶Jonathan Nicholas and John Brown, 'Better Dead Than Gay? Depression, Suicide Ideation and Attempt Among a Sample of Gay and Straight-Identified Males Aged 19 to 24', *Youth Studies Australia*, vol.17, no.4, 1998, pp.28-33; L. Hillier, et al., *Writing Themselves In: A National Report on the Sexuality, Health and Wellbeing of Same Sex Attracted Young People*, Melbourne: National Centre in HIV Social Research, 1997; and Lynne Hillier and Jenny Walsh, 'Abused, Silenced and Ignored', *Youth Suicide Prevention Bulletin*, no.3, 1999, pp.23-7.

⁴⁷M. Goggin and A. Hee, 'Say Yes to Reaching Out', *National AIDS Bulletin*, vol.4, no.9, 1990, pp.17-18.

⁴⁸Victorian AIDS Council, *Positive Approach: Victorian AIDS Council Inc. Gay Men's Health Centre Inc. Annual Report 1991*, Melbourne: VAC/GMCHC, p.8.

discrimination could also be extended to protect homosexuals from vilification, and legislation forbidding consensual sex between men – which still existed in Western Australia until 1989 and Tasmania and Queensland well into the 1990s – repealed, thus providing a new paradigm for the general public to consider homosexuality.⁴⁹ The legalisation of consensual homosexual sex would also allow AIDS educators to target gay men and speak to them about anal intercourse without fear of prosecution. Adopting a more sophisticated approach to health and illness – which viewed the incidence of disease to be determined by a interconnected web of social, psychological, economic and legal factors – AIDS workers both within the gay community and state health departments thus went about lobbying for these outcomes.⁵⁰ This would have been almost impossible while the traditional model of infectious disease control, which viewed disease prevention to be a simple matter of identifying infected individuals and disciplining their behaviour through legislation, held sway. Indeed, it marked a shift from 'traditional' public health ideology to the 'new public health' which emphasised the need for community participation, education, and public policy interventions such as homosexual law reform. In Chapters 7 and 8 I shall discuss how injecting drug users and sex workers – and calls for the free distribution of sterile needles and syringes and the legalisation and regulation of prostitution – were also incorporated into this model.

Recent commentaries on the development of AIDS policy in Australia have tended to suggest that public policy interventions such as these, and the orientation of community-based education programmes, were governed by the recommendations of the Ottawa Charter.⁵¹ The Ottawa Charter was developed by the World Health Organisation in 1986 in an effort to reduce the increasing dependence on technological medicine (such as vaccines and antibody testing kits). In its place, it encouraged nations to improve the "health of all"

⁴⁹For a discussion of this point in relation to the reform of laws against homosexual sexual practices in Western Australia, see Kendall and Walker, 'Teen Suicide, Sexuality and Silence', pp.216-21.

⁵⁰The AIDS/STD Unit of the Health Department of Victoria (HDV), for example, supported the extension of existing anti-discrimination laws to cover homosexuals in order to fight the spread of HIV in 1989. See Memorandum to Tim Daly, Chief General Manager HDV, from John Cribbes, Acting Manager AIDS/STD Unit, 25 August 1989, NBAC/NAAC, ANU, H9/44-2.

⁵¹AIDS Bureau of the NSW Department of Health, *HIV Prevention in New South Wales: Status Report on AIDS Health Promotion*, 1991, NBAC/NAAC, ANU, H5/5(70); and Paul Drielsma, 'AIDS Policy and Public Health Models: An Australian Analysis', *Australian Journal of Social Issues*, vol.32, no.1, 1997, pp.87-99.

by enabling communities to devise and deliver their own health promotion programmes, and by implementing policies in areas such as housing, education and employment that would empower their subjects to make healthy lifestyle choices.⁵² While public health bureaucrats and AIDS Council project officers came to adopt the language of the Ottawa Charter (especially as they tried to attract government funding), it is misleading to suggest that their ideas were initiated by it. Community-based AIDS education and empowerment strategies clearly existed in Australia before the Ottawa Charter, and should be seen as desperate actions to ensure the survival of the gay community rather than as directives from the World Health Organisation.

With this said, it is also incorrect to suggest that the AIDS epidemic and the work of community-based organisations alone brought about the shift in public health ideology. In terms of considering the sociological context of health and illness, critics of 'traditional' public health practices had long argued that poor people were more likely to develop diseases and have higher mortality rates because they were "least able to make informed choices and have [the] least power to control their own lives".⁵³ Feminist health activists had also long maintained that the social and political inequality of women directly compromised the life choices that determined their likelihood of becoming ill.⁵⁴ A result of this critique was the women's community health movement which predated the gay community's mobilisation in response to AIDS by some twenty years. Nevertheless, it can be claimed that it was the incredible success of empowerment strategies and community-based education programmes in controlling AIDS which saw these ideas enshrined in public health textbooks in Australia.

⁵²World Health Organisation, *Ottawa Charter for Health Promotion*, adapted at the International Conference on Health Promotion, 17-21 November 1986, Ottawa, Canada, ACON archive, id: G0000971 (folder: health promotion).

⁵³Richard Taylor, *Medicine Out of Control: The Anatomy of a Malignant Technology*, Melbourne: Sun Books, 1979, p.237; William Coleman, *Death is a Social Disease: Public Health and Political Economy in Early Industrial France*, Madison: University of Wisconsin Press, 1982; and Lesley Doyal, *The Political Economy of Health*, London: Pluto, 1979.

⁵⁴Lesley Doyal, *What Makes Women Sick: Gender and the Political Economy of Health*, New Brunswick: Rutgers University Press, 1995; and Tamsin Wilton, *EnGendering AIDS: Deconstructing Sex, Text and Epidemic*, London: SAGE, 1997, p.44.

This is not to say that many former members of the AIDS Task Force felt that educational efforts *had* been incredibly successful by the end of the 1980s. Professor Ian Gust, for example, a close associate of David Penington who became the Commonwealth's chief scientific and medical advisor on AIDS in the late 1980s, mused:

It's kind of arguable whether the campaigns in Australia that were sponsored by the government had any impact at all or whether or not the gay community had already decided to change their [*sic*] behaviour as a result of what they saw happening to friends and colleagues in the United States, where AIDS was beginning to devastate the gay community.⁵⁵

Earlier, at a meeting of ANCA in June 1989, Gust had queried the value of funds spent on education. His scepticism, he claimed, was based on the findings of papers produced at the Fifth International Conference on AIDS that suggested there was little difference in the rate of HIV-seroconversion among gay men in cities that had well-funded education programmes and those that did not.⁵⁶ As with the remarks made previously by Penington, representatives of the AIDS Councils felt compelled to challenge these statements before they derailed their educational initiatives. In the first case, they argued that it was clear from the rate of seroconversions in Australia in the early-to-mid 1980s that gay men were changing their sexual practices before they, or their friends, personally knew anyone with AIDS. Quite simply, the number of cases of symptomatic HIV infection in the gay community was negligible before 1986, especially in places outside of Sydney, and not all homosexual men had friends in the United States or read the gay press. Second, they argued that while the proportional difference in the annual rate of gay seroconversions was low in contrasting cities such as Sydney (less than 1%) and Vancouver (3-4%) – the latter of which refused to spend money on education programmes – this difference actually represented hundreds or thousands of HIV infections per year.⁵⁷ Professor Ron Penny,

⁵⁵Ian Gust interviewed by Stewart Harris, 12 July 1993, 'The Australian Response to AIDS' Oral History Project, National Library of Australia, TRC-2815/38, p.104.

⁵⁶Memorandum to AFAO Committee, Report on ANCA Meeting no.8, 29 June 1989, from Don Baxter, 7 July 1989, NBAC/NAAC, ANU, H5/1(15).

⁵⁷*Ibid.*

another former Task Force member who went on to become the Commonwealth's chief advisor on AIDS education and prevention, also warned against extrapolating seroconversion rates from cohort populations in communities 'without' education programmes, because the research study in effect operated as an ongoing education programme for the men involved.⁵⁸ His defence of the 'education' model, and his frequent public praise of the gay community's responsibility and initiative, goes to prove my earlier point that individuals within the medical profession, and the AIDS Task Force in particular, should not be viewed as like-minded in regard to AIDS.⁵⁹

As for other claims that gay men had not changed their sexual behaviour and were continuing to seroconvert at an alarming rate, the AIDS Councils pointed to data collected by STD clinics and a series of research studies which tracked the modification of sexual behaviour and HIV infection in the gay community. Sexual health clinics confidently proclaimed that the incidence of anal gonorrhoea had declined by over 92% between 1981 and 1988, which was a strong indicator that most gay men were using condoms or had adopted non-penetrative sexual activities.⁶⁰ In support of this conclusion, long-term large-cohort studies such as the Sydney AIDS Prospective Study, the SAPA study, and Project Male-Call, all indicated that gay men had modified their sexual practices significantly in the 1980s in response to AIDS. The second and third of these studies were a joint undertaking by researchers led by Bob Connell and Susan Kippax at Macquarie University's School of Behavioural Sciences and the AIDS Council of New South Wales, which knew of the results and utilised them to devise education campaigns long before the findings were published.

The first of the studies surveyed 420 gay men living in the inner and eastern suburbs of Sydney during 1987; 205 of the men were HIV-positive. It found that only 6.3% of HIV-positive men continued to practise unprotected insertive anal intercourse, and that less than

⁵⁸*Ibid.*

⁵⁹For Penny's praise of the gay community's efforts, see Ron Penny interviewed by Diana Ritch, 28 June 1993, 'The Australian Responses to AIDS' Oral History Project, NLA, TRC-2815/39, p.28.

⁶⁰G. Hart, 'STD Epidemiology in Australasia: Syphilis and Gonorrhoea', *Venereology*, vol.5, no.4, 1992, p.116; and Australian Gonococcal Surveillance Program, 'The Incidence of Gonorrhoea and the Antibiotic Sensitivity of Gonococci in Australia, 1981-1991', *Genitourinary Medicine*, vol.69, no.5, 1993, p.365.

14% of HIV-negative men surveyed had occasional episodes of unprotected receptive anal intercourse (regarded as the most prevalent way for a man to sexually contract HIV). In each case, the instances of unprotected sex mostly occurred with a partner of known concordant serostatus (and thus did not present a risk of HIV transmission).⁶¹ The results from this survey were substantiated by the Social Aspects of the Prevention of AIDS (SAPA) study, which initially surveyed 535 gay men living in five New South Wales locations between September 1986 and March 1987. The sample represented the best cross-section of MSM of any Australian study at the time. The study found that since becoming aware of AIDS, 42% of the respondents began to use condoms for the first time and a further 29% used them more frequently.⁶² Approximately 31% of the men had at least one episode of unprotected anal sex with their regular partner during the previous six months and 24% had engaged in unprotected anal intercourse with a casual partner (which was deemed to entail a higher risk of contracting HIV).⁶³ In both cases it is unknown whether these partners were of concordant serostatus and whether this sex was 'negotiated', although given the findings of the previous study this is highly likely. These results were considered to be promising, as 'safe sex' had only been actively promoted for about two years before the survey took place.

A 1991 re-survey of 145 men from the original study suggested that this relatively high level of safe behaviour had been maintained. There was a small increase in condom use and a significant decrease in the number of men who had unprotected sex with casual partners (24% down to 11%).⁶⁴ The original and subsequent surveys also suggested that

⁶¹Brett Tindall, *et al.*, 'Sexual Practices and Condom Usage in a Cohort of Homosexual Men in Relation to Human Immunodeficiency Virus Status', *Medical Journal of Australia*, vol.151, 18 September 1989, p.319. A smaller cohort study of Victorian gay men conducted at the same time found that 80% of those surveyed had adopted safe sexual practices in all circumstances. See I.M. Campbell, *et al.*, *A Prospective Study of Factors Influencing HIV Infection in Homosexual and Bisexual Men: A Report of Findings, Stage 1*, Melbourne: Department of Psychology, University of Melbourne, 1988.

⁶²R.W. Connell, *et al.*, 'Facing the Epidemic: Changes in the Sexual Lives of Gay and Bisexual Men in Australia and their Implications for AIDS Prevention Strategies', *Social Problems*, vol.36, no.4, 1989, p.391. 14% of the men gave no response to this question.

⁶³R.W. Connell, *et al.*, 'Danger and Context: Unsafe Anal Sexual Practice Among Homosexual and Bisexual Men in the AIDS Crisis', *Australian and New Zealand Journal of Sociology*, vol.26, no.2, 1990, p.194.

⁶⁴Paul van Reyk, 'AIDS - We've Got It Right: An ACON Perspective for the AIDS Summit', unpublished report compiled for comment within ACON, May 1992, p.8. Also see Susan Kippax, *et al.*, *Sustaining Safe Sex: Gay Communities Respond to AIDS*, London: The Falmer Press, 1993, pp.147-9.

only half of the men were engaging in anal sex, while oral sex was practised almost universally, along with mutual masturbation, kissing and massage.⁶⁵

Project Male-Call was slightly different in scope given its large cohort of gay men and non-gay identifying MSM who were recruited via advertisements placed on radio and in gyms, publications, sex shops, beats, saunas, health centres and personal columns. In all, 2583 men answered the advertisement and were interviewed for about forty-five minutes on the telephone in 1992.⁶⁶ Approximately 12% of the sample reported at least one episode of unprotected anal sex with a casual male partner in the previous five years, although slightly less condom use took place within the (relatively safer) confines of a regular relationship. It was found that men with high levels of attachment to the gay community, and men who had tested HIV-positive, were most likely to have adopted safe sexual behaviour due to the peer support and counselling that they had received.⁶⁷ The researchers thus concluded:

The fact that a large majority of men was consistently avoiding unprotected anal intercourse, either by using condoms or by avoiding anal intercourse, is indicative of a very successful degree of behaviour change, particularly among men who were attached to a gay community.⁶⁸

In real terms, this accounted for the sharp decline of HIV infections in Australia after 1984 (as illustrated by Figure 5.23), and the fact that Australia seems to have managed to reduce its rate of HIV infection faster than any other comparable country in the world.

⁶⁵*Ibid.*

⁶⁶Susan Kippax, *et al.*, *Report on Project Male-Call: A National Telephone Survey of Men Who Have Sex With Men*, Canberra: AGPS, March 1994, pp.2-4. Some of the respondents declined, or were not required, to answer some of the questions.

⁶⁷*Ibid.*, p.97. Other modifications in sexual behaviour, such as the reduction in sexual partners and the use of beats, is summarised in a statistical table on p.31.

⁶⁸*Ibid.*, p.98.

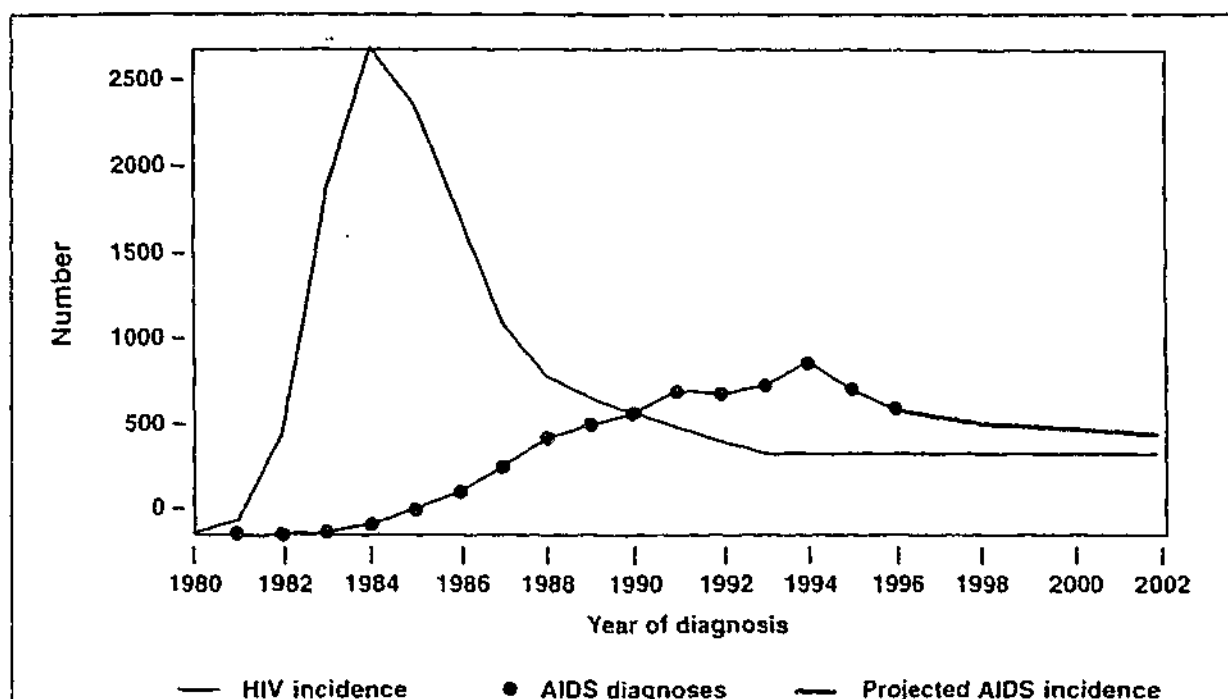


Figure 5.23: Estimated HIV incidence, observed AIDS diagnoses and projected AIDS incidence, 1980-2002.

Note: HIV and projected AIDS incidence estimated by back-projection. Observed AIDS diagnoses adjusted for reporting delay.

Source: Commonwealth Department of Health and Family Services, *Building on Success 1: A Review of Gay and Other Homosexually Active Men's HIV/AIDS Education in Australia*, Canberra: Commonwealth Department of Health and Family Services, 1988, p.29.

The researchers were careful not to draw a direct positive relationship between educational efforts within the gay community and behavioural change, as they recognised that other factors may have also contributed to this. Such factors included knowledge of one's HIV serostatus (after testing) and personal contact with the AIDS epidemic through the death or illness of a friend or lover.⁶⁹ The data collected by the SAPA researchers suggested, however, that "test result is, in general, unimportant" and that "where attachment to gay community is reasonably strong, contact with the epidemic adds little by way of a contribution to change".⁷⁰ This conclusion was also supported by the results from a 1986 study of 318 gay and bisexual Brisbane men (23 of whom were HIV-positive). The study found that the level of condom use for seropositive and seronegative men was almost identical (suggesting that knowledge of one's status did not necessarily determine the adoption of safe sex). It also indicated that 82% of the men had modified their sexual activity because of their awareness of AIDS, but this reduction was equally common among those who had or had not been tested for HIV-antibodies.⁷¹

The AIDS Councils were thus justifiably proud of their educational efforts. They also trumpeted the success of sex-positive and gay-affirmative education by comparing the rate of HIV infection in Australia with countries that had invested in education but refused to endorse the safety of oral-genital sex (fellatio) or protected anal intercourse. Educators in the Netherlands, for example, rejected the notion that abstinence from anal sex and the use of condoms were behavioural options of equivalent safety and demanded that gay men adopt the former.⁷² This proved unsustainable for gay men and, their confidence in condoms undermined, they began to report the highest levels of unprotected anal intercourse among homosexuals in the European community.⁷³ Gay men in America were

⁶⁹Personal communication with Susan Kippax, 1 June 1998.

⁷⁰Kippax, *et al.*, *Sustaining Safe Sex*, pp.90-1.

⁷¹Ian H. Frazer, *et al.*, 'Influence of Human Immunodeficiency Virus Antibody Testing on Sexual Behaviour in a "High Risk" Population from a "Low Risk" City', *Medical Journal of Australia*, vol.149, no.7, p.367.

⁷²Onno de Zwart, Theo Sandfort and Marty van Kerkhof, 'No Anal Sex Please: We're Dutch. A Dilemma in HIV Prevention Directed at Gay Men', in Theo Sandfort (ed.), *The Dutch Response to HIV: Pragmatism and Consensus*, London: UCL Press, 1998, pp.135-52.

⁷³Gary Dowsett, *Practicing Desire: Homosexual Sex in the Era of AIDS*, Stanford: Stanford University Press, 1996, n.3, p.277.

also struggling to sustain a regime of safe sex that was rigidly defined by medical experts who refused to endorse the safety of unprotected oral-genital sex because it carried a theoretical possibility of HIV transmission. Studies then proved that those who failed to use a condom during oral sex generally found it easier to forgo using condoms during anal intercourse because they felt they had probably already exposed themselves to the virus.⁷⁴ Suspecting that both of these situations might occur, Australian AIDS educators downplayed the risk of oral sex and the failure of condoms, thus encouraging gay men to adopt a safe sex regime that was realistically achievable. As Ken Davis, a peer educator with ACON in the mid-to-late 1980s, stressed:

If we ha[d] demanded too much of gay men, if we ha[d] demanded not only that they give up anal sex without condoms but that they give up oral sex and kissing, and...the affirmation that they got from sex with a number of partners, that would have been asking too much and we wouldn't have achieved anything.⁷⁵

When asked to explain how Australia had come to adopt such a pragmatic approach to sex and education that facilitated the dramatic decline in the rate of HIV infection after 1984, Don Baxter, former president of ACON, secretary of AFAO and member of NACAIDS, opined:

It is clear that Australia's community based organisations were very influential. Most of the groundwork in both prevention and policy was laid down by community organisations in the key early years of the epidemic. Australia was then fortunate to have political leadership which recognised early the key role to be played by these communities and organisations, to recognise the need for pragmatic measures rather than moralistic and ideological ones, and to build a

⁷⁴Ken Davis interviewed by Martyn Goddard, 6 July 1992, 'The Australian Response to AIDS' Oral History Project, National Library of Australia, TRC-2815/5, p.27. Also see Jesse Green, 'Flirting with Suicide', *The New York Times Magazine*, 15 September 1996, pp.84-5.

⁷⁵Davis, NLA, TRC-2815/5, p.27. For further discussion of this point, see Edward King, *Safety in Numbers: Safer Sex and Gay Men*, London: Cassell, 1993, pp.109-14.

tripartite partnership between government, the medical profession and the community organisations.⁷⁶

His words have since been endorsed by political commentators, historians and AIDS workers such as Dennis Altman and John Ballard, who each emphasise the extraordinary political leadership offered by Neal Blewett and state health departments in formulating AIDS policy.⁷⁷ Exactly why politicians came to trust gay men, drug users and – to an extent – sex workers, remains unclear, however. I have suggested that they were impressed by the way in which the homosexual community demonstrated its responsibility in mobilising and educating gay men, and by its critique of the existing model of infectious disease control. Yet such urgency and weight of argument has rarely proved sufficient to persuade politicians to adopt 'risky' and innovative policies when their own political survival (and the continuance of their other programmes) are at stake. For example, gay men in the United States (and Queensland for that matter) were also mobilising responsibly and maintained a consistent critique of the 'test and contain' model of infectious disease control, yet their efforts went largely ignored and unfunded by their governments.⁷⁸ The timing of Australia's epidemic was also obviously a factor, as politicians and community groups were able to observe the mistakes made by the United States. Yet many other countries, with the same opportunity to learn from America, failed to do so. In order to understand exactly why Australia came to embrace the concept of community empowerment and the education-based approach to AIDS control, we thus need to explore the unique social, political and institutional context in which individuals such as Neal Blewett made decisions.

⁷⁶Don Baxter, 'The Real Challenge in HIV/AIDS Policy - Not "Have We Got It Right" but "How Can We Do It Better"', address to the Australian Doctors' Fund AIDS Summit - *AIDS: Have We Got It Right?*, Sydney, 14-15 May 1992.

⁷⁷Dennis Altman interviewed by Heather Rusden, 7 July 1993, 'The Australian Response to AIDS' Oral History Project, National Library of Australia, TRC-2815/37, pp.20-1; Dennis Altman, 'The Most Political of Diseases', in Eric Timewell, Victor Minichiello and David Plummer (eds), *AIDS in Australia*, Sydney: Prentice Hall, 1992, especially pp.56-9; and Ballard, 'Australia: Participation and Innovation', especially pp.134-53.

⁷⁸For criticism of political inaction in the US, see Gay Men's Health Crisis, *The First Ten Years: Gay Men's Health Crisis Annual Report 1990-1991*, New York: Gay Men's Health Crisis, 1991; and (the President's own) National Commission on AIDS, *America Living with AIDS. Report of the National Commission on Acquired Immunodeficiency Syndrome*, Washington D.C.: National Commission on AIDS, 1991, pp.1-9.

Blewett was appointed Commonwealth Minister for Health after Bob Hawke's Labor Party swept to victory in March 1983. He retained the portfolio after the Government won an early election in December 1984. This relatively strong electoral support meant that cabinet ministers could pay less heed to objections from conservative and religious leaders when formulating policy, thus allowing Blewett more freedom to adopt a pragmatic approach to issues such as AIDS, homosexuality and drug use. In any case, Australia did not have a recent tradition of politics being overly influenced by the religious Right (and its homophobic tendencies), unlike the United States of America where Moral Majority leader Jerry Falwell had a significant following (and the opportunity to deliver nationally televised sermons), and conservative Republican senators such as Jesse Helms represented a substantial constituency. The obvious exception to this rule was the state of Queensland where the National Party had been in power for twenty years with the backing of conservative rural voters. I have demonstrated how puritanical attitudes towards sexuality influenced the development of AIDS policy in this state. By the end of 1984, Tasmania was the only other state in which a conservative government presided, the Labor Party having won power in Western Australia, South Australia, New South Wales and Victoria. Given their shared traditions and ideological underpinning, these governments were willing to bestow a high level of trust in Blewett, and allowed him more power to co-ordinate a national strategy on AIDS than might have been the case had they been forced to deal with a Liberal- or National Party-dominated government in Canberra.⁷⁹ As Ballard points out, the availability of Commonwealth funds and the Commonwealth's control of access to the HIV-antibody tests also encouraged the states to collaborate and devolve power, as did the fact that AIDS was viewed as 'political poison' by governments facing elections.⁸⁰

The federal Labor Party had a distinguished history of intervening in matters concerning health which, under the Australian Constitution of 1901, fell under the jurisdiction of the states. In the early 1970s, for example, Gough Whitlam's government had established a national health insurance scheme against the strong opposition of a medical establishment

⁷⁹Ballard, 'Australia: Participation and Innovation', p.136.

⁸⁰John Ballard, 'The Politics of AIDS', in Heather Gardner (ed.) *The Politics of Health: The Australian Experience*, Melbourne: Churchill Livingstone, 1989, p.358.

that was committed to a user-pays system of health care. Subsequent conservative governments had whittled away coverage of the scheme, and Blewett's primary task during his first term in government was to revive the idea and implement a programme of universal health insurance and pharmaceutical subsidies.⁸¹ The initiative, named Medicare, threatened doctors' incomes, and was immediately challenged by a group of medical professionals opposed to the "socialisation of health" and the concomitant threat to medical control over fees and health policy.⁸² Blewett prevailed, although he was scarred by the battle. It taught him to be wary of doctors who claimed to always have the best interests of the community in mind. It also soured his relationship with Dr Bruce Shepherd, who led the doctors' bitter fight to maintain a fee-for-service system in New South Wales, leaving him predisposed to rejecting Shepherd's demand for the mandatory HIV-antibody testing of pre-surgery patients in the late 1980s. Indeed, the health minister's stern reply to the AMA's call for the "remedicalisation of AIDS" and Shepherd's accusation that the government had been captured by the 'gay lobby', left no doubt that he was still smarting from the wounds inflicted by Shepherd and his colleagues during 1983 and 1984.

The federal Labor Party combined its interventionist stance on health matters with a long-standing ideological commitment to promoting community participation in health policy.⁸³ Blewett's predecessor in Whitlam's government, for example, introduced the Community Health Program in 1973, which held that "services should be developed in consultation with, and, where appropriate, with the involvement of the community to be served".⁸⁴ This initiative fed into the women's community health movement of the 1970s that saw numerous women's community health centres established around Australia. The lasting legacy of this programme was the continuing support for community health centres in Victoria. As Dennis Altman has pointed out, it was not therefore surprising that the

⁸¹*Ibid.*, pp.135-6.

⁸²Paul Drielsma, 'AIDS Policy and Public Health Models: An Australian Analysis', *Australian Journal of Social Issues*, vol.32, no.1, 1997, p.89; Glenda Thompson, 'The Doctors Taking on Neal Blewett', *Bulletin*, 3 April 1984, p.32; and Jane Smith, 'Bitter and Black Days for Neal Blewett', *Bulletin*, 16 April 1985, pp.30-3.

⁸³Ballard, 'Australia: Participation and Innovation', p.137.

⁸⁴Interim Committee for the National Hospitals and Health Services Commission, *A Community Health Program for Australia*, Canberra: AGPS, 1973, cited in S.J. Duckett, 'Structural Interests and Australian Health Policy', *Social Science and Medicine*, vol.18, no.11, 1984, p.960.

Victorian Health Department, administered by a team of bureaucrats who were inspired by Whitlam in the 1970s and the principles of health promotion in the 1980s, supported the establishment of the Victorian AIDS Council and Gay Men's Community Health Centre as a response to AIDS in 1985.⁸⁵ Victoria was also the first state to employ two gay men, the VAC's Phil Carswell and Ian Goller, to work as project officers within its health promotion branch. They provided the means to co-ordinate AIDS policy with the gay community and gain its input into decision making. These initiatives were in step with Blewett's own preferences for community consultation, and provided a model for the other states to follow.

Blewett's resolve to work with community groups and develop community health solutions to the AIDS crisis was strengthened during an AIDS research trip to the United States and Britain at the start of 1985. He was met by a friend, Dennis Altman, in San Francisco who introduced him to a number of the key gay community AIDS organisations that were working in that city. He learned of the success that they were having with gay-funded peer-based education programmes, but also discovered first hand the effect of the Reagan administration's reluctance to finance AIDS prevention initiatives within the homosexual community. He spoke to frustrated AIDS workers, and toured medical facilities and hospitals with their rows of beds occupied by AIDS patients.⁸⁶ It was if Ebenezer Scrooge was being led by a ghost through the nightmarish streets of an AIDS future. Blewett returned to Australia determined to avoid a repetition of the US experience and the mistakes made by American politicians and legislators who were afraid to offend public sensibilities.⁸⁷

⁸⁵Altman, 'The Most Political of Diseases', p.64.

⁸⁶Bill Bowtell interviewed by Adam Carr, 19 May 1992, 'The Australian Response to AIDS' Oral History Project, National Library of Australia, TRC-2815/2, p.33.

⁸⁷His British counterpart, Norman Fowler, returned to Britain with similar resolve after a visit to San Francisco in 1986. Despite the conservative stance of his leader, Margaret Thatcher, which has been compared to Reagan's, Norman arrived home and within months announced a ten fold increase in his government's spending on AIDS for the next financial year. (John Street and Albert Weale, 'Britain: Policy-Making in a Hermetically Sealed System', in David L. Kirp and Ronald Bayer (eds), *AIDS in the Industrialized Democracies: Passions, Politics and Policies*, New Brunswick: Rutgers University Press, 1992, pp.194-6.)

The minister's observation of the way in which conservative senators in the US exploited the issue of AIDS, coupled with the National Party's attempt to use AIDS and the death of the Queensland babies as a weapon against the government, also convinced Blewett that he must gain bipartisan support for his strategy to combat AIDS. Blewett thus established a Parliamentary Liaison Group on AIDS in November 1985 which was comprised of members from each Australian political party. It provided the means to communicate accurate information about AIDS and to outline the advantages of community participation and explicit education programmes. Liberal Senators Peter Baume and Chris Puplick came on board immediately and, apart from a brief period in 1988 when the Shadow Minister for Health, Wilson Tuckey, added his voice to those calling for a return to 'proper' public health practices, Blewett was successful in maintaining bipartisan support for his strategy.⁸⁸

Blewett also sought support for an 'explicit' mass-media AIDS education campaign in 1987 and the revision of secondary school health education curricula to include discussion of homosexuality and safe sex. In this regard he was fortunate to have the backing of his cabinet colleagues and Prime Minister. Bob Hawke was already well regarded for allowing his ministers freedom to set and pursue their policy objectives, but he had a particularly good reason to trust Blewett due to his minister's skilful implementation of the potentially divisive Medicare scheme. As Bill Bowtell, Blewett's senior advisor, recalls,

[W]e were able to cash that chip in quite often because we had succeeded spectacularly well with Medicare and we had controlled the politics of AIDS...so there was no reason for [the cabinet and Prime Minister] to intervene on any other ground.⁸⁹

The Surgeon General, C. Everett Koop, Blewett's equivalent in the United States, could not claim similar support. He fought a losing battle against the Secretary of Education, William J. Bennett, to introduce pragmatic sex education classes in American elementary schools, and had difficulty in persuading President Reagan to publicly acknowledge the

⁸⁸Wilson Tuckey, 'The Politics of AIDS', address to the Third National Conference on AIDS, 4-6 August 1988, reprinted in *National AIDS Bulletin*, vol.2, no.8, September 1988, pp.45-7.

⁸⁹Bowtell, NLA, TRC-2815/2, p.59.

AIDS crisis or even mention the word "condom" in health promotion literature that was mailed to American households.⁹⁰

It is clear, therefore, that Blewett deserves the praise bestowed upon him by political commentators and doctors involved in the AIDS crisis. These commentators, however, generally overlook the role of Blewett's staff in developing AIDS policy and establishing the consultative mechanism that resulted in the partnership between government, medical professionals and community groups. Bill Bowtell, Blewett's chief advisor on AIDS, in particular, was instrumental in persuading Blewett to trust the AIDS Councils and to withhold absolute power from Penington's expert advisory committee.

Bowtell joined Blewett's staff six weeks after the Labor Party was elected. Both men were Political Science graduates of the University of Tasmania and knew each other already after meeting in Zimbabwe in 1980 while Bowtell was working with the Department of Foreign Affairs. Bowtell had been a member of the Labor Party for some twenty years and sought a position on Blewett's staff as an "unreconstructed Whitlamite" with the sole purpose of implementing Medicare.⁹¹ He was attracted to the issue of AIDS because he felt it was being neglected by other members of the department and because it provided "a bit of light relief from the daily strains of doing Medicare".⁹² His interest increased throughout 1984 as the scale of devastation in America began to emerge. As he recalled, his first instinct was to protect his minister:

I think the worst thing that can happen with a Minister for Health is that a large, unknown, new, infectious, hitherto undiscovered disease, bursts upon the unsuspecting nation while you're taking responsibility for it. You know, adverse political consequences.⁹³

⁹⁰Bayer and Kirp, 'The United States: At the Centre of the Storm', p.35.

⁹¹Bowtell, NLA, TRC-2815/2, p.2.

⁹²*Ibid.*, p.3.

⁹³*Ibid.*, p.8.

He thus began to avidly read the gay press and speak to his associates within the gay community, including the AAC's Lex Watson. Bowtell had met Watson – a vocal campaigner for homosexual law reform – in his former capacity as personal secretary to the New South Wales Attorney General. He respected Watson's political commitment and intellect, a respect which was enhanced as he observed the way in which the activist shunned the Sydney Blood Bank picket in May 1983 and sought negotiation with David Penington instead.⁹⁴ Although the outcome of those negotiations subsequently proved to be disastrous in terms of securing the blood supply, Bowtell was convinced that such consultation would need to continue if the co-operation of a frightened and distrustful gay community was to be secured. Bowtell also frequently spoke with the VAAC's Chris Carter, who was working as an advisor to Don Chipp, Leader of the Democrats, who held the balance of power in the Federal Senate and thus whose support Blewett needed to get Medicare passed by parliament. Carter kept Bowtell informed about the new developments in AIDS, and about the Melbourne gay community's response to the epidemic. He also provided the government with an example of a committed and responsible gay man whom they could trust, and a useful ally in the Democrats camp to help garner bipartisan support for the government's AIDS strategy.⁹⁵

It emerges, then, that whenever Blewett's confidence in community participation and empowerment waned, it was Bowtell who offered the arguments which saw it restored. This was never more important than at the time of the Queensland babies crisis when gay men were being vilified and Blewett was required to quickly establish a national advisory committee on AIDS in order to restore public confidence. He might have simply chosen to give Penington's NH&MRC Working Group on AIDS increased power, as was the advice of the Commonwealth's Chief Health Officer, David de Souza. Instead he was persuaded by Bowtell to commission a broad-based advisory committee comprised of medical experts, public health bureaucrats and representatives of the communities most affected by AIDS.

⁹⁴*Ibid.*, pp.11-12.

⁹⁵*Ibid.*, p.17. Bowtell was also acquainted with the VAAC's Phil Carswell, whom he knew and admired from his days as a student politician.

As Bowtell remembers, Blewett was electioneering in rural South Australia on the day of the announcement in Queensland and could not be contacted. He thus took the initiative of sketching a plan for an AIDS summit between the state health ministers and proposing membership of the national AIDS advisory council. Bowtell was keen to select people other than doctors because he believed that the advice of the Health Department's medical experts had frequently been deficient and that Penington's Working Group on AIDS had not been able to truthfully and calmly relate the facts about AIDS to the anxious public.⁹⁶ He wanted to establish a representative advisory body which would be chaired by a person with a high public profile and in whom the public felt trust. He wanted Ita Buttrose, editor-in-chief of the *Daily and Sunday Telegraphs* and publisher of a national women's magazine. He was keen on selecting a woman, because "women are much better at talking to families [and] ordinary voters and electors and people than are men", and decided upon Buttrose because she had frequently topped the polls as Australia's most admired woman.⁹⁷ An Australian rock band had even written a song about her titled "I believe in Ita". Blewett arrived home at 6 o'clock and took some persuading, but eventually agreed to the proposal. He then sought the blessing of the Prime Minister and telephoned Buttrose. By the end of the night she had agreed to head the new National Advisory Committee on AIDS.

If Bowtell's recollection is to be trusted, Penington and his colleagues were astounded and affronted by the proposal for them to become subordinate to a non-medical professional, a non-politician, an unashamed popularist, and a woman.⁹⁸ As Buttrose lived in Sydney, they were also concerned that decision making about AIDS would be removed from Melbourne, home of Penington, Gust and Fairfield Hospital. Through de Souza, they thus proposed that an AIDS Task Force be established separately from NACAIDS so that doctors could meet more frequently and talk about the technical aspects of AIDS. Blewett and Bowtell were eventually persuaded – "it was the silliest thing I ever agreed to" claimed Bowtell –

⁹⁶*Ibid.*, p.19.

⁹⁷*Ibid.*, pp.20-1.

⁹⁸*Ibid.*, p.27.

and left themselves open to having to deal with confrontation between the two committees, and two different approaches to public health, in the future.⁹⁹

Bowtell never regretted his decision to negate the power that Penington was trying to exercise, however. Indeed, in the years after the two advisory committees were established, he came to view the Task Force chairman with extreme distrust and malevolence – a view which undoubtedly influenced Blewett's opinion of Penington's medical model:

He is an extremely vain and egocentric person, and in most cases most untrustworthy. [He] was...one of the few people I met in politics who is capable of lying stupidly, that is, he could quite easily deny the next day that he had been told something when I'd been the person who told him, and he could tell it to your face. And you tended to eventually get to the way with Penington of saying 'Well, either he's insane, or I'm insane'. But he is a very bitter person and unhappy character all round.¹⁰⁰

Bowtell had less contact with Penington once he left Blewett's service before the 1987 Federal election to take up an advisory position with the Attorney General and Deputy Prime Minister, Lionel Bowen. Before doing so, however, he nominated himself for NACAIDS and subsequently worked on its Education Working Panel and the 'Grim Reaper' AIDS education campaign. He also joined a research trip to France, Britain, Switzerland, Canada and the United States in February and March 1987 which allowed him to see first hand the result of AIDS policies that were constrained by moralism. While overseas, he noted the rapid increase of HIV infection among injecting drug users, but was heartened by the early success of the Dutch needle and syringe exchange programme, which saw him send a cable to Blewett urging: "our highest priority would...seem to be a full review of our programs aimed at needle [sic] and drug users, and the development of protocols with the states to allow further needle distribution programs, subject to adequate

⁹⁹*Ibid.*, pp.26-7.

¹⁰⁰*Ibid.*, pp.60-1.

evaluation".¹⁰¹ Such needle and syringe exchange programmes, which I discuss in Chapter 7, became the key weapon in the fight to limit the spread of HIV infection among heterosexual men and women during the late 1980s.

Critics of the education-based model of AIDS control have been less eager than I to celebrate the role of Neal Blewett and Bill Bowtell in empowering the communities most affected by AIDS to contribute to, and indeed lead, the fight against AIDS. At various times, politicians such as Wilson Tuckey and doctors such as Bruce Shepherd, Fred Hollows, Ian Gust and David Penington have accused Blewett and Bowtell of being 'too close' to the gay community and looking after its interests instead of the health of the wider population.¹⁰² Bowtell certainly was close to the gay community; he was, in fact, a part of it, and more than one member of the AIDS Task Force has claimed that Blewett also had a sexual interest in men while Minister for Health.¹⁰³ Such accusations began at the time of the Grim Reaper campaign, which was interpreted by some doctors and media commentators to be an attempt to take the responsibility for AIDS off the shoulders of gay men.¹⁰⁴ They surfaced again in the late 1980s when Bruce Shepherd and a number of his AMA colleagues accused Blewett of being a stooge of the 'gay lobby', which resulted in the President of the Australian Association of Surgeons, Dr David McNicol, publicly accusing Blewett of being a homosexual in 1989.¹⁰⁵ The claims were made in the months following the tragic suicide of Blewett's wife, Jill. Blewett sued Shepherd, McNicol and a

¹⁰¹Cablegram to Neal Blewett from Bill Bowtell, 19 March 1987, NBAC/NAAC, ANU, H7/26.

¹⁰²Such criticism risks becoming entrenched in the historical record as recent evaluations of Blewett's ministry have repeated the doctors' claims. See, for example, Bob Browning, *Exploiting Health: Activists and Government vs the People*, Melbourne: Canonbury Press, 1992, pp.15-76.

¹⁰³Such accusations were made 'off the record' and I am not at liberty to disclose the identity of the former Task Force members.

¹⁰⁴Michael Gawenda, 'AIDS: Reaping Responsibility', *Age*, 2 May 1987, pp.1-2. Gawenda quoted an unnamed member of the AIDS Task Force who opined that the real agenda of the Grim Reaper campaign was to divert attention away from the gay community by exaggerating the risk of heterosexuals contracting AIDS. This had happened, the source asserted, because NACAIDS was "dominated by the gay community". In July 1987, Penington claimed that "There are people in the leadership positions in Australia who, without it being known, are gay or bisexual and have a firm commitment to aligning themselves with the gay community. I believe the minister is getting advice from these people." (John O'Neill, 'Gay Groups Twisted AIDS Campaign, Says Penington', *Sydney Morning Herald*, 11 July 1987, p.1.)

¹⁰⁵Bowtell, 19 May 1992, NLA, TRC-2815/2, p.73.

Canberra radio station for defamation and won \$125 000, although rumours about his sexuality continued to circulate until he left politics in 1993.¹⁰⁶ Seven years later, in an innocuous magazine profile, Blewett publicly announced that he was happily in love again, this time with a man with whom he had an affair at University in 1952.¹⁰⁷ He claimed that the escalation of this friendship was unexpected – it grew from the grief and loneliness that he experienced after the death of his wife – and that during his marriage spanning 25 years he had never considered a sexual relationship with another man or woman.¹⁰⁸ Bruce Shepherd and the Canberra doctor shall, no doubt, try to test this assertion in court.

During the time that they were speculating about Blewett's sexual orientation, it does not appear that the doctors ever concerned themselves with the question of why the Minister's sexuality should impair his judgement as a politician. Would Blewett's homosexuality confirm that he was a captive of the 'gay lobby' and involved in a conspiracy to protect the rights of homosexuals to the detriment of the health of all Australians? Bill Bowtell refutes this notion entirely. He maintains that his own sexual orientation had as much influence on his policy direction as his left-handedness and Tasmanian heritage – personal characteristics shared by a group of people whom he was not known to favour during his time in Canberra.¹⁰⁹ He claimed that he would have supported the 'test and contain' model, and encouraged the mandatory testing of gay men and possibly quarantine, if HIV had proved to be extremely infectious like typhoid or cholera. Quite simply, however, it was not.¹¹⁰ Bowtell clearly benefited from his discussions with Lex Watson, Chris Carter and Phil Carswell, but he met these men through professional circumstances rather than his social circle, and came to admire them for their intelligence and commitment to saving lives rather than their shared sexual interest in men. If Bowtell's sexuality in any way

¹⁰⁶*Ibid.*, pp.72-3. Also see Jane Cadzow, 'Neal Blewett: Survival of a Civilised Man', *Sydney Morning Herald (Good Weekend Magazine)*, 25 November 1989, pp.24-33.

¹⁰⁷Jane Wheatley (interviewer), 'Two of Us: Neal Blewett and Robert Brain', *Sydney Morning Herald (Good Weekend Magazine)*, 27 May 2000, p.14.

¹⁰⁸Monica Videnieks, 'I Didn't Lie About Sexuality: Blewett', *Australian*, 5 June 2000, p.2; Lawrence Money, 'When We Get Behind Closed Doors', *Sunday Age*, 9 June 2000, p.15.

¹⁰⁹Bowtell, NLA, TRC-2815/2, p.5.

¹¹⁰Bowtell, NLA, TRC-2815/2, p.6.

influenced his decision making process – and this may stand for Blewett as well – it was to remind him that not all gay men were preoccupied with sex, nor would they ignore the risks of AIDS and constantly cave into “strong and urgent” sexual desires. This fact clearly escaped a number of influential medical professionals.

Asked to summarise why he and Blewett came to favour the education and empowerment model of AIDS control, Bill Bowtell explained:

We believed in the common sense, the tolerance and goodwill of ordinary people to combat the disease, provided that they were informed quickly, factually and frankly about the virus. The story of Australia's response to HIV/AIDS is characterised by ordinary people taking responsibility for their own well-being and the health of their friends and family.¹¹¹

Australia's approach to AIDS differed from that of many countries because its policy makers believed that they could trust its citizens, regardless of the way in which some of them had been marginalised in the past. It is debatable whether this was because they believed “in the common sense, the tolerance and goodwill of ordinary people”, as Bowtell asserts, or that this was simply a pragmatic response to dealing with a virus that was deadly yet relatively difficult to transmit, and which was killing people who traditionally distrusted doctors and who had demonstrated their unwillingness to comply with legal restrictions regarding sexual and recreational practices. In any case, the responsibility in regard to AIDS demonstrated by the overwhelming majority of gay men and (as I shall demonstrate later) drug users and sex workers, proved that this trust was not misplaced, and should provide policy makers and public health authorities with a lesson for the future.

¹¹¹Bill Bowtell, ‘An Overview of the Relationship Between Research and Policy - Does Research Matter?’, address to a meeting of the Kettill Bruun Society, 20-24 January 1992, ACON archive, id: G1557.

Chapter 6.

"Is it safe to go bowling?": Reconsidering the 'Grim Reaper' AIDS Education Campaign

Despite the fervent activity of community-based AIDS organisations, doctors, researchers and advisory committees, the number of people diagnosed with HIV infection in Australia continued to rise between 1984 and 1987. And not all of them had used drugs, received blood transfusions or were men who had sex with other men. At least nine Australians had acquired HIV through vaginal intercourse with a heterosexual partner and had gone on to develop 'full blown' AIDS, and dozens more were thought to be infected but were without symptoms of illness.¹ The Red Cross Blood Transfusion Service had also intercepted three HIV-positive blood donations in 1986 that presumably came from 'low risk' heterosexuals, as individuals belonging to 'high risk' groups had been banned from giving blood.² It was obvious that the 'gay plague' was not confined to the homosexual community and that heterosexuals, too, would have to be warned about AIDS and become proficient in the art of safe sex if the epidemic was not to escalate in scale.

Evidence for the bi-directional transmission of HIV (from male-to-female and vice versa) had existed since 1982, when a significant number of women who did not admit to any 'high risk' practices were diagnosed with AIDS in the United States.³ It was suggested that these women had used intravenous drugs yet were reluctant to disclose such activity, just as Africans and Haitians were accused of being reluctant to admit to anal sexual practices when reports of their infection via 'heterosexual intercourse' were published in 1983.⁴ By

¹'Official AIDS Case Numbers', *Gay Health Update*, no.103, 7 August 1987, p.3; and Greg Hunter with David Penington, 'David Penington Interview', *Penthouse*, vol.7, no.12, 1987, p.97.

²Nick Crofts and Ian D. Gust, 'Screening Testing for Anti-HIV in Australian Blood Banks in 1986', *Medical Journal of Australia*, vol.146, 18 May 1987, p.556.

³Henry Masur, *et al.*, 'Opportunistic Infection in Previously Healthy Women: Initial Manifestation of a Community-Acquired Cellular Immunodeficiency', *Annals of Internal Medicine*, vol.97, 1982, pp.533-9; and Carol Harris, *et al.*, 'Immunodeficiency in Female Sexual Partners of Men with the Acquired Immunodeficiency Syndrome', *New England Journal of Medicine*, vol.308, 1983, pp.1181-4.

⁴'AIDS: The Heterosexual Connection', *New Scientist*, 1 December 1983, p.644; and N. Clumeck, *et al.*, 'Acquired Immune Deficiency Syndrome in Black Africans', *Lancet*, 1, 1983, p.642.

the middle of 1985, however, over 130 cases of HIV infection had been reported among American men and women whose only risk factor was vaginal intercourse. Most were spouses of people with AIDS or sexual partners of injecting drug users.⁵ Despite the bleak implications of these data, David Penington and members of Blewett's department did not become convinced of the need for the government to educate mainstream Australians about safe sex until they attended the Second International Conference on AIDS in June 1986, where they heard accounts of the rising rate of heterosexually-acquired HIV infection in Africa, Europe and the United States. By this time, there were over seven hundred American men and women suffering from HIV/AIDS contracted during unprotected vaginal intercourse. The US Surgeon General, C. Everett Koop, issued a report which (belatedly) pronounced that "education is the only cure we have".⁶ It became the mantra of Australia's first national AIDS education campaign aimed at the general population.

The National Advisory Committee on AIDS was entrusted with the task of co-ordinating the campaign. Before it could begin, however, it first had to ascertain the extent of the public's (mis)understanding of AIDS and the risks posed to sexually active heterosexual men and women. It commissioned a market research company to conduct more than 1500 face-to-face interviews with 'ordinary Australians' throughout the country. They were asked over 130 questions regarding their knowledge of AIDS, their attitudes to AIDS education and prevention programmes, and their own sexual and drug-taking practices. The research suggested that 36% of men and women aged between 16-24, and 33% of those aged between 25-34, were engaging in 'high risk' activity (defined as having anal sex, visiting a prostitute, or using intravenous drugs in the past year; engaging in male-to-male sex; or having multiple sexual partners in the previous three years without always using a condom).⁷ They were thus deemed to be in danger of contracting HIV. Incongruously,

⁵CDC, 'Heterosexual Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus', *Morbidity and Mortality Weekly Report*, vol.34, 20 September 1985, pp.561-3. Also see R.R. Redfield, *et al.*, 'Heterosexually Acquired HTLV-III/LAV Disease (AIDS-Related Complex and AIDS): Epidemiologic Evidence for Female-to-Male Transmission', *Journal of the American Medical Association*, vol.254, 1985, pp.2094-6.

⁶C. Everett Koop, 'Surgeon General's Report on Acquired Immune Deficiency Syndrome', *Journal of the American Medical Association*, no.256, 1986, pp.2783-9.

⁷National Advisory Committee on AIDS, 'Media Release, 5 April 1987', p.3, ACON archive, id: G0000956.

while 36% of the respondents believed that the HIV virus could be spread via casual contact including kissing, coughing and sneezing, and 24% believed that public toilets could transmit 'AIDS', most still viewed AIDS as a homosexual disease rather than a danger to themselves.⁸

It was clear that NACAIDS needed to reposition AIDS in the minds of the Australian public: to move perceptions of AIDS away from the media-fostered preoccupation with existing 'high risk' groups, and focus attention on the longer-term risk that HIV infection posed to heterosexuals, particularly the young and sexually active. It thus established a steering committee that included Ita Buttrose and Bill Bowtell, and enlisted the services of Grey Advertising, led by the precocious 22 year-old Simon Reynolds, to devise a campaign that would "shock Australians out of their apathy".⁹

The centrepiece of the \$3.63 million campaign was the 'Grim Reaper' television commercial. The commercial was so widely anticipated by the media, yet cleverly shrouded in secrecy, that, in the weeks preceding the launch, current affair television programmes and newspaper columnists were compelled to preempt what it might say. Most then proceeded to criticise the government for, they imagined, not being candid enough in its warning to the public.¹⁰ The commercial finally screened nationally on 5 April 1987, and provoked a month-long debate within all of the major Australian newspapers and current affairs programmes, not to mention considerable public discussion within community forums. All of this for a television commercial that, remarkably, screened for less than three weeks during April. NACAIDS expected that 80% of the

⁸Bill Taylor, 'The AIDS Campaign: Three Months On', unpublished report by the Communicable Diseases Branch, Commonwealth Department of Health, 1987, p.6; p.8, ACON archive, id: G6079. It should be noted that many respondents, like the report writer whose terminology I use here, failed to distinguish 'HIV', a virus which can be contracted and causes immune suppression, from 'AIDS', a syndrome of chronic opportunistic infections and diseases which debilitate a person's body once his or her immune system has been suppressed. As I shall discuss further on, this conceptual failure to distinguish HIV infection, which a person may 'live' with, and a syndrome from which a sufferer was likely to 'die', was perpetuated by the eventual campaign and was influential in shaping the public's perception of people living with HIV/AIDS as doomed.

⁹'Grim Reaper Ad "Out To Shock"', *Telegraph*, 7 April 1987, p.3.

¹⁰See, for example, the *Sunday* programme, Nine Network, 9 February 1987; and Phillip Adams, 'Killing Ourselves Out Of Coyness for the Facts on AIDS', *Weekend Australian Magazine*, 28-29 March 1987, p.2.

Australian population would watch the commercial at least five times during this period,¹¹ and subsequent academic surveys reveal that it became one of the most frequently recalled advertisements on television, and one of the most commonly recalled sources of information about AIDS.¹²

Nearly fifteen years after it was first shown, the imagery of the commercial remains vividly intact in the minds of many of those who saw it. It portrayed the medieval icon of Death, the Grim Reaper: a macabre scythe-carrying, skull-headed creature swathed in a black hood, bowling in a fog-filled, graveyard-like bowling alley (Figure 6.1). Instead of knocking over ten-pins, the creature struck down a set of stereotypical characters who represented the diversity of 'ordinary' Australians. One by one, a man in shirt-and-tie, a footballer, a little girl, a housewife and her baby (flung from her mother's arms) were knocked over in an attempt to illustrate that everyone was at risk of contracting the 'AIDS virus' (as it was called). The camera panned out towards the end of the commercial to reveal an entire graveyard full of Grim Reapers bowling people over and then celebrating, symbolising the way in which the 'AIDS virus' and death would proliferate and spread through a community that did not heed the Grim Reaper's warning.

On the surface, the purpose of the commercial seemed clear enough: to inform Australians that HIV did not discriminate between age, sex or gender; that sex, and promiscuous sexual activity in particular, was dangerous; and that prevention was the only method Australians had for combating AIDS. The type of preventative measures suggested by the voice-over in the advertisement included to have sex with only one partner, and "always use a condom, always". Critics noted, however, that it did not depict these prophylactic devices nor provide explicit information about the modes of HIV transmission and safe sexual

¹¹John Tulloch and Deborah Lupton, *Television, AIDS and Risk: A Cultural Studies Approach to Health Communication*, Sydney: Allen and Unwin, 1997, p.40. A mid-campaign evaluation of the commercial actually revealed that 97% of the people surveyed had seen the commercial at least once. See Taylor, 'The AIDS Campaign: Three Months On', p.11.

¹²Fiona Bray and Simon Chapman, 'Community Knowledge, Attitudes and Media Recall About AIDS, Sydney 1988 and 1989', *Australian Journal of Public Health*, vol.15, no.2, 1991, p.111. During the five months following 5 April 1987, the campaign also included the publication of large-format advertisements in ten high-circulation magazines on twenty-eight occasions and in daily newspapers on fifteen occasions. The Grim Reaper commercials were also shown in metropolitan cinemas for twelve weeks and periodically broadcast on radio.

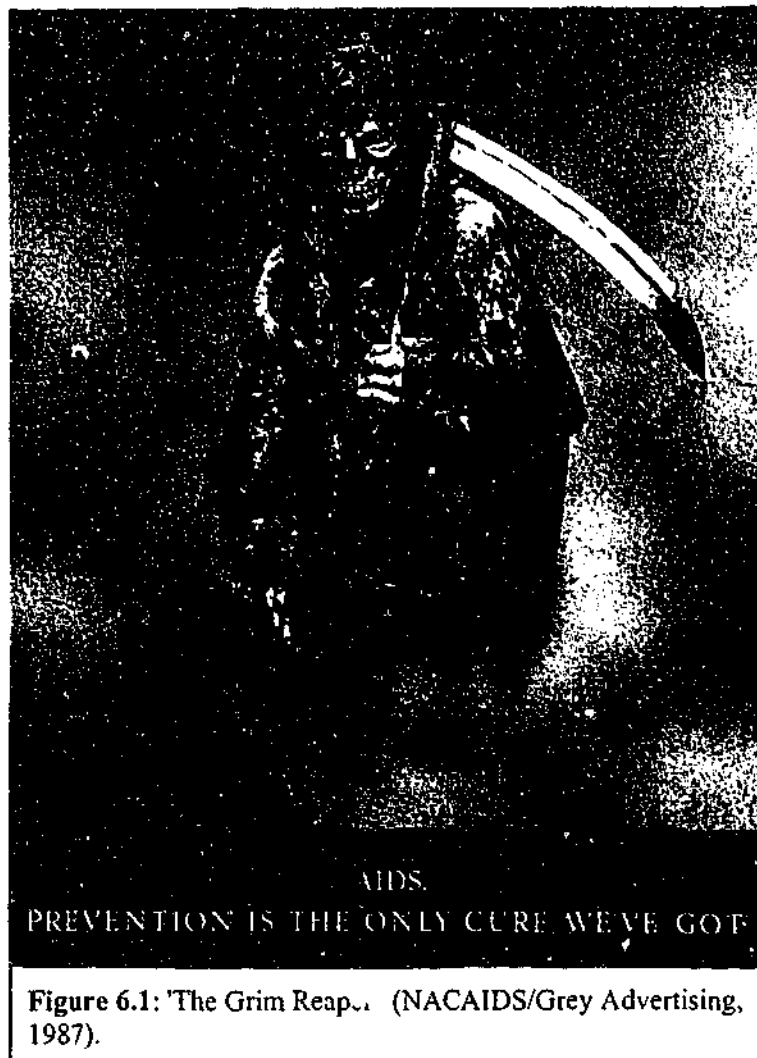


Figure 6.1: 'The Grim Reaper.' (NACAIDS/Grey Advertising, 1987).

practices. Newspaper columnist Phillip Adams, and AIDS Task Force members David Penington and Julian Gold, were also critical of the way in which the commercial exaggerated the risks posed by AIDS to heterosexual Australians. They took particular delight in attacking Buttrose's committee and the 'gay lobby', whose desire to remove the responsibility of AIDS from homosexuals was deemed to be the driving force behind the Grim Reaper's all-inclusive message. This criticism has generally been accepted as valid by cultural historians and communication theorists such as Raymond Donovan, Deborah Lupton and John Tulloch.¹³ Like Adams and some members of the AIDS Task Force, however, they fail to appreciate the constraints placed on the campaign by the social and political environment at the time. For example, they rarely acknowledge how difficult it was to talk about sex on prime-time television in April 1987, or consider the other aims of the campaign, such as the need to manufacture public support for increased AIDS funding and the introduction of explicit sex education in secondary schools. After consulting key members of the NACAIDS steering committee and Grey Advertising, and considering documents produced by these organisations – something which their critics have neglected to do – it becomes clear that the Grim Reaper served a political purpose that exceeded its usefulness as a public health campaign and should be judged accordingly. As I demonstrate in the first part of this chapter, it was successful in reshaping public and political attitudes at the time and ploughed the soil into which the seeds of more radical AIDS-prevention initiatives could be planted.

In the second part of the chapter, I turn my attention to more recent criticism of the Grim Reaper campaign that has emerged as part of a wider critique of state-sponsored health promotion initiatives.¹⁴ Deborah Lupton, for example, has condemned the "oppressive" nature of the Grim Reaper's "risk discourse" (that is, the message that everyone is at risk from AIDS), and the way in which it positioned the Australian government and NACAIDS as paternalist "panoptic agents" of sexuality:

¹³Raymond Donovan, 'Queered Bodies and Straightened Borders: Natur[at]ed AIDS in a Present and Anticipated Plague', *Journal of Interdisciplinary Gender Studies*, vol.2, no.1, 1997, pp.31-47, Deborah Lupton, *Moral Threats and Dangerous Desires: AIDS in the News Media*, London: Taylor and Francis, 1994; and Tulloch and Lupton, *Television, AIDS and Risk*, *passim*.

¹⁴See, for example, Alan Petersen and Deborah Lupton, *The New Public Health: Health and Self in the Age of Risk*, Sydney: Allen and Unwin, 1996.

Risk discourse in the public health sphere serves the ideological function of allowing the state, the owner of knowledge, to exert power over the bodies of its citizens. In the case of AIDS, the state has taken on the role of ultimate producer of knowledge/science and health in its efforts to 'educate' the 'carnally ignorant' population. In Australia in 1987 the metaphors AIDS IS HETEROSEXUAL, AIDS IS A MONSTER, AIDS IS AN APOCALYPTIC DISASTER, SEX IS DANGER and HEALTH EDUCATION AS WEAPON were used both by government officials and journalists to justify attempts to incite widespread panic, anxiety and fear among Australians, and the adoption of a paternalistic disciplinarian role in order to enforce 'correct' bodily deportment...Risk discourse in the control of AIDS, therefore, serves as an effective panoptic agent of surveillance and control that is difficult to challenge.¹⁵

As Lupton explains elsewhere,¹⁶ her analysis is based on the ideas of Michel Foucault, who coined the analogy of the 'Panopticon' to explain the way in which power operates in modern society. The Panopticon was a radical nineteenth-century prison design that encouraged those incarcerated to discipline their behaviour due to the ever-present possibility that they were being observed by an external agent. Prison authorities thus did not need to resort to physical coercion to obtain the co-operation and 'correct bodily deportment' of prison inmates. Foucault contends that, in a modern society, power operates in a similar way; that is, not through repression, violence or blatant control (as in a typical prison), but instead through the creation of expert knowledges about human beings which serve to channel or constrain thinking and action.¹⁷ Applying this idea to the realm of public health and AIDS, Foucauldian scholars claim that the State, working through its public health authorities, encourages its citizens to discipline their sexual behaviour by

¹⁵Deborah Lupton, 'AIDS Risk and Heterosexuality in the Australian Press', *Discourse and Society*, vol.4, no.3, 1993, pp.324-25.

¹⁶Petersen and Lupton, *The New Public Health*, p.xiii.

¹⁷See Michel Foucault, *Discipline and Punish: The Birth of the Prison*, trans. Alan Sheridan, London: Penguin, 1977, especially pp.200-28.

demanding that they comply with the expert knowledge ('risk discourse') about HIV transmission that the State has constructed. Individuals thus keep themselves and their sexual partners under surveillance and modify their behaviour to conform with the wishes of the State. They are, effectively, 'governed at a distance'.¹⁸

In terms of the events of 1987, Lupton contends that the Grim Reaper campaign and the associated media debate (which, she believes, baldly repeated the Grim Reaper's message), was less about protecting the public's health than normalising sexuality; that is, encouraging men and women to discipline their sexual behaviour and adopt abstinence or monogamous relationships. Despite her keen reading of the Grim Reaper text and a comprehensive survey of the mainstream news media, Lupton's argument is problematic in a number of ways. As I demonstrate in the first part of my chapter, she understates the opposition to NACAIDS' 'everyone is at risk' line and ignores the fact that Adams and Penington, among others, provided an alternate 'risk discourse' for 'low risk' Australians to consider. Second, while claiming that the "risk discourse...[was] difficult to challenge", Lupton neglects to investigate whether or not this was true in practice. An analysis of 'active' audience responses to the Grim Reaper commercial and a survey of sexual behaviour in the late 1980s, for example, indicates that homosexual and heterosexual Australians resisted the notion that they were all equally at risk and that their salvation lay in celibacy or monogamy. Finally, Lupton declines to posit an alternative to "oppressive" state-sponsored health promotion campaigns which designate risk and encourage lifestyle modification. This is perhaps unacceptable at a time in which millions of people throughout the world are becoming infected with HIV every year. Inevitably, AIDS is real and not a discourse. And it kills. A government that does not warn its citizens of this fact or advise them of methods of protection is a very negligent government indeed.

¹⁸For a more explicit analysis of the way in which individuals are 'governed at a distance', see Michel Foucault, 'Technologies of the Self', in Luther H. Martin, Huck Gutman and Patrick H. Hutton (eds), *Technologies of the Self: A Seminar with Michel Foucault*, London: Tavistock, 1988, p.16-49; and Nikolas Rose and Peter Miller, 'Political Power Beyond the State: Problematics of Government', *British Journal of Sociology*, vol.43, 1992, pp.173-205.

The earliest and most pervasive criticism of the Grim Reaper campaign was that it failed to provide explicit information about safe sexual practices and the use of condoms.¹⁹ It was noted, for example, that the initial AIDS prevention brochures in the Netherlands were accompanied by a television programme in which a young couple offered a very explicit demonstration of appropriate condom use; while they were mentioned, condoms were never shown – never mind explicitly demonstrated – during the Grim Reaper campaign. Ita Buttrose offered a pragmatic reason for this, namely that NACAIDS wanted the commercial to be given a PG rating so that it could be shown between 7:30pm and 8:30pm.²⁰ Given that condom advertising had been banned on commercial television until the end of 1986 (when it was then confined to late-night timeslots), and that supermarkets were still resisting the display and sale of condoms due to their belief that this would cause offence to the public, her caution was understandable. The Dutch were certainly considerate of public sensibilities and, anticipating resistance, screened their programme late at night. Remarkably, however, most complaints about the programme concerned its late broadcasting hour and it was subsequently repeated at an earlier time.²¹ While the Australian public may have been similarly tolerant, NACAIDS was dealing with commercial television stations which imposed particularly stringent sexual standards. It was even forced to re-shoot its follow-up AIDS prevention commercial titled 'Beds' (Figure 6.2) because it included two men tenderly embracing in a bed despite the fact that their flesh was covered by sheets and a blanket.

As for claims that the Grim Reaper did not specify which kinds of sexual practices were safe, the commercial clearly identified the two most practical ways in which Australians could protect themselves. It advocated sex with one safe partner and the use of condoms, both of which are still the primary means of protection offered by AIDS educators today. In any case, it was never the intention of NACAIDS and Grey Advertising to 'overload' the audience with too much information. The Grim Reaper campaign was designed to

¹⁹See, for the example, Peter Couchman [reporter], 'Raging On' [report], *Four Corners*, ABC TV, 8 February 1988.

²⁰Ita Buttrose, 'Media Release: Speech by Miss Ita Buttrose, ACON archive, id: G0000961.

²¹Gero Kok, Lilian Kolker, Ernest de Vroome and Anton Dijker, "'Safe Sex" and "Compassion": Public Campaigns on AIDS in the Netherlands', in Theo Sandfort (ed.), *The Dutch Response to HIV: Pragmatism and Consensus*, London: UCL Press, 1998, p.26.



Figure 6.2: 'Beds' TV commercial from NACAIDS' second mass-media AIDS prevention campaign, December 1988.

shock Australians and to stimulate their desire to learn more about the disease. Buttrose promised that this initial phase of the campaign would be followed by "more explicit" information, and a new set of advertisements about safe sex and condoms was scheduled to screen in June 1987.²² Australians did not see them for another eighteen months, however, which provoked a second round of critical questioning: why did the crucial follow up advertisements take so long to arrive?

Peter Couchman, a highly-credible journalist working for the influential ABC TV programme *Four Corners*, provided three explanations. First, the Grim Reaper "assault phase" of the campaign had cost so much money that the government simply did not have the funds to televise any more commercials. Second, "bureaucratic confusion" reigned and no one could agree on what was now required. Finally, and most provocatively, Couchman asserted that the campaign had never been planned to occur in stages – as claimed by Buttrose and Siimon Reynolds – but was merely "a knee jerk reaction to the AIDS scare". The government simply wanted to be seen doing something about AIDS without having to spend money on the problem. Once the Grim Reaper had stimulated an audience response and was receiving 'free' exposure in the news media, Couchman claimed, the government felt absolved of the responsibility to provide any more information about AIDS.²³ Couchman's argument was compelling given his fine reputation (and that of the programme), and more than a year later it was repeated in a journal article written by John Tulloch, a lecturer in communications at the University of New South Wales.²⁴

Understandably, Neal Blewett was outraged by the report and sent a letter to the Managing Director of ABC TV and his fellow members of parliament outlining the "gross inaccuracies and distortions" of the programme.²⁵ Pointing to figures from recent Federal

²²Ita Buttrose, 'Media Release: Speech by Miss Ita Buttrose', p.5, ACON archive, id: G0000961; and 'Confidential Report of NACAIDS Meeting (23 April 1987) to AFAO Delegates', from Phil Carswell, AFAO delegate to NACAIDS, NBAC/NAAC, ANU, H9/82.

²³Peter Couchman, 'Raging On' [report], *Four Corners*, ABC TV, 8 February 1988.

²⁴John Tulloch, 'Australian Television and the Representation of AIDS', *Australian Journal of Communication*, no.16, December 1989, pp.101-2.

²⁵'Circular to all Senators and MPs, copy of concerns recently expressed by Neal Blewett to the Managing Director ABC TV', c.1988, NBAC/NAAC, ANU, H19/28.

budgets which indicated that Commonwealth funding for AIDS had increased four-fold between 1984/5 and 1987/8, he argued that the government was clearly committed to the fight against AIDS.²⁶ As for claims that the AIDS prevention campaign was poorly organised and failed to provide specific information about AIDS and sex, Blewett noted that the actual Grim Reaper commercial, including TV and cinema placement, cost only \$850,000, and not “nearly \$3.5 million” as was claimed by *Four Corners*. A further \$1.65 million was spent on providing additional educational material – such as pamphlets, radio and newspaper advertisements, posters and magazine inserts – that explained the Grim Reaper’s warning in greater detail but less alarming tones. NACAIDS had also struck a deal with a cinema company to promote the message of ‘safe sex’ during the screening of the new James Bond film *The Living Daylights*. Reflecting the public paranoia about AIDS, the film featured the famous secret agent discussing safe sex and toning down his notorious sexual promiscuity, and NACAIDS took the opportunity to provide information booklets about AIDS and sex in the foyers of Hoyts cinemas where the movie screened. All of this information had been supplied to *Four Corners*, which declined to use it. Acting chairman of NACAIDS, Ron Penny, was also interviewed for the programme, yet his testimony was omitted from the finished report.²⁷ One might query whether these strategies were likely to be more effective than a second round of television commercials, but one cannot accuse the Commonwealth government and NACAIDS of launching an inadequate, ill-conceived or politically expedient campaign.

Speculation about the inadequacies of the campaign’s supplementary materials removes our attention from the most damning criticism of the Grim Reaper commercial: that it unnecessarily scared ‘low risk’ heterosexuals into submitting to HIV-antibody testing and the adoption of monogamy or celibacy. Phillip Adams was a leading protagonist in this respect. In his popular weekly column in the *Australian* newspaper, for example, he asserted:

²⁶Federal funding for AIDS actually increased from \$5.1 million in 1984/5 to \$8 million in 1985/6, to \$11.6 million in 1986/7, and to \$20.5 million in 1987/8.

²⁷‘Circular to all Senators and Members of Parliament: copy of concerns recently expressed by Neal Blewett to the Managing Director ABC TV’, c.1988, NBAC/NAAC, ANU, H19/28.

Having talked to epidemiological authorities, I believe that the chance of catching AIDS through normal (that is, non-anal) sexual intercourse is very low. To suggest otherwise is to market a monstrous lie and to inculcate fears and guilts that may, in the long haul, be as damaging as the virus itself...Having just struggled out of the dark ages of sexual repression, we now seem determined to turn the next generation into what an angry AIDS researcher describes as sexual cripples.²⁸

The instigator of the "monstrous lie" was NACAIDS, and, in particular, its chairwoman who was reported to have proclaimed:

Abstinence is the best way to stop the spread of AIDS. Fidelity in marriage is vital – so are one-to-one relationships. The message that must be absorbed is: if you don't know where your partner has slept before he or she sleeps with you, then don't. If temptation is too hard to resist, then use a condom.²⁹

Despite her acceptance that promiscuous sex with condoms was permissible, Adams was furious that Buttrose was addressing heterosexuals in such a puritan tone and proceeded to satirise her stance in a series of articles which culminated with "a hot parade of songs for solo singing". Mimicking Ita's prominent lisp and her well-known preference for "radical celibacy", Adams crooned to those whom, he suspected, had resorted to masturbation in fear of 'catching AIDS':

Catching AIDTH jutht ithn't nith
Don't want to get thlithed
By the man with the thythe
Tho don't rithk ditheath
Or a broken heart

²⁸Phillip Adams, 'Killing Ourselves Out Of Coyness for Facts on AIDS', *Weekend Australian Magazine*, 28-29 March 1987, p.2.

²⁹Chris Thomas, 'It's Ita's AIDS Remedy: Say No', *Sydney Morning Herald*, 6 April 1987, p.1.

Give up thekth
Before you thtart³⁰

Rather than urging heterosexuals to take precautions, Adams wanted the focus of AIDS prevention to remain firmly fixed on homosexuals and anal intercourse, which was "the commonest way of transmitting HIV and was therefore the principal cause of the AIDS epidemic".³¹

Adams' view echoed – and, indeed, may have originated in – the opinion of AIDS Task Force members David Penington, Julian Gold and Ian Gust. Despite the fact that Penington had approved the content of the commercial before it was first screened, a point which he denies, the Task Force chairman issued a strong call for the commercial to be withdrawn on the grounds that it was frightening people who were at little or no risk of contracting HIV. Quite simply, he stated, "even those heterosexuals who had multiple sexual partners and practised anal sex did not face the same risk as a homosexual man with the same habits because of the much lower level of seropositivity among the heterosexual population".³² Penington was supported by the *Age* newspaper, which published an editorial on 12 May 1987 mirroring his position, and by Julian Gold, who was upset that his AIDS clinic was forced to cope with a dramatic increase in 'low risk' individuals requesting HIV-antibody tests after the Grim Reaper first appeared.³³ Reflecting on these events some years later, Ian Gust labelled the campaign "incredibly misleading" and suggested that if "it was an

³⁰Phillip Adams, 'A Hot Parade of Songs for Solo Singing', *Weekend Australian Magazine*, 1-2 August 1987, p.2.

³¹Phillip Adams, 'Killing Ourselves Out Of Coyness for Facts on AIDS', *Weekend Australian Magazine*, 28-29 March 1987, p.2.

³²Hunter with Penington, 'David Penington Interview', p.100. Dr Simon Chapman, lecturer in Community Medicine at the University of Sydney, suggested that "for a large proportion of the population the risk of HIV infection is comparable to the chances of dying in an airliner crash, by shark attack at the beach or during other low-risk but potentially deadly activities". See Bray and Chapman, 'Community Knowledge, Attitudes and Medical Recall About AIDS', p.113. Also see Simon Chapman, 'The AIDS Myth That Will Not Die', *Sydney Morning Herald*, 19 June 1990, p.13.

³³Andrew Morlet, *et al.*, 'The Impact of the Grim Reaper National AIDS Education Campaign on the Albion Street (AIDS) Centre with AIDS Hotline', *Medical Journal of Australia*, vol.148, no.6, 1988, pp.282-6.

advertisement for a product, [NACAIDS] could have been prosecuted under the Trade Practices Act".³⁴

The doctors were, of course, correct. NACAIDS over-estimated the risk to most heterosexuals who, unlike gay men, were very unlikely to ever meet an HIV-positive individual never mind share needles or have sex with that person. It was odd for members of the Task Force to criticise NACAIDS for erring of the side of caution, however, when at the same time they were admitting to making "a mistake" by not immediately banning all gay men from donating blood in 1983. As Ian Gust told the *Age's* Michael Gawenda in April 1987: "we, as public health workers, should have acted according to the worst-case scenario rather than the best".³⁵ The doctors were also aware of the AIDS epidemic among heterosexuals which had quickly developed in the United States after the Reagan administration ignored the threat, and were familiar with recommendations of the World Health Organisation which urged all countries to actively promote the risk of AIDS to heterosexuals.

Gawenda's two page feature article reveals why the doctors were so eager to criticise NACAIDS and thus risk undermining the Commonwealth government's first, and most important, AIDS education campaign. It contains statements by an unnamed source within the Task Force who expressed his anger at the way in which power had been invested in NACAIDS and community-based groups at the expense of medical professionals. These organisations were governed by a "homosexual agenda", the source claimed, and did not have the best interest of the public's health foremost in their mind:

The committee that Ita Buttrose chairs is dominated by the gay community, and what the advertisement is designed to do is to take pressure off and to say AIDS is everyone else's problem. They don't want it to be identified as a gay problem.³⁶

³⁴Ian Gust interviewed by Stewart Harris, 12 July 1993, 'The Australian Response to AIDS' Oral History Project, NLA, TRC-2815/28, pp.11-12.

³⁵Ian Gust quoted in M. Gawenda, 'AIDS: Reaping Responsibility', *Age*, 2 May 1987, p.2.

³⁶M. Gawenda, 'AIDS: Reaping Responsibility', *Age*, 2 May 1987, pp.1-2, p.2.

Ian Gust had used words to this effect in private conversations with Bill Bowtell, and David Penington, in an editorial of the *Medical Journal of Australia*, also implied that gay men were mainly interested in protecting their civil rights (such as the right not to be tested) which were threatened whilst they remained the primary 'high risk' group.³⁷ In July 1987, Penington also claimed in the *Sydney Morning Herald* that gay groups had manipulated the federal government into pursuing an inappropriate AIDS campaign "to protect their fast-lane lifestyles".³⁸ By criticising the education campaign and the "gay domination" of the Commonwealth's chief advisory committee, the doctors thus strengthened their case for primacy to be given to traditional methods of infectious disease control, and for high risk groups to be subjected to testing. This was certainly the case in Queensland where, as I mentioned in my previous chapter, the Minister for Health criticised Buttrose's "gay dominated" committee in order to justify his government's 'medical' approach to the control of AIDS and its refusal to distribute educational materials produced by NACAIDS.

The doctors' suspicions about the production of the Grim Reaper campaign were unfounded, however. As Marcia Neave, Professor of Law and long-serving NACAIDS member, pointed out, the gay community simply did not have the power nor the opportunity to influence the development of the campaign. The gay-based AIDS Councils had only two official representatives on the 14 member National Advisory Committee on AIDS, and at any one time no more than three homosexuals sat on NACAIDS (if one was to include men such as Bill Bowtell who represented Blewett's office).³⁹ These men did not always agree with each other – as shown by the feud between Queensland's Bill Rutkin and the other AIDS Council Presidents over the issue of HIV-antibody testing – and it was

³⁷David Penington, 'The AIDS Epidemic – Where Are We Going?', *Medical Journal of Australia*, vol.147, 21 September 1987, p.265.

³⁸John O'Neill, 'Gay Groups Twisted AIDS Campaign, Says Penington', *Sydney Morning Herald*, 11 July 1987, p.1. More than a year later, the *Bulletin's* Glennys Bell repeated these assertions in a scathing attack on the Commonwealth government's education- and community-empowerment approach to AIDS Control. See, for example, Glennys Bell, 'Questions Still To Be Answered', *Bulletin*, 30 August 1988, pp.54-5.

³⁹Letters to the Editor (Marcia Neave), *Ap* . 8 May 1987, p.8. Bowtell was also the only openly gay man on the NACAIDS five-person steering committee that gave final approval to the Grim Reaper campaign.

unlikely that they had the charm or ability to persuade the other eminent committee members such as Professor Neave and Professor Ron Penny to deny their better judgment. They certainly were not in the position to influence the World Health Organisation or Margaret Thatcher's Conservative government in Britain, which were also promoting the threat of AIDS to heterosexuals in apocalyptic tones.

If gay men lacked the power and opportunity to influence the content of the Grim Reaper campaign, they also lacked the motive. As VAC President Adam Carr argued in July 1987, it was simply not in the best interests of homosexuals for NACAIDS and the government to divert attention from their plight and spend millions of dollars educating heterosexuals when this money might be used more effectively to fund smaller-scale gay community-based educational initiatives:

The gay community, with its steadily mounting caseload and increasingly overstretched volunteer and staff resources, has been crying for help from the community, and using every means at its disposal to draw public and media attention to the fact that AIDS is severely affecting gay men. The last thing we want is to see public attention and government support diverted from our community and facilities.⁴⁰

These facts were overlooked by medical experts who felt slighted for not being consulted about the content of the campaign (even though their input was sought), and who felt that their power to dominate the direction of AIDS policy, and public health ideology, was being eroded.⁴¹

⁴⁰Adam Carr, 'The Victorian Gay Community and Its Role in the Fight Against AIDS', address to the Australian Institute of Political Science Seminar, 'AIDS - Public Health, Morals and Civil Liberties', 28 July 1987, NBAC/NAAC, ANU, H9/99; reprinted in 'No "Gay Conspiracy", Says VAC President', *Gay Health Update*, no.103, 7 August 1987, pp.2-3.

⁴¹Both Julian Gold and David Penington were consulted about the content of the campaign, despite the former complaining on the Nine Network's *Sunday* programme that his advice had not been sought. After the programme aired on 8 March 1987, Buttrose sent a letter to Gold which tersely reminded the Albion St Clinic director: "I wrote to you on February 12, inviting you to let me have your views on the education campaign, after failing to reach you because of your unavailability on the phone...I wish you'd mentioned to *Sunday* that in actual fact your non-involvement in the education campaign was of your own choosing and not NACAIDS." (Letter to Julian Gold from Ita Buttrose, 9 March 1987, NBAC/NAAC, ANU, H7/22.)

NACAIDS' defence of its impartiality does not, of course, absolve it from the charge that the Grim Reaper *unnecessarily* frightened perhaps millions of 'low risk' heterosexuals, which potentially led them to become "sexual cripples". This criticism remains valid, however, only while one fails to consider the political imperatives of such a campaign and the complex set of aims which the 'Grim Reaper' was trying to achieve but never explicitly expressed. For instance, at a time in which the government was curtailing public expenditure and the community was reluctant to express its desire for explicit education concerning sexual health, NACAIDS saw the need to manufacture a sense of public urgency that would compel the Commonwealth and state governments to take action on AIDS. As Bill Bowtell recalls, the Grim Reaper was extremely important in shaping the government's spending priorities:

Governments, by and large, particularly a Government at that stage that was cutting back and trimming and reducing government expenditures, will not be easily persuaded about putting more funding into AIDS if there was no problem at hand. You had to create a climate of public opinion which demanded of the government that it do something and provide funding.⁴²

The Grim Reaper was thus timed for the beginning of the budget cycle when Ministers on the Expenditure Review Committee met to discuss the government's spending priorities. Given the public concern and sense of fear aroused by the campaign, it is not surprising that they were able to agree that money needed to be spent on AIDS before thousands of lives were lost.

Bill Bowtell also points out that the urgency fostered by the Grim Reaper campaign was extremely important in persuading the state governments to accept and implement controversial AIDS prevention initiatives such as needle and syringe exchange programmes and sex education in secondary schools.⁴³ There had, for example, been

⁴²Bill Bowtell interviewed by Adam Carr, 19 May 1992, 'The Australian Response to AIDS' Oral History Project, NLA, TRC-2815/2, p.54.

⁴³*Ibid.*

unarticulated support for direct and explicit education prior to the campaign, but it was not until the Grim Reaper appeared that questions were openly raised about the lack of comprehensive AIDS education in secondary schools. The sense of fear within the community that the campaign elicited thus provided state governments with a clear mandate to proceed with the inclusion of education about HIV/AIDS in the school system.⁴⁴ Crucially, this was also the case in Catholic schools, which had been particularly reluctant to provide pragmatic information about sex and AIDS. In the month after the Grim Reaper campaign began, more than four out of five Catholics surveyed in an *Age* poll stated their desire to see their schools provide information about AIDS and sex; three out of five wanted this education to begin in Grade 6! Ten years before, only three in five approved of any form of sex education in Catholic classrooms.⁴⁵

Despite the misgivings of the AIDS Task Force and some journalists, there were other tangible benefits of disseminating a message that everyone was at risk from AIDS. For example, the Grim Reaper provided a means to communicate with men-who-had-sex-with-men but who did not identify as gay or bisexual. While clearly at 'high risk', these men considered themselves to be immune from the effects of the epidemic because their affairs with males were generally sporadic and occasional.⁴⁶ Suspected to be the 'bridge' over which HIV would cross from the homosexual community to heterosexuals, they needed to be targeted through a hard-hitting mass-media campaign because they rarely participated formally in the homosexual community and were thus difficult for gay educators to reach. The Grim Reaper also spoke to owners of brothels, and the men who frequented them, who were encouraged to insist on the use of condoms during sex with prostitutes. The Sydney STD Centre, for example, noted "a marked change in attitudes by managers of brothels, and to a lesser extent by the clients of prostitutes, apparently in response to the educational

⁴⁴Margaret Winn, 'The Grim Reaper: Australia's First Mass Media AIDS Education Campaign', in World Health Organisation (ed.), *AIDS Prevention Through Health Promotion: Facing Sensitive Issues*, Geneva: WHO, 1991, p.35.

⁴⁵Peter Stephens, 'Fear of AIDS Has Forced Changes to Sexual Attitudes, Survey Finds', *Age*, 4 May 1987, p.5. The poll surveyed 2000 registered adult voters drawn from each of the Federal electoral districts.

⁴⁶SBS television screened a documentary in 1993 which interviewed a number of men who fell into this category. See Annabelle Murphy [writer and director], 'Manly Desires' [episode of the *Youth Express* series], SBS TV, Melbourne: Kitaron Productions, 26 minutes, 9 December 1993.

campaign about AIDS. Very many prostitutes have told us that a large number of managers at this time began to encourage the use of condoms on their premises, where previously they had discouraged them, and that the majority of clients now accept that condoms are necessary."⁴⁷ While sex worker collectives were providing information directly to prostitutes, it was the Grim Reaper campaign that convinced brothel owners and managers, who may have personally been at 'low risk', to regulate 'high risk' activity in their establishments.

Clearly, then, the scare tactics employed in the Grim Reaper campaign and its 'exaggerated' message of risk enabled NACAIDS and the Commonwealth government to fulfill a range of crucial political and public health objectives. But what of its impact on the sexual behaviour of 'ordinary' Australians: did it turn them into "sexual cripples" as Phillip Adams and his medical friend feared, or lead to a revival in 'old fashion virtues', such as monogamy and celibacy, as numerous newspaper reports proclaimed? These are important questions if one is to be convinced by Deborah Lupton's argument, outlined above, that the Grim Reaper "serve[d] as an effective panoptic agent of surveillance and control" that attempted to regulate the sexual expression of Australian men and women.

If the 'risk discourse' disseminated by the Grim Reaper and the associated media reporting had an oppressive effect on sexual expression, one might assume that this would have been reflected in the way in which Australians conceptualised and experienced sex after the campaign. After all, the commercial intimated that sex had led Australians down the bowling alley of death, where their permissive attitudes towards sex and sexuality had set them up like ten-pins waiting to be struck down by a new and deadly virus. As Lupton demonstrates, the mainstream news media was keen to develop this theme by printing stories with titles such as 'Promiscuity Now A Dirty Word',⁴⁸ 'Time To Talk About Making Morals Respectable Again',⁴⁹ and 'Back To Old Virtues'⁵⁰ in the lead-up to, and

⁴⁷Chris Harcourt, Jan Edwards and Ross Philpot, 'On the "Grim Reaper" Campaign', *Medical Journal of Australia*, vol.149, 1 August 1988, p.163.

⁴⁸*Canberra Times*, 18 March 1987, p.12.

⁴⁹*Age*, 31 March 1987, p.9.

⁵⁰*Daily Sun*, 7 April 1987, p.14.

during, the Grim Reaper campaign. A *Weekend Herald* editorial preached: "we are being damned by a terrible disease caused by unmitigated sexual lust",⁵¹ while the editor of Adelaide's *Advertiser* assured readers that "old-fashioned fidelity, with or without marriage, or no sex at all, is once again the way to stay out of trouble".⁵² Salvation, it seemed, lay in Australians taking heed of the risk discourse disseminated by NACAIDS and the press, and disciplining their sexuality to conform with a 1950s version of family values.

On the whole, however, they did not. In only focusing on the language of risk discourse at the site of its production – in this case, the TV commercial and newspaper reports – rather than the subtle ways in which people were reacting to it or 'using' it, Lupton and other commentators have tended to downplay the fact that many people targeted by the risk discourse resisted it or simply misunderstood the message. Far from accepting that 'everyone is at risk from AIDS because of the permissive sexual attitudes of Australians' and offering themselves up for (self-) surveillance and control, the gay community frequently displayed an ability to turn the oppressive nature of risk discourse against itself and reveal it for what it was. 'Mainstream' society can also be examined for its resistance to 'risk', although this resistance manifested itself in different ways. Sometimes it merely constituted the inability of men and women to reconcile the range of competing and contradictory discourses about AIDS, sex and risk that were circulating at the time. Adams and Penington provided just one of these 'counter' discourses. Lupton, however, overlooks the effect of their contribution to the debate about AIDS and universal risk.

The homosexual community was the least likely social group to be persuaded to accept a 'return to old virtues'. It had been facing up to the AIDS epidemic longer than the rest of Australian society and was already proficient in informing itself, via the gay press and the AIDS Councils, about how to prevent the spread of HIV. As articles and advertisements in gay publications such as *Outrage* and *Campaign*, and floats and theatrical events in the Sydney Gay and Lesbian Mardi Gras festival, clearly demonstrate, sex and alternative

⁵¹Editorial, 'AIDS: Could It Be Just The Jolt We Need?', *Weekend Herald* (Melb), 13-14 December 1986, p.9.

⁵²Editorial, 'The Morality of AIDS', *Advertiser*, 26 March 1987, p.10.

forms of sexuality were still to be celebrated and permitted as long as it was done safely. The message of an intensive campaign that encouraged condom use was infiltrating the gay community, and life-size plastic prophylactics found their way onto floats parading down Oxford Street and into safe sex posters and videos which were displayed and projected in gay social venues. While the SAPA survey of 1986-87 indicated that some gay men had begun to work at maintaining monogamous relationships and a small minority had given up sex entirely, the alternative message was that condoms and lubricant allowed one to continue one's lifestyle, and that safe sex could be erotic and fun.⁵³

Condoms were also becoming a part of the heterosexual lifestyle, just as the voice-over in the Grim Reaper commercial encouraged and many newspaper articles insisted. In reports with cringe-worthy titles such as 'Better Latex Than Never'⁵⁴ and 'Condoms Billed As Sheer Delight',⁵⁵ the mainstream press signalled its approval of NACAIDS' promotion of condom use. The *Adelaide Advertiser*, the same newspaper which Lupton cited as urging the Australian population to return to "old-fashioned fidelity", remarked that "in the light of present knowledge about AIDS, and the general benefit to the community, the Government is doing the right thing".⁵⁶ Even the conservative *Newcastle Herald* described the condom as "an instrument of national salvation".⁵⁷ Lupton cites these reports in her book about AIDS, apparently overlooking the fact that such encouragement of condom use contradicted advice concerning the adoption of monogamy and celibacy.⁵⁸ Clearly, if NACAIDS and the mainstream media were presenting a message that 'forced' Australians to discipline their sexuality to conform with 'old-fashioned fidelity', then they were also propagating a powerful alternative discourse that celebrated and encouraged condom use,

⁵³For analysis of the SAPA data, see Susan Kippax, *et al.*, *Sustaining Safe Sex: Gay Communities Respond to AIDS*, London: The Falmer Press, 1993, pp.79-91; and Gary W. Dowsett, *Practicing Desire: Homosexual Sex in the Era of AIDS*, Stanford: Stanford University Press, 1996, especially pp.77-83.

⁵⁴*Times on Sunday*, 8 March 1987, p.12.

⁵⁵*Advertiser*, 10 February 1987, p.9. *Playboy*, perhaps, coined the silliest pun in an article titled 'The Condom Comes Into Its Own', *Playboy*, October 1987, pp.52-3, 114.

⁵⁶*Advertiser*, 23 March 1987, p.11.

⁵⁷*Newcastle Herald*, 13 February 1987, p.9.

and thus, implicitly, sex with different partners as long as Australians "always use[d] a condom, always". This alternative message competed with the 'risk discourse' and severely undermined its effect.

Indeed, the most comprehensive survey of post-Grim Reaper sexual behavioural-change indicates that heterosexuals favoured the least restrictive, or least repressive, option offered by NACAIDS and the mainstream media. The study, conducted by Bray and Chapman, surveyed 701 Sydney residents two years after the Grim Reaper first appeared. It revealed that, of those who claimed to have changed their behaviour after becoming aware of the threat of AIDS, only 3% now had fewer sexual partners and only 1% had consciously chosen monogamy. Meanwhile 9% had begun to use condoms.⁵⁹ Given the tremendous increase in the number of condoms sold during and after the Grim Reaper campaign, it is, in fact, likely that a much greater percentage of heterosexuals began to regularly use these prophylactic devices. Between 1986 and 1988, for example, the number of condoms sold by Ansell (the market leader) increased by 25%.⁶⁰

Historians and commentators have overlooked other powerful and simultaneously existing discourses which competed with, and undermined, the 'oppressive nature' of the risk discourse propagated by the Grim Reaper and sections of the mainstream media. In examining the alleged 'anti-sex' discourse of the Grim Reaper commercial and the

⁵⁸Lupton, *Moral Threats and Dangerous Desires*, pp.72-7. Also see Lupton, 'The Condom in the Age of AIDS: Newly Respectable or Still a Dirty Word? A Discourse Analysis', *Qualitative Health Research*, vol.4, no.3, 1994, pp.304-20.

⁵⁹Bray and Chapman, 'Community Knowledge, Attitudes and Media Recall About AIDS', p.112.

⁶⁰Christopher Humphry, 'Condom Marketing in the Age of AIDS - Success or Failure', in Commonwealth Department of Community Services and Health, *Report of the Third National Conference on AIDS*, Hobart, 4-6 August 1988, Canberra: AGPS, 1988, p.486. Unfortunately, the empirical evidence which might further support or disprove these conclusions is unavailable because social researchers at the end of the 1980s were much more interested in measuring homosexual behavioural change rather than investigating heterosexual sexual practices. One must also be cautious in proclaiming a causal relationship between the Grim Reaper campaign and behavioural change as it is impossible to accurately assess the impact of a health promotion campaign without considering the behaviour of a 'control' group that was not exposed to the campaign. This was not feasible in Australia because nearly everyone claimed to have seen the Grim Reaper commercial. Additionally, it is difficult to isolate health promotion campaigns from other social factors which influence behavioural change. As Bray and Chapman point out, the respondents in their survey might have altered their behaviour due to a number of factors - such as becoming married or more sexually conservative with age - yet attributed this change to their concern about AIDS. See *ibid.*

accompanying press reports in isolation, for example, they overlook the fact that numerous 'sex-positive' programmes, reports and advertisements, portraying various forms of sexual liberation, were temporally screened on either side of the Grim Reaper commercial and printed alongside the press reports. Manufacturers and advertising companies were saturating the audio-visual and textual media with 'sex-positive' images of scantily-clad women and muscular men in a variety of romantic clinches, in order to sell ice-creams, sunglasses and holiday resorts, among other things. Indeed, the promotion of sexuality and sex by businesses in order to sell their products has been a long-established marketing exercise, and the notion that 'sex sells', which is underpinned by the premise that 'sex is desirable', was an extremely difficult discourse to counter, no matter how frightening the Grim Reaper and his treacherous bowling ball. The fact that a number of businesses were able to flagrantly incorporate, and subvert, the Grim Reaper's message in their advertising material in the years after the campaign indicates their confidence in the power of the 'sex is desirable' discourse to compete with the 'sex kills' message. A television commercial of the late-1980s for a brand of sunglasses, for example, featured two lovers rolling around in the surf of a sun-drenched beach, frantically tearing off their clothes to a furious musical accompaniment. The music suddenly stops, and the woman asks: "Have you brought protection?", evoking the public health slogan referring to condoms. Her male partner suavely pulls out a pair of sun glasses and puts them on his face, and the furious action and music continues until fade out.

Australians, and heterosexuals in particular, were also less likely to accept the public health authorities' and media's statement that 'AIDS can hit ordinary Australians' because for the past five years they had become accustomed to these same sources telling them that "AIDS is a gay plague" and something that happened to "high risk groups". As Tamsin Wilton, David Miller and Jenny Kitzinger have demonstrated in reference to the AIDS education campaigns in Britain, existing 'lay beliefs' about HIV and sexuality frequently have the effect of filtering the reception of 'expert' discourses about AIDS, thus encouraging reactions in the audience which are quite contrary to those expected by the producers of the discourse.⁶¹ As Wilton suggests:

⁶¹Tamsin Wilton, *EnGendering AIDS: DeConstructing Sex, Text and Epidemic*, London: SAGE, 1997, p.45; Jenny Kitzinger and David Miller, "African AIDS": The Media and Audience Beliefs', in Peter Aggleton, Peter Davies and Graham Hart (eds), *AIDS: Rights, Risk and Reason*, London: The Falmer Press, 1992.

Information about health is not passively consumed but actively processed in the context of pre-existing health beliefs. Any information which appears to diverge greatly from already held beliefs is likely to be rejected or profoundly modified by the individual, and this has been shown to result in sometimes extraordinary lay beliefs about HIV/AIDS.⁶²

Market research commissioned by NACAIDS while devising the Grim Reaper campaign indicated that a large number of Australians would watch the Grim Reaper commercial in April 1987 with the pre-conceived notion that 'AIDS is a gay disease'.⁶³ One way of explaining the fact that many heterosexuals made no attempt to change their sexual behaviour after the Grim Reaper campaign is to assume that they still felt immune from the 'gay plague'; it was something that happened to 'poofers' and other social 'deviants'. This suggestion is supported by a 1988 nation-wide survey of over 2600 randomly chosen individuals. It found that people with the greatest ignorance about AIDS, and its effect on them, still believed that it was a homosexual disease. People from lower socio-economic backgrounds and who had poorer levels of education more often expressed such notions.⁶⁴ With this said, you could still find inaccurate and derisive jibes such as "AIDS = Anally Injected Death Sentence" written by supposedly educated young people on toilet cubicle doors in Australian universities in the 1990s. None of this is surprising considering that

pp.28-52; and Jenny Kitzinger, 'Resisting the Message: The Extent and Limits of Media Influence', in David Miller, Jenny Kitzinger, Kevin Williams and Peter Beharrell (eds), *The Circuit of Mass Communication: Media Strategies, Representation and Audience Reception in the AIDS Crisis*, London: SAGE, 1998, pp.192-212.

⁶²Wilton, *EnGendering AIDS*, p.45. Lupton accepts that this is a possibility and explores the notion of an 'active' audience in her book co-authored by John Tulloch, cited above. She does not, however, revise her previous comments about the 'disciplinary' function of the Grim Reaper campaign. Moreover, in her most sustained critique of state-sponsored health promotion strategies (spanning 192 pages), she devotes only two paragraphs to the possibility of 'resistance' (see Lupton and Petersen, *The New Public Health*, pp.179-80).

⁶³Commonwealth Department of Community Services and Health, *AIDS - A Time to Care, A Time to Act: Towards A Strategy For Australians*, Canberra: AGPS, 1988. Also see Commonwealth Department of Community Services and Health, *National AIDS Campaign 1986-1992: An Overview*, Canberra: AGPS, 1994, p.15, which states that "76% of people surveyed in the study regarded AIDS as a disease of homosexuals".

⁶⁴Michael W. Ross, 'Distribution of Knowledge of AIDS: A National Study', *Social Science and Medicine*, vol.27, no.11, p.1297.

NACAIDS spokespeople and the media constantly contradicted their own risk discourse by using terms such as "high risk groups" during, and after, the Grim Reaper campaign. The term "high-risk group" implies that you are at risk from AIDS because of *who you are* rather than *what you do*, thus contradicting the Grim Reaper's warning.

The presence of powerful alternative and pre-existing discourses, which competed with the NACAIDS message, was not the only reason that the oppressive nature of the 'risk discourse' was diffused. As Michel de Certeau has asserted, subtle forms of resistance to oppressive discourses or physical spaces occur implicitly and inevitably within the cycle of everyday life.⁶⁵ For example, in watching a commercial on television, viewers are sometimes distracted by the surrounding 'static' of their environment – such as the kids fighting on the floor, or spilling cups of tea on their laps – which inhibit the clear reception of the message. Sometimes, they incongruously find an image on the screen funny when this was not the intention of the advertiser, which results in the message, or the 'oppressive intention' of the discourse, being misunderstood or ignored. This was clearly the case for many people who watched the Grim Reaper commercial. Indeed, the campaign stimulated a whole series of jokes: from people ringing up the AIDS hotline and teasingly asking if you could get AIDS from going to the local bowling alley (illustrated in cartoon-form in Figures 6.3 and 6.4), to telling jokes about elderly lawn bowlers who only felt safe when they carried their bowls in condoms.⁶⁶ The campaign was also mocked by media personalities and advertising companies, who satirised the Grim Reaper in an effort to sell their products. Sydney radio personality Doug Mulray, for instance, appeared as the Grim Reaper in a TV promotion that announced his return to radio station 2MMM. He was depicted sending down a bowling ball to skittle the opposition. Meanwhile, television celebrity Graham Kennedy appeared in an advertisement for Norman Ross stores that

⁶⁵Michel de Certeau, *The Practice of Everyday Life*, trans. Steven Rendall, Berkeley: University of California Press, 1984.

⁶⁶I am grateful to numerous people for sharing their memories of Grim Reaper jokes; in particular Kenton Miller (nee Penley) who was the cartoonist for *Outrage* magazine in 1987 and now works at the Victorian AIDS Council. A number of my interviewees also remember drag queens and costume-party goers dressing up as Ita Buttrose and even the infamous bowling ball! As an aside, it will probably surprise few to learn that NACAIDS and the Communicable Diseases Branch of the Commonwealth Department of Health received petitions from bowling alley proprietors who complained that the Grim Reaper advertisements would ruin their businesses, and demanded that NACAIDS remove those parts of the commercial identifying the scene as a bowling alley (see Taylor, 'The AIDS Campaign', p.10).

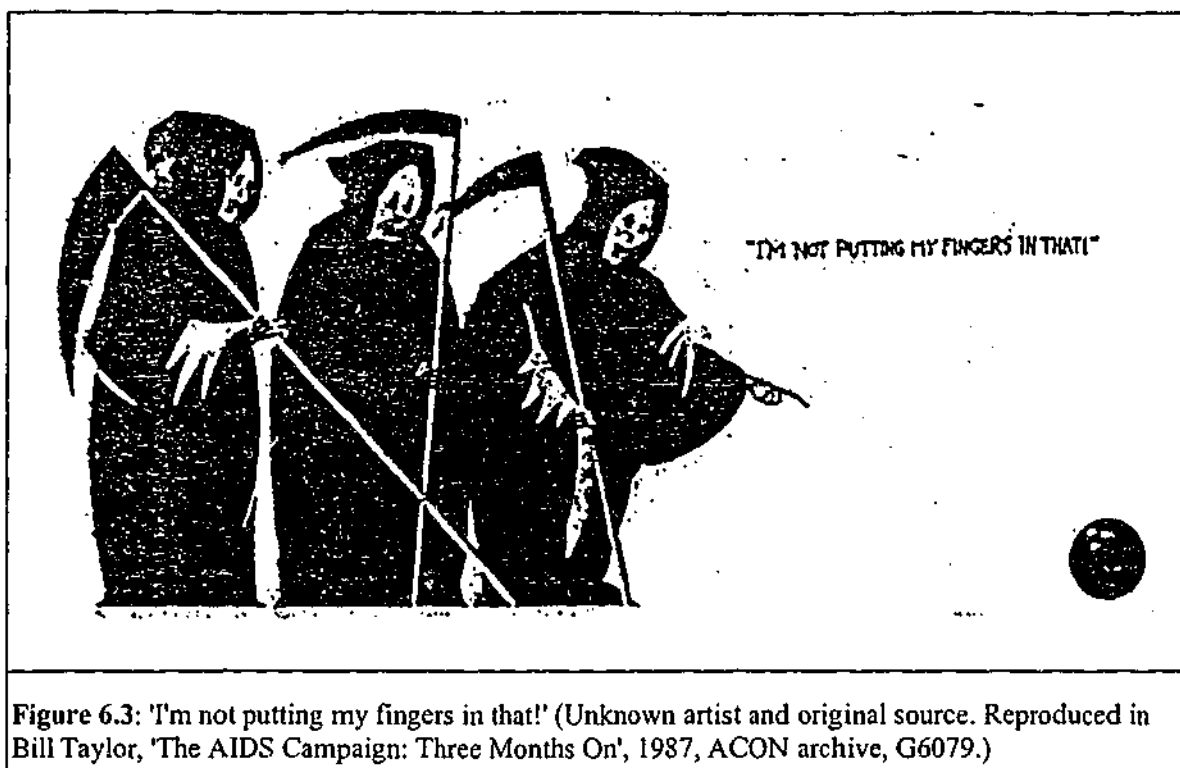


Figure 6.3: 'I'm not putting my fingers in that!' (Unknown artist and original source. Reproduced in Bill Taylor, 'The AIDS Campaign: Three Months On', 1987, ACON archive, G6079.)

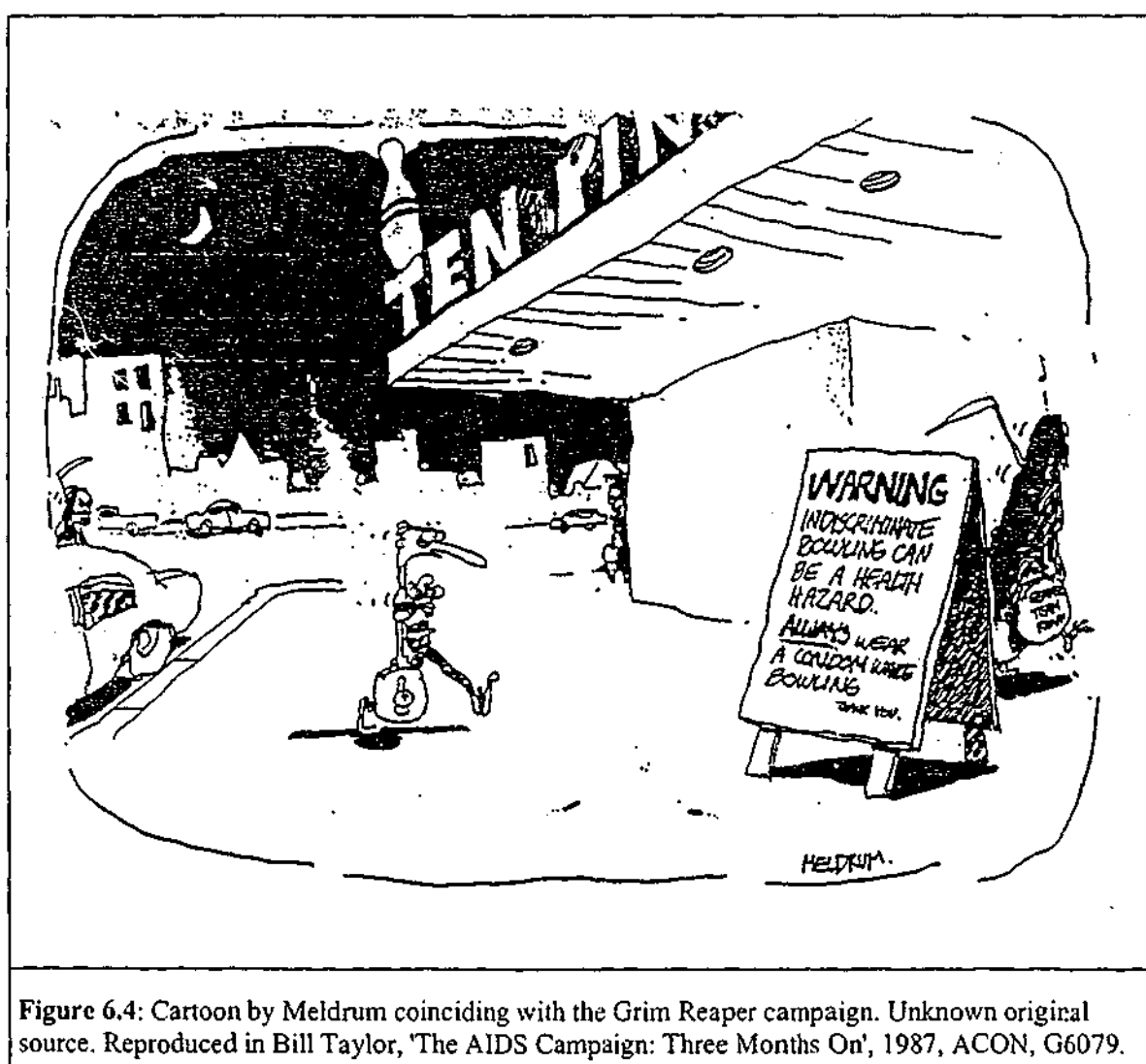


Figure 6.4: Cartoon by Meldrum coinciding with the Grim Reaper campaign. Unknown original source. Reproduced in Bill Taylor, 'The AIDS Campaign: Three Months On', 1987, ACON, G6079.

featured tenpin bowling and the throwaway line: "It's Grim".⁶⁷ Some people even laughed at the most shocking image of the commercial, that of the baby girl spinning out of control of her mother's arms after being hit by the bowling ball. One viewer, interviewed by the *Age*, said that he and his mates "sat there and gave her points out of 10 for degree of difficulty".⁶⁸ On reflection, the rotation of her body is ludicrous, and humorous in the same way that the violence in Quentin Tarantino's film *Pulp Fiction* is funny: it is so unexpected and ridiculously performed that some viewers are compelled to laugh. It is evident that some people found the Grim Reaper funny, rather than frightening, and thus it is likely that the oppressive 'normalising' discourse of the commercial, if this ever was its intention, was deflected in some cases.⁶⁹

I do not want to imply, by any means, that Australians ignored the 'Grim Reaper' campaign and the associated media reporting. They did not. Nor did everyone laugh. At the time, AIDS workers and AIDS hotline operators complained that they were being inundated with calls from people who were frightened by the commercial.⁷⁰ On the whole, however, these people were requesting information about the HIV-antibody test and asking whether you could get AIDS from swimming pools and communion chalices. They were not submitting themselves to the more oppressive aspects of the 'risk discourse' disseminated by NACAIDS or the mainstream media that suggested they abstain from sex or rigidly adhere to monogamy.

⁶⁷'What You Reap is What You Eat', *Outrage*, no.50, 1987, p.7.

⁶⁸A '27-year-old technician' quoted in Peter Wilmoth, 'Grim Reapers Sow Seeds of Suspicion', *Age*, 4 May 1987, p.5.

⁶⁹Historians are becoming increasingly aware of the ability of jokes or humour to disarm potentially oppressive discourses and situations of their power. See, for example, the work of Robert Darnton who examined the widely-read ribald and comic popular fiction which satirised the French King, clergy, and the court at the end of the eighteenth century, thus serving to undermine the authority of the First and Second Estates in the minds of the French people. (Darnton, *The Forbidden Best-Sellers of Pre-Revolutionary France*, New York: W.W. Norton, 1985.) The function of stories, morality tales and humour in peasant resistance has also been stressed by James C. Scott in *Weapons of the Weak: Everyday Forms of Peasant Resistance*, New Haven: Yale University Press, 1985. Luisa Passerini briefly examines the way in which humour and jokes have been used as strategies of resistance by post-war Italians in her book, *Totalitarianism and Fascism*, Oxford: Oxford University Press, 1992.

⁷⁰Morlet, *et al.*, 'The Impact of the Grim Reaper', pp.282-6.

It should also be apparent that I am not necessarily suggesting that Australians had the power, or agency, to actively resist the oppressive intention of the risk discourse at will, or choose which discourse to accept. As I have argued, resistance does not have to be a conscious effort on the part of the 'consumer'. The background static of everyday life alone disrupts oppressive discourses by shifting our attention from where it is required or by undermining the serious nature of the topic. Moreover, the fact that some people were more persuaded by the market-driven 'sex is desirable' discourse, or the 'AIDS is a gay disease' myth, has more to do with the fact that these discourses had become ingrained in the consciousness of Australians due to their longevity and because they were consistent with, and maintained, existing prejudices, rather than because people actively and rationally chose to resist the 'risk discourse'. While we have been taught to celebrate resistance to oppressive ideologies, the ways by, and reasons for, which we resist clearly differ and have different consequences. While some motives and forms of resistance are positive and empowering, resistance is surely counter-productive if it is only achieved by evoking and re-enforcing inaccurate existing myths such as 'AIDS is a gay disease', which made gay men the target of homophobic violence and vilification during the Grim Reaper campaign.⁷¹ Clearly, the consequence of this kind of resistance was not freedom, but persecution.

In exploring the ways in which Australians responded to the Grim Reaper campaign, I have thus far not commented on the reactions of people living with AIDS because, having already contracted the virus, the 'risk discourse' had little relevance to them. This does not mean that the Grim Reaper did not have a profound effect on their lives, however. As John Foster poignantly demonstrates in his biographical account of his lover's struggle with AIDS, rather than having to deal with the message that 'AIDS is heterosexual' or 'sex is dangerous', people living with AIDS were confronted with the other dominant discourse of the Grim Reaper campaign: AIDS is death.

⁷¹A report by the New South Wales Anti-Discrimination Board, *Discrimination – The Other Epidemic*, 1992, cited over 4000 cases of HIV-related discrimination or vilification of homosexuals. For further discussion of this point see Rick Sarre and Stephen Tomsen, 'Violence and HIV/AIDS: Exploring the Link Between Homophobic Violence and the Perception of HIV/AIDS as a "Gay Disease"', in Gail Mason and Stephen Tomsen (eds), *Homophobic Violence*, Sydney: Hawkins Press, 1997, pp.77-90.

Then, most cruelly, in a way that I found unbearable, [my lover] was assaulted, battered with the idea of death. Not death in general, not as an abstract principle or a spiritual reality, but death as a victim of AIDS...[The commercial] would run for only two weeks, they said. But what comfort was that if they were the last two weeks you would spend on this earth; and when you were struggling to make sense of what was happening to you they confronted you with this fantastic cowed creature, socket-eyed and scythe-swinging, knocking down its victims like pins in a bowling alley? No mercy, was the message; violent, impersonal, death as a complete wipe-out.⁷²

Similarly, Carolyn McKenny, whose son, Stephen, had contracted HIV via a contaminated batch of factor VIII, recalls:

I remember when we watched it – Steve came around and we watched it – and I felt it was just awful because it was just that image, you know the image of Death, and it was so graphic and it made me very afraid of what was happening to Steve and what would happen...I found I couldn't bear to see it.⁷³

The 'AIDS is death' (or, more precisely, the 'AIDS is a swift and brutal killer') narrative was not a product of the Grim Reaper commercial, although it became the most visible vehicle for this message. The 1987 campaign had merely tapped into a discourse that was already strongly circulating in scientific literature and the news media. When reports about AIDS in the press carried photographs, they inevitably portrayed bed-ridden or hunched-over emaciated bodies with swollen eye-sockets, not unlike the boney-limbed Grim

⁷²John Foster, *Take Me To Paris, Johnny: A Life Accomplished in the Era of AIDS*, Melbourne: Minerva, 1993, pp.177-8.

⁷³Carolyn McKenny interviewed by Heather Rusden, 6 August 1993, 'The Australian Response to AIDS' Oral History Project, National Library of Australia, TRC-2815/41, pp.37-8. (Stephen contracted HIV in the early 1980s and died in 1991.) In the absence of literature relating to the responses of people with AIDS to the 'Grim Reaper' campaign, I have partially relied on autobiographical and biographical accounts such as Foster's, and conversations with lovers and friends of people with AIDS, to reveal what it was like to be witnessing the Grim Reaper's nightly ritual slaughter as an HIV-positive person. I am also grateful for the AIDS-organisation workers who listened to people living with AIDS discuss the impact of the commercial during the period of the Grim Reaper campaign and then shared their recollections with me. Historians are unable to hear the testimonies of most of the people who watched the Grim Reaper commercial with HIV infection or 'full blown' AIDS as many have since died.

Reaper. In every aspect they depicted 'victims' helplessly waiting to die, ten-pins counting time until their inevitable collision with fate (see Figures 6.5 and 6.6). People *living* with AIDS were absent from the newspaper accounts and current affair programmes despite the fact that, at the time, it was known that a person could live a fulfilling and active life with HIV infection for more than five years without developing the symptoms of 'full blown' AIDS.

Douglas Crimp, an American art critic and AIDS activist, has suggested that mainstream heterosexual society wanted to use this visual depiction of people with AIDS as a moral weapon to punish homosexuals for their 'depraved' lifestyles. The continual reproduction of images of emaciated gay men thus served as an iconographic embodiment of their deviance, reminding mainstream heterosexual society of its moral superiority and warning men who were confused about their sexuality against joining the ranks of the 'diseased'. Furthermore, the representation of people with AIDS as skeleton-like Grim Reapers denied the fact that they retained their sexuality and sensuousness, thus pouring the proverbial 'cold water' on homosexual desire.⁷⁴ Crimp's thesis is interesting, but flawed, as it fails to account for the numerous photographs of emaciated children, women, and people with haemophilia which appeared along-side photographs of disfigured gay men. These women and children were also present in the Grim Reaper commercial.

The context within which the press photography and the Grim Reaper's iconographic embodiment of death arose reveals that a different and more pervasive discourse framed these representations of people with AIDS. AIDS had entered a society in which faith in the omniscience of medical science had become a defining characteristic. The late-1970s had seen doctors announce the eradication of smallpox and polio from the Western world, the development of the 'triple antigen' vaccination for whooping cough, diphtheria and scarlet fever, and a cure for tuberculosis and malaria. Doctors were trusted and held in high public esteem (a confidence only slightly diminished by the Thalidomide disaster). The public hysteria about AIDS, the pessimistic forecasts of mass suffering which accompanied its arrival in Australia, and the Grim Reaper's visual embodiment of swift and brutal death,

⁷⁴Douglas Crimp, 'Portraits of People with AIDS', in Lawrence Grossberg, Gary Nelson and Paul A. Treichler (eds), *Cultural Studies*, New York: Routledge, 1992, pp.117-33.



Figure 6.5: A 'typical' person with HIV/AIDS. Still from 'Raging On', *Four Corners*, ABC TV, 8 February 1988.



Figure 6.6: A 'typical' person with HIV/AIDS. Still from 'Raging On', *Four Corners*, ABC TV, 8 February 1988.

thus reveal a loss of faith in medical science as doctors were forced to admit their vulnerability in the face of a new virus.

The most recent series of AIDS awareness commercials, screened by the Australian National Council on AIDS (ANCA – a 1988 amalgamation of NACAIDS and the National AIDS Task Force) in 1994, reflects the partial restoration of faith in medical science that took place after the development of new drugs to treat people living with AIDS. While explicitly aimed at reducing the level of HIV-discrimination in the workforce and Australian society, the advertisements also redressed the imbalance of the Grim Reaper commercial by depicting people with AIDS playing with their children, gardening, and going to work. Backed by the soft strains of Crowded House's song, 'All I Want', they are literally living with AIDS rather than dying from it. It is also likely that the commercial's images were a response to criticism from advocacy groups and AIDS activists who condemned the representation of people living with AIDS as 'victims' and 'inevitably doomed'.

In referring to the notion that 'AIDS is death' as a discourse, I am not disputing the fact that people die from AIDS (although the idea that all people with HIV infection would go on to develop AIDS and die was not an established fact in 1987, and is far from certain at the present time due to advances in combination drug therapies). It is pertinent to ask, however, whether the type of death portrayed in the Grim Reaper commercial was appropriate or realistic. Did an AIDS-related death have to be depicted as swift and brutal, and completed with a sweep of the bowling lane mechanism which scooped away the fallen 'pins' in an image reminiscent of the film footage of Nazi death camp victims being pushed into mass graves? For, while death from AIDS is undeniable, how one actually conceptualises death, or has it conceptualised for them, is contestable. This is of crucial significance, as medical anthropologists Laurence Tancredi and Nora Volkow argue, because "metaphor essentially creates the framework for the individual's experience of the disease" and influences how a person will deal psychologically and physically with their illness.⁷⁵ There is sufficient evidence to suggest that when people with HIV infection or

⁷⁵The authors support their conclusion by citing studies which demonstrate that many people with AIDS experience a variety of psychological difficulties as a result of its symbolic (as opposed to prognostic)

AIDS conceptualised their illness as one that would lead to a rapid and horrific death, they became extremely anxious and thus placed additional stress on their ailing immune systems. Indeed, a June 1987 review of studies investigating the interrelationship between depression, stress and immunity, concluded that the ability of lymphocytes to divide (and therefore increase in number) was reduced during depression and periods of stress. These 'test tube' findings were complemented by the observation of decreased T- and B-cells (the building blocks of the immune system) in the blood of depressed patients.⁷⁶

In April 1987, the representation of AIDS as a swift and brutal killer in the Grim Reaper commercial may have also led people afflicted by the syndrome to give up hope. Sister Kaye McNaught, a clinical nursing specialist at the Royal Children's Hospital department of clinical haematology and oncology, for example, noted that the child patients in her care confided that the Grim Reaper's message of death had taken away their aspirations for the future: "Kids are saying to me, 'It's all hopeless - we're all going to die'".⁷⁷ Such a conceptualisation of AIDS hardly encouraged people with HIV/AIDS to consider the various alternative medical treatments, or make the dietary and lifestyle changes that would help ward off opportunistic infections. The consequences, therefore, of viewing the Grim Reaper's version of AIDS-related death as "violent, impersonal, death as a complete wipe-out", as John Foster did, may have been the determining factor in 'choosing' to die for many people with AIDS. It is thus apparent that the cruelty of the Grim Reaper commercial lay not in its claim that 'sex is dangerous', and the impact of this discourse on fearful heterosexuals and unnecessarily worried parents, as Lupton and others assert. Its cruelty lay in the supposition that death from AIDS was swift, horrible and inexorable.

As the Grim Reaper commercial appeared for the second time on his television screen, John Foster motioned to change the channel. His lover, Juan, stopped him, however:

meanings. Laurence R. Tancredi and Nora D. Volkow, 'AIDS: Its Symbolism and Ethical Implications', *Medical Heritage*, vol.2, no.1, Jan-Feb 1986, pp.12-18.

⁷⁶See 'Depression, Stress and Immunity', *Lancet*, 27 June 1987, pp.1467-8, cited in David Plummer, 'Depression, Stress and Immunity', *National AIDS Bulletin*, vol.1, no.2, October 1987, p.9.

⁷⁷Eddie Fitzmaurice, 'Help the AIDS Kids - Nurse', *Sun*, 8 April 1987, p.4.

Juan said, "No, no. Leave it. It won't take long." It was, after all, only the TV, and he hadn't spent all those hours watching TV without knowing how it produced its effects. He knew that AIDS was not like that. And as for dying – well, he would see.⁷⁸

The actions of Juan serve as a reminder that we should not rule out the possibility that other people with AIDS resisted the notion that 'AIDS is a swift and brutal killer', just as many other heterosexual and homosexual Australians, immersed in a mesh of competing discourses and the distractions of 'everyday life', effectively resisted or deflected the oppressive discourses contained within the 'Grim Reaper' campaign.

⁷⁸Foster, *Take Me To Paris, Johnny*, p.178.

Chapter 7.

Diving Under the 'Second Wave': Harm Minimisation Approaches to Drug Use and HIV Infection in Australia

As noted in the previous chapter, the information presented at the Second International Conference on AIDS, held in Paris during June 1986, provided the Commonwealth government with the impetus to launch a large-scale mass-media campaign aimed at educating 'ordinary' Australians about the possible (hetero)sexual transmission of HIV. Numerous presenters at the conference also brought news that HIV was moving beyond its loosely defined limits within the homosexual community and, in some countries, had reached epidemic proportions in the (predominantly heterosexual) injecting drug using population.¹ Injecting drug users had, of course, been reported among the first casualties of AIDS, and there is no evidence to prove that they were infected by gay men who shared needles and syringes or that AIDS had 'spread' from the gay community. Nevertheless, this was the epidemiological narrative that emerged as the threat to heterosexual drug users and their sexual partners was articulated. Within months of the Paris conference, the news-media in Australia was warning of a 'second wave' of HIV infection that would 'break' among the heterosexual population unless urgent action was taken to stop the transmission of HIV between people who injected illicit drugs.²

Australian public health authorities and community-based AIDS organisations realised that they had three options to achieve this goal. They could urge the expansion of 'The Drug Offensive' – an already expensive public education programme that implored young Australians to 'Just Say No' to drugs – and support the existing effort to eliminate drug use. This required the policing of laws that criminalised illicit drug use and the possession of non-prescribed needles and syringes. Alternatively, they could treat drug use as a

¹See, for example, B. Hirschel, N. Carpentier and P.J. Male, 'Lymphadenopathy Virus (LAV/HTLV-III) Infection in Geneva Heroin Addicts', *Proceedings of the 2nd International Conference on AIDS*, Paris, 23-25 June 1986, and posters 93, 173, 198, 205, 206, 667, and 668. Throughout this thesis I use the term 'injecting drug users' (IDU) rather than 'intravenous drug users' (IVDU) – which was the preferred term in Australia during the 1980s – because it more accurately reflects the fact that drug users can both inject into their veins and their muscles or other organs.

²See, for example, Louise Carbines, 'AIDS Spectre Now Becomes Universal', *Age*, 21 February 1987, (Saturday Extra) p.3.

physical illness – a chronic and often relapsing psychiatric or metabolic disease – rather than a criminal activity, and provide methadone or various treatments based on psychiatric principles to help users overcome their need to inject drugs. Third, they could take the more risky, and politically sensitive, option to implement needle and syringe exchange programmes and supplement these with education that informed drug users how to sterilise their needles and syringes if they could not desist from sharing them. This third option was risky because only a handful of countries had been prepared to trial such a measure, and their results thus far had proved inconclusive. It was politically unpalatable because the exchange of needles and syringes contravened existing state laws prohibiting the provision of non-prescribed drug injection equipment, and also contradicted the primary message of the Commonwealth's 'Drug Offensive', which was supported by each of the States and was popular with the electorate. Nevertheless, the approach won support among many medical professionals, sex worker and drug-user collectives, and gay-based AIDS organisations, who formed an unlikely alliance in advocating the 'harm minimisation' approach despite their previous disagreements about the primacy of education and 'testing and containment' policies. They did not concur, however, on whether the needle exchange programmes and education should be 'administered' by medical professionals and driven by technological innovation (such as the development of 'one-shot' non-reusable syringes), or devised and implemented by community-based organisations who had experience in speaking with drug users and who knew intimately the environment in which they lived.

To the surprise of many, nearly all of the state governments chose the 'harm minimisation' model of HIV control and followed the lead of the NSW Government, which established the first officially sanctioned needle and syringe exchange trial at the end of 1986. In doing so, the state health authorities took a leap of faith and trusted that marginalised and 'deviant' individuals such as drug addicts and drug-using sex workers cared enough about their own health, and the health of others, to wisely use the information and sterile needles and syringes that were provided for them. They also trusted groups consisting of drug users and ex-users to responsibly spend the money that they were given, and to sensitively promote needle exchange programmes in a way that would attract users but not arouse the attention of conservative members of the wider community. In 1986 and 1987, policy-makers did not have the benefit of hindsight that now reveals the extraordinary success of

these measures, which enabled Australia to dive under the 'second wave' of HIV infection that swamped North America and a number of European countries in the mid-to-late 1980s.³

Australia's decision to act was based on a theoretical and statistical probability, and the experience of other countries such as the United States, which were relying on the 'War on Drugs' to protect them from the 'second wave' of HIV infection. It was known that the injection of HIV-contaminated blood directly into a vein was an extremely efficient means of transmitting the virus that causes AIDS, and that heterosexual injecting drug users (IDU) already constituted approximately 2% of HIV cases in Australia. Despite laws criminalising the possession of needles and syringes and the use and sale of drugs, it was also estimated that between 100,000 and 170,000 Australians injected themselves with illicit substances, of whom 50,000 were regular users.⁴ Moreover, research revealed that most drug users shared drug injection equipment, thus providing the means for HIV transmission. A survey commissioned by NACAIDS in 1986, for example, reported that 5% of the 1500 respondents admitted to injecting illegal drugs, over half of whom had shared needles and syringes in the previous twelve months. Of particular note was the disproportionate level of risk that female users were taking: 71% of women admitted to sharing needles as compared to 40% of the men, and they were more likely to use the needle after their partner.⁵ Two surveys of IDU conducted by the Health Department of

³In effect, of course, the Commonwealth and state governments employed a combination of the three strategies by committing funds to methadone treatment services, NSEP, anti-drug campaigns and the enforcement of laws prohibiting the possession and sale of illicit substances. Australia was remarkable, however, for implementing 'harm minimisation' programmes when most other governments refused to do so.

⁴Statistics derived from *The Drug Offensive, Statistics on Drug Abuse in Australia*, Canberra: AGPS, 1988, p.52; Shane Rodgers, 'New AIDS Push Warns of Spread', *Sun*, 5 June 1990, p.21; and 'Shepherd Attacks New AIDS Ads', *Sydney Morning Herald*, 5 June 1990, p.9.

⁵Julian Cribb, 'Amphetamine Users At High Risk of AIDS', *Australian*, 5 June 1991, p.5; and Australian Market Research, *Preliminary Report: Benchmark Information on Awareness, Knowledge, Attitudes and Behaviour in Australia Prior to the Launch of an Educational Campaign, (vol. 1) and Unpublished Report Prepared for NACAIDS (vol. 2, appendices)*, 1987, p.103. As Priscilla Pyett noted, the NACAIDS commissioned survey was conducted via face-to-face interviews in randomly selected homes, and was thus likely to have seriously under-represented the proportion of IDU in the total population. This is because many interviewees would not have been comfortable admitting to drug use, and itinerant and homeless drug users could not be represented in the sample. See Priscilla Pyett, 'Social and Behavioural Aspects of the Prevention of HIV/AIDS in Australia: A Critical Review of the Literature', unpublished report prepared for the National Centre for Health Program Evaluation, NBAC/NAAC, ANU, H5/5(70).

Victoria in 1985 and 1986 found that 96% of respondents reported sharing drug injection equipment in the preceding five years. The most recent survey (August 1986) found that 71% of respondents shared more frequently than once a week and one-third usually shared with three or more people. Fewer than 5% actually wanted to share drug injection equipment.⁶

These alarming traits suggested that Australia was potentially facing a problem of the magnitude that had emerged in countries such as Italy and Spain, and cities such as Edinburgh and New York – none of which had invested in 'harm minimisation' measures. Indeed, by 1986, 17% of people living with HIV in the United States and 33% of AIDS cases in New York City were heterosexual IDU, indicating that the 'second wave' had well and truly crashed on the shores of North America.⁷ Estimates of the rate of seropositivity among IDU (that is, the proportion of IDU infected with HIV) were as high as 60% in New York, and between 50-76% in Italy (depending on the city), 63.6% in Spain and 64% in Edinburgh.⁸ The speed with which this level of infection had occurred was also disturbing:

⁶L. Edgoose and J. Baillie, 'AIDS and Intravenous Drug Abuse: Risk Behaviour' [letter], *Medical Journal of Australia*, vol.146, 2 March 1987, pp.279-80; and 'Notes for NACAIDS Church in AIDS Conference, August 1987', prepared by Jennifer Baillie, Project Officer for the AIDS, Intravenous Drug Use and Prostitution Health Promotions Unit, Health Department of Victoria, August 1987, p.2, NBAC/NAAC, ANU, H7/59.

⁷CDC, 'Update: Acquired Immuno-deficiency Syndrome – United States', *Morbidity and Mortality Weekly Report*, vol.35, 1986, pp.757-66; and New York City Department of Health AIDS Surveillance, 'The AIDS Epidemic in New York City, 1981-1984', *American Journal of Epidemiology*, vol.123, 1986, pp.1013-25.

⁸Ernest Drucker, 'AIDS and Addiction in New York City', *American Journal of Drug and Alcohol Abuse*, vol.12, 1986, pp.165-81; P.A. Selwyn, 'AIDS: What Is Now Known', *Hospital Practice*, vol.21, 1986, pp.127-64; P. Ferroni, *et al.*, 'HTLV-III Antibody Infection Among Italian Addicts', *Lancet*, vol.2, 6 July 1985, pp.52-3; Gioacchino Angarano, *et al.*, 'Rapid Spread of HTLV-III/LAV Infection Among Drug Addicts in Italy' [letter], *Lancet*, vol.2, 7 December 1985, p.1302; and J.R. Robertson, *et al.*, 'Epidemic of AIDS Related Virus (HTLV-III/LAV) Infection Among Intravenous Drug Abusers', *British Medical Journal*, vol.292, 1986, p.527. The CDC cited an HIV seroprevalence among New York injecting drug users of 87% in a 1984 report, a figure since discredited but one which was likely to have worried policy-makers in Australia in 1986. (See CDC, 'Antibodies to a Retrovirus Etiologically Associated with Acquired Immunodeficiency Syndrome (AIDS) in Populations with Increased Incidences of the Syndrome', *Morbidity and Mortality Weekly Report*, vol.33, 1984, pp.377-9.) The rate of seropositivity among injecting drug users in Edinburgh was accurate, however, and the *Report of the Scottish Committee on HIV Infection and Intravenous Drug Use* (Scottish Health and Home Department, 1986) caused consternation among delegates when it was discussed at the Second National Conference on AIDS in Sydney. See 'Summary of Panel Session Concerning Issues Relating to IV Drug Use and Prostitution', in Commonwealth of Australia, *AIDS: Australia's Response Examined, Report of the Second National Conference on AIDS, Sydney, 31 October – 1 November 1986*, Canberra: AGPS, 1988, p.95.

the seropositivity among IDU in Edinburgh had increased from 0% to 51% in two years.⁹ In Australia, epidemiological data compiled by the Albion St Clinic in 1985 suggested that 11.1% of IDU in Sydney were already infected with HIV (although two-thirds of these men admitted to sexual intercourse with other men and thus may have contracted the virus during unprotected sex).¹⁰

Concerned doctors, public health officials and community groups therefore realised that they had to act, and act quickly, to avert disaster. They correctly assessed that neither the criminalisation of drug use nor the 'Drug Offensive' had significantly reduced the number of drug users, nor stopped them from sharing drug injection equipment. Medical approaches to reducing drug use, such as the rehabilitation of opiate addicts in 'detoxification centres' and the substitution of illicit drugs for methadone that could be administered by medical professionals, were also discounted in the short term because they were expensive and would take time to establish.¹¹ Furthermore, they did not address the problem of needle sharing among first-time and recreational users who refused to identify as 'addicts' nor wished to be included on a register of drug users.

⁹Robertson, *et al.*, 'Epidemic of AIDS Related Virus', p.527; and Editorial, 'The Link Between AIDS and IV Drug Use', *Connexions*, vol.9, no.3, May/June 1989, p.1. An Italian study reported that the HIV seroprevalence among IDU in the city of Bari had increased from 6% in 1980 to 76% in 1985. See Angarano *et al.*, 'Rapid Spread of HTLV/LAV Infection', p.1302.

¹⁰This figure was the source of much contention in 1985 and afterwards. Other estimates of the seroprevalence rate among IDU ranged from 0.5% to over 14%. The figure 11.1% represents the number of IDU who attended the Albion St Clinic and tested HIV-antibody positive while unaware of their serostatus. The higher figure was derived from all IDU attending the Albion St Clinic, some of whom were only attending because they were aware of their HIV-positive status, thus biasing the sample. See P. Blacker, *et al.*, 'Exposure of Intravenous Drug Users to AIDS Retrovirus, Sydney, 1985', *Australian and New Zealand Journal of Medicine*, vol.16, 1986, pp.686-90 (for the lowest estimate); Andrew Morlet, *et al.*, 'Intravenous Drug Users Who Present to the Albion Street (AIDS) Centre for Diagnosis and Management of Human Immunodeficiency Virus', *Medical Journal of Australia*, vol.152, no.2, 1990, pp.78-80; Basil Donovan, *et al.*, 'If I Have Sex With A Duck Does That Make Me A Drake? The Albion Street (AIDS) Centre, Intravenous Drug Use and "Prostitution"' [letter]; and 'Reply' by James J. Guinan, Shane Darke and Julian Gold, *Medical Journal of Australia*, vol.152, 7 May 1990, pp.498-499.

¹¹Methadone maintenance treatment was, however, recognised to be a key weapon in the long-term fight against the spread of HIV among drug users. Following the hard-fought expansion of methadone treatment services throughout Australia, this has indeed been the case. While this is an important aspect of Australia's HIV prevention strategy, in this chapter I have limited my discussion to the history of the implementation and efficacy of needle and syringe exchange programmes.

Instead, public health authorities hoped that a model of peer-provided education, which had proved successful in reducing the rate of seroconversion in the gay community, could be imitated in the drug using population. Such a strategy avoided the need for governments to provide free needles and syringes to drug users which, they feared, might attract criticism from community groups. Thus, with small government grants, 'community-based' groups of drug users and ex-users, such as VIVAIDS in Victoria and the AIDS Drug Information Collective in NSW, were empowered to design and provide education and support for the 'drug using community'. Most of these user-groups were already providing this service without government assistance.¹²

Critics argued that such a task would prove beyond them, however, because drug users did not form a community in a sense that gay men did: by virtue of their criminality, drug users were more likely to be secretive and scattered, and by virtue of the fact that IDU were drawn from all strata of society – the rich and the homeless – they were more likely to inhabit different spaces. Thus, unlike gay men, who generally frequented the same 'community venues' such as bars, beats and bookshops, IDU did not assemble in common places that could provide an outlet for information about safe practices. Moreover, unlike sexual orientation, drug use was a discretionary activity that individuals started and stopped for a variety of reasons; it was not a lifelong commitment. Successful peer-based education campaigns in the gay community which implored homosexuals to adopt safe sexual practices in order to ensure the long-term survival of their community were therefore unlikely to yield the same committed response from drug users. In any case, most first-time and recreational drug users did not identify as 'drug users' and were unlikely to feel a bond with a community of users, nor were they receptive to health education messages aimed at 'junkies' and 'addicts'.¹³

¹²The AIDS Drug Information Collective was formed by current and ex-users in NSW during 1985. VIVAIDS (Victorian Intravenous Drug Use and AIDS), one of the first funded groups of its kind in Australia, was initially financed by forfeited drug-bust money that was contributed to the Costigan Fund.

¹³Adam Carr and Nancy Stoller provide a good discussion of these points. See Adam Carr, 'What is AIDS?', in Eric Timewell, Victor Minichiello and David Plummer (eds), *AIDS In Australia*, Sydney: Prentice Hall, 1992, p.20; and Nancy E. Stoller, *Lessons from the Damned: Queers, Whores and Junkies Respond to AIDS*, New York: Routledge, 1998, p.100.

The notion that drug users did not constitute a 'community' (or at least a number of small, defined communities) that could be exploited to facilitate the circulation of information was criticised at the time, and since, by users and ex-users who established IDU collectives. David Herkt, an IDU and member of VIVAIDS, for example, argued that:

to be a user requires a social network far in advance of many other groups; to score for any illicit drug means to know and to keep in constant touch with a large number of individuals, and to avoid alienating any of them because their service, their company, or their venture capital might need to be utilised some time in the future. Most users have a greater social network and are more competent social managers than many other groups. To be an intravenous user, by definition, is not to be alone.¹⁴

The fact that peer-based education initiatives appear to have achieved a degree of success in bringing about behavioural change (such results are extremely difficult to evaluate due to the numerous determinants of behavioural change), and community-based needle and syringe exchange programmes have encountered few problems in finding participants, indicates that Herkt's statement contains some truth and suggests that scepticism of this approach was ill-founded.

Nevertheless, a strategy that relied on education-driven behavioural change alone was bound to fail – community or no community – while the threat of AIDS remained remote for most drug users. Research conducted before and since 1986 suggested that it was difficult to foster a sense of vulnerability in individuals whose dependency forces them to take risks anyway.¹⁵ Drug users were more likely to be concerned with being arrested by the police, discovered by parents or partners, or scoring a drug which was not contaminated with other chemicals, rather than with the possibility that, ten years in the future, they may die because they shared a needle. This proposition worried doctors such as Alex Wodak,

¹⁴David Herkt, 'Gay IV Users: Who Cares?', *National AIDS Bulletin*, vol.4, no.10, November 1990, pp.27-8. For further discussion of this point, see Elizabeth Anne Patterson, *Injecting Drug Users' Self Organisation to Combat HIV/AIDS: A Critical Ethnographic Study*, unpublished M.H.S. thesis, Queensland University of Technology, 1994, pp.34-6.

¹⁵Louise Carbines, 'AIDS Spectre Now Becomes Universal', *Age*, 21 February 1987, (Saturday Extra) p.3.

Ron Penny and Nick Crofts, who therefore turned their attention towards needle and syringe exchange. While education might fail, they argued, drug users could be persuaded to develop a routine of using sterile needles and syringes if these were provided free of charge from outlets that were easy to access. Such a programme had been operating in the Netherlands since late 1984 and in some cities in England and Scotland since early 1986.¹⁶ Sensing the urgency of the situation, the Alcohol and Drug Service at St Vincent's Hospital began the first officially-sanctioned pilot needle and syringe exchange programme (NSEP) in Australia on 13 November 1986. It was conducted in Sydney's inner-city suburb of Darlinghurst, thereby supplementing a similar service that had been offered, unofficially and illegally, by Sydney community-based AIDS organisations for almost a year.¹⁷

Assessing the raw data from these programmes, a NACAIDS Working Group convened by Ron Penny in December 1986 recommended "the urgent widespread introduction of needle exchange programmes in all States and Territories" and that "funds should be made available, immediately, to enable such programmes to be established [by]...pharmacies, hospital casualty departments, doctors' surgeries, community health centres, youth services, outreach programmes, and alcohol and other drug agencies".¹⁸ As this statement

¹⁶The Dutch NSEP was established by a collective of current and ex-drug users, and was initially opposed by the Health Department. The British programme received funding from the Thatcher government, but relied on local health authorities to establish the exchanges. Many city health departments refused to do so because of their existing anti-drug policies. Liverpool, Glasgow and Kingston in south-west London established programmes, but nearby cities such as Edinburgh and Manchester did not. Concise histories of NSEPs in the Netherlands and Britain are provided by Erik van Ameijden and Anneke van den Hoek, 'AIDS Among Injecting Drug Users in the Netherlands: The Epidemic and the Response', in Theo Sandfort (ed.), *The Dutch Response to HIV: Pragmatism and Consensus*, London: UCL Press, 1998, pp.61-85, especially pp.68-80; Ernst Buning, 'The Role of Harm-Reduction Programmes in Curbing the Spread of HIV by Drug Injectors', in John Strang and Gerry V. Stimson (eds), *AIDS and Drug Misuse: The Challenge for Policy and Practice in the 1990s*, London: Routledge, 1990, pp.153-61, especially pp.157-8; John Street and Albert Wade, 'Britain: Policy-Making in a Hermetically Sealed System', in David L. Kirp and Ronald Bayer (eds), *AIDS in the Industrialized Democracies: Passions, Politics and Policies*, New Brunswick: Rutgers University Press, 1992, pp.185-220, especially pp.207-9; and Gerry Stimson, 'Injecting Equipment Exchange Schemes in England and Scotland', in R.J. Battjes and R.W. Pickens (eds), *Needle Sharing Among Intravenous Drug Abusers: National and International Perspectives*, NIDA Research Monograph 80, 1988, pp.89-99.

¹⁷'IV Drug Users', *Connexions*, vol.9, no.3, May/June 1989, p.18; Norman Booker, Paul van Reyk and Dean Andrews (eds), *Strengthening the Community: ACON and the HIV Epidemic in NSW*, Sydney: ACON, 1995, p.19; Don Baxter, 'The Real Challenge in HIV/AIDS Policy - Not "Have We Got It Right" but "How Can We Do It Better?"', address to the Australian Doctors' Fund AIDS Summit, Sydney, 14-15 May 1992; and Margaret Duckett, 'HIV/AIDS and Australia's Community-Based Sector: A Success Story in HIV Prevention', unpublished report prepared for AFAO, 1992, p.11, ACON archive, id: G2367.

¹⁸'Notes of meeting of the NACAIDS Working Group on Special Education Programme - IV Drug Users', 1 December 1986, NBAC/NAAC, ANU, H9/73.

reveals, the Working Group conceived of a programme that would be administered by medical professionals and social workers rather than community-based organisations and drug users themselves. Indeed, following an amendment to the *Drug Misuse and Trafficking Act*, which prohibited the sale of non-prescribed drug injecting equipment, the initial needle and syringe provision programme operated out of NSW pharmacies. They sold 'Anti-AIDS Kits', consisting of five needles and syringes plus an information card about AIDS, for a (government subsidised) price of \$3.50. The Pharmacy Guild later implemented the Guildpak Scheme in December 1987 which saw pharmacies sell ten needles and syringes in a puncture-proof plastic container (with a built-in disposal section) for \$7.00. If the container, with used syringes intact, was returned to the pharmacy, the pack was replaced for a reduced price of \$3.50. This became the government's preferred private sector scheme as it offered the possibility of safe disposal as well as needle exchange.¹⁹

Proponents of needle and syringe exchange understood that these programmes could do more than reduce the incidence of sharing drug injection equipment among users, however. For instance, outlet volunteers and staff could provide referrals to drug treatment programmes and health care agencies. They could also distribute alcohol swabs (to sterilise the skin and thus prevent other infections associated with unhygienic drug injection), supply sachets of bleach (to clean needles and syringes in the event of the exchange outlet being closed or out of reach), and provide condoms and lubricant and information about their use, as well as advice about safe sexual practices. Most importantly, needle and syringe exchange outlets offered the potential for face-to-face encounters between drug users and educators – something that pharmacies could not – and in the form of a van could travel to the streets where injecting drug users went to score. Community-based organisations such as VIVAIDS and the Prostitutes' Collective of Victoria, who already provided outreach education and support, thus felt that they were in the best position to administer these services. Sharing the same background as the users, they were also less likely to speak in a judgemental manner and thus deter potential clients and, compared to

¹⁹MSJ Keys Young Planners Pty Ltd, 'Evaluation of the New South Wales Needle and Syringe Exchange Program', unpublished report prepared for the NSW Department of Health, November 1989, p.3, NBAC/NAAC, ANU, H5/3(47).

medical professionals, they were more likely to use words and examples which drug users could understand.²⁰ They were therefore justifiably angry when government organisations and pharmacies were funded to the detriment of their own services. Most community-based groups survived only due to the donations and dedication of their volunteers. Nevertheless, the Prostitutes' Collective of Victoria was soon operating the third largest needle and syringe exchange programme in the world, and after VIVAIDS received \$100,000 from the Health Department of Victoria in 1989, it was able to employ three paid staff including a 'Women and IV Drug Use' Project Officer.²¹

The New South Wales needle and syringe exchange programme began tentatively in pharmacies in December 1986, and by June 1989 over forty public sector outlets had been approved in places such as Sydney, Wollongong, Newcastle, Dubbo and the far north coast. By 1994 there were over 250 public outlets in both government and non-government organisations, and over 500 pharmacies operating the Guildpak Scheme. Combined, they distributed more than 3.5 million needles and syringes annually.²² In comparison, by 1995, the Dutch model, which it emulated, provided 122 needle exchange outlets and supplied about one million needles and syringes.²³ Victoria's NSEP, which commenced in November 1987, matched that of NSW in terms of size and scope, and expanded with similar rapidity. At the beginning of 1989, for instance, it provided eleven outlets; by the end of that year it was operating sixty-three outlets in Melbourne and country areas. In the first month of operation, the exchange outlets distributed 176 needles and syringes; two years later they were distributing over 24,000 per month (a figure derived from only the

²⁰A study conducted in Perth by Loxley and Davidson found that many users perceived an overt disdain directed towards them by pharmacists when asking to purchase supplies. Whether this was real or imagined, it affected their decision concerning whether to purchase sterile drug injecting equipment from pharmacists in the future. See Wendy Loxley and Ron Davidson, 'Why Do Injecting Drug Users Take Risks? Barriers to Safer Injecting and Sexual Behaviour in Perth', *National AIDS Bulletin*, vol.5, no.9, October 1991, pp.32-8.

²¹The Women and IV Drug Use Project Officer offered outreach education to women in prisons and drug-treatment centres, and ran workshops on self-assertion and 'safe sex' techniques for females. VIVAIDS also employed a NSEP Peer-Education Officer and an Education and Advocacy Officer, who developed guidelines on education and lobbied doctors, police, and drug and alcohol services to support drug-related law reform.

²²NSW Department of Health AIDS Bureau, *NSW Needle and Syringe Exchange Policy and Procedures Manual*, Sydney: NSW Department of Health, 1994, p.5.

²³These figures are drawn from 1995 data. See Ameijden and van den Hoek, 'AIDS Among Injecting Drug Users in the Netherlands', p.70.

eight largest exchange outlets).²⁴ Needle and syringe exchanges were also established in South Australia, Western Australia, the ACT, and the Northern Territory.

In most of these States and Territories, legislative change to permit the possession and distribution of sterile drug injecting equipment lagged behind the government's approval of needle and syringe programmes. South Australia did not amend its legislation until late 1989, for instance, almost two years after its first needle and syringe exchange programme began operation.²⁵

Not all of the States adopted needle exchange with such relish. In April 1987 the Queensland National Party Government rebuffed its Premier, Mike Ahern, who wanted to legalise the sale of needles and syringes through pharmacies; instead, it allowed doctors to prescribe needles to injecting drug users.²⁶ It finally passed a Bill allowing the implementation of needle and syringe exchange programmes in 1989. Tasmania did not permit the legal exchange of needles and syringes until 1993. Until this time, conservative politicians tried to argue that owing to Tasmania's isolation from the mainland and the 'drug using capitals of Australia', there were no injecting drug users living in the Apple Isle! Lisa Cuatt, the Tasmanian AIDS Council's IV Drug Use Educator, pointed out in 1989, however, that two independent studies estimated that there were between 600 and 1200 injecting drug users in the state. Moreover, as of June 1988, three of the known thirty-two people living with HIV in Tasmania had histories of injecting drug use.²⁷

²⁴Robyn Mullins, 'Report on the Victorian Needle and Syringe Exchange Program', unpublished report prepared for the Health Department of Victoria, 1990, p.1, NBAC/NAAC, ANU, H5/1(10).

²⁵Duckett, 'HIV/AIDS and Australia's Community-Based Sector', p.11.

²⁶'Stick to Your Guns, Mike' [editorial], *Cairns Post*, 23 April 1987, p.6.

²⁷'IV Drug Users', *Connexions*, vol.9, no.3, May/June 1989, p.24. Also see, Robyn Maurice, 'Inaction Leaves Bad Taste...', *Junkmail*, vol.2, no.1-2, 1991, p.5. It has been proposed that the Tasmanian government was slow to adopt NSEP in fear that such a scheme might indicate to the International Narcotic Control Board (INCB) that heroin problems in the state were out of control. Tasmania relied on the endorsement of the INCB to retain its licence to legally cultivate opium poppies for medicinal purposes. I am grateful to Dr Alex Wodak (personal communication, 16 June 2000) and Charles Roberts, Harm Reduction Co-Ordinator TASCARD (personal communication, 11 July 2000), for drawing my attention to this suggestion, which neither man was willing to endorse nor refute.

Needle and syringe exchange was also forbidden in prisons, despite its strenuous recommendation in March 1987 by a NACAIDS Working Group convened by Dr John Dwyer, and its advocacy by the state AIDS Councils and prominent doctors such as Alex Wodak and Nick Crofts.²⁸ Proponents of highly-regulated prison needle exchange programmes supported their call by pointing to the alarmingly high rate of HIV seroprevalence in prison populations overseas,²⁹ and the fact that by the end of 1987 at least one case of HIV-transmission in an Australian prison had occurred.³⁰ Moreover, by the beginning of 1989, a cumulative total of ninety-nine prisoners had returned HIV-positive test results upon admission into Australian gaols, a figure which was likely to significantly under-represent the total number of cases because of the incomprehensive nature of HIV-antibody testing in prisons.³¹ Research also indicated that between 37% and 66% of inmates in Australian gaols had injected illegal drugs prior to their imprisonment,³² and at least half of these prisoners continued to use injecting drugs (by sharing concealed needles)

²⁸'National Advisory Committee on AIDS, Report of the 17th Meeting, 5 March 1987', NBAC/NAAC, ANU, H19/43.

²⁹A study of fifty-two prison systems in Europe estimated that more than 10% of prisoners in European gaols were HIV-positive, and studies conducted in the United States in 1987 and 1988 suggested an American prison population seroprevalence rate of between 1% and 17%. See T.W. Harding, R. Manghi and G. Sanchez, *HIV/AIDS in Prisons: A Survey Covering 54 Prison Systems, Report to the WHO Programme on AIDS*, Geneva: WHO, 1990; T.W. Harding, 'AIDS in Prison', *Lancet*, vol.2, 28 November 1987, p.1260; T.M. Hammett, *AIDS in Correctional Facilities: Issues and Options*, 3rd edition, Washington D.C.: U.S. Department of Justice, 1988; and Theodore M. Hammett and Saira Moini, 'HIV/AIDS in US Prisons and Goals: Epidemiology, Policy and Programmes', paper presented at *HIV/AIDS in Prisons* conference, Melbourne, 19-21 November 1990.

³⁰The man had been incarcerated continuously since before 1980. He tested HIV-antibody negative in July 1987, developed symptoms of seroconversion illness in late 1987, and tested HIV-antibody positive when he was next examined in November 1989. See Kate Dolan, *et al.*, 'Evidence of HIV Transmission in an Australian Prison', *Medical Journal of Australia*, vol.160, 6 June 1994, p.734.

³¹Michael Kirby, 'AIDS Strategies and Australian Prisons', paper presented to the Institute of Criminology *AIDS in Prisons* seminar, Faculty of Law, University of Sydney, 6 November 1991, p.7.

³²David Indermauer and Kathy Upton, 'Alcohol and Drug Use Patterns of Prisoners in Perth', *Australian and New Zealand Journal of Criminology*, vol.21, 1988, pp.144-67; Frances Potter and Lisa Conolly, 'AIDS - The Sexual and IV Drug Use Behaviour of Prisoners', unpublished report prepared for the NSW Department of Corrective Services, 1990, cited in Kate Dolan, 'Monitoring HIV Infection and Risk Behaviour Among Ex-Prisoners in NSW', unpublished paper delivered at the NDARC Sixth Annual Symposium, 2 December 1993, ACON archives, id: G5820 (folio: prisons); Matt Gaughwin, 'Behind Bars - Risk Behaviour for HIV Transmission in Prisons: A Review', in Jennifer Norberry, Matt Gaughwin and Sally-Anne Gerull (eds), *HIV/AIDS and Prisons*, Canberra: Australian Institute of Criminology, 1991, p.99; and Angela Gorta, 'Estimates of Prior Drug Use by Prisoners in NSW Gaols', unpublished report prepared by the NSW Department of Corrective Services, Research and Statistics Division, June 1988, cited in Hans Heilpern and Sandra Egger, 'HIV Policies and Practices in Prisons', unpublished report prepared for the Commonwealth Department of Community Services and Health, 1991, p.1, ACON archive, id: G1199 (folio: prisons).

once incarcerated.³³ In Long Bay gaol in Sydney, it was estimated that some needles were reused 30-40 times per day.³⁴

Despite these facts, the Corrective Services Minister, prison wardens, and the Prison Officers' Association in each state refused to implement needle and syringe exchange programmes in any form. They were concerned that the recognition of drug use within prisons would signify its 'acceptance', which might discourage drug users from trying to rehabilitate themselves. They were also worried that needles and syringes could be used as weapons against other inmates and prison officers. Indeed, a prison officer at Long Bay gaol was infected with HIV and developed AIDS after being deliberately jabbed with a contaminated blood-filled syringe in July 1990.³⁵ Proponents of prison needle exchange programmes argued, however, that such an incident proved that attempts by prison authorities to eliminate injecting drug use in gaol (by enforcing penalties for the detection of drugs during random cell checks and urine tests) had failed. The 'rehabilitation' of drug users was also unlikely as most prisons did not offer 'detoxification' programmes and only a selected few gaols in New South Wales and South Australia offered methadone programmes in the 1980s.³⁶ The Department for Corrective Services, prison wardens and Prison Officers' Associations were obstinate, however, and proponents of prison NSEP had to satisfy themselves with the knowledge that most prisons provided bleach or Milton tablets for all-purpose cleaning which could be used, subversively, by prisoners to disinfect dirty needles and syringes.³⁷

³³Robert M. Douglas, *et al.*, 'Risk of Transmission of the Human Immunodeficiency Virus in the Prison Setting' [letter], *Medical Journal of Australia*, vol.150, 1989, p.722; and Lisa Conolly and Frances Potter, 'AIDS Education in NSW Prisons', *Australian and New Zealand Journal of Criminology*, vol.23, 1990, pp.158-64.

³⁴J.M. Dwyer, 'Diminishing the Spread of AIDS in Australian Gaols', paper presented to the Australian Bicentennial International Congress on Correctional Services, Sydney, 1988.

³⁵Jerry Pratley, 'Prisoner May Face Charges', *West Australian*, 24 July 1990, p.5; and Bernard Lagan, 'Officer Contracts AIDS Virus After Needle Jab', *Age*, 1 September 1990, p.1. The officer, Geoffrey Pearce, subsequently sued the Department of Corrective Services, who settled out of court. Mr Pearce died in 1997.

³⁶Heilpern and Egger, 'HIV Policies and Practices in Prisons', p.4; Simon Lake, 'HIV in Gaol', *Alternative Law Journal*, vol.17, no.1, 1992, p.21; and John Stapleton, 'Jail Methadone is Rationalised', *Sydney Morning Herald*, 26 December 1991, p.10.

³⁷Heilpern and Egger, 'HIV Policies and Practices in Prisons', p.4. Prison authorities did not offer training in this regard, however, and during his term as NSW Corrective Services Minister, Michael Yabsley banned bleach from NSW prisons. It was reintroduced by his successor. At the time of writing, bleach is still not

The arguments used against the implementation of needle and syringe exchange programmes in prisons were similar to those voiced by opponents of NSEP in the wider community. It was feared that once drug users were supplied with sterile needles and syringes, which reduced the risk of injecting, they would be encouraged to continue the practice rather than seek treatment. Furthermore, it was suggested that more people, especially the young, would experiment with drugs if needles and syringes were readily available. Summarising this argument, a frustrated Dr Julian Gold, head of the Albion Street (AIDS) Clinic, stated that it was "like saying that making beer mugs available encouraged drug use".³⁸ In the minds of nervous politicians, church groups and some doctors, however, these threats were real and prevented them from supporting needle and syringe exchange. Their anxiety was slightly eased when the initial evaluations of needle exchange programmes in Amsterdam began to be circulated. These evaluations found that there was "no indication of an increase in drug use among exchangers, no reduction in clients of drug free facilities, [and] no indication of new addicts (in fact, the percentage of young addicts is declining)".³⁹ Subsequent surveys of needle and syringe exchange programmes around the world have substantiated this conclusion and justified the decision of Australian policy-makers to take the risk and trust drug users. Buning, for example, in his 1990-1 review of the Amsterdam NSEP, stated that "no increase in drug use could be validated". While he found that 29% of NSEP clients reported an increase in drug use, 38% had reduced their drug use. Moreover, Amsterdam's drug treatment centres were seeing twice as many patients, indicating that "drug users in Amsterdam are still motivated to enter drug free treatment" despite the fact that drug injection was now safer.⁴⁰

readily available in Australian prisons. Inmates in some Queensland correctional institutions, for example, are required to approach custodial officers in order to obtain a sachet of bleach rather than procuring it confidentially. They are discouraged from doing so because such a request often leads to a cell search for drugs (Tony Falconer, 'The Principles of Health Management in Corrections as it Relates to Drugs', in Barry Ellem (ed.), *Drugs in Prisons: Proceedings of the Australasian Conference*, Brisbane, 6-8 April 1998, Brisbane: Queensland Corrective Services Commission, 1998, p.179).

³⁸'Clean Needles: Weapons in the War on Drugs', *Connexions*, vol.7, no.1, January/February 1987, p.7.

³⁹E.C. Buning, *et al.*, 'A First Evaluation of the Needle/Syringe Exchange in Amsterdam, Holland', paper presented to The Global Impact of AIDS conference, London, 10 March 1988, NBAC/NAAC, ANU, HS/7(83).

⁴⁰Ernst C. Buning, 'Effects of Amsterdam Needle and Syringe Exchange', *International Journal of the Addictions*, vol.26, no.12, 1991, pp.1303-11. Similar conclusions were reached by G.J. Hart, *et al.*,

While programme co-ordinators could refute suggestions that the greater availability of drug injecting equipment would lead to an increase in drug abuse, they faced greater difficulty in convincing sceptics that NSEP would reduce, rather than increase, the number of bloodied needles that were discarded in alley-ways, public toilets, parks and playgrounds. Indeed, they were terrorised by television news stories of early morning joggers who punctured their feet on used syringes that were submerged beneath beach sand and who now faced anxious waits before tests would reveal whether or not they had acquired HIV. Needle and syringe exchange programmes were designed to eliminate this problem by replacing bloodied syringes with sterile ones. In practice, however, a large minority of drug users never exchanged the equipment with which that they were supplied. During January 1988, for instance, only 17% of needles and syringes were returned for exchange in New South Wales. This rate of return grew markedly over time, however, and by June 1989 (when the first evaluation of New South Wales' NSEP was conducted) it had reached 57%. At some outlets, the return rate was as high as 80%, at others – such as those in the closely policed districts of Kings Cross and Surrey Hills – the rate was less than 10%.⁴¹ In Victoria, the return rate was 66.5% in 1988, but dropped to 53.6% in 1989 (when more than three times as many needles and syringes were distributed).⁴²

The failure to return used needles and syringes did not, of course, mean that they would end up in the feet of children and exercise enthusiasts. Data collected from Victorian NSEP clients in 1989, indicated that over 40% of those who did not return their used needles and syringes disposed of them in 'sharps safe' containers which were provided by NSEP staff

'Evaluation of Needle Exchanges in Central London - Behavioural Change and Anti-HIV Status Over One Year', *AIDS*, vol.3, no.5, 1989, pp.261-5; and Don Des Jarlais and Samuel Friedman, 'AIDS and Legal Access to Sterile Drug Injection Equipment', *Annals of the American Academy*, vol.521, 1992, pp.42-64.

⁴¹MSJ Keys Young Planners Pty Ltd, 'Evaluation of the New South Wales Needle and Syringe Exchange Program', p.7. Data collected by the NSW AIDS Bureau indicated that by 1994 more than 70% of needles and syringes distributed through the public needle and syringe exchange outlets were being returned. See NSW Department of Health AIDS Bureau, *NSW Needle and Syringe Exchange Policy*, p.5.

⁴²Mullins, 'Report on the Victorian Needle and Syringe Exchange Program', p.3.

and City Councils.⁴³ NSEP co-ordinators also argued that most clients expressed a desire to comply with the rules of exchange, but were afraid to return with used needles and syringes because of the possibility that they might be stopped and searched by police; in all States the possession of illicit drugs remained an offence in the 1980s and 1990s and traces of drugs and blood found in fits could be used as evidence against users in a court of law. Indeed, the more radical supporters of NSEP asserted that rather than curtailing the activities of needle and syringe exchange outlets, the problem of HIV infection and publicly discarded needles and syringes could be addressed by decriminalising the possession of small quantities of illicit substances, thereby encouraging drug users to return their used fits to exchange outlets. To illustrate their argument, they pointed to the fact that staff and volunteers at a needle and syringe exchange outlet operated by the Prostitutes' Collective of Victoria – traditionally one of the busiest in Melbourne – reported seeing only one client on the day after a police 'blitz' on prostitution and drug use in St Kilda was announced in October 1990. Presumably drug users did not stop injecting during the 'blitz' – they simply went 'underground' and shared the needles and syringes that they had in their possession.⁴⁴ Until their demands for decriminalisation were met, NSEP staff and volunteers continued to educate the police about the public health benefits of using discretion and reducing surveillance in the vicinity of needle exchange outlets.

While the media's portrayal of thoughtless drug addicts discarding their bloodied, government-sponsored syringes on the beach provided the biggest threat to the continued sanction of needle and syringe exchange, the programmes were also under pressure from the doctors and bureaucrats who supported their introduction in the first place. This new threat came in the form of a 1988 proposal, supported by Ron Penny's ANCA Working Group on IVDU, to replace existing syringes with a single-use, or non-reusable, model that Australia was taking the lead in developing. The proposal implicitly demanded that money be taken away from community-based needle and syringe exchange programmes and educational efforts and directed towards the development and implementation of a

⁴³This figure is extrapolated from Mullins, 'Report on the Victorian Needle and Syringe Exchange Program', p.12. By the end of 1989, procedures were introduced into NSEP which required a puncture-proof disposable container to be issued with all needles and syringes.

⁴⁴Andrew Hunter, 'Project Report 3: AIDS Education to Men in Prostitution', unpublished report prepared for the Prostitutes' Collective of Victoria, c.1990, NBAC/NAAC, ANU, H15/7(75-2).

technological quick-fix – a traditional medical response to disease and illness. It took the responsibility of reducing the transmission of HIV out of the hands of drug users and gave it instead to doctors, engineers and bureaucrats.

The idea to replace the existing model of syringe was first endorsed at an ANCA meeting in August by the IVDU Working Group, which recommended “that should single use needles and syringes become available, these nationally replace all reusable 1 and 2 ml needle and syringes and subsequently, single use needles and syringes should be made freely and readily available”.⁴⁵ ANCA then called on manufacturers to submit suitable designs for testing by the Medical Devices and Dental Products Branch of the Commonwealth Department of Health, represented by Martin Van Lith. After evaluating the designs, Van Lith reported to a meeting of ANCA representatives, engineers and Commonwealth officials in November that “the design and future production of a single use non-reusable syringe is an achievable objective” and “the production of such injecting equipment would most certainly halt the transmission of HIV within the intravenous drug using community”. Furthermore, he asserted that “ANCA has a responsibility to make this preventative method an urgent priority”.⁴⁶ At the conclusion of the meeting, the Commonwealth Department of Health was asked to estimate the funding required to bring the project to fruition and ANCA was directed to consult further on the project. This meant speaking to user-groups and other community-based AIDS organisations about the syringe replacement project for the first time. It was only then that the problems with the ‘one-shot’ syringes became obvious, and the deeper issue about the control of AIDS prevention strategies emerged.

The IVDU Sub-Committee of the AIDS Council of New South Wales identified four major problems with the syringe replacement proposal. In the first place, it contended, it would be impossible to replace all of the ‘old-style’ syringes which, if the users’ preferred, could be hoarded or illegally imported. Second, the new ‘single-use’ syringes would not prevent

⁴⁵ANCA IVDU Working Group, ‘Containing the Spread of HIV Infection in IVDU, A Strategy Review for ANCA’, unpublished report prepared for ANCA Meeting No.3, August 1988, p.6, NBAC/NAAC, ANU, H9/146.

⁴⁶‘Minutes from Meeting to Discuss the Feasibility of Non-reusable Single Use Syringes’, 14 November 1988, NBAC/NAAC, ANU, H5/7(84).

two or more people from sharing the same fit – indeed, no syringe could do so. If injecting drug users did not have access to extra syringes, they could simply load two or more doses of the drug into one syringe and share its content by only partially extinguishing the plunging mechanism. Moreover, if nothing could be added to the syringe after the plunger had been pushed to the bottom (as the ‘one-shot’ syringe design demanded), the possibility of rinsing the fit with bleach or alcohol was eliminated. Thus, rather than “certainly halt[ing] the transmission of HIV”, the replacement syringes potentially exacerbated the problem by failing to eliminate sharing while preventing the cleaning of fits. Finally, the cost of the new syringes would prohibit needle and syringe exchange programmes from operating at their current level, and might also prove too expensive for users to purchase. Existing syringes cost between 12-13 cents to manufacture, yet retailed close to \$1.00. Industry estimates indicated that the production of single-use syringes could be as high as 50 cents per unit – making NSEP three times more expensive than their current price. This extra cost would necessitate a reduction in the number of needles and syringes provided by outlets at a time when there was a demand for this service to be expanded.⁴⁷ In its reply to the syringe-replacement proposal, the Queensland Intravenous AIDS Association also suspected that money would be taken from existing education campaigns, outreach and drug treatment programmes in order to facilitate the development and implementation of ‘one-shot’ syringes.⁴⁸

From the perspective of user groups, the logistical problems with ‘one-shot’ syringes were compounded by the fact that ANCA and the Commonwealth Department of Health had not consulted injecting drug users from the outset. After all, injecting drug users were the people most affected by the replacement scheme, and their expert knowledge could have quickly identified the flaws in the syringe replacement proposal. Indeed, ACON’s IVDU Sub-Committee argued:

⁴⁷ACON IVDU Sub-Committee, ‘Paper on “One-Shot” Syringes’, unpublished paper dated 13 January 1989, in bundle NBAC/NAAC, ANU, H5/7(84). Such concerns had already been raised during meetings of the IVDU Working Group, although they were never articulated with this level of clarity and vigour.

⁴⁸Letter to Professor Ron Penny, Chief Commonwealth Education and Services Advisor on AIDS and Co-ordinator of ANCA IVDU Working Group, from Jill Dixon, President of the Queensland Intravenous AIDS Association, 31 December 1988, in bundle NBAC/NAAC, ANU, H5/7(84).

This lack of consultation, the complete disdain that it implies for users and their ability to make sensible decisions about their using, smacks of treating users as idiots. Users have no desire to wreck their veins with used needles or have dirty hits or get HIV infected. Given access to clean works there is no evidence to suggest that they will not take every effort to protect themselves in any realistic situation, and plenty of evidence to show they will. Given access to bleach and education on how to avoid contamination, by HIV and other micro-organisms, they will clean effectively.⁴⁹

In the view of the ACON IVDU Sub-Committee, the debate about 'one-shot' syringes and the emphasis on a technological quick-fix took attention away from where it needed to be: on education, decriminalisation, and expanded NSEP and treatment options. It put the responsibility of AIDS prevention back into the hands of doctors and bureaucrats, who did not understand the ways of drug users, nor the ingenious lengths to which they would go in order to shoot up. And rather than trusting and empowering drug users to take control of their own destinies, it rendered them incapable and, perhaps, doomed without the assistance of doctors and engineers. In defence of the IVDU Working Group, it must be noted that an active injecting drug user *was* invited to attend the meetings of the Working Group, but he frequently missed the appointments.⁵⁰ Given that, at the time, the effectiveness of needle and syringe exchange programmes, methadone maintenance treatment, education campaigns and the work of drug user collectives had not been proven, the Working Group was also obliged to explore any reasonable measure which might have protected the health of drug users and the wider community.

The language in which the call for the introduction of single-use syringes was articulated by medical experts and bureaucrats – Penny's Working Group stated that "the urgency for action is highlighted by the fact that IVDUs are the major channel of HIV infection for the general community and babies" – and the way in which drug users were perceived to be ignored until the last possible moment, reopened a wound that had been festering since

⁴⁹ACON IVDU Sub-Committee, 'Paper on "One-Shot" Syringes'.

⁵⁰Personal communication with Dr Alex Wodak, member of the IVDU Working Group, dated 16 June 2000. This level of consultation may still be deemed to have been inadequate.

epidemiologists and the media had forecast the arrival of the 'second wave' of HIV infection.⁵¹ As the ACON IVDU Sub-Committee's written reply to the syringe replacement proposal expressed, drug users were sick of being considered as an 'after-thought' and a secondary concern to the primary goal of protecting 'innocent' men, women and children from AIDS. Drug users wondered if, in the eyes of policy-makers, their lives were expendable, and whether the NSEP would ever have eventuated if non-drug users had not been implicated in the epidemic. They then watched as the continued existence of the NSEP was threatened by occasional media reports of people stepping on carelessly discarded syringes. They listened to Peter Webeck, President of the NSW Pharmacy Guild, admitting that his organisation only became involved in distributing low-cost needles and syringes after "figures came through showing that addicts were becoming the conduit for the AIDS virus to go out of the homosexual and bisexual groups and into the general community. We decided to take the wider community view – to provide clean needles to help minimise the spread of AIDS into the general community."⁵² Now drug users believed that they were witnessing the government's trust in them, and its faith in community empowerment, evaporate as soon as doctors and bureaucrats devised a technological solution to contain the spread of HIV.

Given the rhetoric that was used by the media in announcing the 'second wave' threat to heterosexual men, women and children, and the language employed by people such as Ron Penny and Peter Webeck in advocating NSEP and 'one-shot' syringes, drug users and user groups could be forgiven for this kind of fear. Their suspicions were understandable, but not based on reality. If the state governments were only concerned about the 'innocent' sexual partners of IDU rather than drug users themselves, they could have spent their money on educating these people through targeted condom- and AIDS-awareness campaigns rather than NSEP. If they were not committed to saving the lives of drug users, and empowering them to protect themselves, they could have ignored the 'harm minimisation' approach, as did the United States, and acquiesced to the public's demand for increased police surveillance of drug users and greater penalties for the use of drugs and

⁵¹ANCA IVDU Working Group, 'Containing the Spread of HIV Infection in IVDU', p.3.

⁵²'Clean Needles - Weapons in the War on AIDS', *Connexions*, vol.7, no.1, January/February 1987, p.7.

possession of syringes. Only Tasmania took the politically safe decision to reject NSEP, and none of the States abandoned their programmes despite criticism that government-provided needles and syringes were being discarded on beaches and in playgrounds. Furthermore, the rhetoric used by people such as Penny and Webeck did not necessarily reflect their own views but, rather, was carefully chosen to persuade their tentative constituencies to support needle and syringe exchange initiatives. Webeck, in particular, faced a difficult job in convincing typically conservative pharmacists to stock and sell low-cost needles and syringes to injecting drug users, and was instrumental in this being achieved.

The opinions of user groups, and the practical problems with 'one-shot' syringes, were taken into consideration by policy-makers, and by August 1989 the syringe replacement proposal had lost the support of ANCA and was explicitly opposed by Blewett's department. Ron Penny continued to be an enthusiastic supporter of the initiative, however, and the Western Australian Department of Health began trialing 'one-shot' syringes in selected hospitals in 1991.⁵³

Needle and syringe exchange and peer-based education programmes thus remained the cornerstone of Australia's AIDS-prevention strategy. They solidified their position at the beginning of the 1990s after evaluations confirmed their effectiveness in enhancing drug users' understanding of HIV and its transmission, and reducing the incidence of needle and syringe sharing. A 1989 NSW survey, for example, indicated that NSEP clients had a high level of knowledge concerning safe injecting practices and that 60% of clients had made appropriate changes to their injecting behaviour since first attending NSEP. The majority of those who had not altered their behaviour said that this was because their own injecting practices were already safe. Two-thirds of NSEP clients in the NSW survey had not shared needles or syringes in the past month, and most of those who did had cleaned their fits before injecting.⁵⁴ In Victoria, 40% of new clients said that they had shared prior to

⁵³Memo to AFAO Committee Members from Don Baxter, ANCA Member, 'Report on ANCA Meeting No.9 (10 August 1989)', 15 August 1989, NBAC/NAAC, ANU, H5/1(15).

⁵⁴MSJ Keys Young Planners Pty Ltd, 'Evaluation of the New South Wales Needle and Syringe Exchange Program', p.8.

registering at the NSEP, but only 5% of clients returning to a NSEP said they had shared since their last visit.⁵⁵ A later Victorian study suggested that NSEP clients were more likely to use a new syringe a greater proportion of the time as compared to non-NSEP clients (77% compared to 68%), and indicated that NSEP clients who continued to share needles and syringes were more likely to properly clean their equipment when compared to users who did not utilise NSEP (46% compared to 14%).⁵⁶

International studies of behavioural change in NSEP clients supported the Australian findings and validated the role of NSEP in reducing the incidence of needle and syringe sharing. Donoghoe's study of NSEP in England and Scotland, for example, found that due to their contact with NSEP, clients reduced the proportion of occasions that they shared drug injection equipment from 34% to 27%, whilst non-NSEP clients continued to share 62% of the time.⁵⁷ In their study based on observations of Amsterdam's IDU population between 1986 and 1988, Van den Hoek *et al.* similarly found that when NSEP were available, the proportion of occasions when used drug injecting equipment was 'borrowed' or 'lent' decreased from 56% to 16% and 44% to 8% respectively.⁵⁸

The reduction in needle sharing facilitated by NSEP would have meant nothing if it did not manifest into low or stable rates of HIV infection among IDU. In Australia this was indeed the case. Researchers in Sydney reported that the seroprevalence rate among IDU presenting to the Albion Street Clinic in 1989 was 10.5% - slightly less than the rate

⁵⁵Mullins, 'Report on the Victorian Needle and Syringe Exchange Program', p.16. Drug users had no reason to lie during this survey as their answers were offered anonymously and did not determine whether or not they would be provided with new needles and syringes.

⁵⁶V.J. Lewis and R.M. Mullins, 'Evaluation of the NSEP Program in Victoria, Australia: 1989-1990', unpublished report, cited in 'Key Questions in HIV/AIDS Control', unpublished briefing paper prepared by the Health Department of Victoria AIDS/STD Unit, 1992, p.3, NBAC/NAAC, ANU, H18/13.

⁵⁷Martin C. Donoghoe, *et al.*, 'Changes in HIV Risk Behaviour in Clients of Syringe-Exchange Schemes in England and Scotland', *AIDS*, vol.3, no.5, 1989, pp.269-72.

⁵⁸J.A.R. Van den Hoek, H.J.A. van Haastrecht and R.A. Coutinho, 'Risk Reduction Among Intravenous Drug Users in Amsterdam under the Influence of AIDS', *American Journal of Public Health*, vol.79, no.10, 1989, p.1356. This trend was affirmed by an evaluation published five years later. See Erik van Ameijden, Anneke van den Hoek and Roel A. Coutinho, 'Injecting Risk Behaviour Among Drug Users in Amsterdam from 1986 to 1992, and its Relationship to AIDS-Prevention Programs', *American Journal of Public Health*, vol.84, 1994, pp.275-81, especially pp.277-9.

recorded in 1985 (11.1%).⁵⁹ Two-thirds of IDU infected with HIV were either homosexual or bisexual men and thus likely to have been infected during sexual intercourse.⁶⁰ In fact, as of October 1990, only 1.5% of AIDS cases in Australia had been attributed to IDU, with a further 2.7% attributed to male homosexual or bisexual contact and IV drug use.⁶¹ This compared with an IDU seroprevalence rate of 62.8% for Spain, 66.1% for Italy, and 22% for the United States, countries in which NSEP were not sanctioned.⁶² Researchers at the New York State Division of Substance Abuse Services, in fact, indicated that nearly 60% of New York City's estimated 200,000 injecting drug users would test positive for HIV, yet no officially funded needle exchange programmes operated in the state of New York.⁶³

⁵⁹James J. Guinan, Shane Darke and Julian Gold, 'Letter in Reply to Donovan *et al.*,' *Medical Journal of Australia*, vol.152, no.9, 1990, p.499.

⁶⁰Jael Wolk, *et al.*, 'HIV-Related Risk-Taking Behaviour, Knowledge and Serostatus of Intravenous Drug Users in Sydney', *Medical Journal of Australia*, vol.152, no.9, 1990, pp.453-8.

⁶¹National Centre in HIV Epidemiology and Clinical Research, *Australian HIV Surveillance Report*, vol.6, supplement 2, October 1990, p.5. Until the end of 1998, IDU constituted approximately 8% of HIV diagnoses in Australia, of whom roughly half were men who also reported a history of homosexual contact. The reported HIV seroprevalence among men and women seen at metropolitan sexual health clinics between 1992 and 1998 who identified themselves as IDU also remained low (0.6%). HIV seroprevalence among people attending NSEP outlets (measured by testing traces of blood on returned needles and syringes) remained low (less than 3%) except among men who identified themselves as either bisexual (4%) or homosexual (27%). See Australian National Council on AIDS and Related Diseases, *Proving Partnership: Review of the National HIV/AIDS Strategy, 1996-97 to 1998-99*, ANCARD, May 1999, p.9; and National Centre in HIV Epidemiology and Clinical Research, *HIV/AIDS and Related Diseases in Australia Annual Surveillance Report 1999*, date to end of 1998 as reported by 31 March 1999, <http://www.avert.org/ausstatg>, accessed 20 January 2001.

⁶²Nick Crofts, 'Patterns of Infection', in Eric Timewell, Victor Minichiello and David Plummer (eds), *AIDS in Australia*, Sydney: Prentice Hall, 1992, p.36. In Europe in 1989, approximately 27% of all reported AIDS cases were related to a history of drug injecting. See Manuel Carballo and Giovanni Rezza, 'AIDS, Drug Misuse and the Global Crisis', in John Strang and Gerry V. Stimson (eds), *AIDS and Drug Misuse: The Challenge for Policy and Practice in the 1990s*, London: Routledge, 1990, p.18.

⁶³Don C. Des Jarlais and Samuel R. Friedman, 'The Epidemic of HIV Infection Among Injecting Drug Users in New York City: The First Decade and Possible Future Directions', in John Strang and Gerry V. Stimson (eds), *AIDS and Drug Misuse: The Challenge for Policy and Practice in the 1990s*, London: Routledge, 1990, p.87; Chris Bull, 'Activists Will Decry New York AIDS Policy During Needle Trial', *The Advocate*, March 1991. Among the more unique impediments to the implementation of needle and syringe exchange programmes in New York was opposition from African-American and Hispanic community leaders and law enforcement officials. Black leaders believed that NSEP would promote drug use in black communities which were already suffering from the social problems associated with wide-spread drug addiction. Drawing on radical critiques from the 1960s which viewed the introduction of drugs into black communities as a deliberate attempt to subdue their inhabitants, black leaders saw NSEP as just another weapon in the 'genocidal' war against black people. When New York elected its first black Mayor and its first black Commissioner of Health in 1990, one of their first actions was to terminate the minute-scale pilot NSEP which had been tentatively operating in New York City since November 1988. They also advocated that the City should withdraw all financial support for organisations and community groups which provided bleach and information about its use to sterilise needles and syringes. For further analysis of why health officials

The correlation between the low rate of seropositivity among IDU and needle exchange programmes was proven by three Australian researchers in perhaps the most comprehensive and methodologically credible evaluation of the effects of NSEP. They collected data from eighty-one cities with and without NSEP, which had maintained statistics on the annual rate of HIV seroprevalence among IDU.⁶⁴ They found that, on average, seroprevalence increased annually by 5.9% in the fifty-two cities without NSEPs, and decreased by 5.8% in the twenty-nine cities with NSEP.⁶⁵ The evaluation confirmed the smaller-scale findings of Rodriguez-Arenas *et al.* who compared individual cities with and without NSEP and reported that London NSEP clients were less likely to be infected than IDU in Madrid (12.8% compared to 45%), because the Spanish city did not operate a NSEP.⁶⁶ Even within one country, significant differences were found to exist between nearby cities. Edinburgh, without a NSEP, had an estimated HIV infection rate among IDU of 65%, whilst Glasgow, seventy kilometres away and with a NSEP in operation, had an infection rate among IDU of only 4.5%.⁶⁷

and politicians in the United States refused to sanction NSEP, see Ronald Bayer and David L. Kirp, 'The United States: At the Centre of the Storm', in David L. Kirp and Ronald Bayer (eds), *AIDS in the Industrialized Democracies: Passions, Politics and Policies*, New Brunswick: Rutgers University Press, 1992, pp.7-48, especially pp.36-7; Stoller, *Lessons from the Damned*, pp.97-112; Warwick H. Anderson, 'The New York Needle Trial: The Politics of Public Health in the Age of AIDS', *American Journal of Public Health*, vol.81, 1991, pp.1506-17; Mark C. Donovan, 'A Tough Sell: The Political Logic of Federal Needle-Exchange Policy', in William N. Elwood (ed.), *Power in the Blood: A Handbook on AIDS. Politics and Communication*, New Jersey: Lawrence Erlbaum, 1999, pp.353-63, especially pp.363-4; and M. Daniel Fernando, *AIDS and Intravenous Drug Use: The Influence of Morality, Politics, Social Science, and Race in the Making of a Tragedy*, Westport: Praeger, 1993, especially pp.43-144.

⁶⁴The cities were drawn from each of the inhabited continents, and their annual rate of seroprevalence was derived from the results of HIV-antibody tests that were conducted on IDU who frequented STD clinics and drug treatment facilities, or returned syringes to NSEP outlets.

⁶⁵Susan Hurley, Damien Jolly and John Kaldor, 'Effectiveness of Needle-Exchange Programmes for Prevention of HIV Infection', *Lancet*, vol.349, 21 June 1997, p.1797.

⁶⁶A. Rodriguez-Arenas, *et al.*, 'Differences in HIV Prevalence and Risk Behaviour in Injecting Drug Users in London and Madrid', paper presented at the 8th International Conference on AIDS, Amsterdam, July 1992. A more recent comparative study of twelve cities produced similar findings. See Meni Malliori, *et al.*, 'Drug Injecting and HIV-1 Infection: Major Findings from the Multi-City Study', in Gerry Stimson, Don C. Des Jarlais and Andrew Ball (eds), *Drug Injection and HIV Infection: Global Dimensions and Local Responses*, London: UCL Press, 1988, pp.58-75.

⁶⁷Donoghoe *et al.*, 'Changes in HIV Risk Behaviour', pp.269-72.

In the mind of Yolande Groenhout, project worker for VIVAIDS, the success of NSEP in limiting the transmission of HIV and preventing the expected 'second wave' of HIV infection

contradicts two of the wider community's most strongly held beliefs about intravenous drug users; the first belief being that intravenous drug users do not care about their health; the second, that intravenous drug users don't care about each other. Our clients have become the most zealous AIDS educators of other intravenous drug users. They drag users that we haven't made contact with into our office to exchange [needles] and get information. People caught sharing syringes are lectured by other users, people too timid or too isolated to use our exchange are having syringes picked up and delivered by other users, general health information is being shared around as is other information. In this way a user friendly needle exchange is one of our most efficient means of providing AIDS information for, and changing the behaviour of, intravenous drug users.⁶⁸

Heading into the 1990s, however, Groenhout and doctors such as Alex Wodak and Nick Crofts, who risked their reputations in the 1980s by becoming advocates of NSEP and drug law reform, were not prepared to let the state governments rest on their laurels. They noted that permission and funding were still denied to other innovative 'harm minimisation' options such as supervised injecting rooms and 'heroin trials' (in which strictly monitored doses of heroin are prescribed to registered addicts by doctors), and that NSEP had not yet been trialed in prisons, despite the large number of incarcerated men and women who continued to use injecting drugs and share needles and syringes. Moreover, the effectiveness of NSEP continued to be impeded by laws which criminalised the possession of small amounts of illicit substances. On the eve of the launch of the 1st National HIV/AIDS Strategy in August 1989, Wodak claimed that there was still a need to increase the capacity of NSEP by a factor of ten, and to triple the number of drug treatment

⁶⁸Yolande Groenhout, 'Community Needle Exchange', in Department of Community Services and Health, *Report of the Third National Conference on AIDS*, Hobart, 4-6 August 1988, Canberra: AGPS, 1988, p.119.

services.⁶⁹ He also said that education programmes needed to be maintained and made new, rather than down-scaled, as approximately 25% of the drug using population in any one year were injecting for the first time and thus may not have been exposed to information about the risks of AIDS and HIV prevention.⁷⁰ While Australia had been courageous and proactive in implementing humanistic strategies to prevent the transmission of HIV among injecting drug users in 1986 and 1987, it could not now afford to turn its back in the 1990s while the second wave continued its seemingly relentless surge to claim the beach.

⁶⁹Dr Alex Wodak quoted in Memo to AFAO Committee Members, from Don Baxter, ANCA member, 'Report on ANCA Meeting No.9 (10 August 1989)', 15 August 1989, NBAC/NAAC, ANU, H5/1(15). Wodak's recommendation has since been supported by a number of studies. For example, 73% of 974 injecting drug users interviewed during the early 1990s cited "difficulty in obtaining sterile injecting equipment" as their primary reason for occasionally sharing equipment (M.W. Ross, *et al.*, 'Explanations for Sharing Injection Equipment in Injecting Drug Users and Barriers to Safer Drug Use', *Addiction*, vol.89, 1994, pp.473-80, cited in Beth Rosalie Crisp, *Calculated Risk Taking: An Explanation for HIV/AIDS Risk Behaviours by Australian Injecting Drug Users*, unpublished PhD thesis, La Trobe University, December 1994, p.12). Conversely, Marsh and Loxley reported a 26% decrease in sharing among Perth IDU following a 144% increase in the number of needles and syringes distributed during their two-year study (A. Marsh and W. Loxley, 'Picks and Policy in Perth', unpublished manuscript, 1992, cited in *ibid.*, p.15).

⁷⁰Dr Alex Wodak quoted in Memo to AFAO Committee Members, from Don Baxter, ANCA member, 'Report on ANCA Meeting No.9 (10 August 1989)', 15 August 1989, NBAC/NAAC, ANU, H5/1(15).

Chapter 8.

Cash is not a body fluid, HIV is not spread on credit cards: The Case of HIV-Positive Sex Workers

Man to man, I don't know if they can
From what I know the parts don't fit (ah, shit)
Now he's sharin' a needle with a drug addict
(He don't believe he has it either)
But now he does, he doesn't know
'Cause he goes straight to a whore
Tell you what, who's next on the block
Wild thinin' on a germ runnin' wild
(Yo, stop!)
But the bag popped (damn!)
"Yo, Terminator, man...
Meet the G that killed me."

AIDS had well and truly infiltrated popular culture and the collective consciousness of Australians by the end of 1987, with the malicious bony grin of the Grim Reaper regularly staring out from magazines and television screens and the disjointed 'rap' of Public Enemy's song about AIDS, 'Meet the G That Killed Me', booming from the portable stereos of young people. Advertising executives and popular music groups had joined scientists and journalists in their efforts to reposition AIDS as a heterosexual problem and construct an epidemiological narrative that would explain how an infection – which they had previously described as a 'gay disease' – was now killing heterosexual men and women. While scientists seeking the origins of AIDS had turned their attention away from gay men to focus on African monkeys, it is clear that their counterparts could not divorce themselves from the notion that gay men were to blame for the danger that heterosexuals now faced. Axl Rose, lead-singer of the American rock band Guns'n'Roses, for example,

¹Public Enemy, 'Meet the G That Killed Me', *Fear of a Black Planet* [album], New York: DefJam/Columbia Records, 1987.

blamed "those immigrants and faggots who come to our country and spread some fucking disease".² In a more sophisticated manner, the Public Enemy lyric, quoted above, established a similar epidemiological narrative: AIDS began with an unnatural sexual act between gay men ("man to man, I don't know if they can/ from what I know the parts [that is, the penis and the anus] don't fit"); it is then transmitted by a homosexual drug user to other addicts, one of whom visits a prostitute, who finally infects the song's narrator when "the bag [the condom] popped". At the conclusion of the song, the narrator turns to his mate, Terminator, in mock resignation and introduces the "G that killed me". Here the 'G' simultaneously signifies the AIDS Germ and Gay men.³

Young people, interested in pop music and identified by NACAIDS as a group that experimented with intravenous drug use and casual sex, were the obvious target audience for this new discourse concerning heterosexual risk. Australian women, previously considered to be 'immune' from the AIDS crisis, were also targeted. NACAIDS attempted to speak to them directly in pamphlets about AIDS which were inserted into *Readers Digest* and leaflets placed in social security offices and doctors' surgeries.⁴ Women were also addressed in articles that featured in newspapers and 'women's' magazines such as *Cleo*. They explained that:

Men who pose a risk to women are mainly bisexuals, intravenous drug users and those who have picked up AIDS via blood transfusions...Women whose husbands and partners visit prostitutes with AIDS antibodies are also at risk.⁵

Ironically, at a time in which the AIDS Councils and NACAIDS were trying to reposition AIDS as 'everyone's problem', and one which was exacerbated by risky *individual*

²Guns'n'Roses, 'One in a Million', *G'n'R Lies* [album], New York: Geffen Records, 1988.

³Richard Goldstein, 'The Implicated and the Immune: Responses to AIDS in the Arts and Popular Culture', in Dorothy Nelkin, David P. Willis and Scott V. Parris (eds), *A Disease of Society: Cultural and Institutional Responses to AIDS*, Cambridge: Cambridge University Press, 1991, p.25.

⁴Older women were also addressed in a song by the American country singer, Reba McEntire, who told the story of a woman who contracted HIV during a one-night stand ('She Thinks His Name Is John'). The song served the same function as lyrics by Guns'n'Roses and Public Enemy though it was released at a later time.

⁵Paula Goodyer, 'AIDS: Why Women Are At Risk', *Cleo*, November 1985, pp.128-9.

behaviour, these simplistic epidemiological narratives effectively reinscribed the notion of dangerous 'high risk groups'; for it was the deviant members of 'high risk groups' who placed 'normal' people at risk. The narrator in 'Meet the G That Killed Me' certainly takes no responsibility for his infection, simply viewing himself as the last link in a chain of depravity that started with the unnatural sexual acts of gay men. He constructs himself as an unsuspecting victim, merely fulfilling the highly sexualised macho role that was sanctioned by the black 'hip hop' culture from which Public Enemy derives, and which its audience understands: a culture which accepts that men have 'natural' sexual needs that extend to paying prostitutes for sex. Women addressed by the media reports were similarly positioned as unsuspecting, and thus innocent, victims of "insidious" husbands and boyfriends who "unknown to a woman, may be bisexual or having encounters with prostitutes".⁶

The identification of gay men, bisexuals and drug users as the cause of AIDS, or worthy of contempt or blame, was, of course, not new in the mid-1980s. There was, however, an original aspect to the narratives which sought to explain how heterosexuals might contract HIV. As each of the above examples illustrates, female prostitutes were now established as a new 'high risk group', a potential source of infection to be feared and loathed. In women's magazines they lurked in the shadows, infecting husbands and boyfriends, and were suspected by doctors of contaminating the nation's blood supply or shooting and sharing HIV-infected needles.

Such concerns were first expressed during December 1984 and early 1985 in front page news articles that solicited readers with sensationalist headlines such as 'AIDS Hits Street Girls'⁷ and 'AIDS Spread Linked to Prostitutes'.⁸ Throughout this period female sex workers became the topic of earnest discussion in the press as doctors, the Red Cross Blood Transfusion Service, and parliamentary committees investigating the possibility of prostitution law reform became transfixed by the idea that prostitutes would become, or

⁶'AIDS! Don't Kid Yourself', *Daily Mirror*, 5 August 1985, p.19.

⁷*The Sun*, 10 December 1984, p.1.

⁸*Sydney Morning Herald*, 4 May 1985, p.1.

were already, vectors of HIV transmission. 'Time to Sound Alarm' declared Perth's *Sunday Times*, '1pc of Pros Carry AIDS?' insinuated the Brisbane *Telegraph*, and 'AIDS Danger in Brothels, Says Doctor' declared the *Age*: sex workers were clearly constituted as dangerous women who needed to be controlled. The editor of the *Sydney Morning Herald*, one of the papers least likely to stoop to hysterical statements, also joined the witch-hunt, warning that "recalcitrant and dangerous infected prostitutes pose a special problem".⁹

Of interest here is why the media, doctors, and regulatory bodies (and one could suspect a good section of the public) assumed that female sex workers were carrying and transmitting HIV. In actual fact, until August 1985 there had been no reported cases of HIV transmission in a commercial sex transaction in Australia. The first alleged case, reported on 9 August, remained unsubstantiated – although it sparked a new wave of media hysteria – until a 1991 report by the Intergovernmental Committee on AIDS declared that there had been no cases of HIV transmitted from a female sex worker to a client in Australia.¹⁰ This lack of evidence did not stop Dr Joseph Santamaria, director of community health at St. Vincent's Hospital in Melbourne, from arguing that "brothels greatly increase the likelihood of AIDS being spread in the community" when he appeared before a Town Planning Appeals Tribunal on 20 September 1985 on behalf of 200 local residents opposed to the establishment of a brothel in Nunawading.¹¹ Nor did it stop the calls for prostitutes to be banned from donating blood (and fined if they did so), and to be compulsorily tested for HIV-antibodies.¹² Such calls were initially rejected in December 1984, but only on the grounds that the HIV-antibody test was still in its infant state of development and prone to producing 'false-positive' results, rather than the fact that to

⁹Editorial, 'Wran's All-Out War On AIDS', *Sydney Morning Herald*, 26 August 1985, p.10.

¹⁰'Man Gets AIDS From Prostitute', *Age*, 10 August, p.1; and Intergovernmental Committee on AIDS report cited in Michael Gordon, 'Sex Laws Must Go, Report Urges', *Sunday Age*, 28 July 1991, p.1. In reporting the first alleged case, the *Daily Telegraph* stated: "It is not known how many men have caught AIDS from the woman but it is believed it be in the hundreds." ('New First in AIDS Crisis', *Daily Telegraph*, 10 August 1985.)

¹¹'AIDS Danger In Brothels, Says Doctor', *Age*, 21 September 1985, p.5.

¹²'Blood from Prostitutes to be Discussed', *Canberra Times*, 12 December 1984, p.4; 'Pros May Face Govt AIDS Test', *Illawarra Mercury*, 16 March 1985, p.3.

implement compulsory testing of sex workers without any epidemiological foundation was discriminatory and an unacceptable infringement of individual rights.¹³

How, then, in the absence of any epidemiological evidence, can one account for the public's expectation that prostitutes were, or would become, infected with HIV and "contribute to the spreading of the virus to the heterosexual population" (as reported by the New South Wales Parliamentary Select Committee into Prostitution in 1986)?¹⁴ The obvious answer lies in the fact that Australian doctors, politicians and the press were taking their lead from their counterparts overseas. They faithfully reproduced the pessimistic forecasts and calls for punitive and coercive controls issued by American doctors, who were observing a degree of HIV-infection amongst sex workers in their own country (although, as San Francisco's Project AWARE has demonstrated, their level of panic was disproportional to the actual problem).¹⁵ Australian authorities were also looking anxiously at epidemiological trends in African and South East Asian nations which were developing heterosexual AIDS epidemics linked to a sex industry informally organised along trucking routes and nightclub strips.

Such a comparison between Australian sex workers and their 'counterparts' in other countries was severely misguided, as anyone who took the effort to understand the vastly different position of overseas prostitutes, and the organisation of the sex industry in foreign countries, would have been aware. In comparison with Australian sex workers, prostitutes in South East Asian and African nations lacked the power or resources necessary to avoid HIV infection. They lacked the skills to negotiate safe sex (unlike the more highly educated Australian sex workers who received training and support from sex worker organisations) and, due to their acute poverty or the fact that they were 'owned' by pimps or brothel owners, they could not afford to decline their services when clients insisted on

¹³Margaret Harris, 'Long Wait to Screen Prostitutes for AIDS Antibodies', *Sydney Morning Herald*, 11 December 1984, p.3.

¹⁴Parliament of New South Wales, *Report of the Select Committee of the Legislative Assembly Upon Prostitution*, Sydney: AGPS, 1986, p.170.

¹⁵Amber Hollibaugh, Mitchell Karp and Katy Taylor interviewed by Douglas Crimp, 'The Second Epidemic', in Douglas Crimp (ed.), *AIDS: Cultural Analysis/ Cultural Activism*, Cambridge: MIT Press, 1988, p.135.

having unsafe sex. Indeed, in many Asian countries, condoms were not culturally accepted and were never suggested. Australian sex workers, on the other hand, had access to high quality condoms and lubricant, and worked in a society that sanctioned the use of condoms. They were also less likely to come into contact with an infected client due to the low prevalence of HIV infection in the Australian heterosexual population, as compared to African and South East Asian nations.¹⁶ Any comparison, therefore, between Australia and these countries was bound to lead to inaccurate assumptions and panic-driven calls for punitive controls. A representative from the Australian Prostitutes Collective made this very point during a public forum screened on *Four Corners* in 1987 (one of the few 'positive' media representations of Australian sex workers). She demanded that people stop talking about Australian prostitutes while they had the vision of African or Asian sex workers in their minds: the two were completely different creatures and should, she said, be treated differently by their respective public health authorities.¹⁷

To simply accept that Australian public health authorities, journalists and politicians were ignorant about the nature of prostitution would be to overlook a more persuasive and insidious cause for their unfounded panic. Their association of sex workers with disease in the 1980s went much deeper than a basic cultural misunderstanding about the way in which prostitution was organised and negotiated in other countries. In constructing narratives which posited female prostitutes as pathways of HIV transmission into the heterosexual population, Australians were actually drawing on a long standing discourse, inscribed in history, literature, art, law and medicine, that saw prostitutes as 'reservoirs of infection'. As Professor Marcia Neave, chief investigator of the 1985 inquiry into prostitution in Victoria and a long-standing member of NACAIDS and ANCA, has written: "in the public mind, prostitution is inextricably linked with disease. The powerful image of women as 'reservoirs of infection' [that] influenced public health policies in the nineteenth century

¹⁶For further discussion and comparison of Australian and international sex workers and the factors influencing infection see Christine Harcourt, 'Prostitution and Public Health in the Era of AIDS', in Roberta Perkins, Garrett Prestage, Rachel Sharp, and Frances Lovejoy (eds), *Sex Work and Sex Workers in Australia*, Sydney: University of New South Wales Press, 1994, pp.208-216.

¹⁷Community Forum held at the Hurstville Community Centre mediated by Andrew Ollie, *Four Corners*, ABC TV, produced by Martin Butler, 12 March 1988.

continues to linger today."¹⁸ In times of panic about venereal disease, prostitutes have always been the target of public health campaigns which saw them subjected to compulsory medical examination and containment. In Queensland in 1868 and Tasmania in 1879, for example, the *Act for the Suppression of Contagious Diseases* and *Contagious Disease Act* respectively made provisions for women suspected of prostitution to be medically examined on demand and incarcerated in Lock Hospitals if they were found to be infected with venereal disease. The legislation was enacted to ensure the supply of 'clean' prostitutes for sailors belonging to Her Majesty's navy when they visited Australian ports.¹⁹

The *Acts* were one of a number of public health measures aimed exclusively at female prostitutes, who were seen to be undermining the masculine virtue and virility of the Commonwealth's defence forces. The fact that public health authorities and the media in the 1980s were exclusively focusing on female prostitutes, rather than male prostitutes – who, by virtue of their contact with the gay community and higher likelihood of living and working on the street, faced greater risk of contracting HIV – goes some way to proving that the 'new' narrative about HIV-positive sex workers and heterosexual infection was merely a reconstitution of a more established one.²⁰ Constrained in their thinking by this historical discourse, public health authorities and the media simply did not think to include male sex workers in their discussions about prostitutes and 'heterosexual AIDS'. They could, however, appeal to a public that had an understanding of female prostitutes as

¹⁸Marcia Neave, 'AIDS and Women in the Sex Industry - Legal Approaches to Public Health', *Community Health Studies*, vol.13, no.4, 1989, p.424.

¹⁹Kay Daniels, 'Prostitution in Tasmania During the Transition from Penal Settlement to "Civilized Society"', in Kay Daniels (ed.), *So Much Hard Work: Women and Prostitution in Australian History*, Sydney: Fontana, 1984, pp.15-86, particularly pp.57-67; Raymond Evans, "'Soiled Doves': Prostitution in Colonial Queensland", in *ibid.*, pp.127-61, particularly pp.141-7. Also see Judith Walkowitz's perceptive analysis of the implications of the *Contagious Diseases Act* in her book *Prostitution and Victorian Society: Women, Class and the State*, Cambridge: Cambridge University Press, 1980.

²⁰In comparison to many female prostitutes, male sex workers were in a less powerful position to negotiate and insist upon safe sex for a number of reasons. They generally worked on the street or in escort work and thus did not have the support of a brothel manager, or 'house rules', which insisted that clients use condoms. Nor did they have regular contact with health workers or sex worker organisations who supplied free condoms and lubricant and provided safe sex education. Street workers also generally charged a lower fee for their services and were thus more likely to consent to unsafe sex when the client offered extra money. In addition, male prostitutes faced a higher risk of contracting HIV because of their contact with gay male clients (who were more likely to be HIV-positive than heterosexual clients using female prostitutes).

'reservoirs of infection' to support their calls for testing and containment. Despite the fact that approximately one-in-five sex workers in Australia in 1985 was male,²¹ each newspaper article that I have cited in this chapter focuses solely on female prostitutes infecting male clients. Indeed, my survey of press articles from the 1980s concerning AIDS and prostitution revealed only four which referred to the specific problem of male sex workers.²²

Beginning in late 1984 a number of different measures, consistent with the 'test and contain' model of infectious disease control, were suggested to deal with the perceived problem of HIV infection in the commercial sex industry. The Queensland and Tasmanian *Contagious Diseases Acts* were examples of this model, which was regarded as the traditional and proper way to respond to the problem of 'diseased' prostitutes. In the 1980s, proponents of this model pushed for laws against prostitution to be fully enforced and, in states which had legalised (or tolerated) prostitution, they called for all sex workers to be regularly tested and locked in hospitals if they were found to be HIV-positive. At the very least, proponents of this old-style approach to infectious disease control – who included the Canterbury and Camberwell City Councils and sections of the print and electronic media – called for laws which would force HIV-positive prostitutes to give up working.²³ They stopped short, however, of demanding that prostitutes be branded with tattoos (as suggested in a number of other countries), or restrained in their homes by the use of electronic tags. (This form of control was actually enacted in one state of the USA where

²¹Marcia Neave, *Inquiry into Prostitution: Final Report October 1985*, Melbourne: Government Printer, 1985, cited in Prostitutes Collective of Victoria, 'Boys' Policy – Draft' [a position statement on men in prostitution], c.July 1991, NBAC/NAAC, ANU, H15/7(75-2).

²²See, for example, 'End of the Wall May Put Boys Beyond Help', *Sydney Morning Herald*, 12 May 1988, p.7.

²³Malcolm Brown, 'Prostitute AIDS Tests Demanded', *Sydney Morning Herald*, 20 February 1989, p.4; and Enrica Longo, 'Mayor Claims Support for Brothel Laws', *Age*, 4 April 1991, p.6. Incidentally, an *Age* editorial which rejected the Camberwell City Council's strategy provided one of the very few positive representations of sex workers and their efforts to deal with AIDS. The editorial claimed: "Prostitutes working in legal brothels have low rates of sexually transmitted disease; indeed they, and their employers, have a vested interest in ensuring that they remain free of disease. Apart from the infringements of civil liberties involved in the registration and mandatory examination of prostitutes, such measures, according to the World Health Organisation, have the effect of forcing prostitution underground." ('Council Is Overstepping Its Role On Brothel', 4 April 1991, *Age*, p.13.) I will explain the reasoning behind the *Age*'s defence of the sex industry later in this chapter.

an HIV-positive "promiscuous" woman was confined to her home and required to wear an electronic monitor that alerted police if she moved beyond two hundred feet from her telephone.)²⁴ Sue Devereaux, a rogue voice allegedly representing the Australian Prostitutes Collective, was the only person to call for an 'AIDS tattoo' in Australia. She suggested that people with AIDS should have a health warning tattooed on or near their genitals.²⁵

While baulking at tattoos and home detention, sections of the media joined a number of doctors and religious groups in demanding that HIV-positive sex workers be quarantined for the protection of the general public, a draconian measure only enacted by the repressive Cuban regime. After the case of an HIV-positive sex worker became public in 1991, for example, the editor of the *Herald Sun* exclaimed:

It's about time Australia used whatever powers exist to limit the spread of this terrible disease. Quarantining was used years ago with tuberculosis. Why not do the same with AIDS in the case of those victims who will not desist from putting others at risk?²⁶

In stating such, the editor and his supporters made the same mistake that others committed over-and-over again throughout the history of AIDS in Australia: equating a highly infectious disease, such as tuberculosis, with HIV, a virus that was not casually transmissible and whose spread was simple to prevent. Founded on a misunderstanding of HIV transmission, their calls for draconian public health measures were entirely inappropriate.

While the campaign to quarantine HIV-positive sex workers was rejected at the parliamentary level, the move to subject all prostitutes to regular and compulsory HIV-antibody tests received widespread support and was seriously considered in Victoria and New South Wales (which had legalised prostitution in registered brothels in the mid-

²⁴Michael Mills, Constance B. Wofsy, and John Mills, 'The Acquired Immunodeficiency Syndrome, Infection Control and Public Health Laws', *New England Journal of Medicine*, vol.314, 1986, p.934.

²⁵'AIDS Tattoo', *Sydney Morning Herald*, 18 November 1989, p.9.

²⁶Editorial, 'Protecting Society', *Herald-Sun*, 27 March 1991, p.8.

1980s), and in states that tolerated prostitution in certain areas (the ACT, Western Australia, Queensland and South Australia). Unlike quarantine laws, compulsory HIV-antibody testing was not considered to be a gross infringement of a worker's individual liberties (at the time, employees in other occupations were subjected to medical examinations before they were passed fit to work). Prostitute collectives and other advocacy groups argued, however, that this measure would be counter-productive and possibly dangerous. As Cheryl Overs of the Prostitutes Collective of Victoria (PCV) asserted in 1986, compulsory testing of all known prostitutes would lead clients to absolve themselves of responsibility for their own health by encouraging them to think that 'all the girls must be clean' and that they, therefore, did not need to use condoms.²⁷ This was, of course, a dangerous assumption to make because a person could be infected immediately after taking an HIV-antibody test and because the test often fails to detect HIV-antibodies which are produced in the body during the three months following exposure. The PCV also suggested that the system of keeping sex workers under medical surveillance, which required them to be registered under their real names, would drive many prostitutes out of brothels and into the illegal street trade for the sake of anonymity.²⁸ Once on the street, sex workers faced criminal prosecution and were more difficult to be found by AIDS organisations and prostitute collectives which provided education about AIDS prevention and advice on 'safe sex negotiation'. Compared to brothel work, street soliciting also placed sex workers at higher risk of coming into contact with HIV because sexual encounters take place at a venue of the client's discretion, where the sex worker may be forced to have unprotected sexual intercourse. The PCV also claimed that due to the lower price of a sexual transaction on the street, street workers were more susceptible to accepting the extra cash that many clients offered if they did not insist on using a condom. Compulsory testing of registered sex workers thus would not solve the perceived problem of HIV; it would simply move it to another, more dangerous, sector of the industry.²⁹

²⁷Cheryl Overs, 'The Neave Report: The Prostitutes Collective Responses', *Legal Services Bulletin*, April 1986, pp.61-2.

²⁸'Submission to Victorian AIDS Council from Prostitutes Collective of Victoria: Rejection of Compulsory Testing For Sex Workers', unpublished paper, August 1989, p.2, NBAC/NAAC, ANU, H9/115.

²⁹*Ibid.*

Commenting on the proposal to test all prostitutes for HIV, Marcia Neave also noted that if the experience of the *Contagious Diseases Acts* had taught doctors anything, it was that the compulsory examination of only one party in a sexual transaction could not prevent the transmission of disease. The *Acts* failed to produce any significant decline in the prevalence of venereal disease in the population mainly due to the fact that, as subsequent studies have proven, it was promiscuous male clients and their partners, rather than female prostitutes, who were responsible for spreading disease.³⁰

It is for these reasons, and the difficulty of identifying and registering sex workers (not to mention the cost), that each of the state governments of Australia declined to subject prostitutes to regular and compulsory HIV-antibody tests. Instead, sex workers became subject to public health laws that applied to all Australian citizens. This legislation, still in effect today, varies from state to state. In most cases, it makes provision for the state's Chief Health Officer to order compulsory medical examinations only when he or she reasonably believes a person to be infected with HIV. Once identified as infected, a person may be forcibly detained in a hospital, but only when he or she does not desist from placing other people in the community at risk of infection. In most states there is no right of appeal against either of these orders.³¹

In rejecting an old-style public health strategy, state governments were still left with the problem of how to reduce the (perceived) risk of HIV spreading through and from the sex industry. Given that a medical cure for AIDS seemed a long way off and that the 'test and contain' approach would clearly prove counter-productive, the 'community empowerment' model of 'HIV prevention through education' looked the wisest solution. Indeed, having viewed the success of gay-dominated AIDS Councils in negotiating with gay men, most

³⁰Neave, 'AIDS and Women in the Sex Industry', p.425; and Norma Marshall and Douglas Laidlaw, 'Presentations at a Communicable Diseases Clinic with Particular Reference to the Role of Prostitutes as Vectors of Infection', Appendix IX, in Marcia Neave, *Inquiry Into Prostitution: Final Report October 1985*, vol.2, Melbourne: Government Printers, 1985, p.80, 82.

³¹While all known prostitutes were not subject to compulsory examination under public health laws, they remained under medical surveillance in states which legalised prostitution in registered brothels. After 1985, for example, Victorian sex workers had to submit to trimonthly medical examinations in order for the brothel to retain its licence. Any worker found to be infected with a venereal disease was banned from working in a brothel until they are cured of their ailment.

state governments were now prepared to invest in peer-education programmes that specifically targeted sex workers. In December 1985 they began to officially integrate sex worker rights organisations, such as the Australian Prostitutes Collective (APC), into their framework of AIDS prevention by allocating small grants to them directly or through the state AIDS Councils and AFAO.³² In doing so, they gave recognition and resources to work that the various prostitute collectives had already begun. Having realised the potential threat to the sex industry that AIDS (and public hysteria) posed in 1984, for example, the APC, with branches in Sydney and Melbourne, had initiated a condom distribution programme and AIDS/STD education outreach work that was funded from its membership fees and cash donations. In 1984, its Victorian branch produced the first sex industry AIDS peer-education pamphlet titled *Facts on AIDS for the Working Girl*.³³

Not all of the states had their own sex worker organisations in 1985, however, and those that did lacked a forum in which workers could meet together to discuss and co-ordinate policy initiatives. This situation was rectified in 1988 at the first 'Sex Industry and the AIDS Debate' conference, organised by the Prostitutes Collective of Victoria (formerly the APC) and held in Melbourne. This meeting of sex workers from each state of Australia saw the formation of the Prostitutes Association of the Northern Territory for Health Education and Referral (PANTHER), the Self Health for Queensland Workers in the Sex Industry (SQWISI), and the Prostitutes Association of South Australia (PASA). They joined the Prostitutes Collective of Victoria, the Workers in Sex Employment (WISE), Sex Workers Outreach Project (SWOP), and the Support, Information, Education and Referral Association (SIERRA, established in Western Australia) in providing programmes aimed at preventing the spread of HIV. The meeting also saw the constitution of Scarlet Alliance, a peak sex worker organisation that continues to represent the various prostitute collectives on the executive committee of AFAO.

³²The Australian Prostitutes Collective (NSW) received \$120,000 in 1985 and actually became the first sex worker organisation in the world to be funded by government. See Margaret Duckett, 'HIV/AIDS and Australia's Community-Based Sector: A Success Story in HIV Prevention', unpublished report prepared for AFAO, 1992, p.10, ACON archive, id: G2367.

³³Andrew Hunter, 'Sex Workers and AIDS - An Introduction to the Issues', *National AIDS Bulletin*, c.1990, NBAC/NAAC, ANU, H15.1(20).

Each of these organisations quickly developed projects to reflect the reality of the AIDS epidemic in Australia, which meant protecting workers from catching, rather than spreading, HIV. In this effort they needed to do more than simply supply sex workers with free condoms and lubricant and provide information about HIV and other sexually transmitted diseases. Most prostitute collectives ran workshops on assertive behaviour and 'safe sex negotiation' which aimed at installing confidence in sex workers to insist on their clients using condoms. During other workshops, experienced prostitute outreach workers taught their less experienced peers how to eroticise condom use (by seductively putting it on with the mouth), and how to fake penetrative sexual intercourse by inserting the client's penis between the thighs. They also ran workshops for clients – a revolutionary idea – which taught 'hot safe sex' tips. Other programmes were aimed specifically at male sex workers and prostitutes from non-English speaking backgrounds who were identified as workers at greatest risk due to their limited bargaining power in the sexual transaction.

The activities of sex worker organisations also extended to publishing. Scarlet Alliance published *Scarlet Letters*, a newsletter providing updates on legal issues concerning sex workers and tips about safe sexual practices. Similarly, the Prostitutes Collective of Victoria published *Working Girl* (and later *Working Boy*) which, among other things, 'road-tested' condoms and gave recommendations on the strongest and most 'sensitive' varieties. The PCV also established a peer-run needle exchange centre in St Kilda in 1988 (based on the first needle exchange outlet that was established in Australia by the NSW branch of the Australian Prostitutes Collective), a drop-in centre for street workers, and a 'safe house' scheme (which accredited brothels that promoted and ensured sex with condoms only). The PCV also liaised and worked with other community-based groups such as the Women and Imprisonment Collective, which aimed to help women recently released from prison find accommodation and establish safe sexual and drug using habits.³⁴ These achievements were recognised in the wider field of AIDS-related service provision when the PCV was invited to help establish the International Council of AIDS Service

³⁴Richard Keane, 'Report to Management Committee, re Needle Exchange Programme', unpublished report compiled for PCV, January 1990, NBAC/ANU, NAAC, H15/7(75-1).

organisations, and to give a presentation at the Fifth International Conference on AIDS in 1989.³⁵

As these activities demonstrate, Australia was clearly witnessing a committed and responsible response to AIDS by sex worker organisations. One should not gain the impression that they received overwhelming support in their efforts from the community and their funding bodies, however. Only SWOP in NSW and the PCV in Victoria had the resources to fund a full-time outreach peer educator for street workers (a significant section of the prostitute population), and CYBELLE, the Tasmanian Prostitute Collective, received only enough money to fund one part-time educator. This person was based in Launceston and was expected to make contact with every prostitute in the state! PASA in South Australia was funded to provide outreach work, but was not given money to supply simple and essential items such as free condoms and lubricant. Furthermore, as prostitution remained illegal in most states, outreach workers found themselves under the constant threat of being charged with aiding and abetting, or getting caught on premises during raids by police, local council and health authorities. During the height of the 1990 National Crime Authority investigation (Operation Patriot) in Adelaide, for example, PASA was forced to stop all outreach and have contact only with sex workers who came directly to PASA's office.³⁶ Andrew Hunter, of the Prostitutes Collective of Victoria, also reported that a police 'blitz' on street soliciting in St Kilda during October 1990 led to a drastic decline in the number of prostitutes using the PCV needle exchange outlet because "people were either locked up or too scared to make the venture along Grey Street to the office".³⁷ Indeed, in an environment of distrust and repression (not to mention community disapproval) which the criminalisation of prostitution fosters, sex worker organisations were hamstrung in their efforts to provide the most effective service to their constituency.

³⁵Andrew Hunter, *First In Best Dressed: The Responses of Australian Sex Worker Groups to HIV/AIDS*, Melbourne: Scarlet Alliance, c.1991, p.35.

³⁶*Ibid.*, p.21. The issue of police harassment that hindered the outreach work offered by the Australian IV League and Scarlet Alliance was also discussed during a meeting of ANCA in November 1990. See Memo from Don Baxter to AFAO Committee Members, 'Report on ANCA Meeting #15 [30 November 1990]', issued 3 December 1990, NBAC/NAAC, ANU, H5/2(26).

³⁷Andrew Hunter, 'Project Report 3: AIDS Education to Men in Prostitution', unpublished report for internal circulation, c.1990, NBAC/NAAC, ANU, H15/7(75-2).

The model of 'community empowerment' and peer-based HIV-education that the state and Commonwealth governments enacted was a compromised one, and one that critics, such as Marcia Neave, came to argue, remained impotent until laws against prostitution were repealed.

On the positive side, peer-based education provided opportunities that the 'test and contain' approach to public health could never hope to realise. Unlike compulsory testing, which could only monitor prostitutes working in registered brothels, peer-education projects could access sex workers soliciting in both the legal and illegal sectors of the industry. Public health authorities simply did not know how many prostitutes were working in Australia, never mind where they would find them. Prostitute collectives, on the other hand, had knowledge of such things, or at least knew the channels through which to go in order to contact isolated prostitutes working in the illegal street trade. Unlike doctors, sex worker organisations also knew how to communicate effectively with prostitutes, using language, imagery and educational materials which were appropriate for their target group. As the posters shown in Figure 8.1 and Figure 8.2 illustrate, this material aimed to eroticise safe sex, and often did so in a sexually explicit manner. If such material was stamped with a Health Department logo, it might have caused a public outrage. Instead, by empowering sex workers to educate themselves, the state and Commonwealth governments were able to provide the necessary resources while distancing themselves from condoning prostitution or displays of explicit sexuality.

Australian sex worker organisations can justifiably take much of the credit for the very low incidence of HIV infection among prostitutes. Paradoxically, part of this success was brought about because they maintained that the Australian sex industry would *never* be free from HIV.³⁸ Indeed, prostitute collectives did not want to guarantee that any of their brothels were 'clean', as this would remove the incentive for clients to use condoms or practise safe forms of sex. This seemed to be an effective strategy: a 'needs assessment' commissioned by Scarlet Alliance in 1990, which interviewed a small number of clients, found that 85% of them insisted on using condoms because they suspected their prostitute

³⁸Outreach workers were aware of a handful of HIV-positive prostitutes (who had contracted the virus from using contaminated needles or having unprotected sex with infected boyfriends) who continued to work.



Figure 8.1: Two posters produced by SWOP (Sex Workers Outreach Project, NSW), c.1990.

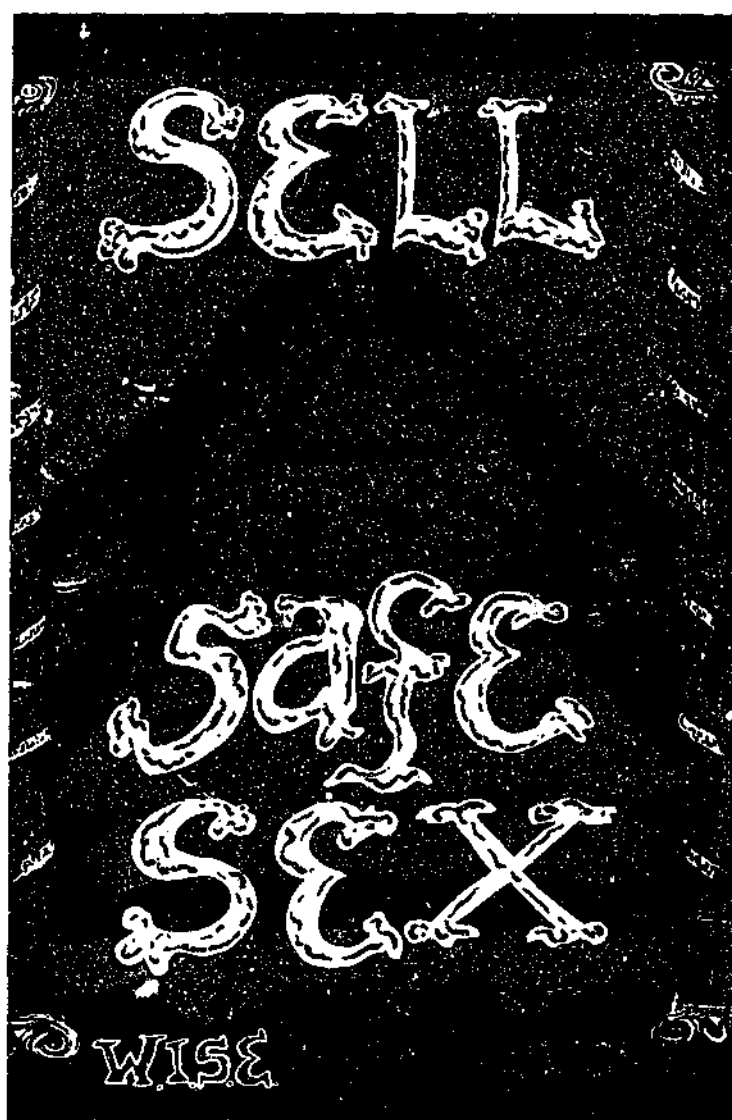


Figure 8.2: 'Sell Safe Sex', WISE (Workers in Sex Employment) poster, c.1989.

might be HIV-positive.³⁹ This principle, a cornerstone of the campaign to minimise the risk of HIV being transmitted through commercial sex, itself became a problem, however, when an HIV-positive Sydney prostitute allegedly admitted to having unprotected sexual intercourse with clients. Her name was Sharleen, and she became one of the biggest news stories of 1989.

Sharleen grew up the eldest of eight children in a family which experienced the hostility and bouts of drunkenness that are so often associated with poverty. When she was fourteen years old, her mother left her father and took four of the children with her. Struggling to cope in the days afterwards, Sharleen's father invited his eldest daughter to join him for a drink. When they were both drunk, he raped her. Sharleen fled her family and her home town and ended up in Melbourne where a new friend offered her heroin for the first time. She became addicted and developed a habit that a nine-to-five job could not sustain. Not wishing to turn to theft to support herself, Sharleen travelled to Sydney, began soliciting on the streets of Kings Cross, and was soon making \$500 a night. It was while on the streets that Sharleen picked up an HIV-contaminated needle from a gutter and thrust it into her arm. This was in 1986 and, as she related, "there were no chemist shops open at that time of night, no needle exchanges and I didn't know about the dangers of AIDS and intravenous drugs".⁴⁰ Shortly after the incident with the needle, Sharleen began to get night sweats and became ill. She went to a doctor who ordered the blood tests which confirmed that she was HIV-positive. The results were relayed over the telephone; she might as well prepare to die.

Sharleen's story was first told by Ron Hicks in a July edition of *The Australian Magazine*. He called her 'Maria ne' and sympathetically explained the reasons why she became a heroin addict and then a prostitute who was unlucky enough to pick up an infected needle. He also recounted instances of violence and abuse that Sharleen endured after her neighbours and fellow sex workers found out that she was HIV-positive. Her mother

³⁹Cheryl Overs, 'Summary of Issues and Positions from the Scarlet Alliance Needs Assessment of People with HIV Who Work in the Sex Industry', 11 July 1991, distributed as a pamphlet during the July 1991 Melbourne 'Love In', NBAC/ANU, NAAC, H15/3(42).

⁴⁰Sharleen quoted in Ron Hicks, 'AIDS: The Second Wave', *The Australian Magazine*, 1-2 July 1989, pp.10-11.

sought, and gained, custody of her four-year-old son and disowned Sharleen, threatening to break open her tombstone and spit on her grave once she was dead.⁴¹

'Marianne's' testimony was one of two stories which Hicks related about HIV-positive women who had become infected through using contaminated needles. His purpose was to warn his readership about the 'second wave' of AIDS cases which threatened to emerge in the intravenous drug-using population and their families. Within days of the article appearing, the Nine Network's *60 Minutes* programme contacted the journalist seeking an interview with Sharleen.⁴² Its intention was to tell a different – but more familiar – story: one that would detail how innocent people could be infected by dangerous and irresponsible prostitutes. When the story went to air in July 1989, accompanied by a feature report on the top-rating programme *A Current Affair*, it was Sharleen's admission that she continued to work as a prostitute with HIV infection, rather than the dangers of intravenous drug use, that became the focus.

In his article, Hicks had mentioned that Sharleen continued to work occasionally "to pay the rent and the gas bills", but stressed that she insisted on using condoms (although her clients sometimes pulled them off). Quoting her own words, he also recalled the time that Sharleen was bound with tape and raped in a vicious attack:

I am very careful. I don't want to see anyone else get [HIV]. But if someone grabs me and takes me in a car and rapes me without a rubber, that is their fault.⁴³

60 Minutes took a different slant on the issue of personal responsibility and condom use. Despite Sharleen's repeated assertion that she always used condoms with her clients, the programme insisted that she did not. When it screened a follow-up report in March 1991 it provided 'evidence' for its claim, citing the testimony of local MP, Sandra Norrie, and

⁴¹*Ibid.*

⁴²Ron Hicks, 'The Troubles of Sharleen', *The Australian Magazine*, 25-26 November 1989, p.73.

⁴³Ron Hicks, 'AIDS: The Second Wave', *The Australian Magazine*, 1-2 July 1989, p.10.

neighbours who claimed to have 'observed' Sharleen.⁴⁴ After the second report went to air, Scarlet Alliance condemned the inaccuracies of the two stories and accused *60 Minutes* of irresponsibility for blaming people with AIDS for spreading HIV, rather than encouraging individuals to use condoms and take responsibility for their own sexual health. It claimed that:

The programme went so far as to suggest that Charlene should feel guilty for possibly infecting a man who raped her. The implication was that people who are HIV-positive should take all responsibility for practising safe sex, even with a knife at their throat. HIV-positive people are being used as scapegoats to allow people who do not know their HIV status to ignore their role in stopping transmission.⁴⁵

The public outcry that followed the original *60 Minutes* and *A Current Affair* reports roused the NSW Department of Health into action. Despite being fully aware of Sharleen's predicament for at least three years, only now did it move to discipline her behaviour. It ordered that she be detained at the Prince Henry Hospital for an unspecified period of time for allegedly continuing to have sex with clients without using condoms. In doing so, the government evoked a little-known amendment to Section 32 of the *Public Health Act* that gave it the right to detain an infectious person at will whilst providing no avenue for appeal.⁴⁶ Sharleen was not charged with a criminal offence by police, however, even though Neville Wran's government had introduced legislation in 1985 to make it illegal for a person with HIV to have unprotected sex with a partner who was unaware of that person's condition. The fact that she was not charged indicates that the health authorities and the police had some trouble proving that Sharleen was indeed having unprotected sexual intercourse.

⁴⁴Jeff McMullen [reporter], 'Dangerous Liaisons' [report], *60 Minutes*, Nine Network, 23 July 1989; and Jeff McMullen, 'Charlene', *60 Minutes*, Nine Network 24 March 1991.

⁴⁵Scarlet Alliance, 'Media Release: Prostitution AIDS Link Dangerous', 26 March 1991, NBAC/ANU, NAAC, H15/3(42).

⁴⁶'Govt Orders AIDS Patient Held In Hospital', *Sydney Morning Herald*, 1 August 1989, p.1.

The New South Wales Minister for Health, Peter Collins, supported the detainment of Sharleen and appealed to Channel Nine and other media outlets to assist the Department in identifying HIV-positive individuals who might be working as prostitutes. Collins also declared that "the detainment of Sharleen [*sic*] and new claims...about another prostitute Tanya, have highlighted the need for a review of the Public Health Act. Quite clearly the Act does not adequately provide for surveillance of AIDS or HIV-positive prostitutes."⁴⁷ The case of Sharleen and Tanya Spence, to whom Collins was referring, did indeed prompt the New South Wales Parliament to overhaul its *Public Health Act* in October 1990. The Act now permits a person with AIDS, deemed by the state to be behaving irresponsibly and risking the lives of others, to be detained for up to six-months without a hearing or right of appeal.⁴⁸

Sex worker organisations were careful not to publicly support Sharleen in her claims that she always practised safe sex. They were perfectly aware that prostitutes were not immune from telling the occasional lie and that some of them did not always insist on using condoms. They were angry, however, at the way in which the NSW Department of Health effectively sanctioned the media's harassment of sex workers and pandered to the public's simplistic understanding of the issue. In particular, they were furious at the Department's failure to relate the facts of HIV transmission. In calling for HIV-positive prostitutes to be removed from the industry, neither Peter Collins nor the media could offer any epidemiological evidence which proved that HIV was being transmitted from sex workers to their clients. They certainly did not stress the need for clients to take responsibility for their own health, nor mention that many clients were offering sex workers extra money to forego the use of condoms. Moreover, the Minister's call to ban HIV-positive prostitutes from working was directly opposed to the principles of the first National HIV/AIDS Strategy that had recently been announced by the Commonwealth Department of Health. The Strategy stated that the identification and coercion of people with AIDS was unnecessary while education and 'safe sex' practices remained effective means of preventing the transmission of HIV. More particularly, the Strategy maintained that

⁴⁷Media Release: AIDS and HIV-Infected Prostitutes, from the Minister for Health NSW, 2 August 1989, NBAC/ANU, NAAC, H15/2(30).

⁴⁸Nikki Heilig, 'Detention for "Risky" AIDS Carriers', *Australian*, 17 October 1990, p.5.

individuals, once informed about HIV, were ultimately responsible for their own sexual health.⁴⁹

Collins' condemnation of Sharleen and other HIV-positive women whom he suspected of working as prostitutes, and the support he received in the media and from the public, did more than undermine the principles of the first National HIV/AIDS Strategy. It revealed and perpetuated a sexual double standard which, this issue demonstrated, lurked beneath the surface of Australian society; a double standard that saw women (who constituted the majority of prostitutes and who were the focus of the media's stories) as solely responsible for their partner's sexual health. It was the behaviour of 'irresponsible' women that was to be controlled, while no similar efforts were made to regulate the behaviour of their sexual partners. One woman interviewed by Scarlet Alliance expressed outrage at this double standard that determined that she – as a homeless, drug-dependent HIV-positive prostitute offering safe sex to a wealthy businessman – was expected by society to save him from his own refusal to wear a condom. If she acquiesced to his demand, it was she who was condemned. (I should note that the woman added that she had never consented to such a request, regardless of the extra money offered, because of the potential for the client to go on and infect her fellow sex workers and because she did not want to add guilt to her existing burdens.)⁵⁰

Of course, the NSW Department of Health and the media were not the only ones calling for HIV-positive sex workers to be forcibly removed from the sex industry. They had numerous allies, some of whom were drawn from the sex industry itself. Brothel owners were keen to rid themselves of infected prostitutes so that they could promote consumer confidence in their industry and avoid potential litigation. Sex workers also expressed a reluctance to work with HIV-positive prostitutes, fearing that the virus may get passed on

⁴⁹Commonwealth of Australia, *National HIV/AIDS Strategy: A Policy Information Paper*, Canberra: AGPS, August 1989; and John Ballard, 'Australia: Participation and Innovation in a Federal System', in David L. Kirp and Ronald Bayer (eds), *AIDS in the Industrialized Democracies: Passions, Politics, and Policies*, New Brunswick: Rutgers University Press, 1992, pp.150-1.

⁵⁰Cheryl Overs, 'To Work or Not to Work?: Questions Facing HIV Positive Sex Workers', unpublished paper delivered to the Australian Institute of Criminology 'Sex Industry and Public Policy' Conference, Canberra, May 1991, pp.5-6; NBAC/ANU, NAAC, H15/3(42).

to them via a customer whom they shared.⁵¹ A survey of 388 sex workers, for instance, found that 184 incorrectly believed that *working* with an HIV-positive prostitute was a high-risk activity.⁵² In addition, Marty, a gay prostitute from Sydney, told the *Sunday Age* that he feared for the safety of clients, claiming that some terminally-ill HIV-positive prostitutes were deliberately not using condoms to "take a few mugs with them. A person who has got AIDS is almost a murder weapon and they think they might as well kill someone with it."⁵³ While this statement disclosed more about Marty's paranoia and distrust of all people with AIDS than anything else, the almost universal condemnation of HIV-positive prostitutes who continued to work revealed a deep-rooted fear that HIV would pass from prostitutes into the wider heterosexual population. In the general public, this fear was clearly based on ignorance about the nature of sex work and the ways in which HIV is transmitted, and a miscalculation (from which sex workers and brothel owners were not immune) of what constituted an 'acceptable' level of risk.

The first of these problems – the public's ignorance about the nature of sex work and sex workers – is simple to trace. As Marcia Neave has written:

The categorization of prostitutes as deviants, even in today's sexually permissive society, makes it easier to regard them as universally irresponsible, materialistic and unconcerned about infecting others. The secrecy of prostitution means that there is little information about the sexual activities of prostitutes and clients. Thus it is assumed that all women who are involved in the sex industry are equally at risk of becoming infected and infecting others.⁵⁴

⁵¹"Notes from Focus Groups, 23 January 1991, convened by Cheryl Overs in preparation of "needs assessment", NBAC/NAAC, ANU, H15/2(30).

⁵²Carol Stevens, 'AIDS Education and Prevention Strategies in the Sex Industry', in Roberta Perkins, Garrett Prestage, Rachel Sharp, and Frances Lovejoy (eds), *Sex Work and Sex Workers in Australia*, Sydney: University of New South Wales Press, 1994, p.251.

⁵³'A Good Time Or A Safe Time?', *Sunday Age*, 31 March 1991, p.3.

⁵⁴Neave, 'AIDS and Women in the Sex Industry', p.424.

The secrecy that surrounded prostitution certainly facilitated the formation of a number of inaccurate myths about sex workers, which compelled members of the public, the media and health authorities to call for HIV-positive prostitutes to be distinguished from the rest of the population and subjected to specific laws aimed at preventing them from having sex. They believed, for example, that prostitutes had more partners and more sexual encounters than anyone else in the community, thus increasing the likelihood of transmitting HIV. Such an assumption was contradicted by sex worker organisations, which pointed out that sex work was not a regular or even frequent occupation for many men and women in the industry. Any law, they concluded, which singled out an HIV-positive prostitute using condoms who worked only one or two nights a month to pay an unexpected bill, was therefore discriminatory. Scarlet Alliance even claimed that female students at the University of Melbourne were at greater risk of contracting and transmitting HIV based on the prevalence of HIV among these women and their average number of sexual partners.⁵⁵

Even prostitutes who worked regularly were not necessarily placing themselves or others at greater risk of transmitting HIV. Sex workers, through their own intuition or training, were adept at avoiding penetrative sexual intercourse whenever possible, safely substituting their thighs, hands, breasts or mouths for their genitals when the cover of darkness or the haze of a client's state of alcoholic inebriation permitted them to do so. This would have come as a surprise to most members of the public – not to mention most clients – who assumed that 'paying for sex' meant paying for penetrative sexual intercourse. Studies indicate that sex workers were also aware of the higher risk of condoms rupturing during anal intercourse and most stated that they would refuse to provide such a service if they were HIV-positive.⁵⁶

As Neave points out, members of the community also sanctioned calls for the removal of prostitutes such as Sharleen from the sex industry because they were "universally

⁵⁵Cheryl Overs, 'To Work or Not to Work?: Questions Facing HIV Positive Sex Workers', unpublished paper delivered to the Australian Institute of Criminology *Sex Industry and Public Policy* Conference, Canberra, May 1991, p.4, NBAC/NAAC, ANU, H15/3(42).

⁵⁶Cheryl Overs, 'Summary of Issues and Positions from the Scarlet Alliance Needs Assessment of People with HIV Who Work in the Sex Industry', 11 July 1991, distributed as a pamphlet during the Melbourne 'Love In', NBAC/NAAC, ANU, H15/3(42).

irresponsible, materialistic and unconcerned about infecting others".⁵⁷ Sex worker organisations providing AIDS-prevention programmes were refuting such claims by their very existence, of course, and prostitutes were demonstrating concern for their own health, their fellow workers, and clients by adopting the use of condoms and safe sex techniques. The remarkable decline in the incidence of gonorrhoea and other sexually transmitted diseases in the prostitute population during the 1980s was evidence of this. The number of cases of sex workers infected with gonorrhoea reporting to the Sexual Health Centre at Sydney Hospital, for example, dropped from nearly 2800 in 1981 to 214 in 1991. Of the 108 female prostitutes who were being treated at the hospital for the disease in 1991, only one was an Australian resident.⁵⁸ In support of this observation, a study involving 280 prostitutes in NSW and the ACT in 1991 found that 95.4% of sex workers were using condoms diligently in the workplace, 26% more than a similar group surveyed in 1985.⁵⁹ The three largest STD/AIDS clinics in Sydney reported that while only 5% of its prostitute patients were using condoms in 1985, this figure had risen to 87% by the middle of 1988.⁶⁰

An awareness of the inaccuracies of such myths did not necessarily translate into a more tolerant attitude towards HIV-positive sex workers. There is evidence to suggest that many Australians maintained a prejudice against infected prostitutes because they misunderstood the likelihood of HIV being transmitted during protected, and unprotected, sexual intercourse and were thus unable to judge whether sex with an HIV-positive person was an

⁵⁷Neave, 'AIDS and Women in the Sex Industry', p.424.

⁵⁸C.R. Philpot, C.L. Harcourt and J.M. Edwards, 'A Survey of Female Prostitutes at Risk of HIV Infection and Other Sexually Transmissible Diseases', *Genitourinary Medicine*, vol.67, 1991, pp.384-8; Frances Lovejoy, Roberta Perkins, Yolanda Corduff, Marina Jo Dean and Amanda Wade, *AIDS Preventative Practices Among Female Prostitutes and Their Clients and Private Risk*, Parts I and II, Report to Department of Health, Housing and Community Services, Sydney: University of New South Wales, 1991, pp.21-2; Chris Harcourt, Ross Philpot and Jan Edwards, 'The Effects of Condom Use By Clients on the Incidence of STDs in Female Prostitutes', *Venereology*, vol.2, 1989, pp.4-7; and Martin Thomas, 'Asian Prostitutes Pose a Risk', *Australian*, 15 April 1991, p.3.

⁵⁹The prostitutes involved in the study averaged 25 clients per week. The predominant reason given for not using condoms was pressure from clients (including the payment of extra money). See Roberta Perkins, Frances Lovejoy and Marina, 'Protecting the Community - Prostitutes and Public Health Legislation in the Age of AIDS', *Criminology Australia*, vol.2, no.2, 1990, p.8; 'Prostitutes Opt For Safer Sex: Study', *Sydney Morning Herald*, 6 May 1991, p.3.

⁶⁰Chris Harcourt and Ross Philpot, 'Female Prostitutes, AIDS, Drugs and Alcohol in New South Wales', in Martin Plant (ed.), *AIDS, Drugs and Prostitution*, London: Routledge, 1990, pp.144-5.

'acceptable' risk. One brothel owner, for example, steadfastly refused to employ any prostitutes who *might* be HIV-positive because she believed that there was a 100% likelihood of HIV being transmitted from an infected female to a male during unprotected vaginal intercourse.⁶¹ This would not have been an uncommon assumption, especially given that the electronic and print media were full of exceptional stories of people who had contracted HIV during 'one-night stands', yet missed the cases of wives and husbands of infected partners who had been engaging in unprotected sexual intercourse for five or more years after infection without transmitting the virus.⁶² In fact, studies suggested that there was only a 1% chance of transmission from an infected female to a male during unprotected sexual intercourse (and only a 3% chance of transmission from an infected male to a female).⁶³ This level of risk was reduced when lubricant was used to prevent the tearing of cellular membranes of the genitals which expose blood vessels to the virus. Conversely, the chance of transmitting HIV during unprotected sexual intercourse increased when either partner had an open wound on or near their genitals or suffered from another sexually transmitted disease (prostitutes regularly checked themselves and their clients for these). On the whole, Australians demonstrated a lack of awareness about such levels of risk, which is understandable given that NACAIDS and the State and Commonwealth Departments of Health were reluctant to disseminate such precise information. It would appear that they did not trust the average Australian's ability to cope with specific facts and figures beyond the Grim Reaper's general warning that 'everyone at anytime is at risk from AIDS'.

The public was also constrained in its understanding of HIV by its pre-conception of the nature of sexually transmissible diseases. They were aware of the extremely infectious

⁶¹Cheryl Overs, 'Interim Report to Scarlet Alliance Groups on the National Consultation on People with HIV in the Sex Industry', unpublished report, 12 February 1991, p.1, NBAC/NAAC, ANU, H15/2(30).

⁶²An exception was 'That One-in-100 Chance', *Sydney Morning Herald*, 2 August 1989, p.4.

⁶³The fact that 'AIDS' was difficult to transmit during sex was discovered very early in the history of the epidemic. In 1983, for example, the *Age* reported the case of an male American with AIDS who had kept a diary of his sexual relationships with over seven hundred partners, only seven of whom were diagnosed with AIDS. (Olga Fernley, 'Gays Are Always Thought Of As Dirty', *Age*, 3 September 1983, [Saturday Extra] p.6.) Five years later, doctors were still unsure exactly why this was the case. Scientists now understand that an HIV-positive person is most infectious when their body contains a high 'viral load'. This generally coincides with two periods: the first few months following exposure to the virus and after the onset of 'full-blown' AIDS.

nature of venereal diseases such as gonorrhoea and genital herpes (which became a public health threat and a major news story in the late-1970s) but conflated these diseases with HIV, which is not easily transmitted during sexual intercourse. Indeed, the constant reference to HIV as an infectious *and* sexually transmissible disease was misleading (although strictly true), because compared to the other diseases in these categories it was neither. Despite this, commentators continually compared HIV to other epidemics of infectious disease and demanded that HIV-positive prostitutes be contained in the same way that typhoid sufferers and people with tuberculosis and syphilis were earlier in the century. The editor of the *Herald-Sun*, for example, supported coercive legislation to remove HIV-positive prostitutes from the sex industry by citing the examples of "cooks with typhoid who would be barred from a kitchen or tuberculosis sufferers who might be quarantined".⁶⁴ This comparison was, of course, completely inappropriate. Typhoid and tuberculosis are both extremely infectious and casually transmissible: one can transmit the disease by sneezing or coughing on another person. HIV, on the other hand, is extremely difficult to transmit if it does not have direct access to the bloodstream, and is more properly identified as a blood-borne virus.

Given the efforts to train and educate prostitutes about safe sex and the fact that most of them were using condoms during their commercial sexual encounters, one might wonder why anyone was worried about prostitutes transmitting HIV during unprotected sexual intercourse. This anxiety did emerge, however, at the height of the publicity surrounding Sharleen's case, and that of two Victorian HIV-positive prostitutes who were arrested by police in March 1991 for continuing to work, when a number of influential AIDS-experts joined media commentators in questioning whether clients really were 'protected' by condoms. From studies undertaken before the onset of AIDS they deduced a condom failure rate of 10%, which was attributed to the fragility of the latex sheath. Community-based AIDS organisations, however, deduced that it was more likely to be the result of clumsiness on the part of inexperienced school-boys and a lack of education about how to use condoms correctly. These problems were addressed with the emergence of AIDS in the

⁶⁴Editorial, 'Painting Over Public Issues', *Herald-Sun*, 29 August 1991, p.12. The NSW Minister for Corrective Services made a similar statement in attempting to justify the segregation of HIV-positive inmates in NSW prisons.

1980s as the government implemented strict condom manufacturing standards and required manufacturers to include explicit instructions on how to use their product. To the delight of Ita Buttrose, information about how to use condoms was also introduced into many secondary school curriculums and shown on television after the Grim Reaper campaign elicited parental demand for such measures.⁶⁵ Educational material also extolled the advantages of using water-based lubricant, and suggested ways in which it could be incorporated into sexual play. Thus, if condoms formerly had a failure rate of 10%, this figure was likely to be much lower by the end of 1987, and lower still among skilled and experienced practitioners such as prostitutes who, above all other members of society, had the greatest interest in using them correctly given that their livelihood was threatened if they contracted a sexually transmitted disease. A team of researchers at the University of Sydney confirmed this point in a study of three inner-city Sydney brothels, which found a condom breakage rate of only 0.6%. The study was conducted over a four-month period in 1988 and involved male and female sex workers who used more than 1200 condoms.⁶⁶ Dr Basil Donovan and his team came to the same conclusion based on their observations at the Sydney Sexual Health Centre.⁶⁷

Critics of 'safe sex' ignored this evidence and refused to distinguish between well-practised prostitutes and the wider population in citing new estimates of the failure rate of condoms. Professor Ian Gust, the Commonwealth Minister for Health's Chief Medical and Scientific Adviser on AIDS between 1989-1992, for example, suggested a condom failure rate of 1-8% when he was interviewed on ABC radio in 1991. As a consequence, he claimed in a letter to the *Australian* that "the regular use of condoms does not and cannot eliminate the possibility of acquiring a blood-borne virus infection" and that "to encourage infected sex workers to continue working and hope they will not infect some of their

⁶⁵Bill Taylor, 'The AIDS Campaign: Three Months On', unpublished report, 1987, p.13, ACON archive, G6079.

⁶⁶'Condoms Get Few Breaks', *Sydney Morning Herald*, 17 January 1989, p.3.

⁶⁷The doctors studied thirty male and four female prostitutes who used 664 condoms. Only three breaks (0.5%) were reported, two of which involved the use of oil-based lubricants which was not recommended by AIDS organisations nor common practice in the sex industry. (J. Richters, B. Donovan, J. Gerofi and L. Watson, 'Low Condom Breakage Rate in Commercial Sex' [letter], *Lancet*, vol.24, no.31, 1988, pp.1487-8.)

clients is irresponsible".⁶⁸ His comments were picked up by Lauchlan Chipman, Professor of Philosophy at Wollongong University, in his column for the *Canberra Times*. Failing to consider that the breakage rate amongst sex workers would be considerably less, he estimated that a condom failure rate of 1-8% "could mean as many as 100 condom fractures on one Saturday night in the sex parlours of Melbourne alone". On this evidence, he proclaimed that HIV-positive prostitutes in Australia's brothels and sex strips were "the 1991 equivalent of Typhoid Mary".⁶⁹ A more sensible approach might have been to multiply the failure rate of condoms used by prostitutes (0.6-1%) with the likelihood of contracting HIV from an unprotected sexual encounter (1-3%, or higher depending on the presence of open wounds), as both things would need to happen before infection occurs. It is on this level of risk – a 0.00006% - 0.0003% chance of contracting HIV from an infected sexual partner – that the media, public health authorities, and sections of the sex industry were basing their calls for HIV-positive prostitutes to be forcibly detained or charged with a crime if they refused to stop working. If they deemed this to be an unacceptable level of risk, they might as well have called for male drivers under the age of twenty-five to be banned from driving motor vehicles as they faced a similar likelihood of being seriously injured on the road.

The low risk of HIV infection in the sex industry was one of the reasons why no cases of HIV transmission had been attributed to a commercial sex transaction in Australia. It was also why each of the sex worker organisations, AFAO and the Intergovernmental Committee on AIDS (IGCA) passed resolutions in 1991 which supported the right for HIV-positive prostitutes to continue working.⁷⁰ In response to Ian Gust's letter to the *Australian*, Leanne Joyce, Executive Director of AFAO, also maintained that "AFAO

⁶⁸Letter to the Editor (Ian Gust), *Australian*, 18-19 May 1991, p.18.

⁶⁹Lauchlan Chipman, 'No Such Thing As Safety Within the Sex Industry', *Canberra Times*, 10 July 1991, p.4.

⁷⁰Minutes of AFAO Committee Meeting No.15, 21 April 1991, NBAC/NAAC, ANU, H5/2(9); John Church, 'Call-Girls In AIDS Shock', *Sun*, 7 May 1991, p.8; Paul Chamberlin, 'Let HIV Prostitutes Work: AIDS Advisors', *Sydney Morning Herald*, 9 May 1991, p.6; Deborah Hope, 'Decriminalise Sex Industry, Regulate Brothels, Panel Says', *Sydney Morning Herald*, 29 July 1991, p.3. It should be pointed out that most sex workers interviewed for Scarlet Alliance's Needs Assessment expressed the intention of leaving the sex industry if they ever did test positive, though some believed that this would be impossible due to their lack of money.

recognises the fact that HIV-positive prostitutes cannot easily leave sex work when many have financial commitments and children to support". Furthermore, she asked that "given the rampant discrimination against both sex workers and HIV-positive people, what are their prospects for alternative employment, especially in a [economic] recession?"⁷¹ AFAO, she said, advocated a "blanket safe sex policy" based on education to deal with the potential problem of HIV in the sex industry "because the only alternative is to impose compulsory testing and exclusion from sex work for those who test HIV-positive. Such coercive measures will not work with HIV/AIDS, particularly due to the transient nature of sex workers...Coercive measures will simply drive prostitution "underground" – away from education and support."⁷² Sex worker organisations also worried that legislation which permitted the detention or arrest of HIV-positive prostitutes would discourage sick sex workers from seeking an HIV-antibody test, fearing that their files would be sent to public health authorities or subpoenaed by police to be used at a later date to prove their culpability.⁷³

In rejecting the claims of 'safe sex' critics and the calls for 'recalcitrant' HIV-positive prostitutes to be detained or arrested, sex worker organisations, AFAO and the IGCA also urged all state governments to uphold the agreed principles of the National HIV/AIDS Strategy – into which each of the states had input. As Scarlet Alliance asserted:

The concepts contained in the National HIV/AIDS Strategy about the responsibility of each person to practise safe sex [and] protect themselves from HIV are rightly based on the inescapable fact that exclusion of people with HIV from daily life is unnecessary, unjust and unachievable when mechanisms for preventing transmission are known and available.⁷⁴

⁷¹Leanne Joyce, 'Sex Realities' [letter], *Australian*, 28 May 1991, p.10.

⁷²*Ibid.*

⁷³Paul Chamberlin, 'Charlene on the Streets After Funding Was Cut', *Sydney Morning Herald*, 2 August 1989, p.4.

⁷⁴Cheryl Overs, 'Summary of Issues and Positions from the Scarlet Alliance Needs Assessment for People with HIV Who Work in the Sex Industry', 11 July 1991, NBAC/NAAC, ANU, H15/3(42). This document was published as a pamphlet during a campaign to support two Victorian HIV-positive sex workers who had

Furthermore, Scarlet Alliance, AFAO, the IGCA and the National AIDS Forum (a 'think-tank' of AIDS experts drawn from the medical professions and affected communities) called on the state governments to consider Sections 5.7.10 to 5.7.12 of the Strategy, which recommended the decriminalisation of prostitution. They argued that this would redress the reluctance of sex workers to carry condoms while working because, in the past, the possession of condoms had been used as evidence to prove that a person was loitering on the street for the purposes of prostitution. The presence of condoms on a premises had also been used to establish that the dwelling was a brothel. In one state, condoms and literature distributed by health workers had even been seized by police to be used as evidence.⁷⁵

Marcia Neave also cogently argued that the illegality of prostitution made it difficult for sex workers to contact each other, circulate information about safe sex among themselves, and engage in collective action to enforce standards on clients. In doing so, she alluded to the gay community which had won its fight for the repeal of laws against homosexuality in most states of Australia in the early 1980s, and the way in which this freedom enabled gay organisations to successfully promote their services, educate and mobilise their community.⁷⁶ While praising the existing efforts of sex worker organisations, Neave recognised that an education-based model of public health that relied on 'community empowerment' would never be completely effective while the formation of this community remained illegal.

Calls for the repeal of laws affecting prostitution based on the grounds of HIV-prevention have largely fallen on deaf ears. Victoria was the only Australian state to legalise prostitution in a limited number of registered brothels in the 1980s, a decision based on the recommendations of a 1985 inquiry into prostitution (which considered the issue of the transmission of sexually transmitted diseases but not HIV *per se*). Queensland, Western Australia, South Australia and Tasmania retain laws to punish sex workers who seek their

been arrested in March 1991 for allegedly "recklessly endangering the public's health" whilst continuing to work.

⁷⁵Neave, 'AIDS and Women in the Sex Industry', p.429.

⁷⁶*Ibid*, p.428.

clients on the streets or other public places, or who work in brothels. In the ACT and all states except South Australia, however, prostitutes may work from their own homes provided they do not advertise their services and are the sole occupier of their dwellings.⁷⁷ New South Wales adopted the most liberal stance on prostitution in 1979 when it repealed its soliciting and loitering laws, permitting sex workers to solicit on the streets as long as their behaviour did not cause "serious alarm or offence". The *Summary Offences Act*, passed in 1988, reintroduced laws affecting street prostitutes, however, so that it is now an offence to solicit or participate in an act of prostitution outside clearly defined 'red-light' districts. It is not an offence to work in a registered brothel, however, unless the premises are used for other purposes.⁷⁸

Most Australian states and territories tolerate prostitution in escort agencies or, at least, have not yet discovered a way to prosecute sex workers whom they cannot see or find. The beauty of escort work for prostitutes and their clients is that there are no premises to bust. As escort workers usually work from home and are only contacted by telephone when a job becomes available, the prostitute cannot be arrested for 'habitually using a premises', 'receiving money in a brothel' or 'soliciting'. This, of course, means that the worker has very little contact with the escort agency, other prostitutes, sex worker collectives or health workers. Unlike brothel workers who are easier to access, therefore, they cannot benefit

⁷⁷In Western Australia, prostitution is regulated by the police under the 'toleration and containment' system, which allows prostitutes to work in 'approved' establishments although the criminal law remains unchanged. Sex workers are required to make their personal details known to the police, and managers are supposed to ensure that they regularly attend STD clinics. In Kalgoorlie, a country town in which brothels have been situated in the same street as the police station for decades, prostitutes are required to abide by draconian rules which insist that they reside on the brothel premises and not have their own families in town. They are also not permitted to visit certain public places such as restaurants and the local swimming pool, and if they leave their employer, must wait for a "cooling off" period before they can work for an opposition madam. (Neave, 'AIDS and Women in the Sex Industry', p.428.)

⁷⁸The laws affecting prostitution in each state are slightly more complicated than I have suggested here and are not necessarily reflected by police practice. In most states an unofficial police policy of 'tolerance and containment' exists where brothels, escort agencies and even street workers are tolerated unless they impinge on residential areas or cause public disturbance, or where there is evidence of other criminal activity taking place. For further discussion of the laws and the individual statutes that they come under for each state, and the way in which they were enforced by police in the 1980s, see Susan Pinto, Anita Scandia and Paul Wilson, 'Discussion Paper No.22, Prostitution Laws in Australia', *Trends and Issues in Crime and Criminal Justice*, May 1990, published by the Australian Institute of Criminology. Also see Commonwealth Department of Community Services and Health, *Consultation Paper No.2, Report of the Working Panel on Discrimination and Other Legal Issues - HIV/AIDS*, Canberra: AGPS, 1989, pp.29-32; and Neave, 'AIDS and Women in the Sex Industry', pp.427-8.

from the exchange of information about HIV and safe sex, or receive training in 'sexual negotiation'.⁷⁹ Exacerbating this problem is the fact that most male sex workers and transsexuals – those most in need of AIDS education and support – are clustered in the escort industry, and the inevitability that clients often demand a 'better' service (that is, sex without condoms) for the higher fee that they pay for using an escort. Thus, while the rejection of legalising brothels in favour of tolerating escort agencies may satisfy community hypocrisy, it does little to alleviate the threat of HIV transmission in the sex industry.⁸⁰

While most state governments have been reluctant to take a proactive approach to HIV prevention in the sex industry by legalising prostitution, they have not implemented compulsory testing for sex workers either. This is in contrast to the twenty-eight North American states which legislated for the mandatory testing of prostitutes between 1986 and 1992.⁸¹ Mindful of the public relations disaster and anger that Sharleen's case provoked, Australian state governments have instead moved to adopt procedures for dealing with HIV-positive prostitutes who show signs or evidence of working unsafely. Such procedures are based on the Victorian '5 stage' model which was drawn up by the Health Department of Victoria, police and sex worker organisations between 1988 and 1991. The procedure allows for a sex worker to be detained only if he or she persists in behaving in an unsafe manner after receiving a warning from health authorities and counselling by a case management team. In effect, public health authorities must receive reports of at least three separate instances of unsafe sexual behaviour before this final stage.⁸² The Health Department of Victoria's approach demonstrates a good deal of trust and understanding of HIV-positive sex workers, accepting that they are not irresponsible or vengeful people, but rather that they continue to work because they are forced to do so by their economic circumstances. As the state's Chief Health officer, Dr Graham Rouch, stated in 1991: "we

⁷⁹Hunter, *First In Best Dressed*, pp.17-18.

⁸⁰Neave, 'AIDS and Women in the Sex Industry', p.429.

⁸¹Raymond Donovan, 'The Plaguing of a Faggot, the Leperising of a Whore: Criminally Cultured AIDS Bodies, and 'Carrier' Laws, *Journal of Australian Studies*, vol.43, 1995, p.117.

⁸²These provisions are outlined in the Victorian *Health (Infectious Diseases) Regulations 1990* and New South Wales *Public Health Act 1991*.

believe most of these people have got some logical explanation for their case".⁸³ Accordingly, the Victorian government has also investigated means to assist sex workers financially – by providing cheap housing and easier access to sickness and social security benefits – thus presenting them with an option to leave the sex industry on their own accord. Such an approach recognises the economic determinants of health and illness, and accepts that the responsibility for disease prevention sometimes lies beyond the capabilities of marginalised and disempowered individuals.

⁸³Bobbi Mahlab, 'AIDS Prostitutes Get Special Help', *Sunday Age*, c.1992, p.9, NBAC/NAAC, ANU, H15/14(153).

Chapter 9.

Imag(in)ing People With AIDS: Art as Activism in the Age of AIDS

One of the most poignant moments of Graeme Murphy's retrospective, *Body of Work*, performed by the Sydney Dance Company and toured nationally in 2000, comes at the beginning of the second half when the audience, revived by the intermission and enlivened by the prospect of things to come, is unexpectedly asked to view a short black-and-white film projected above the proscenium. The film features the faces and names of a host of talented dancers, artists, designers and company staff who had died during, or shortly after, their association with the Sydney Dance Company. Among the faces are Kelvin Coe, principal male soloist with the Australian Ballet and Sydney Dance Company in the 1980s, and Peter Tully, an enigmatic costume designer and artist who had been a long term associate of the Company and the Sydney Gay and Lesbian Mardi Gras. Both men died from AIDS in the early 1990s. The projection fades to black as the haunting strings of John Tavener's *The Protecting Veil* begin to swell within the orchestra pit, thereby initiating the company's sober performance of a key sequence from Graeme Murphy's 1993 work of the same name. During the delicately lit dance, the male soloist is removed from the arms of his lover by an angel of death. Until this final moment, the two lovers tenderly sway and become entwined in each others' limbs, though remain separated by a soft semi-transparent curtain that allows the man to lift and caress the woman from behind but not touch her bare flesh. In the age of AIDS and safe sex, the 'protecting veil' symbolises the prophylactic sheath which now protects the woman from disease but can not detach the man from his past.

The dance has become recognised as Murphy's tribute to his inventive friends who died from AIDS and speaks of the void that was once filled with their creative energy and output. It recalls the death of exuberant performers of the calibre of Coe and Peter Allen, artists such as Tully and his collaborator David McDiarmid, authors such as Timothy Conigrave and John Foster, and the Sydney Symphony Orchestra's conductor Stuart Challender. Each of these artists pushed the boundaries of their respective genres and, in the process, redefined Australian cultural life. Also mourned are the writers and directors who popularised their work and gave them prominence: the political and arts commentator Peter Blazey, international cultural critic, editor and journalist Paul Taylor, and Greg Shears, producer and director of

award-winning drama and documentaries for ABC TV, all of whom died from AIDS in the early 1990s. Given that AIDS had contributed to radically recasting the principles governing public health policy, educational strategies, community-based action, law reform, and modes of medical treatment and care in its first decade, it is not surprising that it should have such an impact on the arts as well.

It is possible to devote an entire dissertation to the profound rupture in Australian cultural life that AIDS occasioned. One might examine the consequences of the deaths of creative Australians or the way in which the epidemic encouraged Australian artists to reject, or at least rethink, the postmodern, or anti-representational, aesthetic that was vogueish in the early 1980s. One might also explore the way in which AIDS art and cultural events such as the Sydney Gay and Lesbian Mardi Gras and Candlelight Vigil served to comfort the grief-stricken, and empowered gay men to continue their fight against the epidemic even while they were suffering the immense loss of friends and lovers. This is a project that I intend to undertake in the future. In this chapter I want to limit my discussion to the way in which Australian artists and cultural producers – by whom I mean film-makers, painters and visual artists, television producers, song-writers, playwrights, poets, choreographers and photographers – challenged the typical media portrayal of people with AIDS as doomed, guilty and dangerous, and offered, for the first time, a new way for the Australian public to perceive people living with AIDS. This was not an insignificant contribution, as most Australians had never met a person afflicted with the illness, and only came to 'know' them through the cultural products which represented them. In this sense, the public's understanding of the epidemic was mediated through culture – one might say AIDS was 'transmitted' via television, newsprint, and theatre ticket stubs – and was a construction of the imaginative faculties of journalists, artists and other cultural producers. Indeed, as the American art critic Douglas Crimp proclaimed in his famous manifesto of 1987:

AIDS does not exist apart from the practices that conceptualise it, represent it, and respond to it. We know AIDS only in and through those practices. This assertion does not contest the existence of viruses, antibodies, infections, or transmission routes. Least of all does it contest the reality of illness, suffering and death. What does contest is the notion that there is an underlying reality of AIDS, upon which are constructed the representations, of the culture, or the politics of AIDS.

If we recognize that AIDS exists only in and through these constructions, then hopefully we can also recognize the imperative to know them, analyse them and wrest control of them.¹

In Crimp's view, the task of representing AIDS had been hijacked by hostile and homophobic journalists, politicians, and a few photographers and television producers who did not have any connection with the communities most affected by AIDS and who thus felt 'immune' from the epidemic. It is from these people, and their miserable portrayal of people with AIDS, that Crimp demanded artists "wrest control" of the politics of representation. Underpinning his demand was an understanding that representations have *real* effects; since they are the only medium through which the public can imagine a person with AIDS, they help determine whether people feel sufficient sympathy to support funding for AIDS research and medical care, and whether or not a person living with AIDS will be ostracised from the community, persecuted in public, discriminated against at work, or shunned as a lover or a friend. Moreover, as I have demonstrated in my analysis of the representation of AIDS as 'death' in the Grim Reaper advertisement, the cultural constructions of the epidemic also influence the way in which people with AIDS experience their own illness: whether they will conceive of themselves as healthy and viable or sick and doomed, innocent victims of the epidemic or its guilty perpetrators who deserve to be feared and (self-) loathed.

Crimp's call for artists to become the new vanguard in the fight against homophobic and stigmatising representations of AIDS was particularly relevant in his own country, where successive Reagan and Bush administrations had failed to provide adequate funding for health care and community-devised AIDS education programmes. In Australia, a unique partnership between state and Commonwealth governments, doctors and communities at risk had resulted in the empowerment of community-based organisations and the introduction of a range of innovative AIDS prevention and treatment programmes. Yet even here artists were continually confronted with the possibility that these achievements and future progress would be compromised as long as AIDS continued to be considered a disease of the deviant and deserving: poofers, junkies and whores. They witnessed the arrest and detainment of

¹Douglas Crimp, 'AIDS: Cultural Analysis/Cultural Activism', *October*, vol.43, 1987, p.3; reprinted in Douglas Crimp (ed.), *AIDS: Cultural Analysis/Cultural Activism*, Cambridge: MIT Press, 1988, pp.3-16.

'reckless' and 'recalcitrant' HIV-positive sex workers, the threatened withdrawal of funding from gay-based AIDS Councils and needle and syringe exchange programmes, and the media's continued portrayal of people with AIDS as doomed and dangerous skeletons. In 1990 they were disturbed by a *Bulletin* survey which suggested that 49% of the population wished to see 'infectious' and 'unproductive' AIDS 'victims' quarantined.² In response they actively sought to recast the representation of people with AIDS, and offered to educate the public about the transmission of HIV at the same time.³

The most public and controversial of these artistic interventions came in the form of the theatrical demonstrations and eye-catching aesthetics employed by members of Australian ACT UP (AIDS Coalition to Unleash Power) chapters who sought to draw attention to the plight of people living with AIDS. In doing so, they utilised the graphics, slogans and tactics devised by a talented collective of commercial artists within the ranks of ACT UP/New York, the parent organisation of the Australian groups. These artists were acutely aware of the persuasive power of visual images to shape the public's understanding of reality, and sought to claim this power for their constituency. Drawing on their training in advertising and commercial design, they produced a works that were distinctive, hard-hitting and explicit enough to be readily processed by the brains of an inattentive public. In short, they designed political statements which were tailor-made for reproduction in press photography and during thirty-second news reports on television.⁴ ACT UP's most distinctive and potent graphic, adopted by ACT UP chapters around the world, was the slogan "Silence = Death". It was

²L. Crisp, 'You in the '90s', *Bulletin*, 18 September 1990, p.50. This figure had increased from 32% in 1987.

³As Terrence Bell extravagantly argued in his review of the *Imaging AIDS* exhibition held in Melbourne during 1989: "In Australia now, as in New York, art workers have taken the lead over the traditional vanguard of activists and social engineers. They are on the frontline of what is likely to remain the most critical political and social struggle of this century - the imaging of AIDS." (Terrence Bell, 'Imagining AIDS', *National AIDS Bulletin*, vol.3, no.2, March 1989, p.34.) His conceptualisation of the imaging of AIDS as "the most critical political and social struggle of the century" was somewhat exaggerated, and it was probably three years too early to be making this pronouncement in Australia, but recast in prophetic terms, it was an accurate statement.

⁴ACT UP/New York was founded by a group of New Yorkers who were inspired by Larry Kramer's second call to action during his address at New York's Lesbian and Gay Community Centre in March 1987. (Kramer had previously co-founded the Gay Men's Health Crisis in New York in response to that city's unwillingness to provide AIDS education and health care to gay men.) Its first protests were directed at the National Food and Drug Administration's (FDA) snail-paced approval process for drugs which combated the effects of HIV and opportunistic infections, and the FDA's alliance with Burroughs Wellcome which had seen the relatively quick approval of that company's drug, AZT, for a price tag of \$10,000 per patient per year - making it the most expensive drug ever sold.

generally printed on a black background alongside an inverted pink triangle, the symbol of homosexual persecution during the Nazi period of rule and, since the 1960s, an emblem of gay liberation and survival. The graphic was reproduced on T-shirts worn in demonstrations as well as in gay bars, and printed on posters and crack-and-peel stickers that were affixed to letter-boxes, power-poles, subway stations and, occasionally, the homes of conservative politicians (Figure 9.1). By the early 1990s, ACT UP chapters in the United States claimed that they had broken the silence and raised the consciousness of apathetic Americans, pressured pharmaceutical companies to sell their product for a reasonable price, and persuaded the National Food and Drug Administration to change its drug approval process, which saw the release of more AIDS treatments and a sharp reduction in the price of AZT. The extent of its role in these reversals has yet to be completely qualified, however.⁵

Given the reported success of ACT UP in the United States, and the sense of agency and optimism which was fostered within its constituency, it is not surprising that a chapter was established in Sydney during the final months of 1989, to be followed by similar groups in Melbourne and Canberra in 1990. Most of the twenty-five active Sydney members, and the several hundred people who were on ACT UP's mailing list, were living with AIDS or caring for an afflicted partner or friend. Like their American counterparts, they were committed to changing Australia's system of drug approval, which was not designed to respond to a new and deadly disease epidemic such as AIDS. They staged their first demonstration outside the Australian Drug Evaluation Committee's office in Kent Street, Sydney, on 27 April 1990, and came to national prominence at the Fifth National AIDS Conference in Canberra where they desecrated a stall of Wellcome pharmaceuticals, alleging that its AIDS drug AZT was overpriced, and branded the new Commonwealth Health Minister, Brian Howe, a "murderer" for his tardiness in reconfiguring Australia's drug approval process.⁶ In the time it took to spray-paint the graffiti, ACT UP had removed the focus from 'dangerous' people living with

⁵A parochial illustrated history of ACT UP/New York's achievements and most successful campaigns is provided by Douglas Crimp and Adam Rolston, *AIDS Demo Graphics*, Seattle: Bay Press, 1990. Also see Ann Cvetovich, 'Video, AIDS and Activism', *Afterimage*, vol.19, no.2, 1991, pp.8-11; Simon Watney, 'Read My Lips: AIDS, Art and Activism', in Simon Watney, *Imagine Hope: AIDS and Gay Identity*, London: Routledge, 2000, pp.89-105, especially pp.92-7; and Paul Taylor, 'Art on the Barricades', *Outrage*, no.113, October 1992, p.31.

⁶Roger Booth, 'Looking Back in Anger', *Campaign*, no.202, January 1994, pp.23-4. The campaign to streamline Australia's drug evaluation and marketing process, and the issues at stake, is described in detail by Robert M. Ariss, *Against Death: The Practice of Living with AIDS*, Amsterdam: Gordon and Breach, 1997, pp.181-92.

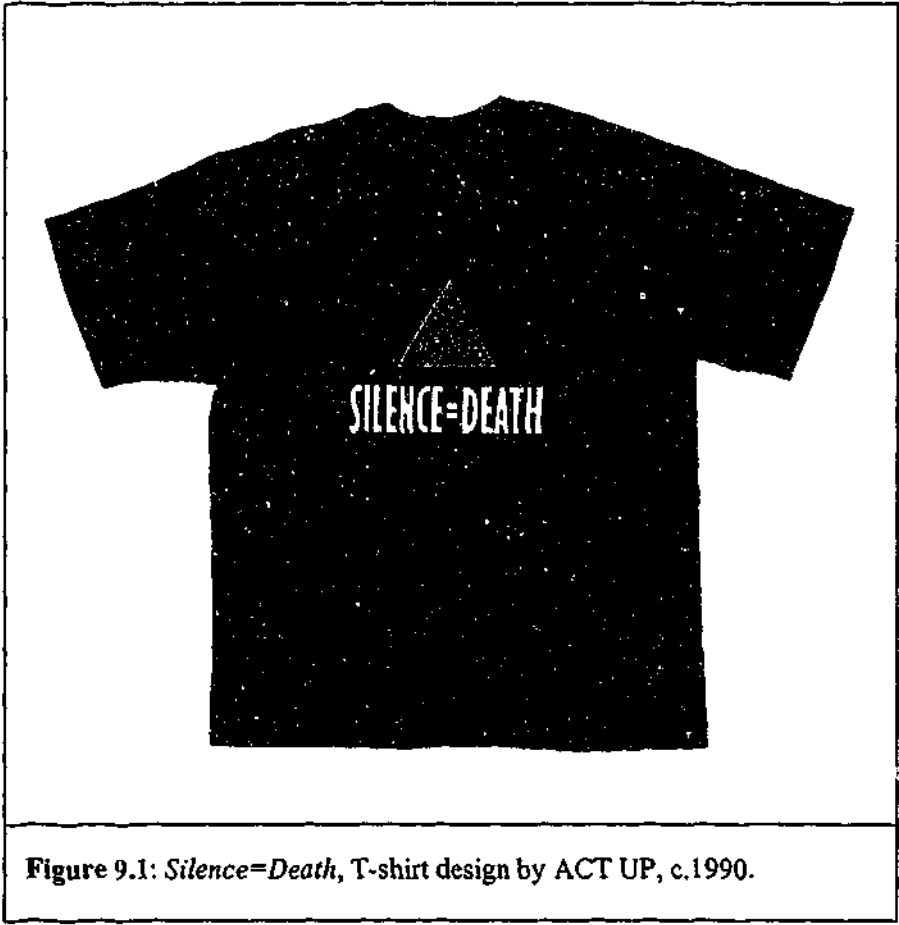


Figure 9.1: *Silence=Death*, T-shirt design by ACT UP, c.1990.

AIDS and portrayed pharmaceutical companies and government ministers as potential killers. They argued that people with AIDS were only thrust into the role of 'doomed victims' once they were ignored by cautious politicians and exploited by profit-seeking corporations.

ACT UP chapters in other cities were no less vociferous in their public protests and readily mimicked the theatrical statements of the American groups to express their anger. On 23 October 1990, for example, ACT UP/Melbourne organised a choreographed 'Die-In' outside St Vincent's Hospital in Melbourne (home of the Catholic Church's Human Bioethics Centre headed by the conservative Nicholas Tonti Filipinni.). The 'Die-In' comprised a supine mass of motionless bodies holding angry placards, or tombstones, which condemned the Roman Catholic Church's prohibition of condom use (Figure 9.2). The protesters also distributed pamphlets outside St Patrick's Cathedral which provocatively claimed "we won't be going inside, incense can't mask the stench of the slaughterhouse".⁷ Nine months later, in conjunction with the Prostitute's Collective of Victoria, the group staged a symbolic 'Love-In' outside the National Gallery of Victoria to criticise the arrest of two HIV-positive sex workers. During the protest, couples of various sexual orientation kissed and writhed upon a gigantic plastic sheet, which symbolised a condom, and distributed pamphlets that proclaimed the sex workers' "right to fuck safely".⁸ They also demanded that clients of prostitutes take responsibility for their own sexual health, thus blurring the boundary between 'innocent' victimhood and 'compliance' with infection.

ACT UP's full-scale assault on the institutions which devised policy concerning AIDS was launched on 6 June 1991, designated D-Day by ACT UP because it marked the date by which the group had demanded the government cease its delays in revising the drug approval process. In Canberra, ACT UP demonstrators fired off a wave of red flares outside Parliament House, while under the cover of darkness in Melbourne, members of ACT UP raided the famous Floral Clock near the War Memorial, ripping out its flowers and replacing them with a field of white crosses (Figure 9.3). Time was running out, they implored, and death would fill the vacuum of the missed opportunities to preserve lives. As Ted Gott suggests, it was a "supreme

⁷ACT UP, 'Blood in the Chalices, Blood on their Hands' [pamphlet], 23 October 1990, NBAC/NAAC, ANU, H9/4.

⁸Alex Messina, 'Protesters Hold A Love-In For Rights of Sex Workers', *Age*, 15 July 1991, p.14; and Mariana Canas, 'Love-In Sparks Outrage', *Herald-Sun*, 15 July 1991, p.3.



Figure 9.2: ACT UP/Melbourne Die-In, 23 October 1990.



Figure 9.3: ACT UP/Melbourne Floral Clock Protest, 6 June 1991.

visual statement (whatever one's political viewpoint) with many layers of symbolic meaning", the full significance of which was ironically borne out in the ensuing days as the news media and public personalities vented their anger at the "sacrilegious" vandalising of a beloved civic attraction.⁹ Their displeasure only seemed to confirm ACT UP's suspicion that the press and politicians cared more about the fate of Melbourne's flower beds than its dead and dying citizens.¹⁰

Despite its public profile, one should not exaggerate the significance of ACT UP's contribution to the politics of representation in Australia. In the first place, the Australian ACT UP chapters were generally mimicking an American aesthetic and were led by naturalised Americans such as Charles Roberts and Bruce Brown, which problematises their status as *Australian responses* to AIDS. The groups' imported aesthetic and aggressive tactics were generally inappropriate and, indeed, counterproductive in Australia, which had already fostered an innovative, inclusive and humane approach to AIDS prevention, as opposed to the United States where the risks and benefits of radicalism were different. The Catholic Church, through its various hospices and charitable services, was doing an extraordinary job at caring for people with AIDS, and certainly did not deserve to be labelled a "slaughterhouse", just as the dedication of Brian Howe's department to fighting AIDS made a mockery of its grim portrayal as a coven of apathetic "murderers". As other AIDS organisations such as the AIDS Council of New South Wales complained, ACT UP threatened to dismantle the carefully constructed public health partnership by failing to acknowledge these contributions and Australia's unique socio-political context. They then watched as ACT UP's membership steadily declined throughout the 1990s as its gestures became increasingly irrelevant.¹¹

In contrast to ACT UP, Australian visual artists were responding to the problem of

⁹Ted Gott, 'Where the Streets Have New Aims: The Poster in the Age of AIDS', in Ted Gott (ed.), *Don't Leave Me This Way: Art in the Age of AIDS*, Canberra, National Gallery of Australia, 1994, p.200.

¹⁰*Ibid.* According to former members of ACT UP/Melbourne, the group's 'attack' on the Floral Clock was motivated by their learning that its flower beds were shortly due to be dug up and seasonally replanted (a point ignored by hostile press coverage). For a summary of the 1991 D-Day events around Australia, see Bill Calder, 'Digging in on D-Day', *Outrage*, no.98, July 1991, pp.5-6.

¹¹See, for example, the comments of David Lowe, NSW AIDS Bureau, and Don Baxter, executive director of ACON, in Booth, 'Looking Back in Anger', *Campaign*, no.202, January 1994, pp.24-5. For further discussion about the politics and tactics of ACT UP in Australia, see Graham Willet, *Living Out Loud: A History of Gay Activism in Australia*, Sydney: Allen and Unwin, 2000, pp.184-92.

representation in a more culturally specific way. The work of the most important of these artists was displayed in a group exhibition curated by Ted Gott at the National Gallery of Australia in Canberra. Titled *Don't Leave Me This Way: Art in the Age of AIDS*, the exhibition opened on 12 November 1994 and did not close until 5 March 1995. The public was fascinated by the exhibition and it became the most well-attended contemporary show ever staged by the National Gallery, attracting more than 130,000 visitors.¹² In recognition of the precious public exposure to the artists' work that the Canberra exhibition offered and, accordingly, of the genuine potential for the artists' ideas to influence wider perceptions of people living with AIDS, I shall devote most of this chapter to a discussion of *Art in the Age of AIDS*.¹³ I will, however, occasionally point to other significant Australian cultural products, such as novels and plays, that represented AIDS and the people most affected by the epidemic. Unfortunately, space restricts me from discussing the full range of artistic endeavours which sought to reconceptualise AIDS. I could easily, for example, have chosen to examine Australian television drama and feature film, such as Lawrence Johnston's *Life*, which is set inside an AIDS-segregated cell block in a Sydney prison, or Constantine Koukias's opera, *Mikrovion*, which explores the experience of living with AIDS through musical melodies that attempt to replicate the sequence of molecules which constitute the Human Immunodeficiency Virus.¹⁴

As a cultural event produced by a curator, *Don't Leave Me This Way* was, itself, a remarkably innovative, unique and bold response to AIDS. It was one of the largest and certainly the most comprehensive exhibition of AIDS-related art ever staged in the world, containing over 140 artworks contributed by more than 100 local and international artists. Despite its unrepentant inclusion of sexually explicit and homoerotic images, it received substantial funding from the Commonwealth Department of Human Services and Health – a proposition that was

¹²Personal Communication with Ted Gott, 4 May 1995. Those who did not attend the show might have seen it featured on television arts and news programmes or read about it in newspaper reviews such as the *Sydney Morning Herald's* special three-page illustrated spread (10 November 1994, pp.22-4). A comprehensive colour catalogue of the exhibition was also sold in bookstores.

¹³I am, of course, aware that by the end of 1994 some of the artworks were already three or four years old and were produced in response to specific events at a particular time. Where it is necessary I shall elaborate on this historical context.

¹⁴*Life*, an adaptation of John Brumpton's 1990 play *Containment*, was written and directed by Lawrence Johnston and screened in Australian cinemas in late 1996. *Mikrovion* was first performed by IHOS Opera in Hobart during 1994. Emily Burke (soloist) interviewed by Paul Sendziuk, 6 July 2000, notes in possession of the author; and Martin Bell, 'Icons Hit the Mark in Bold AIDS Epic', *Australian*, 21 March 1997, p.18.

unthinkable in Britain and the United States, according to a number of overseas critics and artists who travelled to Canberra.¹⁵ In the United States between 1987-92, for example, a Congress-imposed ban on funding for any HIV/AIDS educational material that might have been construed to "promote or encourage, directly, homosexual or heterosexual activity" led to a stipulation that museums, galleries and artists must conform to a strict 'sexual aesthetic' if they wished to receive National Endowment for the Arts funding or subsidies.¹⁶ In contrast, as the *Sydney Morning Herald's* art critic opined, "Australians can take some comfort from the commitment and compassion that [government] sponsorship implies and this exhibition enshrines".¹⁷

Don't Leave Me This Way was organised around five discrete themes and divided into four rooms, each of which, more or less, was devoted to one of the themes. The audience was encouraged to move through the rooms sequentially, so that one room prepared the viewer for the next; the physical passage through space marking, perhaps, a philosophical acceptance of the representations which became increasingly confronting towards the end of the journey. The artworks featured in the first room asked the viewer to shed any preconceptions or prejudgements he or she might have had about people living with AIDS. Some of the paintings and sculptures, mainly by overseas artists, aimed to replicate the HIV molecule as a reminder that AIDS is caused by a microscopic virus and not by someone indulging in a certain lifestyle or belonging to a particular race or class. Other works encouraged viewers to consider the possibility that they, during a particular 'high risk' act in the past, might have exposed themselves to HIV infection and could just as easily have joined the ranks of those frequently portrayed as 'deviant' and 'deserving'. An AIDS awareness poster donated by People Living With HIV/AIDS (Canberra) that was displayed in the first room perhaps best articulated these ideas. It was composed of an eye-catching gold frame that bordered a large sheet of mirror-reflective metallic paper, above which was stencilled the words 'A TYPICAL PERSON WITH

¹⁵See, for example, the comments of Robin Forster and James Barrett, who exhibited as Art'g⁰, quoted in Farah Farouque, 'A Labour of Love, Life, Loss and AIDS', *Age*, 11 November 1994, p.20.

¹⁶Carole S. Vance, 'The War on Culture', in Ted Gott (ed.), *Don't Leave Me This Way: Art in the Age of AIDS*, Canberra: National Gallery of Australia, 1994, pp.91-111, especially pp.102-8. Also see Nan D. Hunter, 'Censorship and Identity in the Age of AIDS', in Martin P. Levine, Peter M. Nardi and John H. Gagnon (eds), *In Changing Times: Gay Men and Lesbians Encounter HIV/AIDS*, Chicago: University of Chicago Press, pp.39-53.

¹⁷Bruce James, 'A Visual Tour de Force', *Sydney Morning Herald*, 10 November, p.22.

AIDS'. It promised a sharp awakening for every passing viewer whose reflection filled the frame.

The curator's intent was to challenge the notion that only 'deviant' gay men died from AIDS, a position that was affirmed by a number of female artists whose work evoked the feminine body and spoke of the unique problems which women encountered in protecting themselves from HIV infection. Kate Lohse, for example, announces the (often overlooked) presence of 'Positive Women' in loud pink neon lettering in her installation *20 Million Whispers* (1992). The symbolism is drawn from Western culture and evokes the relative power of women in Western countries to mobilise political action in their fight against AIDS. This image is juxtaposed with the second component of the installation: a small wooden box, filled with green tea, over which is draped a tiny pendant inscribed with a text written in Mandarin. Discreetly hidden from view, the text draws attention to the enormous number of HIV-positive Asian women whose subordinate position in society and lack of political representation renders their plight invisible.¹⁸

Michele Barker spoke more directly to an Australian audience in her computer generated collage *Let's Fuck* (1992), which frankly demands that women empower themselves sexually in the age of AIDS by taking responsibility for their own sexual health (Figure 9.4). As the curator of the NGA exhibition suggests in his catalogue essay, the four semantic elements of *Let's Fuck* – woman, gun, sex, consensuality – point to the principle of 'Russian roulette' operating in unsafe sexual play, and thus urge women to take control of their bodies during sexual encounters.¹⁹ The piece challenges the existing representation of females as passive victims of the AIDS epidemic by recasting them in a sexually aggressive role – Barker's feminine warrior does not 'go to bed', and is not 'seduced' or 'deceived' by a cheating boyfriend or casual partners as she is so often portrayed in scare-mongering women's magazines.²⁰ Instead she 'Fucks' and takes control of her own sexual health.

¹⁸This description is derived from Ted Gott, 'Agony Down Under: Australian Artists Addressing AIDS' in Ted Gott (ed.), *Don't Leave Me This Way: Art in the Age of AIDS*, Canberra: National Gallery of Australia, 1994, pp.8-9.

¹⁹*Ibid.*, p.10.

²⁰See, for example, Josephine Brouard, 'Is There a MAN in Your MAN's Life?', *Cleo*, December 1987, pp.71-3, p.207.

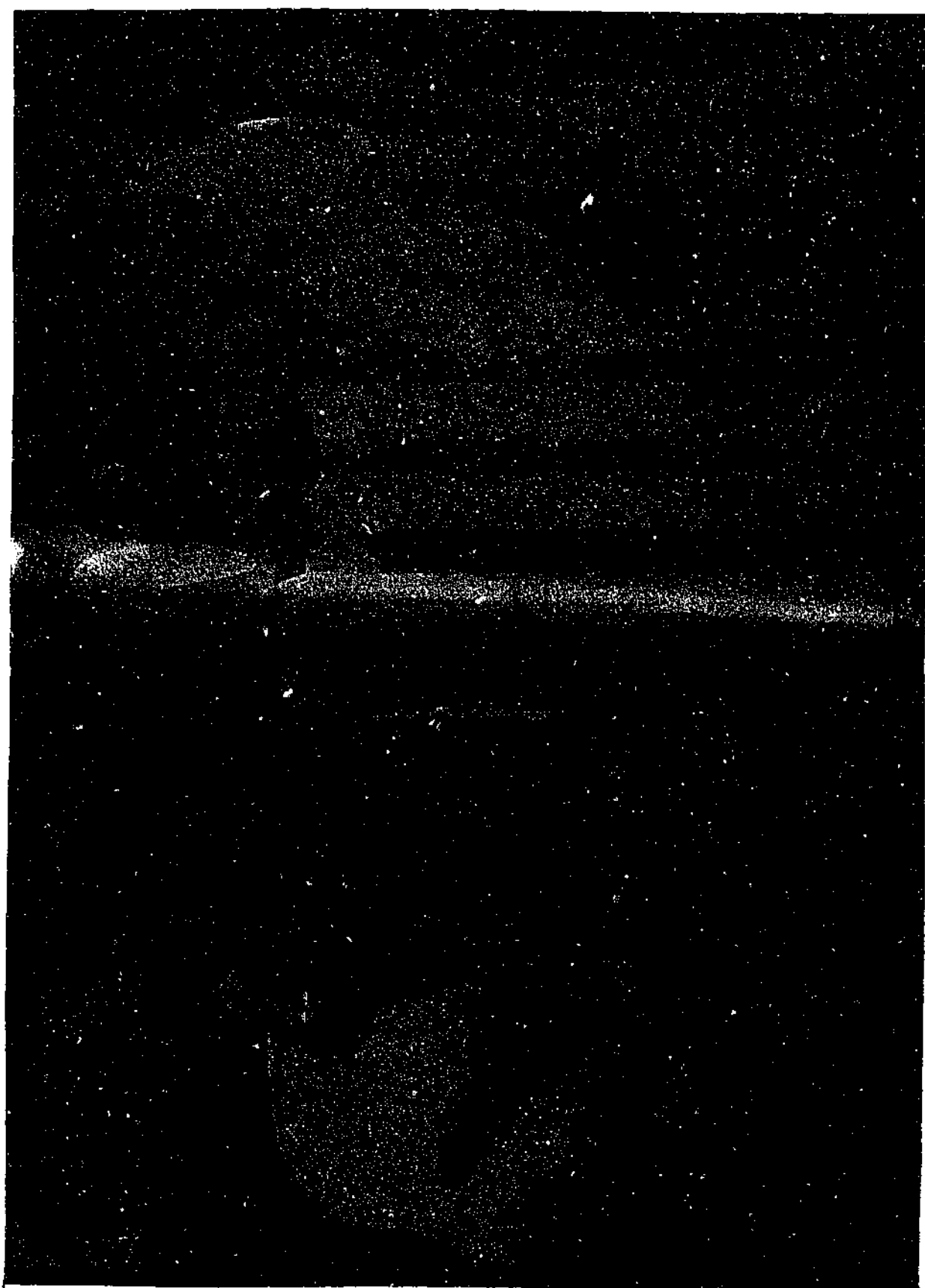


Figure 9.4: Michele Barker, *Let's Fuck*, computer-generated photographic print (90° rotation), 1992.

Artists such as Rea and Kaye Shumack extended the way in which women were imagined and implicated in the epidemic by highlighting the threat posed by HIV to lesbians. Evoking the colloquial term for lesbians in the title and central image of her work *Lemons I-IV* (1994), Rea symbolises the bitter-sweet nature of sexual contact in the age of AIDS while providing a frank instructive text explaining the correct use of dental dams to prevent the transmission of HIV during oral-genital sexual play (Figure 9.5).²¹ Shumack makes a similar yet more subtle point in her series of photographs entitled *Tendances (Tendancies)* (1994), which, Gott contends, "aim to question the elision of lesbian sexuality [that] operates in Australian society".²² Her resonant images of women interacting tenderly, yet elusively, imply the community's avoidance of open discussion about lesbian sexual practices – an aversion that extends to lesbians themselves. As Diane Richardson, a prominent lesbian author, has written:

As lesbians we rarely talk about what we do in bed. This silence about sexual activities is an understandable reaction, given that it is the sexual aspects of being a lesbian that have tended to dominate how others see us. Another important reason is that sexual acts between women are very often interpreted as a "turn on" for men, whether as pornography or not.²³

Such an unwillingness to discuss sexual practices, while protecting lesbians from being exploited by the very people they most wish to shun, places women-who-have-sex-with-women at danger because they are denied the opportunity to learn about safer sex techniques.

The work of Rea and Kaye Shumack clearly disrupt the notion that only men, especially those who practise anal sexual intercourse, contract HIV, and thus are important contributions to the debate about the way in which people with AIDS are portrayed. In challenging one dominant representation of people with AIDS, however, they risk invoking another. After ten years of activists trying to detach homosexuality from the public's understanding of AIDS, their art potentially reinscribes the link between homosexuality and disease by overstating the

²¹Gott, 'Agony Down Under: Australian Artists Addressing AIDS', p.10.

²²*Ibid.*

²³Diane Richardson, *Women and AIDS*, New York: Routledge, 1989, p.95.

likelihood of HIV being transmitted during sexual intercourse between women. While this remains a possibility, there have been no such cases reported in Australia due to the relatively low number of women living with HIV and the inefficiency of this particular mode of transmission. One can be certain that when Douglas Crimp called for the reconceptualisation of people with AIDS in order to reduce the stigma experienced by homosexuals, he would not have had the work of Rea and Kate Shumack in mind as an alternative model.

If lesbians were absent from public discussions about HIV transmission, so too were Aboriginal and Torres Strait Islanders. Unlike heterosexual women and men, indigenous people were not represented in any of the mainstream mass media AIDS education campaigns between 1987 and 1994, and until Australian of the Year Fred Hollows's widely-reported intervention into Aboriginal health and AIDS policy at the first National Aboriginal HIV/AIDS Conference in March 1992, Australians could have been forgiven for assuming that Aborigines did not get AIDS.²⁴ The news media was retarded in offering a contrary view as it was effectively prohibited from reporting on the incidence of HIV infection in Aboriginal communities due to the Aboriginal Health Service's refusal to release any details about HIV infection rates among indigenous people. The Health Service maintained that such confidentiality was essential to prevent any further discrimination towards Aboriginal communities, which were already suffering from the stigma of being branded disease-ridden, sexually promiscuous and unhealthy by the media.²⁵

While representations of indigenous people with AIDS were excluded from mainstream public discourse about AIDS, a number of Australian artists and performers, in conjunction with

²⁴During his address, Hollows controversially called for the mandatory HIV-antibody testing of Aborigines in remote communities and the quarantine of infected individuals who were identified through this process ('AIDS Comments Misinterpreted', *Herald-Sun*, 5 March 1992, p.30; 8 March 1992; Fred Hollows, *Fred Hollows: The Updated Autobiography*, revised edition, Melbourne: Kerr, 1992, p.247; *The Midday Show with Ray Martin*, Nine Network, 25 March 1992). At the conclusion of the conference, fellow delegates issued a recommendation that stated: "That this conference rejects the damaging statements by Professor Fred Hollows regarding the quarantining of Aboriginal people living with AIDS. His statements which received sensational media coverage were uninformed and harmful to the positive education strategies currently being used by Aboriginal people." (Cited in Gabrielle McCarthy, 'The AIDS Summit', unpublished paper presented to the Australian Doctors' Fund AIDS Summit, 15 May 1992, ACON archive, id: G1814.)

²⁵Commonwealth Department of Health, Housing and Community Services, *Report of the Working Panel on Aborigines, Torres Strait Islanders and HIV/AIDS*, Canberra: AGPS, 1989, p.7. Also see 'Fear Hinders AIDS Program', *West Australian*, 20 September 1995, p.21, for recent statements made by the Director of Aboriginal Health defending the decision not to release accurate figures.

health workers in remote communities, were able to inform indigenous people about the risks they faced by devising culturally-specific AIDS-education posters and performance pieces. Richard Mellick's play *No Prejudice*, for example, was performed by an Aboriginal cast (except one) and told the story of an Aboriginal man with HIV who unknowingly infects an Aboriginal woman in a remote community. At a crucial point in the play, the female performer explicitly refutes the myth that AIDS is a disease of urban white homosexuals by telling the audience that "You don't have to be gay to get AIDS".

In an effort to communicate with indigenous people in remote communities, *No Prejudice* toured the Kimberley region of Western Australia (near Broome) for two-and-a-half weeks in June 1992, travelling over 3000 kilometres to play in sixteen outback communities and towns; audiences ranged between twenty and 120 people.²⁶ The play was designed to conform with the traditional method of Aboriginal teaching and learning, and incorporated elements of dance, music and simple but powerful oratory. To ensure that the language of the play was appropriate for the various remote communities where it was performed, the troupe employed Josie Lawford, an Aboriginal cultural-linguistic advisor, to adjust the dialect of the script where necessary. Following each performance, Lawford and the cast members also conducted workshops in which they attempted to dispel the myth that AIDS was a disease of 'the Other' and that AIDS-prevention was a white man's problem. A typical workshop consisted of showing the audience photographs of black people in Africa and the United States who were dying from AIDS-related illnesses, and using plastic models of erect black penises to demonstrate how to correctly use condoms. They also drew upon the everyday experiences of Aborigines in outback communities – such as the way in which head lice is transferred from one person to another – to demonstrate how HIV is transmitted.²⁷

No Prejudice incorporated the 'Don't Be Shame, Be Game (Use Condoms)' message of an

²⁶*Mimi Pulka*, directed by Ruth Carr and Catherine Adams, Voice Productions/SBS Television, 1992. *Mimi Pulka* ('Big Sickness'), a 30 minute documentary, was produced by a film-maker who travelled with the troupe during its tour. It screened on SBS television in 1992.

²⁷For a discussion of similar culturally-sensitive theatre-as-education initiatives in Africa, North America and the Caribbean, see Chandra Mouli and K.N. Rao, 'Performance and AIDS in Zambia', in Allan Klusacek and Ken Morrison (eds), *A Leap in the Dark: AIDS, Art and Contemporary Cultures*, Montreal: Vehicule Press, 1992, pp.235-7; Evan Adams, 'Theatre and AIDS Education in a North American Native Community', in *ibid.*, pp.247-63; Mike Milvasc and Gary Friedman, 'Puppets Against AIDS', in *ibid.*, pp.276-81; and Godfrey Sealy, 'Play On', in *ibid.*, pp.292-5.

1987-92 AIDS education campaign that specifically targeted outback Aboriginal communities and urban centres with a high concentration of Aboriginal residents. The campaign's literature featured the cartoon figure 'Condoman', a dark-skinned superhero based on the Phantom, who was devised at a Commonwealth-funded workshop for Aboriginal health workers held in Townsville during May 1987. Clad in the colours of the Aboriginal flag, and clasping the white man's protective device for indigenous people to appropriate, Condoman implored his target audience to 'Use Condoms' (Figure 9.6). In Northern Queensland Aboriginal and Torres Strait Islander communities this slogan was modified to 'Use Frenchies' because the word 'condom' was not in common usage. Even before his appearance in the Canberra exhibition, Condoman had become a popular figure across Australia and his image was reproduced on T-shirts, crack-and-peel stickers, pencils, fridge magnets, frisbees, and cloth badges for bomber jackets and backpacks. Recognising the broad youth appeal of its superhero, the National AIDS Campaign even brought the character 'to life' in the form of a brightly clad actor who travelled across the country (and was even given his own stall at the Royal Easter Show) to promote the message of safe sex.²⁸

Condoman's message was expressed in a more sophisticated manner in the work of Aboriginal artist Bronwyn Bancroft, whose series of acrylic AIDS paintings was displayed in Canberra. As her work 'Prevention of AIDS' (1992) demonstrates, Bancroft replaced the Anglo-Saxon medieval imagery of the Grim Reaper with traditional Aboriginal iconography in an effort to draw attention to the fact that Aboriginal people could become infected with HIV (Figure 9.7). Reproduced in poster and postcard form, the painting depicts two people safely housed inside a gigantic condom. The womb of the female figure is easily recognisable and represents the importance of protecting unborn children – and the future of Aboriginal communities – from AIDS. Another painting, 'Education about AIDS' (1992), more obscurely depicts the need for injecting drug users to become informed about needle and syringe exchange programmes and safe sex (Figure 9.8). According to the artist, "The small circles house the different groups that are available for counselling and information about AIDS. The flower shapes in the corner represent the spread of good information about AIDS prevention and education."²⁹

²⁸Gott, 'Where the Streets Have New Aims', p.206.

²⁹Artist's statement printed on the corner of the poster, 1992.



Figure 9.6: Commonwealth Department of Human Services and Health & Aboriginal Health Workers of Australia (Queensland), *Condoman*, silkscreen poster, original 1987.



Figure 9.7: Bronwyn Bancroft, *Prevention of AIDS*, poster design, 1992.

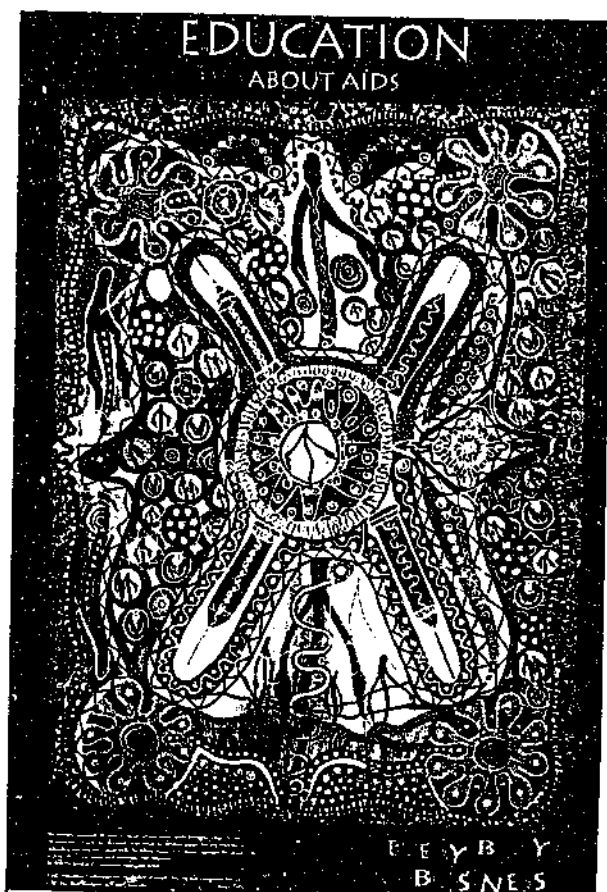


Figure 9.8: Bronwyn Bancroft, *Education About AIDS*, poster design, 1992.

Despite the efforts of Bancroft and the Commonwealth Department of Health to communicate the threat of AIDS to indigenous people in a 'culturally appropriate' way, one has to ask whether it was realistic to assume that Aborigines could 'read' the iconography of traditionally-styled indigenous art. Given their access to contemporary Australian culture via satellite television and radio, and the decline in traditional modes of Aboriginal education, indigenous people were more likely to understand the safe sex message encoded in a Madonna music video or delivered by the doctors on *A Country Practice* than one communicated through an ochre-coloured dot painting. Indeed, the Condoman graphic was successful partly because it derived from contemporary popular culture and the genre of the (English-derived) comic book.

The AIDS awareness paintings of Marrnyula Mununggurr provided a happy medium between the two approaches. As her 1993 painting *Untitled (The AIDS Story)* illustrates, Mununggurr employs the earthy colours of traditional indigenous art and an accessible contemporary visual language to compose an image that can be read by her own people and non-indigenous Australians alike (Figure 9.9). The daughter of a Djuta Djuta elder, Marrnyula Mununggurr's AIDS paintings were commissioned by the Northern Territory's Department of Health and Community Services and were used in AIDS education programmes throughout the state.³⁰

Entries into the public comments books that were kept during the Canberra exhibition indicate that the efforts of Mununggurr, Bancroft, Rea, Shumack and Lohse to reconceptualise the representation of people with AIDS were not wasted on the Australian public. Male and female visitors from country and urban centres, including Wagga Wagga and Grafton and the Box Ridge and Boggabilla Missions, wrote that they now understood how AIDS affects everyone and that they needed to take precautions. Alex scrawled that "AIDS touches every one of us. I have never felt more moved by an exhibition", Sheree remarked that the exhibition "Scared me into ALWAYS using a condom! Need I say more...", and another person using the pseudonym 'R' simply wrote that "I can't help but be hurt that such an exhibition causes so many hours of deep thought on the topic of HIV/AIDS. I may have been careless before;

³⁰Ted Gott, 'Agony Down Under: Australian Artists Addressing AIDS', p.12. For further elaboration of the principles of culturally-specific AIDS education, see G. Joseph Murphy and Peter S. Hill, 'Cultural Identification in Aboriginal and Torres Strait Island AIDS Education', *Australian Journal of Public Health*, vol.16, no.2, 1992, pp.150-7.

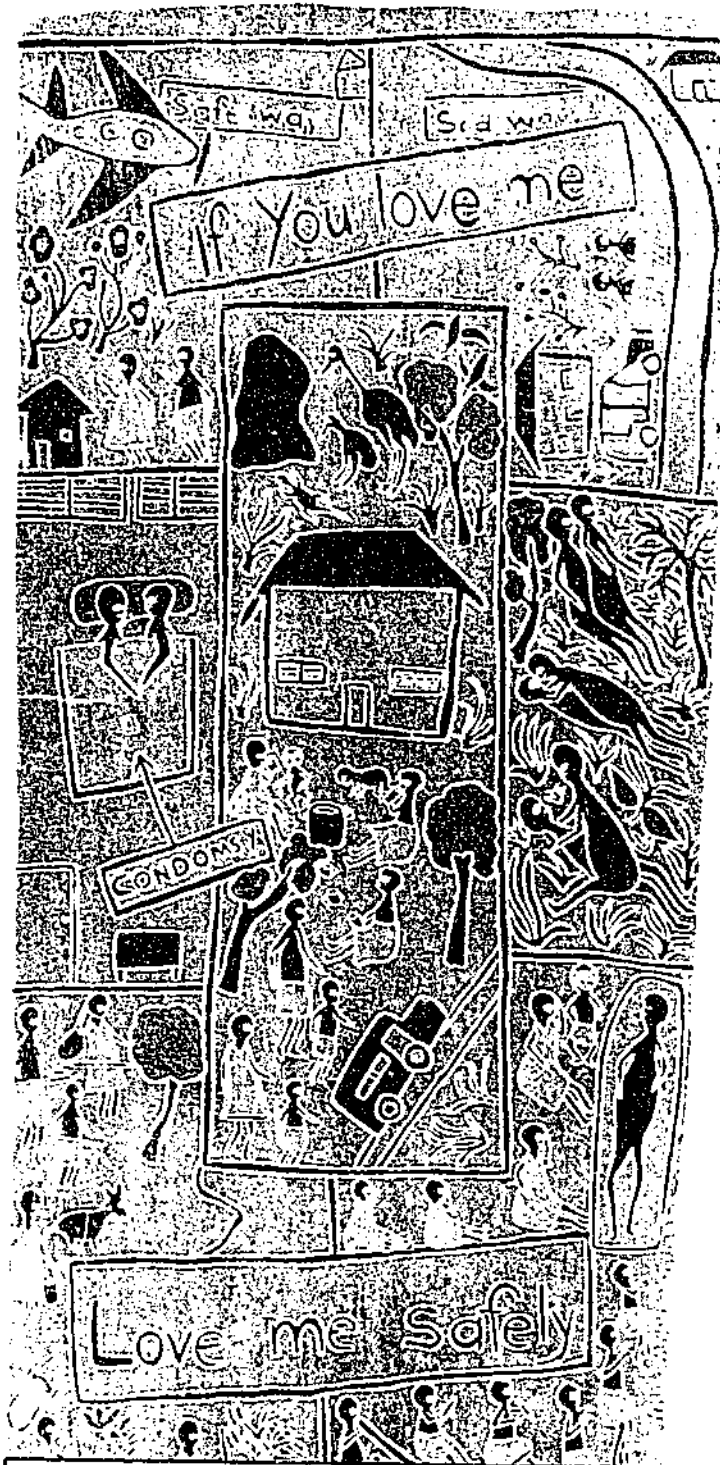


Figure 9.9: Marmyula Mununggurr, *Untitled (The AIDS Story)*, bark painting, 1993.

but I certainly won't be again."³¹

Despite this affirmation of the artists', and the curator's, endeavour, Ted Gott was criticised by other visitors for over-stocking the exhibition with works by gay artists who, in general, represented homosexual men. There needed to be more feminine and indigenous bodies, they argued, and certainly greater attention given to injecting drug users and people with haemophilia living with AIDS. Gott was unrepentant, however, and mid-way through the comments book, took the unusual step of replying to this critics. He wrote:

Given the statistics that, to date, 85% of HIV+ and AIDS diagnoses in Australia have involved gay men...it is hardly surprising that the strongest response to the impact of HIV/AIDS in Australia has come from artists who identify as gay or lesbian...Significant numbers of heterosexual Australian visual artists would seem on the whole to have either not been personally involved with HIV-positive [drug users, women, and people with haemophilia]; or have preferred not to address the topic of HIV/AIDS in their work.³²

There are other explanations for the 'under-representation' of injecting drug users, people with haemophilia and women with AIDS. Injecting drug users would have been unlikely to co-operate with artists or draw attention to themselves due to the illegal nature of their activities; so too people with haemophilia who were desperately trying to distance themselves from the stigma of AIDS. And given that the case for HIV transmission among females – and the demand for women to receive more education and medical attention – had been, arguably, overstated during the 1980s, there was less need for Australian artists to publicise the threat which women faced. Indeed, women had been prominently positioned in the Grim Reaper's sights since 1987 and they remained the focus of subsequent AIDS education campaigns and television documentaries such as *Suzi's Story* until the mid 1990s. It had taken some time for their unique medical requirements to be recognised but this was partially a reflection of the very low number of female AIDS cases in Australia. In terms of care and political

³¹Public Comments Books from *Don't Leave Me This Way: Art in the Age of AIDS*, 12 November 1984 - 5 March 1995, 2 volumes, unpublished manuscript courtesy of Ted Gott and the National Gallery of Australia, p.14, p.37, and p.51 respectively.

³²*Ibid.*, p.25. Also see his catalogue essay, 'Agony Down Under: Australian Artists Addressing AIDS', p.2.

representation, Positive Women centres and PLWA groups specifically for women were established in Melbourne and Sydney in 1988 to provide valuable support and information, and influential female activists such as Levinia Crooks in New South Wales and Michele Kosky in Western Australia became powerful and long-term presidents of their respective AIDS Councils who championed women's issues.³³ It is this relatively powerful position and 'presence' of women with AIDS in Australia that Kate Lohse evoked in one section of her installation. The situation was entirely different in the United States, where women were often excluded from medical and public discourse about AIDS. Indeed, despite the fact that AIDS was the leading cause of death in women under 30 years of age in a number of major American cities, including New York, females were denied participation in drug trials in favour of gay men, and were frequently misdiagnosed by doctors who refused to concede that the symptoms of HIV infection and AIDS differed between the sexes.³⁴ Women in America thus relied on artists to give them a voice which they lacked, even among their own ranks, as few women were able to assume leadership positions within community-based AIDS organisations and political lobby groups. Had Gott curated the exhibition in Chicago or Atlanta, and given the opportunity to display more work by American artists, he would have had greater cause to devise the exhibition in a different way.

After challenging popular notions of who was at risk from AIDS in the first room, the second room of the *Art in the Age of AIDS* exhibition sought to represent the AIDS body as a site of invasion, ravaged by opportunistic infections but also the medical and moralising discourses which render it impotent. Underpinning the work of a number of the artists featured here was

³³I recognise that these statements are contestable, and do not want to suggest that women received a level of support and funding which was comparable to that provided to gay men; Positive Women (Victoria) Inc. did not, for example, receive any government funding until five years after its establishment. The threat to women, and the presence of women living with AIDS, was acknowledged in education campaigns and official discourse, however, even if organisations catering for the needs of women with AIDS were not funded until a critical mass of female AIDS cases developed.

³⁴For a discussion about the exclusion of women in AIDS discourses, education, care and treatment programmes in the United States, see Paul A. Treichler, 'AIDS, Gender and Biomedical Discourse: Current Contests for Meaning', in Elizabeth Fee and Daniel M. Fox (eds), *AIDS: The Burdens of History*, Berkeley: University of California Press, 1988, pp.190-266; Carola Marte and Kathryn Anastos, 'Women - The Missing Persons in the AIDS Epidemic', *Health/PAC Bulletin*, vol.19, Winter 1989, pp.6-13; Gena Corea, *The Invisible Epidemic: The Story of Women and AIDS*, New York: Harper Collins, 1992; Cindy Patton, *Last Served? Gendering the HIV Pandemic*, London: Taylor and Francis, 1994; and Theresa McGovern, 'Barriers to the Inclusion of Women in Research and Clinical Trials', in Nancy Goldstein and Jennifer L. Manlowe (eds), *The Gender Politics of HIV/AIDS in Women: Perspectives on the Pandemic in the United States*, New York: New York University Press, 1997, pp.43-62 (and other essays in this volume).

Michel Foucault's contention that "the body is...directly involved in a political field; power relations have an immediate hold upon it; they invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs".³⁵ Brenton Heath-Kerr, James Barrett and Robin Forster, for example, chose to expose the 'signs' the body is forced to emit when it is medicalised by doctors, labelled 'diseased', and institutionalised in a hospital setting. Heath-Kerr's *Homosapien* (1994), an *in situ* installation piece involving costumed actors, depicts a nurse attending a patient who lays prone on a hospital bed (Figure 9.10). The patient might have stepped directly from the pages of *Gray's Anatomy*; he is all muscles and bones in two-dimensions and devoid of any characteristics which might reveal his personality. The work thus speaks of the way in which doctors and the public frequently reduce unique and multi-faceted human beings living with AIDS to 'AIDS victims' or 'AIDS patients'. By focusing on the discrete biological context of disease rather than the patient's personal characteristics which are testament to a lifetime of choices, *Homosapien* also evokes the traditional medical model of disease and prevention that simplistically views disease as a product of biological anomaly, rather than something caused by a range of sociological factors that constrain life choices.

In a similar way, British artists James Barrett and Robin Forster, who exhibited in Canberra as Art²g^o, expose the way in which homosexual sex has been pathologised by the medical gaze. Their series of photographs consisting of x-ray representations of male-to-male sex criticise the medicalisation of homosexuality which has reduced sexual intercourse to an expression of 'right' or 'wrong', 'safe' or 'unsafe', and which thus prevents doctors and the public from appreciating the very real emotional and physical need that sex between gay men fulfills (Figure 9.11). Doctors, and the public whom they inform, understand that the 'mechanics' of gay sex leads to disease, and therefore view it as act of deviancy that needs to be contained rather than an expression of emotional intimacy and love that might figuratively, and literally in this case, colour the picture.

Sexuality featured prominently in the work of a number of other artists whose creations was exhibited in *Art in the Age of AIDS*. Of particular interest were the colourful lithographs of

³⁵Michel Foucault, *Discipline and Punish: The Birth of the Prison*, trans. Alan Sheridan, London: Penguin, 1977, p.25.

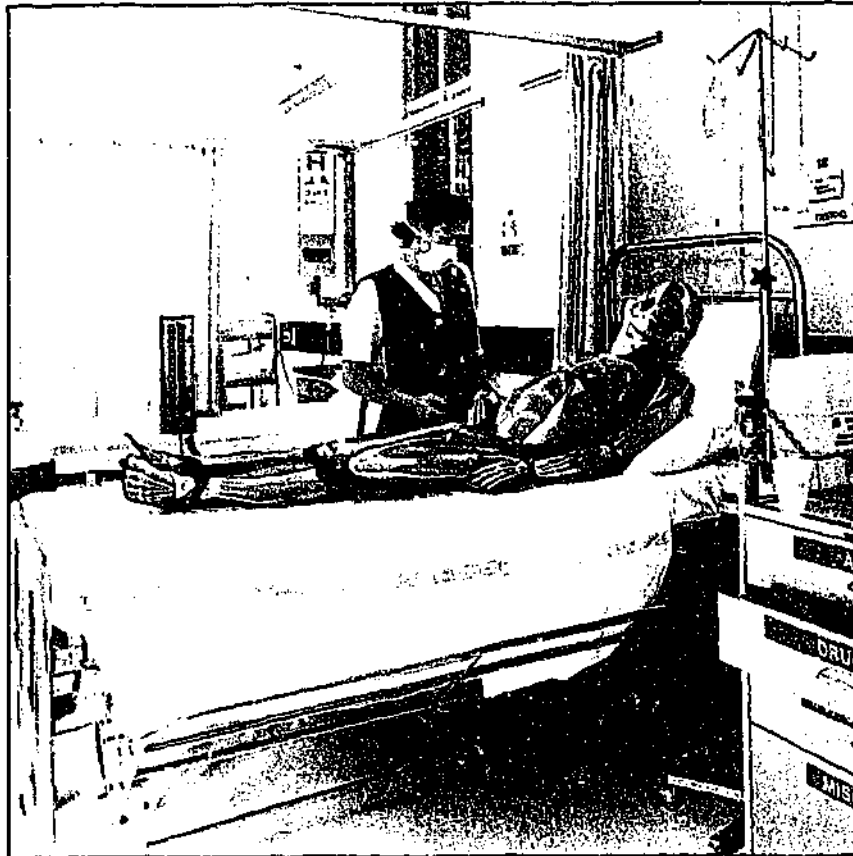


Figure 9.10: Brenton Heath-Kerr, *Homosapien*, full-body costume in hospital setting, 1994.



Figure 9.11: Art^2g^0 , *X-Ray Series #1* (top) and *X-Ray Series #3* (bottom), x-rays, 1992.

David McDiarmid, who was the first Australian artist to challenge the representation of people with AIDS as sexually dangerous by issuing public and celebratory images of HIV-positive sexuality. Indeed, until the solo exhibitions of his paintings in 1991 and 1992, and their subsequent modification and adoption by ACON to be the centre-piece of a very successful 1992 AIDS education campaign, very few representations of HIV-positive sexuality had entered the public domain.³⁶ Those that did generally portrayed 'murderous' and deceitful gay and bisexual men and 'vampire-like' women who continued to sleep with 'unknowing' partners, who were often described as 'innocent victims' by the media.³⁷ The media and the police also occasionally evoked the spectre of the deranged HIV-positive prostitute who refused to desist from turning tricks and who, thus, needed to be physically restrained from doing so.³⁸ In both cases, the opportunities for the partners and clients of these 'sexual avengers' to insist on condom use, or to adopt other methods of safe sex, were ignored. McDiarmid rejected these stigmatising portrayals of people with AIDS by celebrating the right of both sero-positive and negative men (signified by the '+/-' signs on the heads of his figures) to remain sexually active and to be sexually desirable (Figure 9.12 and 9.13). Indeed, evoking the exuberant colour of McDiarmid's portraits, Gott writes:

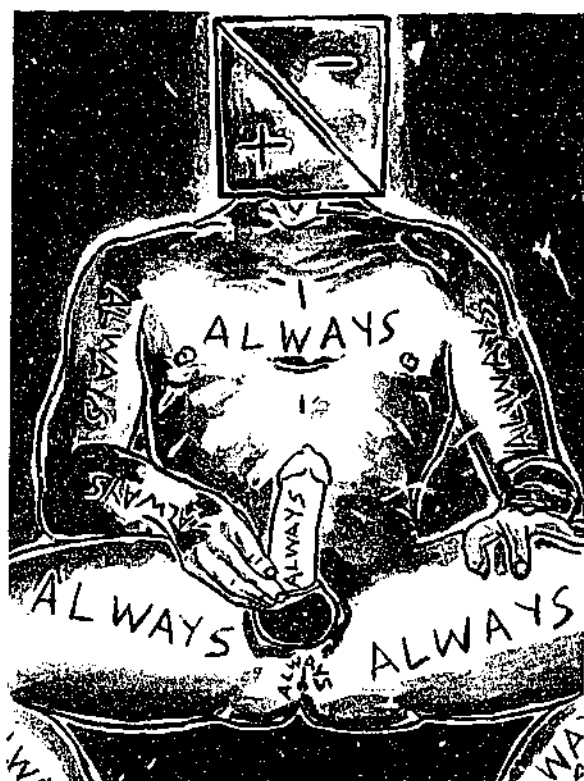
McDiarmid's figures are depicted waving hard-ons, butt-fucking, flashing arse-holes, glowing with drug-hazed desire. Anything but demure, they are palpitating, quivering 'hot zones' waiting to be penetrated, fingered, sucked, eaten out, fucked stupid.³⁹

³⁶McDiarmid's paintings were first shown in Sydney under the banner 'Beauty and the Beast' and 'Kiss of Light' at The Tin Sheds and Syme Dodson Gallery respectively. His AIDS paintings also featured in 'Queershots', a solo exhibition at the Judith Pugh Gallery in Melbourne in April 1992 and 'The Phallus and its Functions', a group exhibition at the Ivan Dougherty Gallery in Sydney in May 1992. Versions of his ACON posters featured in a special AIDS issue of *Art and Text* (no.38, January 1991, p.110), and in *Outrage* (Chris Dobney, 'Kiss of Light: David McDiarmid Interview', *Outrage*, vol.108, May 1992, pp.30-3).

³⁷See, for example, 'Is There a MAN in Your MAN's Life?', *Cleo*, December 1987, pp.71-3, p.207; and 'Brave Victim Fights To Live', *Daily News*, 2 April 1987, p.8.

³⁸See, for example, the reportage of Charlene's case, and the case of two male HIV-positive sex workers who were arrested in Victoria in 1991 (Allison Sloan and Blanche Clark, 'AIDS Man Row: No Public Risk, Court Told', *Herald-Sun*, 27 March 1991, p.3; and Natalie Sikora, 'I'll Fight For Rights - Gay', *Herald-Sun*, 1 June 1991, p.9).

³⁹Ted Gott, 'Sex and the Single T-Cell: The Taboo of HIV-Positive Sexuality', in Jill Julius Matthews (ed.), *Sex in Public: Australian Sexual Cultures*, Sydney: Allen and Unwin, 1997, p.140.



Some of us have HIV, some of us don't
Support each other - share the responsibility

ACON

10/91 200 2000 47 772 50 and equal 823/783 3388

Figure 9.12: David McDiarmid, *Always*, poster for ACON, 1992.



Some of us are in love, some of us are in lust
Relationships are not immune to HIV

ACON

10/91 200 2000 47 772 50 and equal 823/783 3388

Figure 9.13: David McDiarmid, *Safe Love. Safe Lust*, poster for ACON, 1992.

McDiarmid himself commented that "I wanted to do something which would still be pre-sex, especially gay sex" and, as his ACON posters illustrate, the artist was also anxious to explicitly communicate the message for gay men to 'fuck safe' and 'shoot clean'.⁴⁰ He did so through an erotic and colourful visual language which ensured that his posters would find their way onto the walls of gay bars, nightclubs and the homes of gay men. Indeed, in March 1995, two giant murals modelled on two of his posters, *Yes* and *Always*, were unveiled at The Den, a busy gay bar in Sydney, and Ken's Karate Klub, a homosexual sauna in Darlinghurst, ensuring that McDiarmid's conception of HIV-positive sexuality and safe practices were evoked at the sites where they might be most useful.⁴¹

Three of the most popular Australian biographical and fictional accounts of living with AIDS also feature characters who were defiantly sexually active and thus demonstrated to the reader that people with AIDS could continue to enjoy fulfilling sexual lives without posing a risk to others. Bryce Courtenay, in his best-selling narrative of his haemophilic son's battle with AIDS, recalls how Damon Courtenay and his partner, Celeste, decide to continue having sex with condoms despite the reservations of his protective father.⁴² Timothy Conigrave, in *Holding the Man*, enthusiastically relates the numerous hot safe sex encounters he engineered after learning of his HIV positive status. Some of these were with casual acquaintances with whom he first discussed his seropositivity; others were with his HIV-positive partner, John, and are described with erotic verve.⁴³ It is possible that Conigrave's frank descriptions of gay sex may have deterred the readers who most needed to hear his story, but his exuberant explicitness attracted others and, with the assistance of favourable literary reviews, helped his book to become an unexpected best seller in 1995.

Holding the Man followed the critical success of *Shadows on the Dance Floor*, a novel by Garry Dunne in which the author uses humour to disarm a number of potentially confronting

⁴⁰McDiarmid quoted in Chris Dobney, 'Kiss of Light: David McDiarmid Interview', *Outrage*, vol.108, May 1992, p.33.

⁴¹Gott, 'Sex and the Single T-Cell', p.141.

⁴²Bryce Courtenay, *April Fool's Day* (1993), Melbourne: Mandarin, 1994, p.218, 222.

⁴³Timothy Conigrave, *Holding the Man*, Melbourne: McPhee Gribble, 1995. See, for example, p.171, 221, 246-7.

sexual scenarios.⁴⁴ The narrative traces the daily trials of Mr Pointy Head, a person with AIDS who retains his appetite for life and sex after learning of his diagnosis. Challenging the representation of HIV-positive impotency, one of Mr Pointy Head's most hysterical sexual encounters occurs in a place most often associated with sterility, abstinence, and prohibition: the AIDS hospice. As the narrator recounts:

The following morning the door to his room was shut. I knocked and entered. He was sitting, propped up in bed with pillows and grinning from ear to ear. On the floor, poking out from under the bed, was a pair of hairy legs with short white socks and workman's boots on the end of them.

I looked at him, looked at the legs and looked back at him.

"Well?" I finally asked.

"The bed's fucked", he replied and raised his eyebrows.

"I'm not surprised."

The legs moved and I jumped. A slim teenager in faded tight King Gee shorts slid out from under the bed.

"Sprung", I said to no-one in particular.

"No. It's a modified waterbed", the lad replied. "The mechanism for raising and lowering is jammed." He smiled at Pointy Head. "They'll have to get you another one. I'll be back after lunch." He stood up and collected his tools. "Thanks for the drink and all that." He winked and left.

"Well?" I asked again.

"Where there's hair, there's hope", he replied and climbed out of bed, picked up his copy of *Patrick White, A Life* and headed for the en suite.⁴⁵

People living with AIDS organisations and self-help groups were also encouraging their members to talk about their own sexual desires and experiences, and published the results in magazines such as *Talkabout*. This publication featured two issues devoted almost entirely to discussing HIV-positive sexuality in the early 1990s, dispersing pages of poems, short stories

⁴⁴Published in 1992, *Shadows on the Dance Floor* was commended for the Banjo Award (Fiction) in 1993 by the National Book Council of Australia.

⁴⁵Gary Dunne, *Shadows on the Dance Floor*, Sydney: Black Wattle Press, 1992, pp.60-1.

and photographs which portrayed tender, and sometimes frenzied, sexual encounters in between advice columns written by AFAO and ACON experts about the risks of HIV transmission during unsafe sex.⁴⁶ The second of these issues, published in May 1993, featured the photography of Jamie Dunbar, whose images were based on the conceptual design of Andrew Morgan, a person living with AIDS.⁴⁷ One of the photographs, *PositHIV Sex Happens*, depicts a goateed Morgan (connected to an IV drip that signifies his HIV-positive status) and a partner in a hot but safe sexual encounter (Figure 9.14). It was produced in response to the blandness which Morgan and Dunbar perceived to pervade the most recent AIDS education material that was being produced by the gay community and the AIDS Councils.⁴⁸ The photographs were then appropriated by ACON and used in a poster and postcard campaign that encouraged the community to consider the possibilities of HIV-positive sex.

PositHIV Sex Happens deliberately incorporates and challenges a number of myths about HIV infection that had been constructed by the media and public policy over the previous decade. At the most explicit level, the photograph refutes the notion that HIV-positive people cannot, or should not, have sexual intercourse. As Morgan stated in a 1994 interview: "for too long people with HIV/AIDS have been receiving messages that tell us we shouldn't be allowed to be sexual beings after a positive diagnosis. This misconception has to change."⁴⁹ He understood that people with AIDS could continue to have sex safely with condoms, or by practising non-penetrative forms of intimacy (as the photograph appears to be displaying). On a less-explicit level, the photograph disrupts the predominant representation of people with AIDS as morose and impotent creatures, who stare blankly into space as they wait to die, as was typical in the media portraits of Grim Reaper-like 'AIDS victims' that I discussed in Chapter 6. In Dunbar-Morgan's work, people with AIDS are portrayed as passionate, virile subjects, who are capable of maintaining the lifestyles that they enjoyed before contracting HIV. Of course, in this respect, *PositHIV Sex Happens* only offers one possibility, and does

⁴⁶*Talkabout* is the magazine-format newsletter of People Living With HIV/AIDS (NSW) Inc. The issues were published in 1991 and 1993 and were followed by another in February 1997.

⁴⁷'Love, Sex & T-Cell Counts', *Talkabout*, no.32, May 1993, pp.6-8. The artists' work was chiefly financed by *Talkabout*, with additional funds contributed by PLWHA (NSW).

⁴⁸Jamie Dunbar interviewed by Paul Sendziuk, 14 July 1998, notes in possession of the author.

⁴⁹Andrew Morgan quoted in Mark Hoskins, 'Enjoy This', *Talkabout*, no.41, 1994, p.5.



Figure 9.14: Andrew Morgan and Jamie Dunbar. *Posithiv Sex Happens*, gelatin silver photograph, 1993.

not reflect the reality of living with AIDS for many people who do not continue to have sex nor maintain vigorous lives because they are either too sick or, as is more common, are prohibited from doing so by other people's discriminatory attitudes. People with AIDS are also coerced into believing that they were neither capable nor deserving of leading normal lives by the pervasiveness of popular discourses which portray them as fragile and impotent, or as guilty perpetrators of the epidemic who should be ashamed of the way that they 'brought the disease upon themselves'. Dunbar and Morgan rile against these disempowering narratives by providing representations of people with AIDS enjoying their sexuality. In the opinion of the *Art in the Age of AIDS* curator, their photographs are "at once cathartic and healing for their subjects, and instructive for all who study them".⁵⁰

While artists and writers such as Dunbar, Morgan, McDiarmid, Conigrave and Dunne were actively seeking to expose and reconceptualise the taboo of HIV-positive sexuality, the work of other artists, which focused on the connection between sex and death, risked reaffirming the dominant representation of people with AIDS as sexually dangerous. One, for example, might construe that the dread of HIV-positive sex underlies Michele Barker's *Let's Fuck* (1992), which features the image of a face and the barrel of a gun overlaid with the artist's suggestive statement printed in bold blood-red letters. As I have pointed out, however, this piece can be read in another, more affirming, way. Less ambiguous is Mathew Jones' installation *Over My Dead Body*, which was exhibited in Canberra and during his solo shows (Figure 9.15). Consisting of a sterile-white mattress, this piece draws apocalyptic conclusions from intimate expressions of HIV-positive sexuality. Discounting the effect that such art might have on people living with AIDS, critic Mark Pegrum celebrates the educative power of these artists' conceptions, describing them as "some of the most effective works of the AIDS era". In comparison to the Grim Reaper and other fear-based educational initiatives, he contends, they are successful because they "avoid metaphors of plague and do not focus on a specific section of the population".⁵¹ Pegrum overlooks the fact that the Grim Reaper did, at least, offer condoms as a means for people, HIV-positive and negative, to continuing seeking sexual fulfilment. Mathew Jones' *Over My Dead Body* offers no such choice.

⁵⁰Gott, 'Sex and the Single T-Cell', p.143.

⁵¹Mark Pegrum, 'A Big Disease with a Little Name: Responses to AIDS in Contemporary Culture', *Mots Pluriels*, vol.1, no.3, 1997, <http://www.arts.uwa.edu.au/MotsPluriels/MP397mpeg.html>; accessed 2 December 1999.

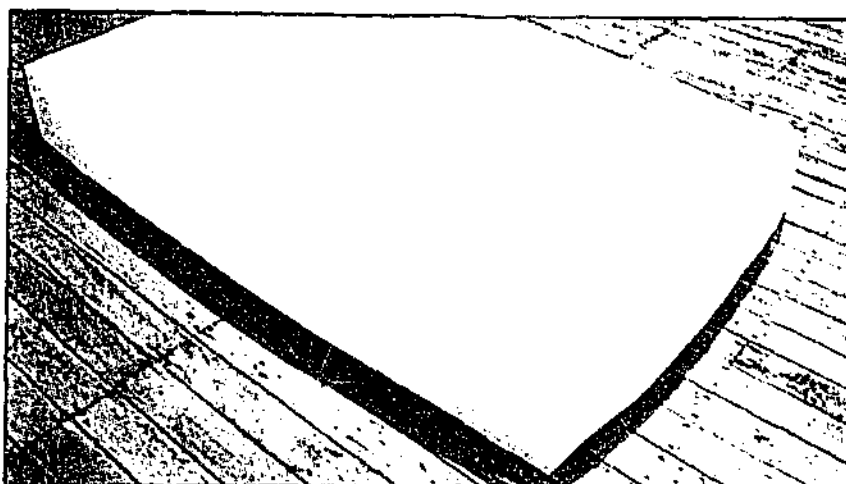


Figure 9.15: Mathew Jones, *Over My Dead Body*, gesso on cotton duck, dacron, marine ply, 1991.

Visitors to the National Gallery had to wait until they entered the final room of the exhibition before they viewed, arguably, the most confronting conception of HIV-positive sexuality. It came in the form of a delicate monochrome photograph of 'Michelle', belly extended with child, who stared out from the frame in a relaxed and defiant fashion (Figure 9.16). Rather than a deteriorating gay man, or an impotent and unattractive 'AIDS victim', the viewer was confronted by a young pregnant woman with AIDS in sexy lingerie, whose gaze demanded recognition.⁵² She represented the thousands of women around the world who contract HIV shortly before or after becoming pregnant, and then confound their doctors and communities by choosing to carry the pregnancy to full term. The chance of Michelle's baby being born with HIV infection was between one-in-ten and one-in-three.⁵³ These slim odds did not deter Michelle's neighbours from harassing her nor, as Michelle claims, from spray-painting the words "child killer" on her front door.⁵⁴ Their ignorant response of fear and revulsion was probably a result of the total absence of representations of pregnant women with AIDS in the public sphere and the panic-stricken portrayals of 'dangerous' sexually-active people with AIDS that the Australian media perpetuated. Their anger might have also stemmed from a belief that Michelle, supposedly condemned to die quickly and horribly, was acting

⁵²Michelle's photograph reached an even wider audience as it featured in a number of pre- and post-opening press reviews of the Canberra exhibition. The *Sydney Morning Herald*, for example, reproduced the photograph with the caption: "The doctor said it was a gay disease and I said 'Well, how come I have got it?'" (Bruce James, 'The Long Shadow of AIDS', *Sydney Morning Herald*, 9 November 1994, p.21.). The caption was provided by Michelle, and was drawn from the text of her 'personal history' that accompanied the photograph on display. Michelle's photograph and personal history were also reproduced in the colour catalogue of the Canberra exhibition and displayed in *A Friend of a Friend* exhibition, Dubbo Regional Gallery, 29 March - 21 April 1996.

⁵³Studies at the time of Michelle's pregnancy suggested a vertical (mother-to-child) transmission rate of between 10% and 33% (John B. Ziegler, 'Notes on HIV and Reproduction', unpublished paper produced for the Australian National Council on AIDS, c. 1991, ACON archive, id: G0001226 (pregnancy); Warwick Giles, 'Managing HIV+ Pregnancies', in Brent Waters, John Ziegler and Annette Gray (eds), *Children and Adolescents with HIV/AIDS: An Update*, Sydney: Prince of Wales Hospital, 1990, p.25; and European Collaborative Study, 'Risk Factors for Mother-to-Child Transmission of HIV-1', *Lancet*, vol.339, 1992, pp.1007-12). The risk of transmission was much lower if the woman's HIV infection was not advanced and she did not breast-feed her baby. This knowledge, gradually acquired, and the adoption of prophylaxis treatment with AZT, saw the rate of vertical transmission fall below 10% in some countries by 1992. (D.T. Dunn, M.L. Newell, A.E. Ades, and C.S. Peckham, 'Risk of Human Immunodeficiency Virus Type 1 Transmission Through Breastfeeding', *Lancet*, vol.340, 1992, pp.585-8; John B. Ziegler, 'Commentary: Breastfeeding and HIV', *Lancet*, vol.342, 1993, pp.1435-6; E. Conner, *et al.*, 'Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 with Zidovudine Treatment', *New England Journal of Medicine*, vol.331, no.18, 1994, pp.1173-80; and Peter J. Collignon and D. Ashley Watson, 'Why Aren't All Pregnant Women Being Tested for HIV?', *Medical Journal of Australia*, vol.166, 16 June 1997, pp.670-1).

⁵⁴Michelle, extracts from a personal history, November 1991 and May 1993, *Self-Documentation, Self-Imaging: People Living with AIDS* project co-ordinated by Kathy Triffitt, *Don't Leave Me This Way: Art in the Age of AIDS*, National Gallery of Australia, 12 November 1994 - 5 March 1995.



Figure 9.16: Michelle, photograph from *Self-Documentation, Self-Imaging* project, 1991.

irresponsibly by giving birth to a child who would soon become dependent on Australia's welfare agencies.

Michelle's photograph, and the text of her 'personal history' displayed alongside the image, was the result of her participation in the *Self-Documentation, Self-Imaging: People Living with HIV/AIDS* project, initiated by Kathy Triffitt, a Sydney photographer and art therapist, in 1988. As Triffitt suggests, *Self-Documentation* was established to counter the situation that led to Michelle being branded a "child-killer":

The image of HIV/AIDS, as it then was, was restricted to medical and media interpretation. On the medical side what we saw represented were afflicted body parts; physical signs and symptoms. On the media side, we saw the rather shamed silhouette of the sufferer, the victim. There wasn't really anything my [HIV-positive] friends or the public could identify with.⁵⁵

As an artist, Triffitt thought that she could address this problem by constructing her own counter representations. She thus invited five people with AIDS into her studio and attempted to produce photographs which mirrored their conceptions of themselves. As Triffitt recalls, however:

To my dismay, when I went into my darkroom to process these photographs, I found I had created photographic biopsies. Influenced by the medical reading I had done by way of well-meant research, I had dissected people into body parts. I had created yet more representations of victims...Since I didn't know what it was to be HIV, the clear and only solution was to hand the camera, the imaging tool, over to those who did.⁵⁶

Self-Documentation, Self-Imaging: People Living with HIV/AIDS was the result. The (on-going) project's participants take their own portraits and Triffitt transcribes their oral histories,

⁵⁵Triffitt quoted in Bruce James, 'Workshops, Seminars and Exhibitions, All Help Educate', *Sydney Morning Herald*, 10 November 1994, p.24.

⁵⁶*Ibid.*

offering them the opportunity to edit the completed text before they are put on display in public libraries and art galleries.⁵⁷ In doing so, Triffitt purports to bypass the artist – whom Douglas Crimp relies upon to “wrest control” of the power of representation – and bestows, instead, this power on people with AIDS. Indeed, Triffitt was so keen to distance herself from the process of producing other people’s images that, during the launch of *Art in the Age of AIDS*, she introduced her project via a pre-recorded video. A number of the project’s participants who were ‘planted’ in the assembled audience also spoke at the opening with the aid of a roving microphone in an effort to take focus away from a single ‘creator’ up front.⁵⁸ Bruce James, the *Sydney Morning Herald*’s arts critic, suggested that such

deferral of authorship is at once the most striking and most moving aspect of the project. Viewers are accorded a privilege of such unmediated intimacy and frankness as to render the experience more in the nature of a discourse with a person than an inspection of an artwork. It’s not that the images and texts lack aesthetic interest, rather than aesthetics is concentrated in the expression of personal and political truths.⁵⁹

Triffitt’s effort to dispense with the artist, and James’ contention that the project’s co-ordinator had succeeded in offering “unmediated intimacy” and “personal and political truth”, requires scrutiny, however. In the first instance, most of the project participants were recruited through a series of ‘body image’ workshops that Triffitt conducted, which claimed to “look at ways in which we can re-claim and re-imagine the body as a part of the healing process”.⁶⁰ During the workshops, Triffitt provided a highly subjective visual and textual language for the participants to draw upon when conceptualising their own experiences of living with AIDS,

⁵⁷Before the Canberra exhibition, *Self-Documentation* was displayed twice at the Mitchell Gallery of the State Library of New South Wales, and later travelled to regional New South Wales and the *A Friend of a Friend* exhibition at the Dubbo Regional Gallery, 29 March - 21 April 1996. Photographs and personal histories from the project also featured in the special AIDS issue of *Art and Text* (vol.38, January 1991, pp.99-107). The *Sydney Morning Herald* also published a near-full page article on Triffitt and included a photograph by one of the project participants (Bruce James, ‘Workshops, Seminars and Exhibitions, All Help Educate’, *Sydney Morning Herald*, 10 November 1994, p.24).

⁵⁸Kathy Triffitt interviewed by Paul Sendziuk, 30 March 1996, notes of the interview in possession of the author.

⁵⁹Bruce James, ‘Workshops, Seminars and Exhibitions, All Help Educate’, *Sydney Morning Herald*, 10 November 1994, p.24.

⁶⁰Promotional leaflet titled ‘Re-Imagining the Body - People Living with HIV/AIDS’, c.1991.

and it is not surprising to find Triffitt's politicised rhetoric recurring in many of the photographs and 'personal histories' on display. Second, although Triffitt does not take the photographs or write the testimonies, she determines the context in which they are viewed by the public. She arranges the order in which they are encountered (thus imposing a larger narrative framework) and chooses which stories and photographs are, and are not, exhibited. She also quotes selectively from the personal histories rather than displaying the texts verbatim, thus potentially censoring statements which do not agree with her personal aesthetic or politics. The participants' snap shots of living with AIDS are thus filtered through Triffitt's ideological lens.

In giving people with AIDS unprecedented access to the public through the art gallery, and offering art as therapy, it is perhaps inevitable that such mediation would occur. It does not detract from the overall contribution of the project which, while failing to fulfill Triffitt's philosophical premise, nevertheless profoundly challenges the established AIDS mythology by offering the viewing public a glimpse at a world which the media largely ignores. It was a world populated by women such as Sue, living with AIDS for over four years, who pleaded to be seen as a 'normal' woman – a housewife, a mother, and an employee – rather than a dangerous creature to be feared:

I have looked after my child and my husband for four and a half years while I have had this virus, neither of them has it. Neither is worried about catching it from me. We are just another family! You think of us as people who are going to run around infecting you...Everytime they put [the Grim Reaper] up, that horrible thing coming towards them, that is me and a lot of other people I know. People were terrified of it. I think that probably 95% of the general public would be absolutely, totally amazed if they knew that I just got up in the morning, took my child to kindergarten, hung out the washing and did a bit of cooking. I am just a very normal, ordinary housewife, if you can use that word. I think that they would be totally astonished.⁶¹

⁶¹Sue, extracts from a personal history, June 1989, *Self-Documentation, Self-Imaging: People Living with HIV/AIDS* project co-ordinated by Kathy Triffitt, exhibited at the Mitchell Gallery of the State Library of New South Wales, 12 Sept - 28 Oct 1990; and *Don't Leave Me This Way: Art in the Age of AIDS*, 12 November 1984 - 5 March 1995.

Sue was determined to change the public's perception about people with AIDS by documenting her experience, but refused to photographically represent herself in fear that she might be recognised by the parents of the children who play with her daughter: "I can see all sorts of terrible things happening to her at kindergarten and school if people knew I was HIV positive, though there is nothing wrong with her."⁶²

Chris had no such reservations. Having suffered the ignominy of being captured "looking like death" in black-and-white by a newspaper photographer in 1986, he set about "undoing the myth that h-i-v = aids = death".⁶³ Having lived for over six years with the virus, he preferred to photograph himself in lively colour, making direct eye contact with the lens with a proud and contemplative expression on his face (Figure 9.17). He states in his personal history, that "there is one achievement that I am really happy about...we have managed to change the language in this country so that we talk about people living with aids. I just sit back and when I hear that expression from a whole range of people I think, yes, you didn't understand that before did you?"⁶⁴

Chris was just one of a number of project participants who were reacting against the Grim Reaper's apocalyptic representation of people with AIDS. Another, John, notes that:

That Grim Reaper advertisement was wonderful – doom and gloom. AIDS it will get you and you will die. That's the media!...Everytime you pick up a newspaper article it's either statistics on the death rate, statistics on the infected people, statistics on the probable death rate. Not everyone falls into that category. People I know haven't fallen into that category of being another statistic. They are still alive and well and going from one strength to another...A lot of people with HIV are very withdrawn once they find out they have got the disease and it is because

⁶²*Ibid.*

⁶³Chris, extracts from a personal history, February 1990; *Self-Documentation, Self-Imaging: People Living with HIV/AIDS* project co-ordinated by Kathy Triffitt, exhibited at the Mitchell Gallery of the State Library of New South Wales, 12 September - 28 October 1990; and *Don't Leave Me This Way: Art in the Age of AIDS*, 12 November 1984 - 5 March 1995.

⁶⁴*Ibid.*



Figure 9.17: Chris, photograph from *Self-Documentation, Self-Imaging* project, 1990.

of the media - that doom and gloom. Bad luck at least in two years you are going to be gone - five years you are a long term survivor and you should have something. You should have full AIDS. There are people who haven't and no one knows that.⁶⁵

Triffitt's determination to recast the language in which AIDS was communicated did not always meet with success, despite the powerful photographs and testimonies of her project's participants and the practical workshops which she conducted for local print and broadcast journalists. Most of the journalists who reviewed the second exhibition of *Self-Documentation, Self-Imaging* at the State Library of New South Wales in 1990, for example, continued to use the terms 'AIDS sufferer' and 'AIDS victim'. When Triffitt angrily confronted the offenders on the telephone, she was told that it was a "matter of column inches and spacing"; apparently "victim" fitted into the lines better than "person living with AIDS".⁶⁶

Triffitt and her project's participants pressed on, however, to the point that they were soon offering an image of AIDS as life-enhancing rather than as an embodiment of death. Alistair photographed himself on stage playing the bass guitar with a band, for example, stating that "it's really important that I use that representation because that's where I'm at now. That, for me, is something I have always wished I could do but never had the confidence".⁶⁷ Barry and Ian offered a portrait of a loving couple, whose life together had been enriched by caring for each other as they battled with the virus. As Barry wrote:

AIDS is a disease not a disgrace...We offer you a share of our sadness, bewilderment, loneliness and despair. But we also invite you to share our very ordinary routine lives and we offer you a share of our smiles and laughter, and

⁶⁵John, extracts from a personal history, April 1989, *Self-Documentation, Self-Imaging: People Living with HIV/AIDS* project co-ordinated by Kathy Triffitt, exhibited at the Mitchell Gallery of the State Library of New South Wales, 12 Sept - 28 Oct 1990; and *Don't Leave Me This Way: Art in the Age of AIDS*, 12 November 1984 - 5 March 1995.

⁶⁶Bruce James, 'Workshops, Seminars and Exhibitions, All Help Educate', *Sydney Morning Herald*, 10 November 1994, p.24.

⁶⁷Alistair, extract from a personal history, October 1992, *Self-Documentation, Self-Imaging: People Living with HIV/AIDS* project co-ordinated by Kathy Triffitt, *Don't Leave Me This Way: Art in the Age of AIDS*, 11 November 1994 - 5 March 1995.

especially the love for each other that this illness has strengthened and made delightful! It has also shown us how to love our circle more easily, and more! There is beauty in sadness and we hope you will see the beauty in the following photograph.⁶⁸

Such insights were rarely articulated by the mainstream media, which could not consider AIDS to be anything but terrifying, shameful and dangerous (or gay relationships to be anything but fragile and temporary, and unable to withstand the strain of terminal illness). Situated in the last room of the *Art in the Age of AIDS* exhibition, they marked the end of a challenging journey for the viewer who had been invited into communion with people living with AIDS and, as the comments in the visitors' book testify, emerged enlightened and moved by the experience. They also marked, as Bruce James describes, "a shift in the prevailing aesthetics of AIDS from fatality and from the medicalisation to which it commonly surrenders".⁶⁹ As he surmised:

So far as theory goes, it is now considered more conducive to cultural production of an original kind to affirm the living in advance of memorialising the dead; not denying that memorialisation on an epic scale is an essential response to the pandemic. Those who call for a withdrawal from a blatantly mortuary art of AIDS do so in advocacy of the living whom they consider diminished by it.⁷⁰

⁶⁸Barry from Barry and Ian series; *Self-Documentation, Self-Imaging: People Living with HIV/AIDS* project coordinated by Kathy Triffitt, *A Friend of a Friend*, Dubbo Regional Gallery, March 1996. The accompanying photograph portrays an older, but attractive, thin man with aware blue eyes that are accentuated by his light-blue T-shirt. He sits on a sofa with a cat, staring out of the photograph with mouth slightly agape as if about to speak.

⁶⁹Bruce James, 'Affirming the Living Amid the Agony and the Cruelty of AIDS', *Age*, 30 November 1994, p.25.

⁷⁰*Ibid.*

Conclusion

In June 2001, the National Centre in HIV Social Research at the University of New South Wales released findings from a study that disturbed most workers in the field of HIV/AIDS treatment and prevention. The study obtained responses from 1832 Australian men-who-have-sex-with-men, 46% of whom admitted to engaging in unprotected sexual intercourse with a regular partner during the previous six months, an increase of 21% since a similar survey was conducted in 1996. Approximately 26% of the sample had unprotected sex with a casual partner, up from 15% in 1996.¹ The researchers were not too concerned about the unsafe sex between regular partners, as the survey confirmed that this was 'negotiated' and generally occurred between partners of concordant serostatus.² However, the researchers also noted that such negotiation requires a high level of trust and communication which is often lacking in casual sexual relationships, leading them to conclude that men-who-have-sex-with-men were now placing themselves at significantly greater risk of contracting HIV during casual sexual encounters. Fortunately, HIV surveillance reports indicate that the decrease in condom use at the end of the 1990s did not coincide with a rise in new HIV infections in any of the states except Victoria.³ This low rate of HIV infection will be difficult to maintain or diminish, however, if the trend towards unprotected sex continues.

At a superficial level, the results of this large-scale study appear to contradict the history of Australian responses to AIDS that I have presented, a story characterised by a remarkable degree of behavioural change within communities most at risk from AIDS, largely brought about by successful community-based education programmes. We should be wary, however, of viewing the history of Australian responses to AIDS in the 1980s through a lens coloured by contemporary concerns. The long-term nature of the epidemic and the development of drug therapies has presented individuals and educators with an entirely new set of problems and possibilities to negotiate in the twenty-first century that were not

¹Paul Van de Ven, Patrick Rawstorne, June Crawford and Susan Kippax, *Facts and Figures: 2000 Male Out Survey*, Sydney: National Centre in HIV Social Research, 2001, p.27, 31; and Julie Robotham, 'Safe Sex By Arrangement As Many Gay Men Reject Condoms', *Sydney Morning Herald*, 7 June 2001, p.8.

²*Ibid.*; and Steve Dow, 'AIDS Not Stopping Unsafe Gay Sex', *Age*, 21 November 1996, p.9.

³Steve Dow, 'Unsafe Sex Makes a Comeback, and the AIDS Toll Goes On', *Age Online*, 9 June 2001, <http://www.theage.com.au>.

previously apparent. For example, the advent of life-sustaining triple combination drug therapies since the mid-1990s has fostered a sense of optimism and perhaps a false sense of security within the communities most affected by AIDS. The drug therapies reduce the level of 'viral load' within the bodies of HIV-positive individuals, which, some believe, reduces their chances of transmitting or contracting the virus during sexual intercourse. It certainly enables people with HIV infection to live much longer before succumbing to AIDS. The virus has thus come to be viewed as less threatening, which has diminished the urgency to practise safe sex.⁴ Gay men who adopted safe sex in the early 1980s with the assurance that a cure for AIDS would soon be found appear to be the most willing to forego the use of condoms. They are suffering 'safe sex fatigue' and want to experience, perhaps for the first time, sex without latex.⁵ Complacency is also prevalent among young gay men who became sexually active at the end of the 1990s but who rarely mix socially with older gay men. They 'came of age' with drug treatments and have never experienced the scale of death and loss that scarred those who lived through the previous two decades. Some of these men also lack the basic training in safe sex and negotiation skills that older homosexuals received in the 1980s.⁶

Thus, the present reluctance of gay men to always use condoms is a response to the unique circumstances in which they find themselves at the start of the twenty-first century and should not undermine a generally enthusiastic assessment of Australian AIDS education initiatives. Nor does it signify the failure of community-based AIDS organisations to foster a culture of safe sex and mutual protection. Indeed, now more than ever, gay men need the advice and encouragement of their trained peers who understand what it is like to feel frustrated or fatigued, and who have wrestled with the temptation to exaggerate the significance of drug treatments. The personal struggle of peer educators to deal with these issues, and the empathy that they bring to their task, bestows a degree of credibility and

⁴P. Van de Ven, J. Crawford, S. Kippax, S. Knox and G. Prestage, 'A Scale of Optimism-Scepticism in the Context of HIV Treatments', *AIDS Care*, vol.12, 2000, pp.171-6; and P. Van de Ven, G. Prestage, J. Crawford, A. Grulich and S. Kippax, 'Sexual Risk Behaviour Increases and is Associated with HIV Optimism Among HIV-Negative and HIV-Positive Gay Men in Sydney over the Four Year Period to February 2000', *AIDS*, vol.14, 2000, pp.2951-3.

⁵Steve Dow, 'Unsafe Sex Makes a Comeback, and the AIDS Toll Goes On', *Age Online*, 9 June 2001, <http://www.theage.com.au>

⁶Personal communication with Kenton Miller, Peer Education Officer, Victorian AIDS Council, 16 July 2001.

legitimacy to the advice and support that they offer. They are therefore likely to continue to be more effective in shaping the sexual culture of the gay community than medically-trained 'AIDS experts' and counsellors, most of whom have contrasting life experiences. They are also in the best position to remind young gay men of their obligation to preserve the community that they have recently entered – a community that would not have survived but for the dedication and responsibility of older gay men.

As I have suggested throughout this thesis, Australia's approach to the prevention of HIV/AIDS in the 1980s was successful because the Commonwealth and nearly all of the state governments recognised that the men and women who established community-based organisations were 'AIDS experts'. They were skilled in providing education, upon which AIDS prevention in the 1980s depended, as they knew where to find and how to speak to marginalised and distrustful individuals. Community-based organisations were therefore incorporated into a partnership with medical professionals and government to provide policy advice, education, home care and support. In part, the decision to embrace education as the primary means of AIDS prevention and to empower the communities most affected by AIDS was a pragmatic one. 'Traditional' methods of infectious disease control such as mass screening, quarantine, and the enactment of laws against the 'knowing' transmission of disease were expensive, difficult to implement and likely to be resisted by individuals whose sexual behaviour and drug use already suggested an unwillingness to conform with laws and regulations. A reliance on HIV-antibody screening as the primary method of disease control was likely to be particularly ineffective because, until the late 1980s, doctors could not offer treatment to those found to be infected. There was therefore little incentive for high-risk individuals to take the test while the anticipated social consequences of testing HIV-positive were discrimination, ostracism from the community and the loss of privacy and rights.

Governments in other Western countries who came to this conclusion did not necessarily empower community-based organisations to provide education and support, however. They funded health departments, advertising agencies and medical professionals to devise and implement AIDS education campaigns instead. With the exception of Queensland, Australian governments differed in their approach because they decided to trust gay men, sex workers and drug users – some of the most despised and maligned members of the community – to care for their own health and the well-being of others. They were

persuaded to do so because these groups proved themselves to be responsible and committed to the fight against AIDS by mobilising quickly and adopting their own innovative strategies to prevent the transmission of HIV. They raised funds for research, devised educational materials, held information forums and safe sex workshops, and sought alliances with sympathetic medical professionals and open-minded politicians. They angrily refuted the notion that they were recklessly spreading disease and deliberately poisoning the blood supply, and, in the case of homosexuals, proved themselves to be committed lovers and friends by tending to the sick and frightened. Their actions defied the stereotypical representation of them as hedonistic, selfish and irresponsible.

The educational strategies and material devised by community-based organisations were effective because they carefully considered the various impediments to the adoption of safe practices. AIDS Councils, for example, had to find a way to market the condom to gay men who had never used them as birth control devices and judged them to be akin to taking a warm shower in a raincoat. In the hand of peer educators and the designers of colourful campaigns, which depicted glistening latex-clad bodies in a selection of steamy sexual scenarios, condoms became the hottest sex toys of the 1980s, promising safe sexual pleasure. AIDS Councils and drug user groups also faced the challenge of educating injecting drug users about how to sterilise needles and syringes. When they pasted stickers and posters outlining such information on the doors of public toilet cubicles in an effort to reach this transient and nebulous population, they risked being accused of promoting drug use, just as the eroticisation of protected gay sex risked being construed as the promotion of homosexuality. While these risks inhibited many countries from supporting the work of community-based organisations, the Commonwealth and most state governments (and both of the major political parties) accepted that homosexual sexual activity and drug use would continue regardless and agreed to fund their educational efforts. They thus committed themselves to the principle of harm minimisation, which placed the lives of gay men and injecting drug users ahead of public sensibilities and 'community standards'.

Two other examples serve to illustrate Australia's pragmatic approach to AIDS prevention. The first was the launch – relatively early in Australia's epidemic and before many heterosexuals had been infected – of a large-scale mass-media AIDS education campaign. The 'Grim Reaper' campaign cost over \$3.6 million and aimed to inform Australians that HIV did not discriminate between age, sex or gender, and that, in the absence of a cure,

prevention was the only method of combating the epidemic. It implored sexually active Australians to have sex with only one partner or, alternatively, to "always use condoms". The campaign was criticised at the time, and subsequently, for exaggerating the risk to 'ordinary' Australians and frightening children with its macabre depiction of death from AIDS. Prominent members of the National AIDS Task Force suspected that its message of widespread risk was designed to remove the responsibility of AIDS prevention from gay men, thereby alleviating the compulsion for them to be tested for HIV-antibodies. These criticisms overlooked the fulfilment of the campaign's other aims, which relied on members of the public personally identifying with the epidemic. For instance, at a time when the government was curtailing public expenditure in response to an economic recession, NACAIDS wanted to manufacture a sense of public urgency that would compel the Commonwealth and the states to fund AIDS programmes appropriately. It also sought to elicit public and political support for the introduction of comprehensive AIDS and sex education in secondary schools and the establishment of needle and syringe exchange programmes. The realisation of these goals, and the failure of a second wave of HIV infection to swell within the heterosexual population of Australia – in contrast to many other countries – vindicated NACAIDS' decision to spend a large sum of money scaring Australians and to speak frankly about safe sex on prime-time television.

The establishment of large-scale needle and syringe exchange programmes in nearly all of the states by 1988 represents another example of Australia's commitment to harm minimisation. Despite opposition from critics who claimed that the provision of needles and syringes would encourage drug use and lead to children and early-morning joggers puncturing their feet on carelessly discarded needles, Australia's needle and syringe exchange programme became the largest and most comprehensive in the world. Originally meant to be conducted by health professionals and pharmacists, community-based organisations were also funded to distribute sterile injecting equipment, alcohol swabs, puncture-proof disposable containers, condoms, and safe sex information. Their success in preventing the widespread transmission of HIV among injecting drug users was demonstrated in international studies that found a large discrepancy between the rates of HIV infection in cities with, and without, needle and syringe exchange programmes. Success was also reflected in the continued low level of HIV infection among injecting drug users in Australia in the 1990s.

The establishment of needle and syringe exchange outlets was, in part, born from the acceptance that education concerning AIDS prevention would not necessarily result in behavioural change among people who lacked the resources or the power to act upon the information. Drug addicts without access to sterile needles and syringes or the means to purchase them would be forced to continue to share injection equipment regardless of their understanding of the risks involved. AIDS prevention workers, both within community-based organisations and the medical profession, also recognised that poor and homeless prostitutes, perhaps fully informed of the consequences of unsafe sex, would find it difficult to insist that their clients wear condoms when they were forced to work, without peer support and at the mercy of their clients, on the streets and from the back-seats of cars. Equally, there was little prospect of gay men taking pride in their health and always using condoms when they were being humiliated and bashed at school, persecuted and vilified in the community or rejected by their families. Clearly economic, legal, sexual and psychological factors ensured that it was more difficult for some people to make healthy life choices.

Australia's success in preventing the spread of AIDS relied on countering these impediments. Governments funded AIDS Councils to offer workshops that aimed to build the level of self-esteem within the gay community, comprehensive needle and syringe exchange schemes were established, and one state legalised prostitution in brothels as a means of providing a safe working environment in which condom use could be enforced and prostitutes could receive training in safe sex techniques and negotiation. This model of disease prevention, which recognised the need both to educate and empower the communities most at risk from AIDS, was very different from the traditional medical model that viewed disease prevention as a fight against microbes in which only doctors and medical researchers could engage. It challenged the validity of traditional measures of infectious disease control that focused on identifying and restraining infected individuals on the assumption that these people were autonomous agents capable of behaving 'rationally' once they were informed of their serostatus and faced with the prospect of imprisonment if they 'wilfully' endangered the lives of other people. It also contradicted the idea that some people with AIDS were 'guilty' and deserving of their plight because they became infected through unsafe practices despite being aware of the risks.

Not all of the states embraced the principles of explicit education, harm minimisation and community empowerment with the same degree of enthusiasm, and none was willing to act upon all of the recommendations of the AIDS Councils and the Commonwealth's chief advisory committee. Queensland refused to distribute NACAIDS approved educational materials or have contact with its AIDS Council until the end of 1987, and baulked at the establishment of a needle and syringe exchange scheme until 1990. Tasmania resisted such a scheme until 1993. All of the states enacted laws against the 'reckless' and 'knowing' transmission of HIV, and New South Wales displayed little hesitancy in detaining a 'recalcitrant' HIV-positive prostitute in a hospital against her will. Brothels remained illegal in most states but escort agencies were tolerated, despite the fact that they do not provide a place for prostitutes to gather or receive training from sex worker organisations. Similarly, laws were changed to allow for the possession and exchange of condoms, needles and syringes on the street, yet neither condoms nor sterile injection equipment was made available in gaols despite strong evidence that drug use and anal sex frequently occur between prisoners who are at high risk for AIDS. Finally, while governments were willing to fund community-based organisations to provide explicit and eroticised safe sex education for gay men, Tasmania refused to repeal laws that criminalised homosexual sexual activity, which made it difficult for AIDS educators in that state to contact homosexuals. Western Australia refused to lower the age of consent for homosexuals to match that of heterosexual adolescents, thus suggesting to young gay men that their desires were unnatural and illegitimate. It also made it difficult for AIDS organisations to target young homosexuals in safe sex campaigns without appearing to encourage or condone unlawful sexual activity.⁷ All of these things contravened the guiding principles of Australia's approach to AIDS prevention forged in the 1980s and they remain challenges for activists and AIDS prevention workers to overcome today.

With these exceptions noted, and in comparison with many other countries, Australia's political response to AIDS was quick, innovative and humane, and defined by its trust in the communities most affected by AIDS to behave responsibly and care for themselves. The Australian public did not fully support this approach, however, and opinion polls conducted throughout the 1980s suggested that the majority of respondents favoured the

⁷For elaboration of this point, which I have not discussed at length, see Christopher Kendall and Sonia Walker, 'Teen Suicide, Sexuality and Silence', *Alternative Law Journal*, vol.23, no.5, 1998, pp.216-21.

quarantine and compulsory testing of high-risk groups. Many declared their sympathy for children and people with haemophilia infected with HIV, but few admitted sorrow for homosexuals living with AIDS and their traumatised community. Their feelings were in part inspired by the media's portrayal of the infection of 'innocent victims', and the representation of homosexuals, drug users and sex workers as selfish, irresponsible and sexually dangerous – representations which had long historical roots. Community-based organisations and activists realised that Australia's exceptional response to AIDS remained under threat while these representations went unchallenged. In the 1980s their actions defied their depiction as reckless and irresponsible, and in the early 1990s they were joined by Australian artists and cultural producers in attempting to recast the public's imagination of people with AIDS and 'deviant' and 'dangerous' individuals. Historians, in demonstrating the benefits of trusting and empowering communities to care for themselves, have a part to play in this struggle.

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