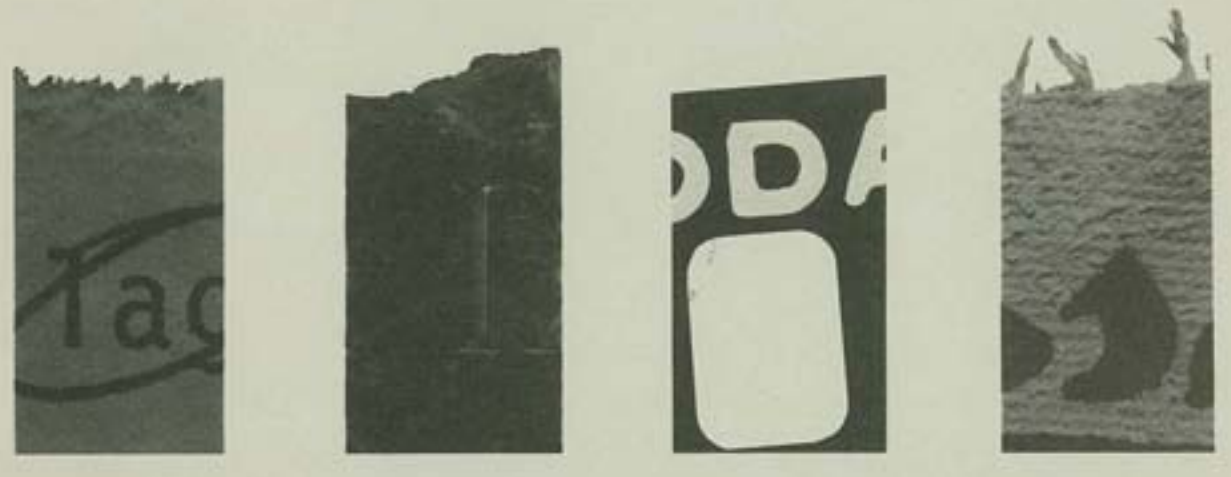
I M A G I N G



A COLLECTION OF ESSAYS PUBLISHED IN
CONJUNCTION WITH THE IMAGING AIDS EXHIBITION

EDITED BY STEPHANIE HOLT AND CHRIS McAULIFFE

IMAGING AIDS

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and

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INTRODUCTION

The "Imaging AIDS" project is an independent project staged in co-operation with the 1989 Mid Summa Festival under the auspice of the Australian Centre for Contemporary Art. It has been undertaken with the following aims in mind: to promote awareness, and critical analysis, of the many issues surrounding AIDS in Australia; to encourage a socially and politically engaged arts practice; to provide a visual arts component for the 1989 Mid Summa Festival which recognises the impact of AIDS on, and the positive responses made by, the gay male community, while also addressing the need to place AIDS in a wider context and examine the issues from a diversity of perspectives; to contribute to fundraising efforts and generating volunteers for AIDS support work.

The "Imaging AIDS" project consists of three components; an exhibition of work by visual artists at ACCA and Linden, the publication of this collection of essays, and an exhibition of mass produced educational and information material related to AIDS (to be staged in March 1989). Members of the working group for the project were; Graeme Byrne, Terry Harding, Stephanie Holt, Robert Jacks, Chris McAuliffe, Richard Perram, and Stieg Persson. Graham Hare offered valuable assistance as a member of the working group in the early stages of the project.

The following organisations and individuals provided support for the "Imaging AIDS" project: ACCA, The Health Promotion Unit of the Victorian Health Department, St. Kilda City Council, the Howard Norman Trust, Chris Perks, Greg McIntyre, the Victorian AIDS Council, and 70 Arden Street. Their assistance is gratefully acknowledged.

This publication would not have been possible without the support - practical, moral, and financial - of many people. We wish to thank the Howard Norman Trust and ACCA for funding the essay collection. Technical assistance was provided by Matt Healy and the *Farrago* team, Terry Harding and Ghetto Design, Irene Verins, Ian McCrabb, and Deborah Kelly. The Social Biology Resources Centre provided access to their extensive collection of AIDS research materials. Above all we would like to thank the writers and artists whose enthusiasm for the project and generosity and patience in producing work at short notice has been vital to its realisation. Special thanks to Dennis Altman who gave encouragement and advice in the formative stages.

Stephanie Holt and Chris McAuliffe
January 1989

THE BLACK KING

The house has been quiet for more than a year. Parties, not wild but happy, used to distract the whole block, and several of the neighbours did not shy from joining in a celebration they knew nothing about or did not quite understand. The man in this house was an open neighbour. He did not have a history, nor did he seem to create any that could be seen from the street. Amiable and talkative when he stopped at a fence to say hello, and often seen carrying a face that was all smile, he was to some people eminently approachable, and to others plainly weird.

But women liked him. They liked him perhaps because he was conscious of not letting his eyes drop to their breasts and hips, or perhaps because, when he spoke, ordinary words would reveal an emotion.

The house was different. Unchanging. Weather and years had no effect on it. So, when he disappeared inside it, he was no longer a neighbour but a secret.

I don't want to imply that the house was severe or gloomy. It was nothing like that. When he arrived, I think it was eight years ago, he stripped the ugly paint off it, planted evergreens front and back, and put startling pink azaleas in pots under the sills of the front window. On tables beside windows which faced the other street — the house is at a corner — he grew obconicas mainly, friendly flowers that I don't like because when they are perfect they look artificial. From either street it was possible to see the rooms. They were sparsely furnished but painted in warm colours, and each of them differently. The picture of the house had been completed eight years ago and it never changed. A house should be a process, accumulating life. Parts of the garden should die, others flourish. Paintings, photos, tables and chairs, should move. Neglect should inspire unfitness of its looks, at least occasionally. And then, probably, there should be more than visitors. A family should scar it, graze the skin. A little mending and changing is good for a house. In this house, though, there was none of that. The house seemed inconsistent with the man. It had the rigidity of a silence intended to end argument and change. A picture of stability which could be happiness.

Through most of this time I never spoke to him. That was not willful. The opportunity never arose; though it could also be said I never made one. When we first met I was one of the team whose work would be to care for him during the last few months of his life.

"I've seen you," he said and eyebrows lifted to form an irony.

"Yes, I live close by."

"It must be strange. Is it allowed?"

"We talked it over. I don't think there will be any problems."

"If I'd known I could have invited you up for a meal," he said, in that manner that was to become familiar, talking as though there were no more chances to do or to plan. For a moment I stumbled on the thought of objecting vigorously.

"You still can."

He laughed, surprised to find he talked about himself in the past tense. "Yes, of course, though you may have to cook if I feel like shit."

"I'm not that bad a cook, really. You may be disappointed."

In the first half of the last year the house was noticeably closed. Window shutters locked a month at a stretch, the canary yellow car disappeared, and the grass, what small area of it there is, grew too long. He was in hospital while the burglars moved in.

I am told that when he was in hospital he was a different man completely. The place reminded him of his dependence on other people and the truth of his illness. Why would a perfectly able and competent person be in hospital? He hardened against the forms of help

and incessant prodding and testing which are natural (or at least unavoidable) in hospitals, so that it seemed to the staff he was normally unfriendly, plaintive, and terse. They were glad to get rid of him when it was decided he could stay at home, or, rather, that there was nothing more that they could do for him.

In his house he could be difficult, too, but here at least there was time for him to explain what he wanted and didn't want, and the team considered it part of its work to make these adjustments — within reason.

With some people the problem is an excessive willingness to be helped; these people want servants who will turn dying into a style of luxury. —That's what I'm told.

In the first weeks he would allow us little more that to drive him to appointments with his doctors, for tests at the hospital, or to visit relatives. He was uncomfortable driving when he discovered his vision could suddenly blur. For a long while he relied on friends, those who were not afraid to visit or, rather, to wait through the long silences or bouts of crying that could erupt at almost any moment. If it was not plain fear that kept some away, the uncertainty of dealing with certain death restrained the rest from visiting. It was to provide relief for those people who had helped most that we were here.

Elizabeth was the first of us to notice his passion for chess. Among the books in his library was a section devoted to the game, and in the living room an old cabinet contained at least a dozen sets of men and boards.

"Everyone says that. Without fail, it is always the first thing you hear."

"No, really, I think I know the rules, but I'm sure I'm no good at it," Liz replied. "I like board games, though."

"I like them less now."

"What do you mean?"

"For some reason people always advise a new opponent they are really no good at the game," he said, setting up the black pieces on his side of the board. "They think of it as an intellectual game. The mind goes on the line."

"No reason for you to worry, if you're good at it."

"I suppose not," he said with some anger.

"Well, we can just play. You don't have to talk about it," Liz said.

In the middle-game he started to talk again, looking at the board. "If I castle, plant a knight in front of this position, and play safely, the defence works itself out. I wouldn't need to force a win. Draws can be very satisfying. It's not at all like life; there's too much art in it."

"Competitive, too," Liz offered, struggling with his cryptic messages.

"With you, unfair competition."

"I'm easy!"

"All of you together, it's unfair."

We learned not to be so rigid in our scheduling and we let him arrange us around him, realising that eagerness to help could destroy the will. It was unfair.

But this, like everything in the last few months, also changed. At first, he wouldn't allow us to do the laundry. He persisted with this ban longer than anything else, for reasons that must have been quite irrational because he didn't mind at all that we did the ironing. In the meantime, we restored the house when he wasn't looking, repaired the garden, and potted plants. The picture of the house got better as he deteriorated.

He never forgot about the washing completely. His body would not allow him to forget. During long periods of diarrhoea he lost weight into his bedclothes and trousers; and when the problem wasn't diarrhoea he would be throwing up every meal. We became adept with buckets and towels. That was easy enough. It was much harder to cope with his embarrassment and sense of degradation.When he felt this most acutely he wouldn't talk to

talk to us, answering with shrugs, grimaces, and nods, instead of words. Moods fluctuated with his body, though, and when he felt better, he talked more.

Twice he asked to speak to meetings of volunteers and it was during these meetings we heard that he thought about us.

"I hate every one of the people, every one of those volunteers who come into my house," he said. "I hate seeing my clothes neatly pressed. I hate having the bed made for me. I hate hearing questions like 'Would you like a cup of tea?' 'Do you think you will be able to have some dinner tonight?' 'Would you like to see your mother tomorrow?' So I swear and curse. I think that if I hate everything that is happening to me enough, if I am angry enough, it will all go away. Stupid. What's amazing is that these people decide they are not going to give up on me. Anger makes me feel better. It keeps me going."At the start of summer his mother arranged a birthday party, gathering all the reluctant, complaining family at the house. She wanted us to be there, too.

It seemed to me the more light came into the house the worse he looked, the easier it was to see those purple blotches which had appeared on his face. —No, not really the light. It was seeing more of his family made me realise how divisive and frightening illness could be. Mother watched everyone keenly, afraid that at any moment someone would let a taboo word loose like a bullet in the air. Sister hugged him too quickly, and careful not to let her lips touch his face. Elder brother's wife and child had conveniently found other duties with a mother-in-law. All this healthy prejudice and fear made him look ill.

I winced with embarrassment whenever someone took up their duty to make conversation.

His cousin, Tom, arrived like a change of weather, strode into the living room with a large, brown-papered parcel, and larger smile, planted himself on the sofa, and kissed the thin, sick man on the lips — leaving some of his smile there.

"Sorry about the paper."

"Oh, god, not another one."

"Who did you say was the chess player?"

"John. Over there," he said, looking at me.

"Good. I'll beat him first then."

"Not if I have anything to do with it," I said, accepting the challenge.

The brown paper tore open, revealing a new chess board and heavy, wood box.

"That's the last thing he needs," the elder brother moaned.

"Yeah, I know, aren't they wonderful?" Tom replied, opening the box and taking out two of the pieces. "Come on, we'll set them up on the table in there."

Tom and I played chess, on the table with the obconicas. Brothers and sister talked, I thought too eagerly, with Liz and Mary, the two women on the team. Perhaps they thought if the conversation with the women lapsed they would have to speak with the men. With the women they could simply be grateful, but the men were another matter. They would have to ask, "Why are you doing this?" or "What are you really doing this for?" Tom, though, felt no need to avoid any of us.

"He told me you live near here."

"Yep. Just down the street a bit."

"You didn't know him before?"

"No. We'd never met."

"Well, he likes you. I mean he likes you more than the others. Not that he isn't grateful to all of you, but he likes you the most."

"I don't understand that at all."

"He says you say what you think and you wouldn't let him win at this," Tom said, nodding at the board.

"I don't beat him anyway."

"You will, though....You know he uses the game to keep watch on himself."

"No?"

"He doesn't care about the Kaposi's and the rest of it. Well, that's not right: he does care. He just doesn't want to go off his head as well. He couldn't stand that. He's afraid he won't be able to think."

"Oh, I see."

"He's got a nickname for you."

"Does he?"

"Yeh."

"Are you going to tell me?"

"Guess."

"I don't have the faintest idea."

"The black king. That's what he calls you. Silly, isn't it?"

"I hope so."

"Well, you're not doing too well today. I'm going to win, I think."

"It does look bad for me."

"So why are you doing this?"

"Helping, here?" I asked, to make sure I would answer the right question.

"Of course."

"Lots of reasons. Just to help, for a start. Then, so he will know he's not alone, I suppose."

"What about you, though? What do you get out of it? And if you say 'satisfaction' I'll hit you."

"No....To tell the truth I don't know yet."

From its first days everyone thought that summer would be particularly hot and mulled over hot synonyms like an incantation. Scorch, blaze, and the rest.

A week after the birthday party another heat began. Mary telephoned one morning and waited at the gate for me as I ran down the street. We may have committed some indiscretion, or maybe one of the family had trusted a neighbour. It was just as likely that gossip and guessing had, for once, converged on the truth and spread like fire to the surrounding houses. On the footpath a great slash of red paint spilt from a can underlined the four letters of my neighbour's new name, written with a thick, bold brush. I was astonished and Mary was crying. "That's not all," she said.

"What else!? What else could the bastards do?"

She took one hand from her face to point at the letterbox which was filthy with excreta.

"Does he know?"

"He can see from the window, John."

"Please, you go inside, Mary. I'll get rid of this."

For a moment I thought of cleaning it, but really I wanted to kill, and might have except there was no-one to lay my hands on. I settled for a sledgehammer, taking a swing at the box to knock it off the fence in one blow. There was nothing to do about the paint. Hosing down turned the red slash into a red blur, but the word was already dry and could not be moved. It stood screaming on the footpath for days and was never removed entirely.

There were more important things to worry about. Our friend joked about the shit. "You know, you are too quick to condemn my neighbours. It could have been a very agile dog, or that big cat a couple of doors down." Or he joked about my sledgehammer. "I'm lucky I still have a house the way you people behave!" I think it was resignation that released this humour on us, turning everything terrible into laughter. Weeks of humid, breathless heat, which I enjoyed, suffocated him. "It's all right," he said, "this heat now and no hell later will suit me fine." He flatly refused to return to hospital. No-one there would understand his new jokes.

He died the night of the promised change, just to show that life really can imitate the weather. Tom tells me that Liz made all the calls when it was clear he would not last. Tom knocked on my door and said I'd better come. He didn't need to say why. I knew it would be like that.

Large, cool drops of rain crashed on my glasses and shirt as we ran down the street. The house, which had been sealed tight against the heat all day, was uncomfortably still and warm. As soon as he entered, Tom cried out, "Oh, for god's sake, open the bloody windows!" It was dark, too, and I stood, sweating, in the shadows of the hall that led to the bedroom. Now, I thought, if only the doctor and nurse will not come. I wished for them not to come so there would be no more injections and orders, no more parody of medicine. I stood outside his door and wished he would die. Liz went from window to window, almost in a panic, as though opening them would save him. I hoped and wished and knew that nothing would.

"Richard, it's me — Tom. Do you want anything? Johnno's here. Do you want to see him?"

Tom put out his arm to call me into the room. It was Tom calling, though, not the man in the bed. Except that his ribs moved under the single, light sheet, he was dead already, and I doubt he could hear Tom spluttering about a game and that the black king was here.

I sat behind Tom on Richard's bed. I put my arms around Tom's arms and chest to stop his fidgeting and prodding. While he sobbed, I closed my eyes and wished again.

Then, while the house cooled, before the others came, there were no more questions, only answers.

Steven Williams *is a Melbourne writer .*

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TAMING THE "GAY PLAGUE": AIDS AND GAY COMMUNITY

A great deal has been written on the way in which the construction of AIDS as a "gay plague" has affected social and political attitudes to the disease. Equally important is the way in which this perception, and the heavy toll the epidemic has taken in the gay community, has affected homosexuals ourselves. While AIDS has severely strained the mores of sexual adventure and experimentation that seemed an integral part of gay male life until the early 1980s, it has also made clear that a sense of gay identity and community rests on more than a shared set of sexual arrangements.

AIDS and the Strengthening of Gay Community

It may be the case that for a few gay men the fear of AIDS has encouraged them to seek a change in their sexual identity. As Brendan Lemmon wrote in a recent short story: "Somewhere towards the end of the AIDS decade, Paul decided to go straight".[1] What evidence we have, however, suggests that AIDS has affected neither the incidence nor the fundamental meaning of homosexuality in western societies. It is, however, producing real changes in the ways in which we experience homosexual identity, both at an individual and a collective level.

The onset of AIDS undoubtedly created a strong sense among many gay men that we had a responsibility to do something about this disease, not just at an individual level but as members of a community. "We have to look after gay men, because no-one else gives a damn" was a common feeling I encountered in the United States in the first years of the epidemic.[2] While there has been less reason for bitterness in Australia, except perhaps in Queensland, the sentiment is echoed here.

In every state the epidemic has seen the creation of large volunteer organisations concerned with providing education, support services and counselling, both to those already infected with the HIV virus, and to the much larger group threatened with infection. These organisations have basically grown out of, and remain linked to, the gay community, although to differing degrees; there is a clear distinction between the Victorian AIDS Council, which has declared itself as having a special role to safeguard the interests of lesbians and gay men, and AIDS Councils in some of the smaller states which very carefully disassociate themselves from any special connection with the gay community, leading to criticism as has recently been expressed in several articles in the Sydney and Adelaide gay press.

A major development over the past year has been the emergence of other community-based AIDS organisations, representing drug-users, prostitutes and people with the virus themselves. The logic of these developments will be either to make AIDS Councils more self-consciously representative of gay men, or, alternatively, to seek to be umbrella organisations combining all these special interest groups, in which case there will probably be pressure to create special groups for gay men.

Whether AIDS organisations see themselves as specifically gay or not, they have become the most visible part of the gay movement for the outside world. Moreover, the AIDS Councils all include large numbers of gay men working alongside lesbians, straight women and (usually) a far smaller number of straight men. This in turn raises real questions about the definition of "gay community". In addition to older questions about the relationship between identity and behaviour, and the contentious questions of whether lesbians and gay men constitute one or two communities, there is now the reality that a number of non-gays have become so involved through AIDS in working alongside gays that they too have claims to belong to the gay community.

In some cases the role of these people has been, ironically, to sharpen the sense of community among gays themselves. Many gay men come into AIDS organisations with no political awareness, and motivated largely by a desire both to help those who are sick and to deal with their own fears and uncertainties about AIDS. To find people, both gay and straight, who take the idea of gay community for granted in turn helps develop that sense among newcomers, and creates a new self-perception and a new acceptance of their sexuality.

My experience with the Victorian AIDS Council suggests that voluntary AIDS Councils become important community resources, through which people, in addition to their direct involvement in certain projects, develop very close ties of friendship and support. Melbourne has been unique - probably in the world, certainly in Australia - in that AIDS spawned two government-supported and gay-based AIDS organisations, the AIDS Council and the Gay Men's Community Health Centre. After considerable internal ructions the two organisations decided to integrate in early 1988, and have developed into a major organisation, involving 500 volunteers, 14 paid staff and a health centre which offers a range of services to the community.

While VAC/GMCHC stand out for the extent to which they proclaim themselves gay community organisations, there is no way in which the perception of AIDS can be fully dehomosexualised. In the long run it is likely that Australia will see the same epidemiological pattern as has emerged in other western countries, namely a decline in transmission through homosexual contact, and a marked increase in cases through needle-sharing, heterosexual contact and perinatal transmission. The cultural face of AIDS, however, has been irretrievably marked by the gay experience, even if much of our exposure comes via the American perception of the epidemic, just as much of gay culture in this country has been heavily influenced by American patterns.

Almost without exception it has been the gay communities of the western world who have produced cultural images and reflections on the meanings of the epidemic, through films, novels, theatre and art. It is hardly accidental that theatre, far more immediate an art form than either the cinema or the novel, has proven a particularly appropriate forum to convass the emotions and issues raised by AIDS, and Australia has seen several indigenous theatre pieces (best known being the Griffin Theatre's *Soft Targets*) as well as productions of Larry Kramer's *The Normal Heart* and William Hoffman's *As Is*. Most striking of the cultural responses to AIDS is perhaps the Names Project originating in San Fransisco, whose Quilt, remembering those who have died from AIDS, now includes thousands of names, weighs sixteen tons and includes five miles of fabric. In both Sydney and Melbourne there are now groups involved in adding Australian panels to the Quilt.

This discussion has been largely restricted to gay men, although in some countries lesbians have played crucial roles within AIDS movements. In Australia most of the women who have participated in AIDS work have been straight, and it seems that one consequence of AIDS has been to increase separateness between gay women and men, not least because of the official perception of the 'gay community' as exclusively male. This is emphatically not the case in the United states, where lesbians have consistently taken the lead on AIDS issues, from the "Blood Sisters" in the early days of the epidemic to the 1987 March on Washington, where a majority of those arrested for direct action were women.[3]

I do not want to offer too rosy a view of gay community and support as the response to AIDS. There is another side to the story, which is the considerable amount of fear, paranoia and unfocused anger which is also evident in some of the gay world. For some the reaction to the epidemic has been irrational anger or apathy - irrational not in the sense that it is not understandable, or in the case of anger unjustified, but irrational because it does little to meet the challenge. While some of us have found a way of coping with grief and loss by participation in communal and support organisations, others have retreated, so scared - and scarred - by the prospect of the disease that they avoid any form of emotional commitment.

While I think he is unduly pessimistic, we should note the warning of San Francisco writer Paul Reed that: "It would seem that our community is becoming increasingly fractured and useless, that there is no reason for self-improvement, for spiritual nourishment, for emotional maturity".[4]

AIDS and Gay Legitimacy

One of the paradoxes of AIDS is that it has forced governments to deal with gay movements and openly gay individuals to an unprecedented extent. Whereas the response of all but a handful of governments has been to demand greater surveillance and repression of homosexuality, a demand not unheard in even the most progressive of societies, most liberal democracies have seen the necessity to establish contact with their gay communities to better respond to AIDS. On a global scale the countries in which a meaningful gay community/movement exists are a minority; one can only fear the worst as fear of AIDS adds to official homophobia and authoritarianism in the countries of Eastern Europe and much of the Third World.

Australia was possibly the first country to accord official recognition of the gay movement's stake in determining AIDS policy. In late 1984 the federal government established the National Advisory Committee on AIDS (NACAIDS), chaired by Ita Buttrose, and appointed two gay leaders to its membership. (This representation was continued when NACAIDS and the AIDS Task Force were replaced by the National Council and Forum on AIDS in early 1988.) Since then the Federal government has facilitated the establishment of a Federation of AIDS Organisations (AFAO), made up of the state AIDS Councils, and has funded a national conference of educators and researchers into gay/bisexual behavioural change. Sitting at the opening session of that conference, while a woman psychologist lectured an audience which included government officials on fisting, water sports and other "exotic sex practices" was a vivid mark of how AIDS has made the previously unmentionable the subject of official discourse and helped legitimise (and, let it be acknowledged, control) gay sex as well as the gay movement.

This recognition of gay community has not been without its critics; there have been periodic attacks, most frequently in *The Bulletin* and *The Australian* on the gay influence over AIDS policy making. (A very strong attack on the "gay lobby" was levelled by Professor Pennington, former Chair of the AIDS Task Force, timed to get headlines just before the 1987 Federal election.) This claim has been taken up by right wing moralists, who have used AIDS as a new pretext to encourage homophobia and reverse what gains have been made in the past decade.

Thus AIDS is invoked whenever there are suggestions to decriminalise [male] homosexuality (still an issue in Queensland, Tasmania and Western Australia) or to extend anti-discrimination protection. When the police moved to arrest law reform demonstrators in Hobart's Salamanca Place in late 1988 they wore gloves, allegedly because of fear of AIDS. It is AIDS that Fred Nile has invoked in his attempts to ban the annual Mardi Gras procession and party in Sydney. And there are reports of increasing anti-gay violence, often linked to AIDS paranoia.[5]

Nonetheless, AIDS has meant a new visibility for gays, and increased access to governments. One of the consequences of this is the creation of a new class of gay leader, people who sit on government committees, hold government-financed jobs and travel at government expense to international conferences. As one of these people I know only too well the risks of becoming alienated from the people we seek to represent.

Elsewhere this development has been less marked. In most European countries there has been some consultation with gay groups, though in very few has it been institutionalised and publicly recognised to the extent in Australia. The United States is a special case because of the importance of local governments; while San Francisco included gay representatives in city policy making from very early on in the epidemic, elsewhere gay/AIDS organisations

have been totally ignored. When President Reagan finally established a Presidential commission on AIDS in mid-1987 he reluctantly included one openly gay man, but one who was there for his medical expertise, rather than his links to the gay movement. Even this degree of recognition seems unlikely in countries such as Mexico, Brazil, the Philippines or Japan, in all of which there are gay organisations which are almost totally unacknowledged by the authorities.

AIDS and the Construction of Sexuality

There are few examples in history to match the dramatic changes in sexual behaviour which have occurred among homosexual men since the onset of widespread safe sex advice. (There are, of course, few comparable times when sexual behaviour has been so closely scrutinised and monitored, which itself raises some real questions: is gay behaviour, even identity, changed by the enormous attention that has been paid to it by both professionals and the media as a consequence of AIDS? when does legitimacy and representation become control and co-option?)

Considerable numbers of epidemiological surveys and reports from sexually transmitted diseases clinics in a number of countries all point to a sharp decrease in unprotected anal intercourse in the male homosexual population. It is not merely that tens of thousands of men have incorporated condoms into the act of intercourse; there is considerable anecdotal evidence that anal intercourse itself has been abandoned by very many gay men (which makes the term 'sodomite' even less appropriate than previously as a synonym for homosexual.)

At the same time AIDS has led to the creation of new forms of sexual expression, of which the American 'jack-off clubs' are the most obvious. The ability of many thousands of men to eroticise forms of behaviour once thought of as mere preludes to 'real' sex - most obviously mutual masturbation - is a strong indication of the elasticity of sexual desire. (Probably because there was less fear of *any* form of bodily contact in Australia, and perhaps because of greater shyness, J/O clubs never really got off the ground in this country.) It is important to note, however, that what is involved is a change in specific *behaviour* but not in the *object* of desire.

For some, AIDS has become a reason to argue against sexual adventure and erotic experimentation; AIDS is being used by many prominent forces in our society to argue for a return to 'traditional values', by which they seem to mean heterosexual monogamy and homosexual celibacy. Within the gay world debate about the sort of sexual behaviour that is appropriate since AIDS is often marred by bitter and irrational arguments, in which wild accusations of either puritanism or irresponsibility are thrown back and forth. Thus Randy Shilts' otherwise excellent book *And the Band Played On* is marred by his total inability to accept that not everyone who thought it wrong to close the bathhouses in San Francisco was irresponsible and unconcerned by the spread of AIDS (just as those on the other side of the debate saw everyone who believed in closure as homophobic and probably fascist.)[6]

In Australia there has been surprisingly little agitation to close sex venues, and a recognition that they are important places for the spread of safe sex/AIDS information to otherwise hard-to-reach populations. It is my impression that after some initial decline homosexual sex venues are once again flourishing - but with new practices, above all the almost automatic acceptance by most patrons of the use of condoms for anal sex. Equally some of the most innovative AIDS education has involved reaching people through prostitutes and material aimed at specific populations, such as the *Streetwize* comics.

The most interesting changes are, however, not in sexual behaviour but in patterns of interaction and intimacy, where we can only venture guesses based on necessarily very limited personal experience. More gay men are, I think, developing close friendships and affectionate relationships in which genital sexuality plays a lesser role, and affection and

Something for everyone!

• *Whenever one of the household staggers home in the morning after a night out, we all sit round the kitchen table and tease him, "Well, did you have safe sex?". They usually say "Oh yes, let me tell you ..." All but Jason. He just looked worried. He'd had one of those moments of temptation. We talked till lunchtime and both ended up in tears. But it's never again been as hard for him to say "No".* •

From *Big Picture, Little Stories*, VAC/GMCHC, December 1988. Produced by Education Image Ltd. Photograph by Steven Broadhurst. (Original in colour, cropped from a double page spread.)

shared commitment to community a greater. Writing before the onset of AIDS Edmund White suggested that: "The current situation in New York [may] be a mere transition, a new recuperation of old opression, and we would expect this period to be followed by a sweeter, calmer one in which romance and intimacy and sustained partnership between lovers would emerge again."[7] There are those who would argue that this is now happening because of AIDS.

AIDS and the Return to Gay Liberation

Over the past year it has struck me that AIDS is leading gay men and our organisations towards some of the practices associated with the gay liberation movements of eighteen years ago. Consciousness-raising is now referred to as workshopping, and gay pride as self-esteem, but the basic premise, that internalised self-hatred can only be overcome by empowering people to overcome social stigma, is being rediscovered as a central plank of attempts to alter sexual behaviour patterns. (Research evidence at this point is rather inconclusive, but it does seem that gay men who have low self-image and little contact with a 'gay community' find behavioural change more difficult than others.)[8] Current peer education programs in all states, and the Victorian AIDS Council summer education campaign, quite consciously use gay community building as a central part of encouraging behavioural change.

During the late seventies and early eighties it became fashionable to dismiss earlier gay liberation ideals and structures as unrealistic and utopian. The gay movement sought a new respectability, influenced by the development in the United States of groups like the National Gay Task Force and Gay Business Associations, although the attempt to build a respectable middle-class pressure group in Australia was far less successful.[9] To some extent AIDS has meant a strengthening of this tendency, in the already discussed entry into advisory groups and government bureaucracies. But it has also meant a new militancy and a new stress on grass-roots organising.

This has been most obvious in the emergence over the past year of organised groups of People With AIDS (sometimes People Living With AIDS). In both Sydney and Melbourne the decision by people who are HIV-positive to organise their own groups and articulate their own concerns has had a major impact on AIDS Councils, and has made certain issues (especially treatment) more central. It was the energy of People With AIDS which led to demonstrations in early 1988 about the expense and unavailability of the drug AZT, and the presence of large numbers of openly positive people at the Third National AIDS conference in Hobart in August was a highlight of the conference.

But new awareness engendered by AIDS has also led to an increase in more general gay political activity. The past year has seen attempts to mobilise the gay vote in both the N.S.W. and Victorian state elections (in N.S.W. the only Liberal seat lost was the seat of Bligh, won by pro-gay Independent Clover Moore, and in Victoria a meeting of the Gay Electoral Lobby was addressed by State Attorney General Andrew McCutcheon, whose St. Kilda seat has a large gay population.) Sydney has seen the development of the Gay and Lesbian Rights Lobby, and the National AIDS Conference energised the Tasmanian Gay Law Reform Group, who won a major confrontation with the Hobart City Council over their right to distribute petitions in Salamanca Place after over 100 arrests. More recently gay law reform groups have emerged in Perth and Cairns. At least in Hobart I was struck by the equal participation of women and men; I hope this is a sign of a new coming together of what has in recent years been one of the most gender-segregated gay movements in the western world.

The Survival of Gay Community

It is difficult for those of us who have not lived in the major centres of the epidemic to recognise the extent to which it has devastated our community. A friend of mine in New York tells of going to the funeral of someone who had died of AIDS, and commenting on how small was the attendance. That's because, he was told, most of those who would have

come are already dead. In a growing number of cities, already including Sydney, anyone -- gay or straight, women or men - with ties to the gay community is experiencing the sort of devastation that Andrew Holleran captures in this interchange in his wonderful story *Friends at Evening* :

> "So you think nothing will ever, ever be the same?" said Ned.
>
> "Nothing" said Mister Lard, screwing the cap on his jar of face cream. "We're all going in sequence. At different times. And will the last person out please turn out the lights?"[10]

The long term implications of this amount of death and suffering for those who survive AIDS are as yet hard to determine. We know something of the psychological costs in the short-term; we have yet to come to grips with the full extent of the long term effects. Large numbers of gay men in their thirties and forties are dealing with the constant presence of death several decades before they would otherwise expect it. Even if medicine finds ways of curing and preventing this disease, a whole generation of gay men will bear its scars for the rest of our lives.

When AIDS first hit there was an understandable reaction which claimed it invalidated the sexual liberationist struggles of the previous decade. Some went further and prophesised that it meant the end of gay life as we had come to understand it in the past two decades. This, after all, was not an impossible scenario - gay life in Germany, which had seemed fairly well established in the 1920's, was very quickly wiped out by Hitler. But seven years into the epidemic I think we can be fairly sure that while the losses have been enormous, and the grief of those of us who survive will stay with us for the rest of our lives, gay life, gay identity and gay community will not disappear. As Paul Berman wrote in the Village Voice:

> The sexual revolution of the last twenty years can be reined in, it can be redirected, but it can't be repealed . . . Naturally the plague will cause changes in sexual behaviour and imagination, both in the immediate present as emergency measures and in the post-emergency long run. But those long run changes will be an evolution towards something, new, not a return to something old. Neither utopia nor conservatism will be the future.[10]

However horrible the devastation caused to our people by AIDS, the gay communities constructed in the last two decades have proven too powerful to be undone by the epidemic.

Dennis Altman *is the author of* AIDS and The New Puritanism *and a member of the National AIDS Forum.*

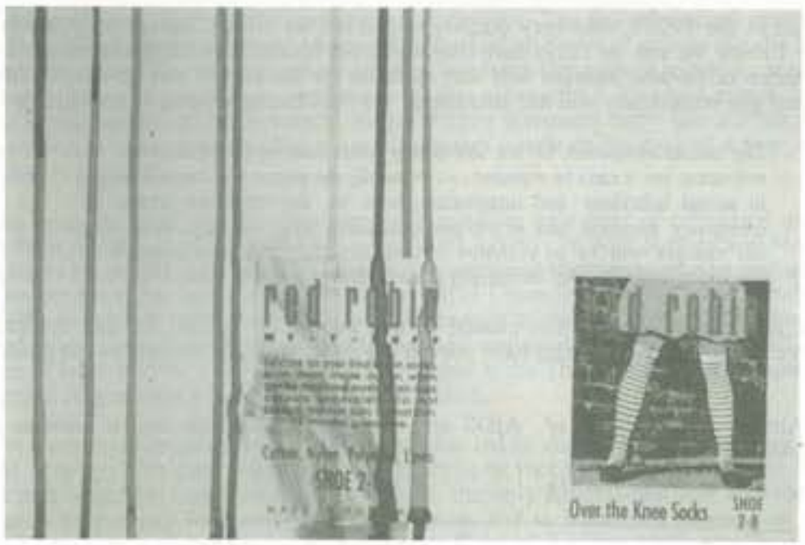
Notes

1. B. Lemon, "Female Trouble", *Christopher Street*, no. 116, 1988, p. 48.
2. See D.Altman, *AIDS and the New Puritanism*, London, 1986, esp. Ch. 4.
3. Cindy Patton, "No Turning Back", *Zeta Magazine*, January 1988, pp. 67-73.
4. P.Reed, *Serenity*, Berkeley, 1987, p. 17.
5. See J.Chater, "Ninja Gang Attacking Homosexuals", *The Sydney Morning Herald*, 17 December 1988.
6. R. Shilts, *And the Band Played On*, St. Martin's Press, New York, 1987.
7. E.White, *States of Desire*, New York, 1979, p. 279.
8. The Macquarie University AIDS Research Project (Sydney) is producing evidence which strongly supports this conclusion.
9. See D.Altman, *The Homosexualisation of America*, Boston, 1983.
10. A.Holleran, "Friends at Evening" in G.Stambolian (ed.), *Men on Men*, New York, 1986, p. 95.
11. P.Berman, "Culture Shock", *Village Voice*, 23 June 1987.

THE ABORTED ROMANCE

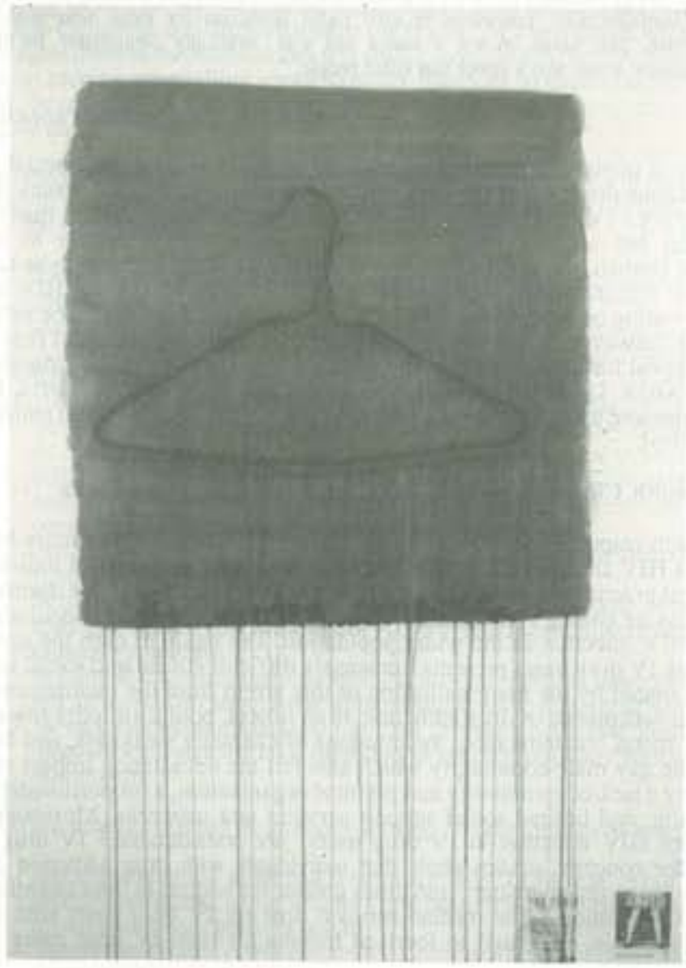
This work deals with the issue of fertility and AIDS. During pregnancy a woman at risk of HIV infection faces a higher chance of infection, and a woman already infected risks a more rapid progression of infection. She may also give birth to a child infected with the virus. To avoid these women can choose education in safe sex and contraception, HIV testing before marriage or pregnancy, or abortion. But AIDS is not simply a health risk. Women are now actively encouraged to have an HIV anitbody test before contemplating pregnancy; pregnant women with AIDS, or antibody positive, are faced with the option of abortion or giving birth to a child that will be HIV positive. Women risk losing control over their bodies. Safe sex and contraception might be seen as the woman's responsibilty. Testing raises the possibility of state intervention in fertility (this is already happening in the United States). A woman's body might be seen as tainted and fertility lose its positive qualities. This is suggested in the image - the color red changes from being associated with innocence in the Red Robin label to suggesting danger and evil. AIDS has placed an extra burden on women, forcing them to reassess their fertility where previously they had taken it for granted. This is what I consider to be the aborted romance.

From a conversation with Sally Mannall.



(Above) detail, bottom right, *The Aborted Romance*.

(Facing page) Sally Mannall: *The Aborted Romance* , 1988
Gouache, charcoal, mixed media on paper; 100 x 70 cm.



AIDS AND INTRAVENOUS DRUG USE
AN ETHICAL ANALYSIS OF HIV ANTIBODY TESTING POLICIES

> In the nex t twenty minutes, the President laid out his views on AIDS. There was little talk of education and a lot of talk of testing. There was no mention, however, of confidentiality guarantees or civil rights protection for those who tested positive. The words created a stance that was politically comfortable for the President; it was also a stance that killed people.
>
> Randy Shilts, *And the Band Played On*

The complexity of public policy issues engendered by AIDS is clear. For special populations such as intravenous drug users (IVDU) and their sexual partners, the issues reach a new level of complexity.[1] IV drug users are characterized by behaviour that, in many settings, is not only illegal but socially unacceptable. There is a simple answer to curbing the transmission of Human Immunodeficiency Virus (HIV), widely believed to be the causative agent for AIDS: require testing of everyone considered to be at risk for HIV infection or, worse, require testing of everyone - whether or not they are at risk - just to be safe.Like most simple answers, however, it is wrong Widespread HIV antibody testing, at first glance, has considerable appeal for policy makers who search for 'the answer' in the struggle to contain the spread of AIDS. Upon closer examination, the test emerges as a useful, but limited, public health measure that should be adopted only after certain fundamental ethical standards have been satisfied.

The Public Health Challenge of HIV Infection Among IV Drug Users

The public health response to AIDS and HIV infection among IV drug users has been one that focuses on HIV antibody screening as a tool to educate and counsel individuals about safe behavioural practices in an effort to minimise HIV transmission. The dramatic increase of HIV transmission among IVdrug users is of critcal concern since this population serves as a conduit for HIV infection in the wider population. The battle to curb the spread of HIV infection among IV drug users presents immensely difficult ethical and social issues; issues that are compounded by the marginalisation of this group from the mainstream of society. Despite official acceptance of drug addiction as an illness, public attitudes toward drug use are marked by moral condemnation, assumptions of character weakness, and fear. IV drug users, unlike the gay male community which also felt the devastating impact of AIDS, are characterised by a lack of community and political organization, a proportionately poor level of general health, and limited social support services and networks. Moreover, the social consequences of HIV infection in IV drug users are considerable.[2] IV drug users have special cause for concern: studies show that individuals with drug addiction die from all causes at a rate seven times greater - ten times greater for addicts in their twenties - than that for the general population.[3] The median survival time for IV drug users with AIDS is ten months after diagnosis, compared to fourteen months for non- IV drug using people with AIDS.[4]

Part of the public health challenge in curbing the incidence of HIV infection in IV drug users stems from the following consideration: the traditional philosophy for drug treatment programs has been to *cure the addict,* with the goal of abstinence; it therefore emphasises the element of choice in 'kicking the drug habit'. Unfortunatley, many drug users make this choice only to discover that placements in existing drug treatment programs are not available.[5] The public health challenge of reaching the IV drug using population is exacerbated by the difficulty of motivating drug users, particularly those who are addicted to heroin, into presenting themselves for treatment. This challenge is also compounded by the issue of confidentiality, which is of particular importance for a socially stigmatised population that faces legal sanctions. Although public helath authorities in several countries have called for routine counselling and HIV antibody testing of individiuals at risk for HIV infection, including IV drug users, reported breaches of confidentiality regarding antibody test results have deterred many people from seeking testing.

The Benefits and Limitations of HIV Antibody Testing

Because shared use of needles and syringes has been documented to be an efficient conduit for HIV transmission, HIV antibody testing of IV drug users has been proposed as a necessary public health measure to contain the spread of HIV infection and AIDS. The nature and scope of testing programs vary. Some public health officials maintain that antibody testing should be required for all identified IV drug users; others support testing as part of neeedle-exchange and drug treatment programs. At a minimum, there appears to be widespread agreement in the medical and scientific communities that IV drug users should be encouraged to receive counselling about safe sex practices to minimise HIV transmission, and should be offered the opportunity to be tested, with appropriate assurances of confidentiality and informed consent.

The HIV antibody test continues to raise complex questions about the appropriateness of its use; as a public health measure, it clearly offers both benefits and burdens. The perceived benefits include the following:

- Detection of antibodies to HIV, which implies HIV infection and infectiousness.
- An opportunity for (pre-test and post-test) counselling and education about AIDS, particularly how to protect oneself from infection, if seronegative, and how to protect others from infection, if seropositive.
- An incentive for seropositive individuals to do the following: (a) adopt a healthier lifestyle, thought to be a positive step in possibly delaying the onset of AIDS; (b) particpate in clinical trials for experimental treatment; and (c) if an AIDS diagnosis is confirmed by the antibody test, obtain licensed antiviral treatment, such as AZT, that has been documented to delay the onset of opportunistic infections for some persons with AIDS.
- An incentive for seronegative individuals to modify their behaviour to minimise the risk of future infection.
- A diagnostic tool for AIDS, when used in conjunction with other laboratory tests that confirm the presence of AIDS-related opportunistic infections and clinical symptoms.
- A clinical case-management tool that may be useful in determining whether or not an individual should risk immunosuppressive therapy or surgery.
- A valuable epidemiological tool that provides necessary information to map prevalence rates for HIV infection in specific populations and in the general community.

In addition to the benefits offered by antibody testing, several limitations emerge:

- Because the initial screening instrument (the ELISA test) is not 100% specific or 100% sensitive, a confirmatory and costly (Western Blot) test must be used for all blood with positive results.
- Tests have limited predictive value. Current official estimates indicate that a seropositive individual has (approximately) a 35% - 50% chance of developing AIDS in the next five years, with many public health authorities speculating that a much higher percentage is more accurate.[6] It is not possible to predict with precision if or when a seropositive person will develop AIDS.
- Tests have limited therapeutic value. There is currently no cure or vaccine for AIDS, nor is there any therapy that has proven to delay or prevent the onset of AIDS among seropositive individuals, although clinical trials in this area are underway. Although AZT has been documented to delay the onset of opportunistic infections for some persons with AIDS, evidence that it is maximally effective and minimally toxic is not yet reflected in current research protocols.

- The usefulness of test results is limited by the approximately three or four month (and possibly longer) *window period* where the antibody response to recent infection may remain undetected. Moreover, the test would not identify HIV infected individuals whose immune systems were so damaged that they did not produce antibodies or who, in rare cases, lose antibodies after infection.
- Positive test results, compounded by the predictive uncertainty and the lack of effective antiviral therapy, are psychologically debilitating.
- Testing may lead to adverse consequences for seropositive individuals including loss of housing, termination of employment, and discrimination in medical treatment and care.

Given the benefits and limitations of HIV antibody testing as a public health tool, what type of testing program for IV drug users is morally justified? Is mandatory HIV antibody testing morally defensible? What ethical standards should guide policy development?

HIV Antibody Testing Policies: An Ethical Analysis and Guidelines

As a disease that generates fear and hysteria, causes social disruption, appeals to prejudices, and invites stigma, AIDS dramatically illustrates the timeliness and importance of fashioning a humane and effective public policy response. A morally justified HIV antibody testing policy is one that respects the dignity of - and does not discriminate against - individuals, is effective in achieving a proportionate public health benefit, and is feasible, or capable of being widely implemented and acted upon. The following five conditions, therefore, are proposed as ethical threshold standards - a 'moral minimum' - by which policies may be justified: human dignity, efficacy, proportionality, non-discrimination, and feasiblity. Given these five ethical standards, how do HIV testing policies for IV drug users measure up from an ethical perspective?

The ethical standard of human dignity requires that the burdens of testing be balanced by a corresponding benefit. Knowledge of serological status for IVdrug users, who often experience guilt, desperation, anxiety, depression, and isolation relating to drug use, may exacerbate an already compromised emotional and physical state without offering a clear therapeutic or public health benefit. The ethical standard of human dignity also requires that HIV antibody test results remain confidential. Documented breaches of confidentiality regarding test results deter IVdrug users from voluntary testing and from entering drug treatment programs where testing is required. Confidentiality, however, often appears to be an elusive standard, and breaches of privileged information continue to occur.

In Australia, most state and territory public health legislation contains confidentiality provisions which prohibit unauthorized disclosure of personal information without the individual's informed consent. However, although these provisions generally protect the disclosure of confidential personal information, unauthorized breaches have occured. In a complex public health network, the possibility of shared access to self-identifying patient information raises particular concerns about inadvertent breaches of confidentiality within the health care setting or to third parties, e.g., insurance companies and employers. Breaches of confidentialtiy can also occur when disclosures about serological status are made to drug treatment program and health care staff, presumably on a 'need to know' basis, i.e., when knowledge of serological status or an AIDS diagnosis is necessary to effectively coordinate drug treatment, medical care, or counselling. Moreover, several states and territories require notification of the names of seropositive individuals to public health authorities which will be recorded on a central computerised registry.

Although state and territory public health legislation requires confidentiality of personal medical data including serological status, with limited exceptions, several important questions need to be addressed and discussed with the individual before HIV antibody testing is conducted or before the individual enters a drug treatment program where testing is required:

- Is HIV antibody testing conducted in a manner that identifies the individual, or is it conducted on an anonymous basis, e.g., information is recorded under a codified identification system?
- If test data are codified, who is knowledgeable about the codification system?
- Who has access to and control over records in which serological staus is recorded?
- Does the state in which HIV antibody testing is conducted require reporting of seropositive cases? If reporting is required, is personal identification notifiable, or merely the incidence of HIV infection?
- Does the HIV antibody testing program require contact tracing of the seropositive individual's sexual and intravenous drug-using partners?

Before being tested, individuals should be informed of the nature of the confidentiality safeguards, the manner in which data will be recorded, and the legislative requirements for the reporting and release of confidential information, including serological status, and for contact tracing, if required. If confidentiality safeguards are determined to be inadequate, then HIV antibody testing should be conducted on an anonymous basis, with appropriate assurances of counselling and informed consent.

The standard of efficacy requires that HIV antibody testing must be capable of achieving its public health goal of HIV prevention. However, testing IV drug users is not an efficacious means to motivate individuals to adopt safer practices. For those IV drug users who are not enrolled in drug treatment programs and continue to use intravenous drugs, knowledge of serological status provides no clear public health or therapeutic benefit. Monitoring of subsequent sexual activity or drug practices is not possible, and the efficacy of clinical treatment, e.g., AZT, for asymptomatic seropositive individuals has not been conclusively established. Moreover, knowledge of serological status does not clearly serve as a sole incentive to change needle sharing practices.[4] Indeed, it is the uncertainty of the serological status of drug-using and sexual partners that may compel IVdrug users to modify unsafe behaviour. This desired public health goal of behaviour modification to minimise HIV transmission may be achieved without an undue reliance on HIV antibody testing.

Some proponents of HIV antibody testing of IVdrug users maintain that the test could be used as a clinical case-management tool by drug treatment staff to confirm AIDS diagnosis or to coordinate clinical care. Moreover,a person with AIDS, if he or she has a severely depressed immune system aand related opportunistic infections, may require special clinical care management. These cases, however, are not common; most seropositive individuals do not require special medical treatment and care, and treatment for drug addiction would not pose any special clinical concerns regarding HIV transmission. HIV antibody testing as a diagnostic tool therefore offers limited public health benefits. One justified use of the test would be as a diagnostic tool that is used on a clinically-indicated basis, e.g., when an individual presents with HIV-related symptoms or illness, or AIDS-related opportunistic infections.

Proponents of HIV antibody testing also argue that the test could be used by drug treatment program staff to ensure that infection-control precautions are routinely observed. However, knowledge of serological status by drug treatment program staff would offer little public health benefit, and could result in irrational fear about HIV transmission, if the patient is seropositive, or in a false sense of security, if the patient is seronegative. Because of the practical limitations of the test, including the window period during which the virus may remain undetected, the more sound and appropriate policy would be a cautious one under which all clients are presumed to be infectious.

Broadbased HIV antibody screening also has been proposed as an epidemiological tool; data obtained from testing could be used to map HIV prevalence rates in a population that engages in high-risk behaviour. Given the associated harms and limitations of HIV antibody testing, e.g., the possibility of inadvertent disclosure of serological status to third parties, the limited availability of effective treatment for asymptomatic seropositive individuals, the potential for HIV-related discrimination in housing, employment, and medical treatment and care, and the test's limited prognostic capability, mandatory HIV screening of this population would provide a disproportionate public health benefit. Drug treatment programs, or other programs where broadbased HIV antibody testing of IV drug users is required, should examine the relevant state and territory requirements for notification of HIV infection and AIDS to public health authorities. If the state or territory in which testing is conducted requires the reporting of self-identifying information for seropositive IV drug users, and if confidentiality safeguards are perceived to be inadequate, then a broad-based, mandatory HIV antibody screening program for IV drug users would not be morally justified.

If the sole purpose of the screening program is to generate epidemiological information as the basis for coordinating an effective public health strategy, HIV antibody testing should be anonymous and reported to public health authorities only with relevant demographic data, e.g., age. gender, geographic location. IV drug users should be informed that anonymous HIV antibody testing will be conducted solely for epidemiological purposes, should be given the opportunity to provide written consent to the test, and should be able to be informed, if they desire, of test results. Disclosure of test results to IV drug users who request such information would be possible if blood samples are codified in a way that links the sample to the appropriate individual without recording self-identifying information. If HIV antibody testing of IV drug users is to be conducted in the context of an epidemiological research study, testing should be *routine*, and not *mandatory*. [5]

The ethical standard of non-discrimation is of particular importance for the IV drug using population, many of whom suffer widespread discrimination in medical care, employment, housing, and other services because of a history of HIV infection, drug use, or drug addiction. The purpose of HIV antibody testing of IV drug users, and for the use of test results, must be non-discriminatory. Proposals to screen IV drug users as the basis for differential and discriminatory treatment not based on relevantly distinguishable considerations would not be morally justified. A drug treatment program's purpose for HIV antibody screening, for example, can not be to deny treatment to seropositive IV drug users. Nor can screening be used to segregate seropositive IV drug users from other clients in a residential drug treatment program where contact between staff and clients, or among clients, poses no - or a negligible - risk of HIV transmission. There may be instances where an IVdrug user with AIDS has suppressed immunity, and therefore requires special self-protection measures to minimize the risk of exposure to infections. However, although this possibility may justify HIV antibody screening when clinically indicated, it does not justify a broadbased mandatory testing and segregation policy.

The ethical standard of feasibility poses a few problems for HIV antibody testing that is conducted in the context of drug treatment and needle exchange programs. Testing could be conducted without great practical or logistical difficulty as a condition for entry into the program, or during the course of treatment. However, because a majority of IV drug users are not enrolled in existing drug treatment programs or related rehabilitation services, many IV drug users would not be reached. A broad-based HIV antibody screening policy designed to reach a large proportion of IV drug users, who compromise a 'low profile' population generally characterised by a low utilisation of health care and social services, would not represent a feasible public strategy to combat HIV infection and AIDS. Moreover, a policy for mandatory HIV antibody screening in the context of drug treatment programs, which fails to gain access to IV drug users not in treatment, would appear to discriminate against a sub-group of IV drug users who choose to seek assistance in abstaining from drug use.

Ethical Guidelines fror HIV Antibody Testing Policies for IV Drug Users

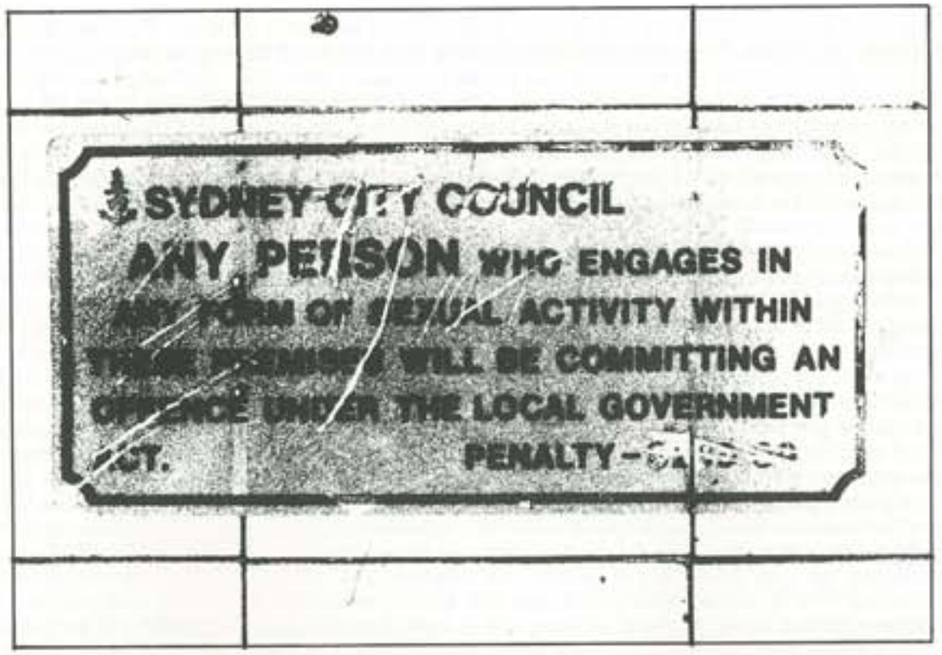
The public health objective of reducing the spread of AIDS and HIV infection in the IV drug using population requires an integrated approach that incorporates HIV education and counselling, drug treatment and rehabilitation services, and a limited use of HIV antibody testing, the purpose of which must be non-discriminatory. The following ethical quidelines are proposed for the development of HIV antibody testing policies.

HIV antibody testing offers only limited benefits as a public health strategy for AIDs prevention amonh the IV drug using population. There is no clear justification for mandatory HIV antibody testing of IV drug users. HIV antibldy testing, with appropriate assuraances of counselling, informed consent, and confidentiality or anonymity would be justified on a voluntary basis and on a clinically-indicated basis. Broadbased testing of IV drug users for epidemiological purposes is justified only on a routine and anonymous basis which enables the IV drug user to receive counselling, to consent to the test, and to be infored of test results, if he or she desires such information. HIV antibldy testing shoul be conducted only after extensive pre-test and post-test counselling, and upon the provision of the informed consetnt of the drug user. Counselling should offer the seropositive IV drug user drug treatment programs, encourage notification of sexual and drug using partners, with the provision of peer support group networks, as well as information on HIV infection and safer drug using and sexual practices.

Maura O'Brien *is a graduate student at Georgetown University, Washington D.C., and conducted research in Australia while based at the Monash University Bio-Ethics Centre.*

Notes

1. Several disenfranchised sub-groups comprise the IV drug using population: prostitutes, women, people of colour. An analysis of the myriad social and ethical HIV-related issues for these groups is beyond the scope of this essay which focuses on the general IV drug using population.
2. In Australia the majority of AIDS cases has been diagnosed among white homosexual or bisexual males. However the number of new cases of AIDS and HIV infection among heterosexuals, including aboriginal and immigrant populations, continues to rise. In the US intravenous drug use accounts for 27% of national AIDS cases, and is the fastest growing category of new HIV infections.
3. San Francisco health officials revised previous estimates of the percentage of seropositive individuals who will go on to develop full AIDS. The new estimates project a 65-100% progression to full disease within 16 years following HIV infection,
4. Knowledge that one is seronegative has not been conclusively documented to provide an incentive to abstain from drug use, to enter treatment programs, or to refrain from sharing needles and syringes. Knowledge of a positive HIV antibody test result however has been documented by some researchers to result in a significant change in *sexual* practices.
5. The interchangeable use of "mandatory" and "routine" in the context of HIV antibody testing has resulted in confusion. As used approriately "mandatory" HIV antibody testing implies that an individual would be denied services upon refusal to be tested. "Routine" testing implies that treatment is offered routinely in a specific setting, and is accompanied by adequate counselling and informed consent.



Lachlan Warner: *Beat Graffiti*, 1988.
Black and white photographs; 40cm x 51cm.

THE AIDS CRISIS: LEGISLATIVE RESPONSES

In Australia, as elsewhere, it seems that in the absence of medical solutions to the AIDS epidemic (there being no vaccine and no cure) people have looked to the law for protection, and to allay usually groundless fears. Various public figures and interest groups have called, among other things, for mandatory HIV antibody testing of the entire population/people crossing national borders/"high risk" groups/job applicants/homosexual parents; the creation of "AIDS-free" zones; the closure of gay venues; and a ban on Sydney's Gay Mardi Gras (its replacement to be an education seminar on AIDS). Underlying many demands for legislative action was the notion that AIDS is caused by homosexuals rather than by a virus.

It could be argued that the denial of civil liberties inherent in these proposals is too great a price to pay even for effective AIDS prevention, and that such prevention would have to await less harsh and restrictive measures. We now know that implementing any of these proposals would be not only ineffective but couterproductive in halting the spread of HIV, and yet in a recent poll 75% of people interviewed believed that suspected drug users and suspected homosexuals (the survey failing to distinguish between gay men and lesbians) should be tested for AIDS.[1] Many issues concerning education and information arise from these sorts of findings, and it is not possible to explore them fully here, but the poll results are interesting for the perspective they give to legislative action which governments *have* taken since the spread of HIV within Australia was first recognised. The President of the New South Wales Court of Appeal warned in 1987 that "democratic legislatures stimulated by hysteria and ignorant fear can be repressive and ill-directed".[2] While there has not been a flurry of legislative activity introducing mass compulsory testing, quarantining or restriction of movement, there *is* now compulsory testing in certain circumstances (all prisoners in Tasmania, Queensland, Northern Territory and South Australia). There have also been instances of existing laws being used to persecute groups perceived to be at risk of (or carriers of) HIV infection.

Despite there being nothing intrinsically "homosexual" about AIDS, recent national statistics show that the overwhelming majority of people currently diagnosed with AIDS are gay and bisexual men.[3] For as long as this situation continues, legal responses to the epidemic will be closely interconnected with laws relating to homosexuality. The confluence of disease and traditionally taboo sexual practices is forcing our society, in the interests of public health, to reassess its attitudes towards these taboos and the laws which underpin them.

Homosexual acts between consenting adults in private have been decriminalised in New South Wales, South Australia and Victoria. New South Wales and South Australia have also amended their equal opportunity legislation to outlaw discrimination on the grounds of sexual preference. In Victoria, proscription of discrimination on the grounds of physical impairment now includes discrimination on the grounds of actual or imputed HIV infection and AIDS. In the remaining states and territories homosexual acts between men are criminal. Needless to say, in these jurisdictions there is no legislative proscription of discrimination on the grounds of sexual preference, HIV infection or AIDS.

During 1988 the law was used with renewed vigour against gays in Queensland and Tasmania, and it is difficult to avoid concluding that the fear and ignorance surrounding the transmission of HIV and the connection in many people's minds between homosexuality and AIDS, were behind the actions. In Queensland, there was a marked increase in the number of prosecutions of men for homosexual behaviour in semi-public places (such as showers and toilets). These recent prosecutions included distinctive and novel features. Firstly, instead of being charged with summary offences, as was previously the case, defendants found themselves charged with more serious offences under the Criminal Code, carrying heavier penalties of between three and seven years imprisonment on conviction. In addition, most cases involved the use of young police officers as *agents provocateurs* , purporting to be available for casual sex and often initiating contact with the defendants.

In Hobart last year, over 130 people were arrested at the Salamanca Place outdoor market for displaying placards supporting the Tasmanian Gay Law Reform Group (TGLRG). The TGLRG had set up a stall collecting signatures on a petition to state parliament, calling for the decriminalisation of homosexual acts. They were eventually granted permission to conduct the stall when, after a three month battle, the Hobart City Council on December 9th, reversed its earlier decision banning the groups from the market. Although the news media found the vision of police arresting pro-gay activists newsworthy, newspapers around the country were remarkable for their silence on the progress of this major civil liberties battle. It may only have been the flood of local support the TGLRG received as a result of being persecuted which eventually led the council to allow them to operate from the market.

These events bear directly on the spread of HIV. Legal sanctions serve to stigmatize and drive underground those people who are likely to engage in high risk behaviour, and who must be the target of information and education campaigns if the spread of HIV is to be slowed and eventually stopped. Research shows that education regarding HIV transmission is most successful where there is a strong sense of community among target groups, and a minimum of persecution by public bodies. This is why authorities such as the World Health Organisation and the United States Surgeon General argue that decriminalisation of homosexual acts is essential for successful AIDS education programs.

The AIDS epidemic has also highlighted the fact that where laws do not actively proscribe homosexual acts, the existence of homosexual relationships is ignored. A further level of discrimination becomes apparent, in which those rights, benefits and obligations attaching to hetersoexual marriages (and, to a large degree, heterosexual de facto relationships) are denied the participants in homosexual relationships. Nowhere is this more clearly demonstrated than in a case which came before the Victorian Social Security Appeals Tribunal in 1987. This case concerned whether the lover of a gay man ill with AIDS, who provided home care, was entitled to receive the Carer's Pension. The Social Security Act provides that a person who provides constant care and attention for a severely ill relative in the relative's home (and who is therefore unable to earn an independent income or to seek employment), is entitled to receive the pension. It was argued that the two men were spouses for the purposes of the Act. The men had lived together in a monogamous sexual relationship for four years; they presented to the outside world as a couple; they provided mutual care and support throughout their relationship; purchased real estate together and shared finances; and the man with AIDS had made a Will and Power of Attorney in favour of his lover.

The Tribunal was not swayed by these considerations, and in denying the appellant's entitlement to Carer's Pension, referred bluntly to the intention underlying the relevant section of the legislation:

> The fact is that there is not the slightest possibility that Parliament intended the word "spouse" in this Act to include a partner to a homosexual marriage and it is of course because of this and other instances of legislative preoccupation with or preference to heterosexual relationships that there is a movement for legislative changes in the interests of homosexuals.

Subsequent to this and a similar case in New South Wales the Social Security Act was amended, and from February 1988 the person providing care is no longer required to be a spouse or other relative in order to qualify for the pension. The change is encouraging evidence that in the face of the AIDS epidemic the law is being forced to move from its traditional heterosexism towards a recognition of the diversity of relationships people form. Of course its significance should not be overstated, there is generally little validity accorded sexual relationships other than heterosexual ones. There is no statutory communal property rights between partners of gay male or lesbian relationships. Gays and lesbians have no claim against the estate of their deceased lover, a fact which, with the increasing deaths of gay men, is creating additional hardships for their surviving partners.

There is a role for legislation in AIDS prevention in facilitating health education. Where they are still criminal, homosexual acts must be decriminalised. Obscenity laws impeding the presentation of sexually explicit information to the general public must be repealed. The confidentiality of HIV test results must be protected and discrimination on the grounds of HIV positive status or AIDS must be proscribed. Condoms and syringes must be freely available. Optimum conditions for the success of education programs will only be created if discrimination against people perceived to be in "high risk" groups, whether as gay men, prostitutes, or IV drug users, ceases:

> Until there is a vaccine or a cure, it is self evident that a society that cares about life will target its laws on prevention of the spread of the infection. All else is detail.[5]

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The author wishes to thank Elisa Whittaker of the Fitzroy Legal Service.

Notes

1. "AIDS: Most support marriage and hospital testing", The Age, 3 December 1988, pp. 1 and 4.
2. "The Law's Five AIDS Commandments", The Age, 15 June 1987, p. 11.
3. National Health and Medical Research Council's Special Unit in AIDS Epidemiology statistics cited in A.Carr, "The State of the Epidemic", The Journal, vol. 3, September 1988. (The official monthly journal of the Victorian AIDS Council [VAC] and Gay Mens Community Health Centre [GMCHC].)
4. "The Law's Five AIDS Commandments".

(Overleaf) Malcolm J. Enright: *Another Inseparable: Person/Compassion* ,1988

Colour Xerox on 5mm Coreflite; each panel 297 x 210 mm, total 891 x 1260mm.

Courtesy of Milburn and Arte Brisbane.

You don't catch AIDS, you let someone give it to you.

Wilson Tuckey.

Deliberate Acts, Unnatural Acts: Representing AIDS to Australians

Wilson Tuckey's comments at the most recent National AIDS Conference in Hobart, for all of the furore they caused at the time, faded rather quickly from public view. Mr. Tuckey lost the shadow Health portfolio, his party embraced bipartisanship in AIDS policy, and ruffled medical experts regained their composure. But we should resist simply discounting this as the work of a political maverick. On stage, surrounded by persons with AIDS (PWAs), gay activists and their 'allies', and with a national audience, Mr. Tuckey was representing a constituency. Perhaps he relished this opportunity to mount a counterattack on behalf of Australian moral and political conservatives. Against the neutral or even positive images of PWAs and homosexuals which occupied centre stage, Mr. Tuckey pushed forward repressive images of danger and disease. While the social response to AIDS has been ambivalent, with disinterest as prominent as backlash, it is nonetheless important to understand and anticipate such conservative representations of the virus and its relationship to homosexuality. This is especially true as other groups, like the Catholic bishops, speak out against homosexuality, or, in the case of the Liberal Party, launch policies which attack 'diversity' as the root cause of some ill-defined national malaise.

I am interested here in using Mr.Tuckey's remarks as a starting point for a critique of repressive images of AIDS and male homosexuals. Part of this will involve critically examining alternative images created within medicine as well as within the gay community itself. Images define and organise their subjects; attempts to control the meaning of words like 'AIDS' and 'homosexual' always have broadly political intentions that can be traced and criticised. One of the most vital acts in taking charge of our future is knowing more about repressive and affirmative representations of our lives and our desires, starting with how we are discussed and imaged in the context of AIDS.

In just two simple phrases, "[y]ou don't catch AIDS, you let someone give it to you", and "AIDS is very much a disease which results from deliberate and possibly unnatural activity", Mr. Tuckey gives us his neat and effective version of the problem: AIDS is the consequence of sexual deviancy. The body of the speech is far less important than this simple recasting of the opposing forces in the war on AIDS. On one side are the practices and the people associated with the disease; on the other is the 'general community' they endanger. The speech is in this sense a call to battle, not against the virus, but against its human 'agents'.

Mr. Tuckey's choice of words also shows a determination to rein in the meanings of 'AIDS' and of 'homosexual' and to guard repressive definitions of both against further corrosion. Representing AIDS to Australians is a struggle between competing defining images. There is a growing concern among conservatives that potent, repressive, *blaming* images are losing ground in the struggle to control popular definitions of the disease and its implications. Responses to AIDS are generating images which move beyond the purely repressive. Medical and public health images, even homosexual images, are invading the territory once occupied by infected babies and threatening queers. They are casting the disease in the language of science and self-help, not prohibition. Bewilderingly, AIDS has empowered its victims and its villains. This disease should have driven gays underground, dismantling our public presence and subduing our political claims once and for all. Our afflicted bodies were to be a lesson to others and to ourselves. But AIDS has disrupted the power relations of sexuality to the extent that doctors and governments are even endorsing gay community mobilisations against the disease. Conservatives fear that they are losing the chance to control the images and thus the meanings of AIDS. And with that goes the chance to control the understanding of homosexuality as well.

The way out of this dilemma is to ensure that public discussions are loaded with negative images of behaviours — public or private — which threaten the continuity of healthy sexual practice and heterosexual love. And this is not simply a matter of restating the sexual prohibitions and definitions conservatives see, against history, as eternal. We are not asked simply to 'go back', wherever 'back' might be. This is a creative deployment of words and images which urges its listeners to incorporate the dangers of AIDS into their understanding of homosexuality and the stigma of homosexuality into their responses to PWAs. Constructing a more repressive categorisation — AIDS=homosexuality=AIDS — is a process from which the 'normal' can draw great strength. But we others to the heterosexual norm can also draw strength from such repressions, challenging them in our own images and our own understandings. Each new repression, in a way, records our successes in shifting the balance of power.

Mr. Tuckey's first phrase, "[y]ou don't catch AIDS, you let someone give it to you", makes PWAs distinctive: unlike other targets of disease, they can be *blamed* for being diseased and for diseasing others. If it stopped being 'given', if we, as Mr.Tuckey later argued, "ceased those homosexual practices" from which we 'take' AIDS, then the disease would disappear, would "work itself out" of the heterosexual community. One implication is that the disease would continue to afflict non-heterosexual communities. Another is that our sexual practices are inevitably acts which corrupt the giver and the taker. Our intercourse is doubly unnatural: both giver and taker are men, and, worse, what we give and take is disease. Disease is represented as an integral part of our sexual exchange, as the ultimate measure of our perverse pleasures. The villain is desire, not the virus. If only we could leave ourselves alone (not, Mr. Tuckey argued later, that we can), then the virus would disappear. We introduced it, we spread it, we die from it: the logic is simple and compelling. AIDS , a self-inflicted disease, keeps pace with homosexual desire. Gay men are not the first to be subjected to such compelling logic. Prostitutes with venereal disease, even women who are raped, suffer similar accusations of inviting affliction by misusing their bodies. Historically, powerful images also construct sexual disease in terms of class. Homosexuals are the latest targets in the repressive linking of otherness with disease, where disease becomes the outward sign of inner corruption.

Of course, insofar as Mr.Tuckey refers to the dangers of unprotected anal sex, he is not so distant from the gay language of sexual responsibility. Untying the choice of homosexuality from the consequence of AIDS while at the same time informing ourselves about safe sex is, after all, a difficult balancing act. Mr. Tuckey implies a need for more rigorous sanctions, and it is important to confront him on that ground. But we can also challenge the universalising link between homosexual desire and disease which structures his image of AIDS. It is *blame* which characterises negative constructions, and it is blame that must be rejected. For not only is our desire blamed for the transmission of a killer disease, but because of that AIDS itself is made out to be an inevitable retribution for the desire. This is especially so because Mr. Tuckey fails to provide the usual qualifiers in the image of AIDS victims: the haemophiliacs, the blood transfusion recipients, the babies. This image contains no 'innocence' or 'blameless' transmission. These words invite blame quickly and without exception: PWAs are the sacrificial victims of their own perverse practices.

It is in the second phrase — which links AIDS to "deliberate and possibly unnatural activity" — that the negative representation widens to take in homosexuality itself. And in a sense it must. Blaming the victims takes repression only part of the way; one must also target the acts and all those who practice them, sick or not. PWAs must be shown as culpable accomplices rather than adversaries of their illness. And homosexuals become potential accomplices by their continued participation not just in specific risky acts, but in a whole immoral practice. In Hobart, Mr. Tuckey reminded his audience of the consequences of unnatural activity. I read his "possibly" as ironic, a possibly with raised eyebrows: we all *know* that homosexuality is unnatural. 'Unnatural' is the key here: it ties the image of culpable PWAs to perverse acts, so confronting the acts themselves and those who are identified with and by them. Public images of

PWAs are too qualified by tragedy and pathos. Negative images play upon deep-seated fears of homosexuality in order to cut through such complications: PWAs must be identified not by their disease alone but by the activities which invited it in. They may be brave, but remember how they got it. If you lose a few 'truly tragic' cases in the condemnation, it is a small price to pay. So, where images of disease might begin to crumble around the edges, the images of aberrant practice are rock hard. Drug abuse, prostitution and, most powerfully of all, sexual deviance: condemnation flows through the images, reinforcing them against counter-representations. After all, these practices are freely chosen, deliberate floutings of accepted morality. No-one forces you to live on the wrong side of the moral divide. Moreover, these practices constitute an entire deviant identity — drug abuser, slut, queer - which is easily imagined by all. It is also important to qualify the images and give such practices a history. If they were to "cease" implies that they once "began". In a peculiar sense, the groups most identified with AIDS, and especially gay men, have been made *responsible* for changes in sexual practices and morals over the last twenty years. All of the negative connotations of those changes — faceless sex, promiscuity, a 'retreat from commitment' — are suddenly forced on our lives, leaving us deserted on the front lines of the sexual 'revolution' and accountable for its failures.

The rewriting of our history denies the gains of gay liberation. If homosexuals are abruptly cut off from a 'general community' safe within monogamous domesticity, then this is, after all, a return to the natural order of things. The charge of "unnatural activity" is a particularly fertile source of negative images, setting in train a long accounting of our offences against biology and manhood. Potent images of deviancy, all with a heavy cargo of prohibition, swing into action: from the feminized male in the dress to the crazed, almost supernaturally powerful perverts who stalk the front pages of the tabloids. Deviants are deficient men and they are also dangerous men. Participate, if you will, (and if you were raised in modern Western culture then you certainly can) in a recitation of tantalising and damning images. Consider these acts in all their carnal baseness, condemn these unnatural desires, demand confessions of guilt, and above all be confirmed in the knowledge of your own sexual health and normality. The invitation is by no means simply prohibitive. It is an incitement to consider sexual acts and to examine yourself for evidence of unnatural desires. As you cast out those desires, wield your power against those who have given in to them. The words — "unnatural", "deliberate" — play upon deeply-held fears, but they also reshape and rearm them, renewing the commitment to make deviant practices targets of confession, treatment or attack. The imaging of homosexuals in the context of AIDS does not look backward, nor is it passive; it looks to a political future and to active intervention. If gay liberation meant that we won the power to define 'gay' for ourselves, AIDS provides the perfect opportunity for conservatives to take that power back.

In particular, interrogating Mr. Tuckey's remarks uncovers two important and related political projects arising out of AIDS. The first is a marshalling of the 'general community' against the sexual habits of 'others'. The second, which flows from the first, is a warning to gays about the limits of their legitimacy.

The first project involves tightly controlling the meanings of sexual normality and sexual otherness, limiting 'normality' by constant reference to what is 'abnormal' and thus 'other'. It is the power of the other and the extent of its danger which cement the powerful bonds of 'us'. Mr. Tuckey's phrases contain three key ideas which define homosexuality as 'other' and prompt commonsense explanations of sexual diversity. First, homosexual desire is unnatural and peculiar to certain individuals, arising out of some sexual pathology or inadequate sexual experience (all he/she needs is a good woman/man). Second, homosexual behaviour is deliberate, a matter of choice, or, better, indulgence. Such desires should be vigorously suppressed, not indulged (I thought people like that killed themselves). Third, homosexual desire, especially if carried over into behaviour, is definitive. The male homosexual is encompassed by his deviant practice: every act, every thought, every choice, expresses and confirms that he is one of 'them'. Homosexuals are the archetypal sexed beings. We have no reality prior to sexual intercourse and precious little beyond it.

The implication of these definitions is powerful and simple: heterosexuality is none of these things. It is neither deliberate, nor peculiar, nor definitive. Heterosexuals, if defined at all by their sexual practices, possess a natural and eternal sexuality, a happy marriage of biology and pleasure. Moreover, heterosexuals are represented as a unified group. This is the key political point: by marginalising homosexuals, this image of a natural and immutable sexuality promotes bonds where there are none. All heterosexuals, regardless of class, or cultural or gender barriers can join in the making of a compact against those made abnormal by their sexual choices.

The second political project implied in the speech, which I suspect is Mr. Tuckey's primary objective, is to revitalise the power relations which deny homosexuals political legitimacy. If, inevitably, money must be spent and attention given to PWAs, that must not mean any retreat from negative representations and subordination. What is at stake here is not just that gays might be funded, nor even that condoms and 'unnatural practices' might permeate the public consciousness, it is that gay men might gain legitimacy or even political power from the collective experience of AIDS. The conservative position must be a strong denial of any such gains. Hence the importance of controlling the meanings of AIDS and homosexuality, of mobilising hostility and fear against both. It must be 'known' that AIDS is a plague for which gays are ultimately responsible because it stems from their deliberate flouting of sexual taboos. The Catholic bishops, in their recent condemnation of homosexuality, went so far as to say that heterosexual transmission could usually be traced back to us as well. Given this, we cannot expect to be treated as legitimate partners in decisionmaking. Further, claims for participation can be cast as self-serving attempts to evade the consequences of our guilt. The true front line in the war on AIDS is not that between virus and potential victim, but between natural and unnatural communities.

Ironically, of course, such representations sponsor their own opposition. They bring forth other knowledges and contrasting images and galvanise the 'others' into powerful responses. As ever, negative representations of 'homosexuality' help create 'homosexuals' who challenge and modify their repressive intent, turning the most vindictive motifs into resources for personal and collective identity. We can identify at least three other broad strategies for representing AIDS and its relationship to gay life and identity, all of which challenge conservative images at key points.

The first strategy is the image of neutral expertise proposed by doctors and public health officials. This represents AIDS as a general health problem rather than as a gay plague and as such is a significant advance over neglect or repression. Unfortunately, this representation too is riddled with some telling qualifications which marginalise PWAs and gay men as thoroughly as any conservative image. PWAs are victims, which lends them a certain nobility in their suffering but does not challenge the notion that the suffering is self-inflicted. More common is the use of the term 'general community' to define a body which does not include high-risk groups. As potential patients and burdens on welfare systems, we have to be incorporated into programmes, even praised for our good works. But recognition stops there. Leading doctors challenged Mr. Tuckey's comments with images of *innocent* victims of AIDS and the *tragedy* of blood transfusions. We can read the implications for ourselves. The doctors also insist upon the power of their knowledge and their expertise, which they claim gives them a distinctive neutrality in health policy. But the power of expertise has always included a power to judge, define and condemn, especially on questions of abnormality and deviance. As governments launch national health strategies, it is clear that our practices are still to be represented as threats, even if the charge of 'spreading it' to 'normal' people has now been laid at the door of drug users and prostitutes. This is a new and rather more sophisticated medicalisation of the 'homosexual problem', but treatment still seems to rely on stopping us doing whatever it is we do. Having already struggled to rescue our bodies and our minds from 'neutral' psychologies and bodily therapies, we should remain wary of returning that power to doctors in a new guise.

That the representation of AIDS has in fact not been entirely dominated by doctors is largely due to a second strategy emanating from the gay community itself. The dominant images here are of AIDS as a general threat and of homosexuality as a responsible and respectable minority group.

We can perhaps call it a representation of 'respectability', which makes us into responsible partners in the anti-AIDS campaign. We therefore deserve a fair stake in policy development and funding. It was perhaps inevitable that the idea of minority identity/minority rights would be the base of successful claims to legitimacy and recognition in the age of AIDS. To an extent, this strategy also flushes opponents of gay rights into the open, to the point where they must begin to attack diversity itself as well as specific minorities.

Yet this representing strategy has its dangers, not least that we might forget that 'respectability' is a creature of political opportunism and should not become our sole political style. The image does not really give much space to wider visions of the political future nor of human rights responses to AIDS, but it needs to coexist with less direct self-representations which maintain something of our basic challenge to structures of power and their homophobic images.

It is these other self-representations which constitute a third strategy, much less focused than the second. They reflect our recognition that the experience of AIDS is having more impact on our lives than changing sexual behaviours. It raises profound questions about our sexuality and challenges our understanding of ourselves, our relationships with our bodies and each other. It also raises again our demand that *we* define the disease and its relationship to gay life and culture. In cabaret, in film, in cartoons, in poetry and prose, and in art, that challenge is being posed to gays and to the heterosexual images of our lives. Some reject the idea that AIDS is or should become the sum or centre of gay experience: while we cannot yet imagine a world without AIDS, we can attend to our lives and our politics beyond disease. Some question those images of innocence for the uninfected which prompt us to define the well against the sick. Some show the nurturing and caring activities of the gay community. Others question and parody the nature of medical knowledge, still others question the tactics and the implications of respectability. Above all, these efforts address the need to create positive and supportive images of PWAs and their relations with the wider community. Critical examinations of negative images are complemented by the exploration of positive representations in a variety of media.

Where might such representations venture? This exhibition might give some directions for the future and is to be welcomed at the very least for that. Eroticising safe sex? That demands rethinking our erotic priorities, especially the concentration on phallic penetration, perhaps even imagining another erotics, of hands, mouths, of the whole body. We have all known it in our sexual experience but it has never been dominant in our self-images. And how will playing with erotic images challenge sexual practice? If, as I would contend, our sexual acts are fundamentally different from heterosex, and not just because the 'object' of intercourse happens to be male, what should a changed erotics celebrate? Might the celebration also project outward to question the erotics of heterosexuality? I think of affirmative images of homosexuality which challenge our construction as peculiar individuals. Images of male intimacy which question the limiting of homosexual desire to the sex act. Images of male homosexuality and lesbianism, which interrogate sexual power and male power. Threats to the construction of male identity around the absolute of heterosexual performance. Most of all, representations of our desire which establish its universality, against the incitement to cast it out of accepted sexuality. Our affirming difference is our physical and emotional relationship to homosexual desire, not its possession. This is a kind of recognition which destabilises the constructed barriers between 'us' and 'them' and highlights the arbitrary nature of repressive sexual categorisations. Respectability has the capacity to keep rights, legitimacy and liberties locked together in a useful political image. But we also need to pursue representations which confirm and celebrate the legitimacy and the pleasures of our desire.

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POSITIVE WOMEN?: FEMALE SEXUALITY AND SAFE SEX EDUCATION

When I first began thinking about educational responses to AIDS I felt a cautious optimism, soon followed by exasperation; optimism that feminist challenges to ideologies of sexuality in our society could provide excellent strategies for the prevention of HIV transmission; exasperation that the AIDS education material I found, produced for a "general" (read non-IV drug using, non-prostitute, heterosexual) audience, had so clearly failed to utilise such strategies. In this article I will particularly examine educational material targetted at young people.

Whereas the gay male community has recognised that safe sex involves not only promotion of protective measures, but the eroticisation of safer sexual practices, and encouragement of an environment of mutual care and support within which safe sex can be practiced, safe sex education for heterosexuals has largely stopped at the "condom or celibacy" level. I would argue that an effective heterosexual "safe sex" requires the same degree of challenge to underlying assumptions about sexuality and sexual relationships. A comparable project in regard to heterosexual safe sex would require privileging of the diversity of pleasures within female sexuality, eradication of double standards of sexual conduct for men and women, and reduction in the social inequalities between men and women which affect all social, and intimiate, relationships. Education campaigns which are premised on traditional ideologies of femininity have produced images of women as both threatening and powerless. They are, by implication carriers of disease - positive women. In contrast effective safe sex education requires production of positive images of women and of female sexuality.

Recent feminism (by which I mean the feminism of the past two decades) has undertaken a critique of heterosexuality propelled by the notion that "the personal is political", and seeking to understand sexuality and sexual relations in the context of unequal social and economic power of sexual partners. While the complexities of sexual fantasy, desire, and experience preclude a simple or unified response from feminists or imposition of an "ideologically sound" sexual practice, some clear issues emerged. These included recognition of the sexual objectification of women within cultural production and of the role that female sexuality, and the taboos surrounding it, played in gaining women's complicity with their inferior social status and their primary identification with the nuclear family. Having identified women's sexuality as a site of both pleasure and danger it was possible to propose changes to increase women's sexual pleasure and autonomy and to minimise their sexual vulnerabilty. From this stemmed demands for, among other things, a breaking of the taboos on rape and incest, access to adequate contraception and abortion, lesbian visibility, and removal of the double standard of sexual morality (and sexual fulfilment) within heterosexual relationships. A plurality of sexual desires and practices was proposed which would remove penetrative, reproductive, male-initiated, heterosexual sex from its position as the one socially sanctioned sexual act. It is a similar endeavour which must be undertaken now, with regard to heterosexual "safe sex".

Prevalent attitudes to sexuality are frequently grouped under the rubric of "the double standard", a notion arising in the nineteenth century and expressing, at its crudest, the idea that male sexual activity is natural and accepted, whereas female sexual activity is acceptable only within strict moral and institutional bounds. Whereas a blind eye could be turned to a young man "sowing his wild oats",a woman who, but once, engaged in pre- or extra-marital sex was irredeemably "fallen". Although marriage is no longer the necessary threshold of respectability for a sexually active woman (and the standard varies of course between class and cultural groups) it remains that female sexuality is acceptable only within a "serious" relationship, whether that be marked by marriage, engagement, sexual exclusivity, or romantic attachment. As the double standard itself, the ideas about female sexuality which underpin it have persisted, with little modification since the nineteenth century.

Most fundamental is the point that "the sex act" itself has always been defined by men. Despite a mystique of authenticity around sexual feelings, as if they are somehow too personal and direct to be subject to social influences, it is clear that the articulation and understanding of our sexual experiences is powerfully shaped by wider influences. This has had a devastating effect on women, whose sexuality has been largely defined by men. Of course penetration per se has always been a more efficient way of getting a woman pregnant than of getting her an orgasm. Yet women, as well as men, have largely accepted that non-penetrative sexual practices are either a prelude, or an unfulfilling alternative, to the real thing. The hierarchy of sexual practices which equates "going all the way" with penetration (and "getting there" with male orgasm) is a denial of women's own sexual feelings and potential..

Beyond defining the sex act from a male perspective, sexuality itself came to be regarded as an inherently male possession. Women were seen as fundamentally asexual, or at least, having a sexuality which was primarily passive and responsive. The supposedly inherent urge toward motherhood could then be regarded as the woman's equivalent to the male sex drive. (This explains both the invisibility of lesbianism, and the depiction of the lesbian as totally deviant, being the desirer, the definer, and the initiator of her own pleasures.) While such a denial of female sexuality would rarely be heard today, the assumption that women should be more sexually passive than men, and that a man's "sex drive" is somehow more urgent, is still prevalent.

It was the woman, lauded as inherently moral, who was charged with maintaining male sexuality within socially acceptable limits, and with the responsibility of maintaining her own chastity. There was no suggestion that men should take responsibility for, or modify, their own sexual behaviour. Of course it was also women who bore the moral stigma when they failed to control man's sexuality. Whereas a man might be judged respectable or virtuous due to his achievement in the public world or his personal character, a woman's status rested solely on whether or not she was both desirable and chaste. Again the notion of a "reputation" still functions as a powerful moral inhibitor for women.

Essentially virtuous, and without an active sexuality of her own, the woman became the object of an over-riding male sexuality; innocent yet seductive, threatening in her desirablility. Hidden in every woman was her converse, an "unwomanly" creature of sexual entrapment and danger.

These attitudes to women, and to female sexuality, are still carried in the images of women produced in our culture. Advertising and mass media technologies have perpetuated stereotypical and eroticised images of women, even as institutional and legal structures constraining women's sexuality (divorce, contraception, financial support for single mothers, de facto rights) have been liberalised. In the current political climate, in which both major parties seek to construct, and address, a single unified Australian constituency, public health campaigns backed by government resources and utilising the latest advertising techniques, have disseminated conservative notions of the family and of traditional familial and sexual roles as at the heart of Australian life.

A recent precursor to government AIDS education initiatives is the National Campaign Against Drug Abuse ("The Drug Offensive") launched in 1986, which began with the mass delivery of an "educational" booklet to all Australian homes. The campaign was family centred, positioning the family as the safe haven within which guidance and protection against drugs were given, with drugs the threatening force from beyond. What this meant to the 1 in 4 young women who are victims of abuse within the home, and for whom drug addiction is a likely consequence, one wonders. A more recent phase of this campaign features television advertisements in which young women complain that "boys who drink only want one thing" while teenage boys joke that girls who drink (and sleep around) "aren't the sort you get serious about". Good old fashioned family values and the double standard are here mobilised as rallying points for a public health campaign.

This is all perhaps a long way from AIDS, but it is helpful in understanding the assumptions which inform the series of educational booklets produced by NACAIDS (the National Advisory Council on AIDS) which I will be discussing further here. The booklets I will look at were produced by NACAIDS in August 1987 and were reprinted in February 1988. While the text of these booklets is neutral and straightforward the images used, like the slip of the tongue or the unthinking remark, if not revealing a "hidden agenda" at least suggest some unsettling contradictions between intent and effect. In particular, the images embody the ideas of female sexuality described above which seem to me antithetical to the successful development and promotion of heterosexual safe sex practices.

In the course of preparing this essay I found myself giving the various images shorthand names strangely reminiscent of trashy 50s and 60s paperbacks. The first image is one I have dubbed "The Office Slut". This is obviously a favoured image as it is used in three of the NACAIDS pamphlets: *AIDS: the facts everyone should know* , *How to enjoy safer sex,* and *Everything you ever wanted to know about condoms.*

Many AIDS carriers look and feel perfectly well. Many don't know they have it. Don't risk unsafe sex with someone just because they appear healthy. So reads the caption to this image. Despite this caution however the image clearly segregates the three figures in the shadowy foreground from the glare of the open space beyond, marking them out as "at risk". Despite the apparent "office party" scenario the young woman wears a tight leather sheath exposing half her back. One young man places a proprietal hand on her arse while another watches, effectively blocking her entry into the office at large. The woman appears trapped and outnumbered. Her dress, her drinking and her isolation from the crowd mark her out as sexual prey, a fact emphasised by her position at the centre foreground of the image. She herself is passive, her sexuality resting on her attractiveness, and bestowed by the gaze of her two "admirers". Here is a woman as sexually defined, seductive, and yet powerless. The most potent bond in evidence is not in the interaction of the central man and woman, but in the shared sexual attitudes of the two men who watch and enfold her. The young woman is the link between them. In the context of AIDS it is she who is marked as the carrier.

Whatever the caption another message is revealed here - you can tell an AIDS carrier - they're the kind of girls that let themselves get felt up at office parties.

A second image, not reproduced here, uses a similar set-up. Although less marked with the "whorish" this image ("The Bikie Moll") demonstrates that "you are not at risk of catching AIDS by social kissing" by showing a woman pillion passenger on a man's motorbike, leaning over and kissing a man in the car beside her. While less explicitly sexual this image again posits a woman as the visual, and presumably sexual link between two men . Sexual involvement is immanent in these two contacts. Apparently stopped at traffic lights together a more fleeting encounter (or a more casual sexual contact) could not be imagined.

In contrast to the threesomes featured in the images discussed above, is an image which I have called "Caged Women", in which two young women and a young man appear. "Abstinence is one way to avoid catching AIDS. Practicing safe sex is another" is the caption. This image contrasts the healthy "naturalness" of the boy with the dangerous and deviant qualities of the young women. While he stands outside, unrestricted (his mobility attested to by his skateboard) the young women are effectively caged behind a barred window. If restraints are to be placed on the possibility of sexual contact it is apparently women who must be locked away, out of harms way, their threat contained behind bars. This prison-like image reinforces the idea of active female sexuality as aberrant and destructive. There is no communication between the two women; instead they represent the two seemingly incompatable aspects of womenly nature,the one innocently yearns for the outside world,the other knowingly engages the young man's gaze.

A seemingly random schoolyard scene provides the cover image for *AIDS: don't let it happen to you.* Again two young men are shown with a young woman the passive, and this time unknowing, object of their gaze. She is shown as removed from, and yet essential to, their role in an implicitly sexual drama .These images consistently portray women as sexually objectified and passive, embodying the dangers of sex; in this little distinction is made between women who accept, or who flout conventional sexual standards.

Images such as these have frequently been produced in our culture with the prostitute standing for the "dark" side of woman, the seductive, the immoral, the threatening and the diseased. In these images, and in the specific context of AIDS,it is clear that all women carry danger.This blurring of the ideological distinction between the "respectable" woman and the prostitute not only means that any woman can be made the scapegoat for the spread of disease if she steps outside a restricted sexual role, it also serves to obscure the very real economic and legal structures which bind the prostitute.

The final NACAIDS image is interesting. Here at last is a pleasing, natural image of women Two young women are shown together, sharing surprise and laughter. It is significant however that what occasions this laughter, is information about condoms. While not questioning the importance of giving young women the message of condom use in disease prevention, the implication that it is women who must learn about condoms, and who must be persuaded to use them, is misplaced. The responsibility of ensuring safe sex, and especially the responsibility of convincing their male sexual partners to co-operate in what is frequently (wrongly) regarded as a major obstacle to male sexual pleasure, is being placed on women.

Although this is perhaps a "positive" image of women, it shares, with the previous images, an assumption that the responsibility within heterosexual sex, whether it be moral responsibility, or the practical responsibility for contraception or disease prevention, rests on the female partner. Male sexuality is a "given" and unproblematic, and men, it is assumed, need initiate no positive intervention in their sexual activities. In fact it is precisely the construction of male sexuality which makes condom use such an issue.

Within all these images are assumptions worthy of any Victorian moralist. Men and male sexuality are the given; women, and female sexuality are the "other", deviant, threatening, and misunderstood.

While my reading of these images may be a little flippant there is a serious intent. Premising AIDS education on conventional, and fundamentally discriminatory and repressive images of female sexuality, is not only objectionable for promoting, and legitimising these attitudes, but is counter productive in the interests of AIDS prevention. Rather than challenging discriminatory ideas, they are reinforced by such material.

Young people are in fact very aware of sexual double standards, although not surprisingly this situation is accepted without qestion by boys, despite being a cause of concern among girls.

> A guy tends to want to dominate the female, rather than having an equal role. It's easier for a boy to have intercourse because if he does, it's being a man, and if a girl goes around, having it off with everyone they call her a slut and things like that. And also they haven't got the risk of getting pregnant.
>
> In relationships in our age groups the girls are sort of, well, it's more on the girl's mind than the guy's side to work on the telationship. In most relationships girls are holding it together; they put in the work. Guys should learn to share in the relationship and not make it one way.[1]

Whereas young women identified issues of relationships and intimacy as an essential requirement of sex education, the attitude of boys could be characterised by the one who spelled out his questions as "How do they get pregnant? How do we go about rooting?".[2] Boys continued to see sex in straightforward terms as primarily a reproductive issue for women, and a test of masculine performance for themselves. The possible risks of a sexual relationship are reduced to a woman's need for contraception. This of course is a quite inadequate basis for education to prevent AIDS, or indeed any other sexually transmissable disease. And in fact increased accessibility of female contraception (the pill) has removed one of young women's traditional sexual bargaining chips.

The implications of these attitudes for AIDS prevention are serious, and indeed research suggests that AIDS education is not getting through to young people, being associated more with moral judgements than with realistic risk levels. The fundamental message that it is what you do, not how often, or with whom, you do it, which places people at risk of HIV infection, has not been heeded.

A recent survey of *Dolly* readers found that 43% claimed to have changed their sexual habits since AIDS. However for most this meant simply "being more careful about the sexual partners they choose".[3] In another study "all but one of the male group... were emphatic that one could discern the sort of woman who was likely to have an STD or AIDS: by looking at a woman you could see what sort of person she was and the likelihood of her having the disease".[4] Of course any material which does not challenge implicit moral judgements about sexual behaviour (precisely the area where material such as the NACAIDS pamphlets described fall down badly) will encourage this identification of risk with moral status. The promotion of monogamy as an AIDS prevention strategy is also likely to be misinterpreted in this way, given the plethora of qualifiers which would need to be understood. (eg. monogamy is safe if neither partner have shared needles, or had other sexual partners, in anything up to the past ten years) for monogamy to be a realistic safe sex practice.

The combination of male sexual irresponsibility and female powerlessness is particularly revealed in attitudes to condom use. Mindful of their reputations, and sure of the redemptive power of true love, girls have been traditionally reluctant to ask boys to wear condoms because of the implication that sex will then be a planned, rather than a spontaneous activity. In fact condom use will always be more reliable if it has been decided on and discussed before the heat of the sexual moment. Boys on the other hand are concerned that their pleasure will be minimised, and that condoms will be seen as sign of sexual immaturity. These attitudes reveal the persistence of the expectation that the male will be the initiator and decision-maker in sexual relations, with the girl attuned more to his pleasure and safety than to her own. The expectation that her partner will object stops many young women even broaching the subject of condom use.

Heterosexual safe sex should, however, involve far more than penetrative sex with condom protection. A concentration on mutual sensuality, rather than male performance, allows for an endless range of "safe" activities, barely conveyed in the prosaic language of safe sex education of "hugging, kissing, and mutual masturbation". Recognition of the diffuse sexual, and sensual, pleasures of female sexuality is a good place to begin exploring these safe erotic possibilities. What needs to be promoted is not only prohibitions on selected unsafe activities, but a concerted effort to make safe activities seem appealing (or rather to break down the male-derived definitions of sexuality which constructs them as secondary and unsatisfying in contradiction to most women's own experience.)

Achieving this goal is of course not simple. Among other things it requires a teaching of sexual education which questions traditional notions of sexuality, and active encouragement for young womne to respect, and explore their sexual potential; education for a fulfilling and responsible sexual life, rather than for reproduction. Boys must learn to appreciate women as equal partners in sex and to develop the skills involved in establishing open and non-exploitative relationships with them. Wouldn't it be wonderful if instead of measuring his masculinity in his ability to get a girl "into bed", a young man couldpride himself on his ability to ensure they both enjoy what happens there. A sex which is more attuned to women's pleasure will be a sex within which safe sexual practices take a larger part, and in which women have greater control over their sexual involvements. It could also be a sex within which the delineation between penetrative and non-penetrative sex is blurred, undermining the pressure placed on women to "go all the way". Learning to talk about sex is vital. Here again, young women have expressed a desire to discuss and explore diverse issues around sexuality. Boys, on the other hand would choose to have sex educationn information presented to them in as impersonal a way as possible.[5] It is boys, who must change their attitudes, for it is they who have avoided questioning and discussion of their sexuality and sexual attitudes.

As long as girls are subject to unrealisable expectations of both attractiveness and popularity, judged solely in sexual terms, as long as they are taught that their sexual feelings are unacceptable or inconsequential, as long as their experiences of sex are frequently marked by violence and abuse, then no amount of safe sex knowledge will protect them from risk.

In developing and promoting a satisfying heterosexual safe sex a far more involved strategy than simply presentation of information is called for. However some points can be made about the presentation of AIDS prevention information for young people. AIDS education must be tailored specifically for young people using appropriate language and images, and recognising the social context which limits young people's and particularly young women's sexual autonomy. Gender-specific issues must be addressed. Finally , images of women, and of female sexuality, must be positive ones, with a corresponding use of images of male sexuality which offer a more sensitive, open and responsive sexual standard for young men to follow.

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Notes

1. Tricia Szirom, *Teaching Gender?: Sex Education and Sexual Stereotypes*, Allen and Unwin, Sydney, 1988. pp. 6,7.
2. Anne Mulholland, "What do adolescents want to know?" in Wendy McCarthy ed. *Talking About Sex: The Australian Experience*, Allen and Unwin, Sydney, 1983.
3. *Dolly*, November 1988,"Let's Talk About Sex" p.77.
4. Simon Chapman and Julia Hodgson, "Showers in Raincoats: Sttitudinal Barriers to Condom use in high-risk heterosexuals" *Community Health Studies*, 12/1/88, p.99.
5. Tricia Szirom, *Teaching Gender?* p.127.

Streetwize Comix, Redfern Legal Centre, special AIDS issue no, 15.

THE USE OF DISTINCTIVE LANGUAGE IN AIDS EDUCATION

Prior to the production of the "Grim Reaper" advertisements in 1987, a survey was conducted to determine what people knew, did not know and wanted to know about AIDS. The story goes that in a group of older adolescents from Sydney's western suburbs, the word "homosexual" was defined as someone who has sex at home, and "heterosexual" as a person who has sex away from home. The veracity of this anecdote may be doubted, but the message inherent in it is profoundly sobering: what we say or teach is understood only in as far as we, the educators, ensure that we are understandable. And for those of us involved in educating about AIDS --- as we all are, whenever we make a comment, raise the subject or respond with word, gesture or action --- we are constantly communicating about AIDS. The language we use is of the utmost significance.

This is especially true with regard to the epidemic that is presently causing shock and disbelief world-wide. The disease AIDS is a phenomenon of awesome complexity. It imposes on every one of us inescapable implications and challenges: emotional, social, educational, ethical, theological, political, legal, economic. And not the least of these is the educational challenge. Indeed, in the long run this may well turn out to be the most crucial of all of the challenges which AIDS has so abruptly thrust at us, for unless we can educate ourselves and our community about this terrible phenomenon and the potential it has to devastate our world, we will not have the skills and commitment essential to win against the Human Immunodeficiency Virus [HIV]. For we cannot address the two major imperatives of AIDS, which are to prevent further spread of the virus and to care properly, compassionately, for those people who are already infected, unless there is a change in our thinking such that we all recognise, respect and act on, our shared humanity and responsibilities.

At present education is the only effective weapon we have to use against AIDS. In the absence of a vaccine or an anti-viral drug there is literally no medical prevention or cure available, and suggestions to screen and isolate those infected with the virus are economically impossible, logistically absurd and ethically unacceptable. So we are left with education, or more precisely, with AIDS prevention education, and the sooner we start the process of educating our community the better are our chances of winning the war against AIDS.

Before rushing into action however, there are issues which must be considered. We need to ask what health education is, how it is done, and by whom and for whom, in order to ensure that it is maximally effective. We do know that education is not simply a matter of providing accurate and credible information, of telling people what to do and what not to do. If education about health and well-being were so satisfyingly straight-forward, there would be no problem with drink-driving, with excessive salt intake or with tobacco consumption. In all of these areas there is ample reliable, health-enhancing information which is being ignored, or at best, not utilised, by our community. Information is a "head experience", and it is all too easy for it to remain at that intellectual level ("that's interesting"; "what a terrible thing"). Knowing does not necessarily give birth to either understanding or action. We know that a person begins to use health information, begins to translate it into health-enhancing behaviours, only after the information has become personalised, has been incorporated into the unique beliefs and values system of the individual, when it is seen to have real personal meaning. And our language, the precise words that we use, can easily be one of the obstacles that prevents information (or knowing) from developing into personalised awareness (or understanding).

Misuse of words can, in fact, actually create educational difficulties. One of the most formidable barriers to community AIDS prevention education is the widespread belief that "AIDS doesn't affect me, I don't need to worry. It belongs to other people". This belief has

been fostered by the use, in public discussion and the media, of labels for particular groups supposed to be responsible for the spread of AIDS. Labels such as "homosexual", "IV drug user" and "prostitute". The reality is that membership of a group does not necessarily predict an individual at risk of either becoming infected with HIV or passing it on to someone else. *It is what a person does, not who they are, that constitutes a risk.* AIDS is a consequence of infection with a virus that can be passed from an infected person to an uninfected one via certain precisely understood routes or behaviours. These are (1) sexual intercourse, both anal and vaginal, with anal intercourse being a higher risk behaviour; (2) direct injection of infected blood into the circulating bloodstream of another individual; and (3) from an infected female to her baby during pregnancy, childbirth or breast-feeding. It is of the utmost importance to describe transmission risks in terms of precise behaviours and not groups, because failure to do so results in a vital message being misunderstood. Homosexuals and IV drug users as such are not spreading the AIDS virus, but the human behaviours of anal intercourse and the sharing of IV needles and syringes most certainly are. To assume that anal intercourse is a homosexual behaviour, and to describe it as such, may have dire educational consequences: for example, the man who does not identify as gay [either to himself or publicly] but who has occasional male-to-male sexual contact, will not hear the message; the woman who is a partner in anal intercourse will think "that information is not relevant to me". To talk about the infection risks of IV drug use is similarly misleading, with possibly tragic consequences, because we know that there are many young people who, although experimenting with "shooting up", do not identify with the description "IV drug user". They don't identify with the label or with the group, because, as they say, they are not regular users, they are not addicted, it's just for fun. And of course they don't have their own needle and syringe, so they share someone else's. Which puts them in extreme risk of becoming infected with HIV; doubly so because the information about how the AIDS virus can be passed on is not heard simply because the words used to present the literally vital message are imprecise or euphemistic.

Who are these people described above, and how can we contact them and talk with them urgently? They are our daughters and sons, our husbands, wives and sexual partners, our colleagues and our friends, and all we have to do is to use words which convey an unequivocal message.

There is another issue which determines our use of language in education. If we are to become able to prevent and manage HIV infection and AIDS, we have to acknowledge that AIDS is first and foremost a sexually transmitted disease [STD], and that educating for the prevention and management of STDs involves discussion about human sexual behaviours, working with the sexual thinking and believing of each individual, and dealing with sexuality norms and traditions within the culture of each country and community.

Yet this is precisely an area in which we as members of a community are both incompetent and embarrassed. We feel neither skilled nor confident in talking openly and honestly about sexuality, at discussing sexual behaviours unemotionally and objectively, simply because the experience of human sexuality is so potent and personal, and there are a plethora of socially inculcated and reinforced regulations which constrain the expression of our experiences.

I am not arguing here that it should be otherwise; rather that in order to use the only AIDS prevention tool we have, namely education, we must know our tool well, appreciating both its potential and its limitations. One of these limitations is that AIDS education compels us to talk about human sexuality, yet the talking itself provokes discomfort and even offence, which we attempt to avoid through the use of euphemisms, vague or academic descriptions. It is not so much that we lack a language of sexuality, rather that we fear embarrassment, ridicule or censorship if we use appropriate words. Words appropriate for the group we are talking to. For each social sub-group in society has its own language, particularly its sexual language, and this language is an audible indicator of the sexual values, assumptions and expectations of those who use it. In order to facilitate AIDS awareness educators must be

Deborah Kelly: pen/brush, ink, mixed media; 170 x 170 mm.

able to use language that has meaning to the group. The Sydney youngsters who were surveyed seemed not to understand the word "homosexual", and an effective educator of such a group would need to ensure that they heard the definition of "a person who is sexually attracted to someone of the same sex. Both males and females can be homosexual". The values held about homosexuality will be indicated by the particular slang or euphemisms used, and educators may need to be able to utter words that are by no means part of their usual personal linguistic repertoire.

However, AIDS is not about homosexuality. The enemy is a virus, not people. A virus that is relatively new and that is spreading rapidly from the specific groups in which it first became apparent, that is the gay male and the IV drug using groups, into the larger community. It is spreading through specific sexual and social human behaviours, namely anal intercourse and the sharing of needles and syringes, behaviours which have powerful emotional and moral implications for many in our community, behaviours which we may not like to contemplate or talk about, which we may not want our children to know about. Our personal moral code however must not result in the ultimate immorality, that of not passing on information that literally may be the difference between life and death. With AIDS there is no choice: regardless of our individual moral code, each of us has an ethical responsibility to inform everyone, and in particular young people who are not yet at risk of infection with HIV, of the ways in which this virus is passed on. Ignorance, not knowledge, is the health hazard. So we have to learn how to talk about the details of human sexual sharing whether we blush or not, we have to say "anal and vaginal intercourse" rather than "sleeping with" or "making love" because love-making is not a health hazard, only the intercourse part is. We have to admit that "heterosexual sex" can involve anal intercourse. And we must never assume even then that our message is clear, that our listeners are as educationally privileged as we are. The word "intercourse" may be alien for some people, and we must be able to describe exactly what it means and if need be, say "screw' or "fuck", simply to ensure comprehension. I remember with appreciation the 22 year-old man who asked me what an anus was; my comfortably academic word was meaningless to him, but "bum" was right and enabled us to continue communicating about risks behaviours. Which is a prerequisite to preventing the further spread of the virus by interrupting transmission. This is the essence of AIDS prevention, yet the language we use here is also often alienating or obscure. Words like "celibacy", "abstinence", and "monogamy" can embody excellent prevention concepts, but lack real meaning for many younger people, either because they haven't heard the words before or because the values implied in the words are not relevant to them. There are people who have a sexual life-style of serial monogamy which may put them at considerable risk of infection with HIV, depending on whether their partners have previously been involved in risky behaviours with an infected person. And people who, tragically, have become infected through their first sexual relationship, believing their partner to be "safe". Young people often tell me that a "safe partner" is the best HIV prevention strategy. Am I "safe" with someone I really love and who makes me feel marvellous? The prevention messages must be crystal clear: no anal or vaginal intercourse with a person who is infected with the virus, unless a condom is used. And never share needles and syringes. Given that we believe there are many people unknowingly carrying the virus, without any symptoms, then every single one of us must take on the personal responsibility to behave in ways that ensure that the AIDS virus is neither picked up nor passed on.

The word "promiscuous", often associated with descriptions of AIDS, is another one which must be used with extreme caution. We cannot hope to communicate well with people who feel criticised or judged by us, and this word says more about the user's values and expectations than it does about sexual behaviour. Kinsey, the American sex researcher, suggested that "promiscuous" means "anyone who is having more sex than I am", which is warning enough for any educator. There may be situations that require us to offer moral advice about sexual behaviour, but when educating about AIDS prevention the priority must be to give accurate and useful information. Sharing risk behaviours with a number of different people obviously increases the chance of meeting the AIDS virus, but it is not the number of partners, rather their infection status and the behaviours shared that is crucial.

The use of condoms is one of a number of HIV prevention strategies, one which has appeal to many people who choose, for a variety of reasons, not to forego intercourse. We need to enable these people to use condoms properly, for no health tool is any better than the care with which it is used. Proper use of any health tool, be it a toothbrush, a cake of soap, or a condom , depends on both knowing how it is used, and feeling comfortable, familiar with it. Again the words we use may be all important, and if there is the need to use the colloquial language of the group, to facilitate their learning, then we have only to remember the devastating potential of the Human Immunodeficiency Virus for us to discover our untapped ability to be creative, courageous and caring communicators.

As an AIDS Prevention Educator I have a responsibility to communicate health-promoting information and awareness, to encourage people not to put themselves at risk of infection, but to become personally responsible for their own health and well-being. And I am obliged to accept that they may choose to do this via a moral code that is substantially different from my own. Human sexuality expresses itself in many different ways, and to acknowledge and accept this may be one of the biggest challenges presented by the AIDS phenomenon. If we as a community can rise to this challenge, if we can accept and respect others who differ from us, if we can respond creatively to the urgent need for AIDS prevention education, if we can use the appropriate words to communicate our prevention messages and support health-enhancing behaviours, then we can stop the spread of HIV now. And then we will be better able to care, with all our personal and community resources, for those who are already infected and who need us.

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Deborah Kelly:pen/brush, ink, mixed media; 130 x 130 mm

TRANSMITTING AIDS: AIDS IN AUSTRALIAN TELEVISION DRAMA

Illness has long been a staple of television drama. Medical conditions can be used to generate emotional extremes in individual characters, and long-running tension and dramatic climaxes in the narrative as a whole. This isn't restricted to dramas based in hospitals; it's difficult to think of a soap opera that hasn't used illness as a dramatic device at some stage. Television producers, it seems, are constantly searching for new traumatic ailments to use in their shows. AIDS is no exception, having appeared in several television dramas: in the U.S.A. *An Early Frost* (1985), *The Young And the Restless* (1988), *All My Children* (1988), *Another World* (1988) and *Favorite Son* (1988); in the U.K. *Buddies* (1986), *Eastenders* (1986) and *Intimate Contact* (1988); in Australia *The Flying Doctors* (1986) and *A Country Practice* (1988). These productions run the gamut of fictional formats; feature length telemovie, daytime soap, evening family soap and night time "super" soap.

Within these programs, there are a variety of different ways that AIDS can be depicted. The primary distinction is whether AIDS is explicitly displayed in the form of a person with AIDS (PWA) or implicitly suggested in references to an unspecified "threat". In *Favorite Son* and *Dynasty* ,for example, AIDS exists only potentially whereas it is actually displayed (however coyly) in all the other shows listed. Given the epidemiology of the Human Immunodeficiency Virus (HIV) several kinds of PWAs are possible: gay male, prostitute (male or female), intravenous drug user (male or female), bisexual , haemophiliacs or blood transfusion recipients (male or female), heterosexual (male or female). [The latter two groups are medically possible but account for 'only' 7.7% of cases in Australia][1] In addition a character could be shown at different stages: at risk, HIV antibody positive, AIDS related complex (ARC) or full-blown AIDS. Given the number of groups and the stages of infection, a bewildering variety of scenarios is possible.

The fertile imaginations of script writers have invented at least one more - a man injected with the HIV virus by the CIA in order to assassinate him (*Favorite Son*). The implication, in this unlikely plot, that AIDS is a kind of poison, is evident in several other stories, particularly those in which the HIV virus is contracted through blood transfusion. (Needless to say such scripts ignore the fact that blood screening procedures now minimise such infection.) This idea leads on to a major division within PWAs on television - the "innocent" and the "appropriate" victim. Haemophiliac and transfusion infected PWAs are innocent, they have done nothing to "deserve" the virus. Gay or bisexual men, prostitutes and IV drug users - marginal groups - on the other hand, are expected to have the virus, not simply because they may engage in high risk practices but because they are morally at fault. In many instances AIDS is depicted as a sexually transmitted disease, conveniently ignoring transmission through needle sharing so that the traditional moral outrage at venereal disease can be wheeled out.

So a number of pairs are set up: AIDS as actual or potential; transmission as sexual or accidental; PWAs as innocent or deserving, normal or marginal. The complex combinations of these in real life isn't recognised in the more lurid American shows, later in this essay I'll look at the way Australian production have attempted to avoid sensationalist and moralistic stereotypes and to recognise the intricacies of AIDS.

Before speaking about specific programs it's worth looking at more general responses in the television industry. In the broadest terms this has been to see AIDS as a sexually transmitted disease related first to gay men and then to heterosexuals. This tends to mirror general medical and social responses to AIDS. The syndrome was first referred to as Gay Related Immunodeficiency (GRID), and the belief that it was associated with "promiscuous", "fast-lane" gays was exploited by conservative social groups. It was only when heterosexual infection was recognised that AIDS became "real" issue.

In the United States at least, it's difficult to even conceive of showing gay men on television, let alone portraying them sympathetically. In the case of An Early Frost , "the real issue of concern to the network's [NBC's] broadcast standards department was not so much the presentation of AIDS as the treatment of homosexuality".[2] Steven Carrington, a central character in Dynasty , is shown as an acceptable gay man but there could be no question of him being sexually active since this would require embarrassing talk of safe sex. The latest series sees a celibate Steven living with his ex-wife while the producers work out what they're going to do with him. Their only options at the moment are the elimination of the character or the elimination of the possibility of sex - by literally having him enter a monastery! (I won't spoil it for Dynasty fans by letting on what happens.) This timidity of course ignores the fact that, more than any other group, gay men have recognised the need to avoid high-risk activities and that it is precisely those people who think that only sexually active gays get AIDS who now need to be addressed.

But given the moral climate of the 80s the general response of TV has been to broadcast AIDS as a means of policing sexual activity. Gay men are ignored and AIDS is seen as a solution to moral decay:

> AIDS has succeeded where the police failed in forcing [Dallas callgirl Serena] to give up prostitution.[3]
>
> AIDS is doing Mrs Whitehouse's work for her.[4]

The reaction is fairly simple; monogamous heterosexual relationships or celibacy will avoid transmission of the virus, indeed will avoid the need to even address it as an issue:

> Bedhopping, once an integral part of most big budget movies and top-rating TV shows, is being replaced by stable, loving relationships.[5]
>
> America...has led the way in suggesting that real men - and good girls - don't sleep around any more.[6]

The temptation to moralise about promiscuity and to promote a monogamous heterosexual ideal overshadows the fact that it's what you do, not how many people you do it with, which is the key to transmission or avoidance of the HIV virus.

In extreme cases AIDS is projected as a punishment for sexual promiscuity and prostitution. In both Another World and The Young and the Restless, American daytime soaps also shown in Australia, the PWA is a female prostitute now apparently paying the price for her wicked past. As Deborah Rogers writes, "Although soaps are often criticised for condoning immorality...sexual transgressions are invariably punished in the end.[7]

I want to spend the rest of this essay looking at AIDS on Australian TV. I'll make general remarks about soap operas, using four episodes of A Country Practice (ACP) as an example. The episodes, "Sophie parts 1-4", were screened in August 1988 and dealt with HIV transmission and IV drug use. The plot saw Dr Terence Elliott track down his daughter Sophie, a heroin addict, in Kings Cross and return with her to Wandin Valley. There it's found that she's HIV antibody positive and the repercussions for her and the Elliott household, and the responses of the residents of Wandin Valley to her condition, form the basis of the drama.

That the plot of ACP dealt with IV transmission shows that the producers were prepared to avoid the stereotyped, alarmist and inaccurate treatments of American TV. But what I want to show is that in spite of the best intentions the representation of AIDS is dictated, at least in part, by two important factors: the notion of how "social issues" should be handled on TV, and the dramatic form of soap opera. It's important to recognise these constraining factors in order to understand the effectiveness of TV drama in public health and education initiatives.

For some years the ideas of "quality television" and "social issues" have been intertwined. A quality soap such as ACP finds the happy medium between the two imperatives of television - entertainment and information. There's been no shortage of social issues on ACP; alcoholism, corneal transplants, unemployment, leprosy, racism, epilepsy, abortion, sweated labour, glue sniffing.... It's safe to say, however, that ACP had no intention of making AIDS the "disease of the month" and cynically cashing in on it.

The producers of ACP see the program as having an "authoritative voice"[8] in the community, even as being "credited with setting moral standards"[9]. This is recognised by the many government departments, professional and community groups who approach them with requests to tackle issues or who endorse particular episodes. Such was the case with the "Sophie" episodes, which were endorsed by the Federal Health Minister, Neil Blewett, the National Campaign Against Drug Abuse, and the Sydney Albion Street AIDS clinic. The margin between soap opera and community service narrowed to the extent that the producers delayed any AIDS plot until it was possible "to do this thing properly".[10]

There's no denying the good intentions of the producers; "Sophie" was well-informed, sensitive and intelligent. However, some constraints remain. First, the 7.30 pm "family viewing" timeslot makes some issues untouchable. This doesn't appear to have ruled out either AIDS of homosexuality however. Although in "Sophie" IV drug users carry the HIV virus, ACP had in an earlier episode featured a sympathetic treatment of a gay male couple.

Second, on television issues become Issues - monolithic problems rather than complexes of social, medical and psychological factors. Problems, and responses to them, become oversimplified, choices become black and white, and are presented by archetypal, even melodramatic figures. Again ACP seems to have avoided this problem. Since the program blends finite groups of episodes with a continuous serial form characters can develop, rather than being simple archetypes. Thus their responses can develop and complexities can be addressed. This is certainly the case in "Sophie" where Esme Watson, initially afraid of the HIV positive Sophie, learns that her fears are groundless, and becomes the only person from whom Sophie feels able to accept sympathy and support. Issues become sites of education and negotiation rather than hard and fast rules. The negative aspect, however, is that issues must generally be brought to the show by outsiders. Regular cast members carry the response to the issues, not the issues themselves. Consequently issues arise, are resolved (more or less) and fade away rather quickly.

Third, and most important, is the notion of the "responsibility" the quality soap has to its audience. Responsibility to whom? The producers see their audience as the "family" viewer - a standard, homogenous heterosexual family with stereotyped gender and age roles. To a certain extent then, the treatment of issues on ACP, and the responses of characters to them, will mirror those of what the producers see as the generic family. As a result, individuals who carry issues which are marginal to, or beyond, this ideal family unit will always remain "deviant", however sympathetically they are portrayed.

No matter how well intentioned and well informed the plot may be, it still constitutes a social structure (both on screen and in the mind of the viewer) of norm and deviance. Even in the case of the AIDS plot on *The Flying Doctors*, where the gay male PWA was loaded with signs of acceptability - old age, war hero, played by Gerard Kennedy - he still remained an outsider, he still came to Cooper's Crossing from beyond. "The disease", the producer remarked, "was easier to assimilate in the form of a 'guest' story".[13] The point being, of course, that AIDS will never be 'assimilated' with the familial structure of the soap.

The fundamental characteristics of the dramatic structure of ACP also affect the way that AIDS can be depicted. The primary elements of ACP are: its combination of serial form with 'closed' episodes, character development, rural location, medical/hospital focus, and the need for sympathetic characters with whom viewers can identify or empathise.

A Country Practice : Terence Elliott (Shane Porteous) comforts his daughter Sophie (Katrina Sedgwick) after discovering she is HIV antibody positive.

Courtesy Channel 7, Melbourne.

These components both contribute to and handicap a complex treatment of AIDS. As I've already mentioned, the serial form allows character development thus avoiding stereotyped responses to issues, but at the same time it requires that 'deviant' issues be carried by outsiders. This effect, combined with the need to close plot lines regularly (usually every two or four episodes) means that issues are always disappearing - moving on or dying.

This sense of insiders and outsiders is reinforced by the rural setting of ACP. Wandin Valley may have its fair share of problems but many of them are literally only passing through. A bedrock of stable, idyllic values survives all the traumas. There's a split between nature and culture; the self-contained, self-sufficient rural community is always being threatened by evils from beyond, especially from the city. Sophie comes from Kings Cross, surely the heart of urban darkness in Australia. It's not a case of demanding that she be allowed to live on in Wandin Valley as a permanent character but of recognising that the nature/culture, normal/deviant. insider/outsider structure will always eat away at the most sympathetic of portrayals. The mythic opposition of good and evil, so crudely displayed in the "super" soaps like *Dallas* and *Dynasty*, operates more subtly here, but it is present all the same.

The belief that a character must be sympathetic also raises problems in imaging AIDs on TV. John Davern, the producer of ACP, gave two reasons for not dealing with AIDS earlier:

> We gave it a lot of consideration and we find that, at this date, February 1986, still not enough is known about how the disease is transmitted, and I don't believe in scaring people. And the fact that it's linked so strongly with homosexuality makes it very difficult to make a homosexual AIDS victim a 'goody' and sympathetic.[12]

Given that all modes of transmission were understood by 1983 one could uncharitably suggest that it was only the unpalatability of a (sexually transmitted) "gay disease" for a family audience which held things up. Or perhaps it was the sheer contrivance needed to render gays sympathetically which put off the producer - an earlier episode had legitimised a gay male by first having him save a child's life, then himself suffer a kidney failure. (And why is a gay man with a kidney failure sympathetic, and one with AIDS not? Because kidney failure is neither infectious nor sexually transmitted perhaps?)

Whatever the case the viewer is still confronted with the implication that IV drug use is more palatable than homosexuality. This is putting it too bluntly of course. In fairness to the producers I think they've recognised, quite rightly, that HIV transmission through needle sharing is now the most rapidly increasing form of infection. But the nagging suspicion remains that AIDs can now be dealt with in the family timeslot because it is no longer sexually transmitted.

Since the family is the basic bond uniting ACP characters (closely followed by community) the image of AIDS could be expected to circulate round the family, especially since it has been de-homosexualised by "Sophie". AIDS exists within this framework as a force which will either break the family a part or bond it more closely. (Such is also the case in *An Early Frost*).

Typically ACP takes the more complex middle path. Initially Sophie threatens the stable marriage of Drs Terence and Alex Elliott: she is the child of a previous marriage, she is a heroin addict, and she tests HIV positive. This threat increases as Alex sees her husband's attention drifting to Sophie and finds her professional judgement being affected by domestic turmoil. Later the family stands on the brink of disintegration as Terence leaves Wandin Valley to track down the runaway Sophie. Her eventual death from an overdose almost drives Terence to drink, leaving a bitter Alex to cope with a medical practice and a shattered home. A reconciliation is eventually effected but only at the cost of leaving the PWA behind. Again this mirrors *An Early Frost* (although ACP is streets ahead in sensitivity), the family is bonded more closely by the elimination of the PWA , not by his/her presence.

The display of the human frailty of doctors in "Sophie" also cuts both ways. Showing that doctors are fallible introduces a degree of sophistication in the soap but can cast the PWA positively, as the site of complex professional issues or, in the case of Sophie, negatively, as a potential home wrecker.

All of this is by way of recognising that television drama does have an important role in raising issues related to AIDS. "Sophie", for example, allayed fears about the infectious nature of the HIV virus, it pointed to the fastest growing means of transmission in Australia, it distinguished between being HIV positive and having full blown AIDS, and it even raised the possibility of government controlled distribution of heroin. This is all a major advance over the lurid or mawkish portrayals typical of some American shows, and sensitively and accurately reflects some of the major areas of concern in Australia. For all that, however, it has to be recognised that the nature of ACP, and particularly of its perceived audience, represent inherently limiting factors in any discussion of the full complexities of AIDS. The positive impact of ACP should not be underestimated, but to say that it did well given the circumstances is not enough. It's only by recognising the limiting conditions of its form that it becomes possible to overcome barriers to a full challenge to AIDS itself.

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Notes

1. NH & MRC special unit in AIDS epidemiology and clinical research figures quoted in "AIDS: The Disease that Changed the World", supplement to *The Age*, 5 Dec. 1988, p. 5.
2. S.Farber, "A Drama of Family Loyalty, Acceptance and AIDS", *The New York Times*, 18 Aug. 1985, Section 2, p. 23.
3. Wendy Leigh, "Top TV Soaps Come Clean", *The Sun* (Vic), 22 Aug. 1987.
4. Patrick Stoddart & Alex Sutherland, "How AIDS Cleaned Up The Screen", *The Weekend Australian*, 28-9 March 1987.
5. Leigh.
6. Stoddart & Sutherland.Deborah Rogers, "AIDS Spreads to the Soaps, Sort Of", *The New York Times*, 28 Aug. 1988, Section C, p. 29.
8. John Davern quoted in Carolyn O'Donnall & Ed Bark, "TV, Sex and AIDS", *The Herald*, 30 Nov.1987.
9. Bruce Best, co-producer, quoted in Sandra Carlson, "Practice Makes Perfect For 500th ACP Show", *Illawarra Mercury*, 24 July 1987.
10. Davren in O'Donnall and Bark.
11. Oscar Whitbread, producer, in O'Donnell and Bark.
12. John Tulloch and Albert Moran, *A Country Practice: 'Quality Soap'*, Currency Press, Sydney, 1986, p. 291.

AIDS FOR THE MASSES

In this country we have had very little by way of public representations of AIDS, as compared to the U.K. or the U.S.A.

Perhaps this is because Australia lacks a truly 'gutter' press of the kind that flourishes in the U.K., and adores photos of emaciated bodies propped up in hospital beds. Certainly we lack a royal family of any sort, let alone one whose members are always ready to descend upon the nearest AIDS ward, and show the cameras that it really is safe to touch.

It may simply be that we have yet to reach that critical mass, already exceeded in the U.S.A., where almost everybody knows someone who is a 'victim of AIDS', or is about to become one.

Whatever the reason, in this country AIDS is still largely invisible, though we have no shortage of AIDS education, of AIDS experts, of AIDS carers, even of people *living* with AIDS - just no plain, ordinary *people with AIDS*.

That is, until they die. And in this country, as has happened already in America, we are about to witness an amazing feat of magic. AIDS will be made visible, and its now discarded cloak of invisibility is to be recut and resewn, fashioned into a Quilt of Remembrance.

While it is unlikely that an Australian quilt will ever be the equal of the US original - quilting is not one of our recognised traditional folk arts, and our body count, thankfully, won't produce anywhere near four acres of patchwork - nevertheless, it is likely to become an enormously powerful influence in setting the scene in which many of our images of AIDS appear. However recent events in the U.S.A., in particular the rumblings of anger and criticism which are beginning to be heard in some gay communities, should alert us to the pitfalls of unquestioning endorsement of this kind of project.

AIDS ON A HUMAN SCALE: 8,288 panels weighing 16 tons; with 57 miles of seams; 11 miles of canvas edging; 5 miles of walkway fabric; 37,660 grommets --- otherwise known as the U.S. Names Quilt . . . . Soon we will have our own. (Photograph Peter Cashman)

The misgivings reported more and more frequently in American gay newspapers seldom detract from the personal expressions of loss, grief and love that the individual panels represent. Rather, it is the public vehicle, the quilt as public spectacle,that is attracting critical attention.

One gay activist wrote in a letter to founder Cleve Jones, shortly after the Quilt's return to Washington:

> When I first heard about the Names Project I was deeply moved and impressed. . . . However, as I became familiar with your literature it became clear to me that you were making a decision to drastically limit the association between AIDS and gay men. I respect your apparent motive - to 'destigmatise' the image of AIDS and attract vital resources from society at large - but I feel that omitting references to gay men serves to defame those who have died.

Defending their policy of limiting any references to gay men in official literature and events, co-founders Cleve Jones and Mike Smith in December this year wrote "It is true we do not often use the words 'gay' and 'lesbian'....Our critics who insist on such labels cause great harm. They strip away the individuality of each life and once again reduce the epidemic to categories and statistics".

This reverence for the unique individual has some part of the stock rhetoric of quilt-talk. It is reproduced wherever quilt-talk is heard, most recently at the Sydney launch of the Australian Quilt.

We are told that the quilt has the power to release and validate our private grief, pent up for many people by the stigma that clings to a death by 'venereal disease'. It encourages support for PWAs and their loved ones. It shows us the humanity behind the bland statistics. All this, in a non-threatening, non-confrontational, and all-inclusive way.

The American Quilt; Looking for a Loved One
(Photograph Peter Cashman)

This shedding of the socially imposed shame, fear and disgust, is posed as the rediscovery and preservation of the authentic individuality of those who have died. It goes beneath the artificial categories and labels which shroud our lives and deaths, and looks at the real face of AIDS, the human face, the face of the unique individual. But the sexuality of this unique individual and the means by which the disease was contracted is considered to be irrelevant, or as some have suggested, inconvenient, especially when you are trying to snare celebrity endorsement and popular appeal. AIDS for the masses, or popular AIDS is born.

The U.S. Quilt today has become a commodity prepared for consumption by the fictitious mass audience that exists in the imagination of modern media. Paradoxically, it has also started to generate its own distinctive class of statistics: it weighs sixteen tons, has 8,288 panels, 57 miles of seams, 11 miles of canvas edging, 5 miles of walkway fabric, 37,660 grommets. It represents fifty U.S. states, 13 foreign countries and a lot of unique individuals whose uniqueness did not include their sexual preference or their drug-using habits.

As yet Australian Quilt organisers have not indicated whether they will be borrowing these policies along with the idea of the quilt itself. However, there is a depressing similarity between American and Australian quilt-talk which the difference in accents does not conceal. There is the same conflict between wanting to tell the true story of each individual who has died, by wanting just as much, not to offend, threated or confront the general populace for whom homosexuality and drug-use are the warty disgusting face of AIDS.

If if takes a similar course to that pursued in America, it will still provide the opportunity for individuals to publicly express their grief and loss and to memorialise their love. But it will not be a project that enhances or enlarges affirmative images of gay lives, with or without AIDS.

Terrence Bell *is a person with AIDS, an AIDS activist and a volunteer worker with the* Star Observer, *Sydney.*

Australian Quilt; December 1st Launch - Still Manageable
(Photograph Terrence Bell)

The photographic narration of Aids reinforces the before-and-after conventions of standard photojournalistic practice. The emphasis is placed on the question of fatality. There is no representation of people *living with Aids*. People with Aids are presented as impossible to identify with.

The nature and purpose of this programme is to investigate the positive narration of people living with Aids, to establish an identity and to depict individuals and social groups who have taken control of their circumstances and definitions of health and disease

Kathy Triffit

Besides an awkward feeling, I feel I am preying for a victim, rather than being what society terms a "victim" myself. How to explain the guilt associated with HIV is hard to explain, but on the other hand I have many times advertised this fact unnecessarily. I might feel guilty about my sexual needs but most certainly not about my right to dignity and self-respect.

Paul Young, Diary entry 23/4/88

(Facing page) Kathy Triffit and Paul Young: Untitled, 1988.
Black and white photographs with text. Each image approx. 43 x 46 cm. (The reflective gloss of the image surface has been lost in reproduction. It is intended that the viewer's reflection be considered an element of the piece.)

SOME IMPORTANT DATES IN THE HISTORY OF AIDS

This chronology of AIDS is based on one in the recently produced media workers' guide to AIDS *Partners in Prevention*. This extremely useful document was written by Adam Carr for the Australian Federation of AIDS organisations and produced by Designer Publications Pty Ltd. I would encourage readers to seek out this publication as it provides probably the most accessible and comprehensive guide to AIDS in Australia.

C.1940 (speculated) Human immunodeficiency virus (HIV) crosses from an animal host (possibly the green monkey) across to humans in a remote area of Central Africa.
1959 Oldest evidence of HIV infection in stored African blood samples.
1960s (speculated) Population growth along with increased mobility in Central Africa leads to HIV infection throughout the Congo Basin. The virus undoubtedly caused disease but this went unnoticed amongst all the other health problems of the region.
1960s and 1970s (speculated) HIV is carried from Africa to Europe, the Carribean and the United States possibly via guest workers or tourists. The virus enters western gay male communities and begins to be sexually transmitted there.
1969 First known case of AIDS in the United states (identified later from stored blood samples).
1976 A Danish woman surgeon who had been working in Zaire contracts pneumocyctis carinii pneumonia (PCP) in Denmark and dies. She becomes Europe's first case of AIDS.
1978 People from Central Africa and Carribean countries begin to appear in European hospitals with a range of previously rare opportunistic infections. Meanwhile about 2% of San Francisco gay men had unknowingly become infected with HIV. This figure has been calculated by retrospectively examining blood donated by gay men in efforts to develop a Hepatitis B vaccine.
1979 PCP and the previously rare skin cancer Karposi's Sarcoma (KS) are first recognised in a few gay men in New York and San Fransisco.
1980 Rumours begin to circulate in the American gay community and the gay media of new illnesses surfacing in gay men. More and more cases are seen by doctors.

1981

January 1 43 cases of PSP and KS have been reported to the U.S. Centres for Disease Control (CDC). At the same time a substantial number of cases would be unrecognised and therefore unreported.
June 5 *Morbidity and Mortality Weekly Report (MMWR)*, the newsletter of the CDC, publishes "Pneumocystis Pneumonia - Los Angeles" by Dr Michael Gottliab - the first published description of AIDS.
July CDC establishes its Task Force on Karposi's Sarcoma and Opportunistic Infections and appoints Dr James Curran as head.The first article on AIDS appears in the Australian gay press.Gay Related Immune Deficiency (GRID) was one of the terms used to describe the range of illnesses and infections being reported.

1982

January 1 270 cases of AIDS have now been reported in the United States.
June 11 The first cases of PCP and KS are reported among heterosexual American intravenous drug users.
July 16 CDC reports the appearance of PCP among people with haemophilia in the United States. Crisis meetings are called inside the blood transfusion system to clarify the situation.
September 24 The term GRID is quietly dropped by CDC in favour of the more general Acquired Immune Deficiency Syndrome (AIDS).
October Professor Ron Penny (St Vincent's Hospital Sydney) examines the first suspected case of AIDS in Australia. The patient was an American tourist who is still alive at the time of writing this chronology.
December 10 CDC reports AIDS related disease amongst recipients of blood transfusions in the United States.

1983

January 1 1,285 cases of AIDS reported to the CDC.
January 7 CDC reports AIDS among female sexual partners of men with AIDS.
May Sydney gay community establishes an AIDS action committee. This group will work with other existing groups in the gay welfare and health areas.
May 20 Professor Luc Montagnier (Pasteur Institute, France) announces the discovery of a retro-virus (Lymphodenopathy -associated virus - LAV) that could be the cause of AIDS.
June Major meeting of Melbourne gay community called by ALSO Foundation to hear a panel of doctors "tell all they know" about AIDS. An overflow crowd packs the Dental Hospital Auditorium.
July 8 Death in Melbourne of the first Australian to be diagnosed with AIDS.
July 12 Gay community establishes Victorian AIDS Action Committee (VAAC). All areas of need highlighted by AIDS would be addressed such as education, support, fundraising and political organisation.
July Australian National Health and Medical Research Council (NH&MRC) establishes a Working Party on AIDS. State Health Departments begin to have the issues around AIDS raised by their local community-based AIDS organisations. Early gay community education campaigns are underway.

1984

January 1 4,107 cases of AIDS in the United States. 7 in Australia.
May 4 Dr. Robert Gallo (US National Cancer Institute) announces that *he* has discovered a retrovirus that could be the cause of AIDS. He gives it a different name - HTLV III.
October The National Executive of the Australian Federation of Haemophilia begins alerting its State organisations when it is realized that blood products have been contaminated.
November 15 Just two weeks prior to a Federal election the Queensland government announces the deaths of four infants as a result of HIV contaminated blood transfusions. Major media storm erupts. Ian Sinclair, leader of the Federal National Party, lays blame on Labor government policies.

November 18 All state Health Ministers meet with Dr. Neal Blewett, their federal counterpart. Professor David Pennington is appointed to head the National AIDS Task Force. Ita Buttrose will lead the National Advisory Committee on AIDS (NACAIDS). $5 million were allocate to various priority areas including establishment of education, counselling and support services.
December 6 VAAC holds major public meeting - becomes Victorian AIDS Council (VAC) and launches major education drive.

1985

January 1 9,801 cases of AIDS reported in the United States. 49 in Australia.
March AIDS antibody screening introduced at all Australian blood banks. Voluntary exclusion of 'high risk groups' backed by punitive legislation for wrongful declaration have desired effect.
April 14 First International AIDS Conference meets in Atlanta, Georgia.
May Cliff Dolan, outgoing President of the Australian Council of Trade Unions (ACTU), issues a staement calling for non-discrimination and a national response to AIDS. This is the first statement by such a body in the world.
August 27 NSW Government announces it will legislate to make antibody tests notifiable. Immediate result is a substantial drop in attendance at testing centres by members of 'high risk groups'.
October 2 Rock Hudson dies of AIDS. This leads President Reagan to say the word AIDS in public for the first time. 18,000 Americans are now diagnosed with AIDS.
November 17 Australia holds its first National AIDS Conference in Melbourne. 200 delegates address the theme "Meeting the Challenge". Keynote speakers were from the Shanti Project, San Francisco, and San Francisco AIDS Foundation.
State AIDS Councils join to form the Australian Federation of AIDS Organisations (AFAO).
December $1.5 million is allocated federally for AIDS research.

1986

January 1 19,888 cases of AIDS reported in the United States. 162 in Australia.
June 23 Second International AIDS Conference meets in Paris. World Health Organisation estimates that there are at least 50,000 AIDS cases in eight Central African countries.
June A roundtable conference held between the Task Force, NACAIDS, the Federal Health Minister and representatives of the gay community to hammer out a solution to the various issues associated with antibody testing which was threatening to become a major dividing issue.
September 19 A drug called azidothymidine (AZT) is announced as a potential treatment for some people living with AIDS.
September The AIDS Task Force issues a public statement urging access to clean needles for intravenous drug users.
October 31 Australia holds its Second National AIDS Conference in Sydney. 500 delegates discuss the theme "Australia's Response Examined".
November 4 California voters reject a proposal that would quarantine people with AIDS.

1987
January 1 34,862 cases of AIDS reported in the United States. 385 in Australia.
April 5 The Grim Reaper appears on Australian television as the flagship of the National AIDS Education Program. The advertisement was developed by a sub-group of NACAIDS.
April The AIDS Trust of Australia is launched by the Governor-General, Sir Ninian Stephen.The United Nations passes General resolution 42/8 - a statement on AIDS. Australia is principal sponsor of the move, the first time a resolution about a disease has been debated in the United Nations General Assembly.
June 1 Third International AIDS Conference held in Washington, D.C. Over 7,000 delegates attend from all over the world.
July Australia hosts a regional meeting of the World Helath Organisation dedicated to AIDS. All South East Asian and Pacific countries attend.

1988

January 1 50,787 cases of AIDS reported in the United States. 722 in Australia.
March 28 Existing Task Force and NACAIDS are abolished by the Federal Government. A unitary committee, the Australian Council on AIDS (ANCA), is formed. This council is supported by the broadly based National AIDS Forum.
May 15 From All Walks of Life - a walkathon for AIDS - raises over $32,000 on a wet Sunday afternoon in Melbourne.
July Fourth International AIDS Conference held in Stockholm, Sweden. No major news points to a long haul ahead.
August 4 Australia holds its Third National Conference on AIDS in Hobart, with 1,300 delegates and the theme "Living with AIDS - Towards the Year 2000". The general consensus is that the speech by Wilson Tuckey, Shadow Minister for Health, was the only sour note. Six weeks later Tuckey was removed from the Shadow Health portfolio.
September 21 Australia records its 1,000 th case of AIDS. 500 Australians had died from AIDS since the first case was notified in late 1982. This is approximately the same number of Australians who died in the Vietnam War.
October - November Conferences were held for those with AIDS (the Living Well Conference), those working as prostitutes (the Sex Industry and the AIDS Debate Conference), and for people with Haemophilia.
December 1 First World AIDS Day, organised by the World Health Organisation.

1989

January The Federal Government releases its Green Paper on AIDS - *A Time to Care, A Time to Act.*

Meanwhile 5 to 10 million people worldwide could be infected with the HIV virus and 100,000 deaths have occurred. Soon more deaths will have been recorded than in World Wars I and II, the Korean War and the Vietnam War.

When will the tide start to turn?

Phil Carswell *was the inaugural President of the Victorian AIDS Council, he is also a Trustee of the AIDS Trust of Australia and an Executive member of the Australian National Council on AIDS. He works as the Senior Policy Officer for the AIDS Unit of the Health Department of Victoria.*

THE DAVID WILLIAMS PROGRAM

The David Williams Program provides financial assistance for those affected by the HIV virus. Many people infected by the virus, their families and partners are in need of emergency funds.

The program was established in mid-1987 in memory of David Williams, a gay man who died from AIDS and who wanted a financial assistance program established.

The Program provides emergency funds to cover costs such as gas, electricity, telephone, rates, rental and mortgage payments, ambulance insurance cover, family reunions and specialist care.

In 1987/88, 91 applications had been made, involving grants or loans totalling $19,289.

Demands for financial assistance will increase rapidly in the years to come, resulting from the increase in cases and greater awareness of the Program. Meeting those demands, especially the fundraising associated with the Program, will be a major challenge.

The program is also likely to seek to offer a wider range of services to clients, particularly by upgrading its financial counselling service.