# THE ICONOGRAPHY OF EVE: EPIDEMIOLOGIC DISCOURSE IN NEW ZEALAND'S RESPONSE TO HIV/AIDS

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# ABSTRACT

This thesis seeks to explain the complex responses to HIV/AIDS in New Zealand. The discourses, themes and ideologies of previous epidemics are examined according to their impact on understandings about HIV/AIDS. This thesis argues that a significant outcome of such responses is the identification of 'Eve', the sexual icon that recurs in popular discourse of epidemics like leprosy, syphilis and HIV/AIDS. The 'Eve' icon is seen as representing the Garden of Eden view of woman; sexual woman, feminisation as a socio-sexual process, and specific women. Popular and public health responses are described in previous epidemics of leprosy, bubonic plague, syphilis and cholera. New Zealand's experience of the 1918 influenza epidemic and 1916-1962 poliomyelitis outbreaks, and the history of syphilis specifically, indicate how a deadly affliction like AIDS might be construed in the local context. In particular, the discourses associated with these prior and current diseases are linked, showing a commonality of themes related to victims, blame and sin.

Discourses about HIV/AIDS are examined with respect to the theories of Sander Gilman (iconography) and Michel Foucault (discursive power and sexuality). Three case studies involving major actors in New Zealand's response to HIV/AIDS (the media, parliament and community groups) link the organisations according to discourse and image-making. Local and overseas news items are examined for their iconogpraphic content in stories about AIDS

icons, including New Zealand's Eve van Grafhorst. Discourse production is then analysed in parliamentary debates about HIV/AIDS, and in strategies of the New Zealand Prostitutes' Collective.

The thesis explores how iconography from prior epidemics that are particularly influential in the New Zealand context are evident in responses to and by gay men, sex-workers, and New Zealand's principal AIDS icon, Eve van Grafhorst. Discourses about syphilis and other epidemics expressed an ethic of blame directed toward marginalised individuals such as gay men, sex-workers and injecting drug users in the HIV/AIDS epidemic. Paradoxically, this ethic of blame also led to the deification of Eve van Grafhorst. The media, parliament and community sector influences on image-making in New Zealand's AIDS context has led to icons being both victimised and served by discourses about AIDS.

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# ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AAC | AIDS Advisory Committee |
| ACAS | Auckland Community AIDS Services |
| ACTUP | AIDS Coalition To Unleash Power |
| ADIO | Auckland Drug Information Outreach |
| AFAO | Australian Federation of AIDS Organisations |
| AIDS | Acquired Immune Deficiency Syndrome |
| AmFAR | American Foundation for AIDS Research |
| ASO | AIDS Service Organisation |
| CART | Community AIDS Resource Team |
| CAS | Canadian AIDS Society |
| CASONZ | Committee for AIDS Service Organisations in New Zealand |
| CCS | Crippled Children's Society |
| CDC | Centers for Disease Control (USA) |
| CHE | Crown Health Enterprise |
| CIVDURG | Christchurch Intravenous Drug Users Resource Group |
| CMV | Cytomegalovirus (AIDS-defining disease) |
| COGS | Community Organisations Grants Scheme |
| DC | District of Columbia |
| DIVO | Dunedin Intravenous Outreach |
| DOH | Department of Health |
| DMO | District Medical Officer |

| | |
|---|---|
| ESCAP | Economic and Social Commission on Asia and the Pacific |
| GMHC | Gay Men's Health Crisis |
| GRID | Gay-Related Immune Deficiency |
| HIV | Human Immunodeficiency Virus |
| HIV+ (-) | Infected/not infected with HIV |
| HRC | Health Research Council |
| IDCCHA | Interdepartmental Coordinating Committee on HIV/AIDS |
| IDU | Injecting Drug User |
| IGCA | (Australia) Intergovernmental Committee on AIDS |
| INNZ | Index New Zealand |
| IV | Intravenous |
| KS | Karposi's Sarcoma (AIDS-defining disease) |
| MOH | Minister or Ministry of Health |
| MP | Minister of Parliament |
| NCA | National Council on AIDS |
| NGO | Non Government Organisation |
| NPLWAU | National People Living With AIDS Union |
| NPR | National Public Radio (USA) |
| NZAF | New Zealand AIDS Foundation |
| NZFPA | New Zealand Family Planning Association |
| NZMJ | New Zealand Medical Journal |
| NZPC | New Zealand Prostitutes' Collective |

| | |
|---|---|
| NZPD | New Zealand Parliamentary Debates |
| NZWW | New Zealand Woman's Weekly |
| PHC | Public Health Commission |
| PIAT | Pacific Islands AIDS Trust |
| PLWA | Person Living With AIDS |
| PWHIV | Person With HIV |
| POBOC | Payment On Behalf Of Crown |
| PWA | Person with AIDS |
| PCP | Pneumocystis Carinii (AIDS-defining disease) |
| RHA | Regional Health Authority |
| STD | Sexually transmitted disease |
| TRT | Te Roopu Tautoko (Maori) |
| WAAOC | West Alabama AIDS Outreach Center |
| WCTU | Women's Christian Temperance Union |
| WHO | World Health Organisation |
| WIDE | Wellington Information Drug Education |
| VD | Venereal disease |

# CHAPTER ONE

## INTRODUCTION

## 1.1 Introduction

This thesis is about responses generated by the people involved in AIDS organising, the media and in politics. The struggles, passions, ideologies and politics which are involved in the production of these responses during the HIV/AIDS epidemic are examined in detail. For the purpose of this thesis, the term 'response' refers to activities relating to HIV/AIDS in New Zealand as they are embedded within, and are productive of, discourses about sexuality and disease.

Historical analysis of earlier epidemics shows that AIDS discourse is not new: it draws on the sub-texts of 'sexual epidemics' such as leprosy and syphilis, and 'catastrophic epidemics' such as the bubonic plague and cholera. True to the precedent of other epidemics, an ideology of blame has framed the HIV+ individual. Thus, this thesis is also about prejudice; about how the stigma that surfaced in other epidemics persisted to shape the lives of people with AIDS (PWAs). The study is framed by insights from the history of epidemics as a means of understanding the nature of responses to a 'new' pandemic like AIDS.

## 1.2 The Title Defined

The title of this thesis is "The Iconography of Eve: Epidemiologic Discourse in New Zealand's Response to HIV/AIDS." The initial

step for consideration of this topic is a definition of the component elements within the title. These definitions are intended to clarify both the meanings and applications of these meanings within the present project. Six discrete components are involved: iconography, Eve, epidemiologic, discourse, New Zealand's response, and HIV/AIDS.

### *1.21 Iconography*

The formal definition of iconography stems from the concept of icons as images, statues, figures, pictures or representations.[1] Iconography itself is the study of societal understandings about icons; that is, how groups of people are presented, created and reproduced through pictorial, textual or media representations.[2] The application of this definition is directed to icons of People with AIDS (PWAs) and HIV/AIDS as a phenomenon. In this thesis I investigate the ways in which iconography serves to reveal compelling but rarely stated frameworks around which meanings and understandings are organised. Iconography may be thought of in this context as a study of attributions on broader societal levels to images that are particularly relevant to HIV/AIDS.

### *1.22 'Eve'*

This descriptor is used with four levels of meaning. At the first

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1 Webster's Dictionary, second edition: 1979

2 Gilman, S. "AIDS and Syphilis: The Iconography of Disease" in D. Crimp (ed) *AIDS: Cultural Activism, Cultural Analysis*, 1988. See Part II for further elaboration

level is the biblical meaning, of Eve in the Garden of Eden as temptress of Adam and instrument in the destruction of man's innocence. A broad range of biblical criticism and discussion has attended to the story of Eve, mostly focusing on the early Hebrew characterisations of Eve as icon (that is, representation) of woman as subversive or corrupt. It should be noted that some contemporary feminist scholars have reinterpreted the story of Adam and Eve to cast 'woman' in a different and positive light.

At the second level of meaning, Eve is defined as a broad category representative of all women, but especially women deemed 'sexual'. That is, the image of Eve as temptress is utilised as a shorthand and compressed label for common ideas and understandings about women. This category is further divided into an 'angel/whore' dichotomy in which women are defined as either 'pure' or 'impure' depending on their socially-defined status.

At the third level, Eve is used to describe 'feminisation' as a socio-sexual concept. A persistent theme developed in this thesis is that feminised men (gay men[3], 'fops') as well as women have been targeted as objects of blame and approbation in the context of epidemic disease.

At the fourth and final level, 'Eve' is used as a contemporary proper noun. Eve van Grafhorst was a much

[3] The use of 'gay' rather than 'homosexual' throughout this thesis follows the practice of activist-theorists seeking to problematise acceptance of the medical-psychiatric category of 'homosexuality' that framed them as 'sick'.

publicised child with AIDS in New Zealand, and the iconography of her celebrity is discussed in detail in Part II.

The term Eve as part of the title is thus intended to refer to these multiple levels of meaning. Although the four thematic threads will unfold within the thesis, 'Eve' serves to capture the essence of these four expositions.

### *1.23 Epidemiologic*

The phrase 'epidemiologic discourse' requires consideration of each term separately, followed by an explanation of its joint meaning. The word epidemic has been defined in its noun form as "an outbreak of a contagious disease that spreads rapidly and widely"; in its adjectival form as "spreading rapidly and extensively by infection and affecting many individuals in an area or a population at the same time."[4] Epidemiology is the study of epidemics. The term epidemiologic may thus be understood, in the first instance, as pertaining to epidemics. As I will note shortly, the word is used in a somewhat different context in this thesis.

### *1.24 Discourse*

Discourse is the language, limitation, and forms of what is said and written about a topic, including, as Lupton has observed, such

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[4] American Heritage Dictionary

varying topics as objects, events, concepts or actions. Discourses seek to address audiences in such a way that the listener is influenced to act or believe in certain ways.[5]

The phrase 'epidemiologic discourse' is not intended to suggest that the focus of this thesis is on epidemiology. Epidemiology as a formal subject of study or analysis is outside the scope of the present work. Rather, the intention is to examine discourse about epidemics in general, and the HIV/AIDS epidemic in particular. The phrase 'discourse about epidemics' was considered, but it was not included because of its vagueness and morphological awkwardness. The term 'epidemic discourse' was seriously considered because it is more literally descriptive of this study. However, that term has a second meaning, which is an unending and relentlessly spreading discourse. Because the prospect of such an exaggerated document differs from my actual aim, the term epidemiologic discourse has been chosen as a middle ground. 'Epidemiologic discourse' is used in the title and throughout this document to refer specifically and directly to discourse about epidemics. Any other implication of the term should be set aside for the present purposes.

### *1.25 New Zealand's Response*

Discourse about 'Eve' (women and feminised men) has shaped responses to HIV/AIDS in New Zealand. The phrase 'New Zealand's Response' refers to the ways in which discourse about sex-

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5 Lupton, D. *Moral Threats and Dangerous Desires: AIDS in the News Media,* 1994

workers and gay men as putative vectors of HIV/AIDS have shaped community, media, public, governmental and medical sector responses to the epidemic. This response is not just limited to the discursive outcomes of commonly-held beliefs about 'Eve' in New Zealand's HIV/AIDS epidemic; it includes the challenges mounted to iconography by the 'risk groups' themselves.

### *1.26 HIV/AIDS*

The term 'HIV/AIDS' rather than 'AIDS' signifies the two different stages of HIV infection; that is, the latent and often asymptomatic stage (HIV) and the symptomatic stage (AIDS). In the often inaccurate and sensationalistic reporting about AIDS (eg: 'The AIDS Virus'), this distinction is blurred. The use of HIV/AIDS throughout the thesis acknowledges this difference. It also draws attention to medical constructions that define and categorise different stages of disease progression or symptomology, thus powerfully shaping popular understandings about epidemic disease.

## 1.3 Central Theme of the Thesis

Women and feminised men are objects of blame and the foci of discourse in sexual epidemics; this blame process is constructed through iconography, and is also challenged by the blame objects themselves.

The foundations for this theme are developed in the first four chapters in Part I where responses to both 'deadly' and 'sexual' epidemics are described. The theme is approached by reporting on the nature of three epidemics in which blame was not attributed to women or to feminised men, namely polio, influenza and bubonic plague. These chapters focus on the nature of 'risk groups' and xenophobic identification of the 'other'. In the case of epidemics identified as sexual - leprosy, syphilis, and AIDS, the theme of women and feminised men as blame objects emerges through iconography and epidemiologic discourse. The construction of blame in the HIV/AIDS epidemic then addresses gay men, injecting drug users, and African sex-workers as putative vectors of disease. Part II develops the theme of 'Eve' in the New Zealand context, and provides an analysis of the way iconography both shapes and is used by the popular media, AIDS organisers, politicians and the 'general public'.

## 1.4 The Literature about HIV/AIDS

A massive literature has emerged about HIV/AIDS. Texts have not been confined to medical or epidemiologic accounts of AIDS, but included a number of socio-cultural analyses and critiques along with self-help guides, documentaries, and personal accounts of the epidemic. Among the scholarly critiques, most texts, reports and studies reflected the 'sociological' nature of the epidemic. Critiques and analyses emerged to both challenge and reframe bio-medical definitions of HIV/AIDS. Many critiques were written by gay activists or academics involved in AIDS

organising. The iconography of 'Eve' emerged in both epidemiologists' and activists' accounts of the epidemic, often in counterpoint as each struggled to define and control the epidemic, public health responses, and popular understandings about AIDS.

Historians writing about HIV/AIDS situated their work in epidemic and public health history. Brandt,[6] Fee,[7] Musto,[8] and Risse[9] placed HIV/AIDS in epidemiologic context by identifying the patterns and responses of prior epidemics such as leprosy, syphilis, bubonic plague, yellow fever, and cholera. Along with explanations of how epidemic precursors shaped responses to AIDS, historians have provided chronologies of public health responses, judged the efficacy or shortcomings of these measures, and identified the various ways in which victims had been marginalised.

Social analyses of HIV/AIDS offered a wide range of insights, overviews and perspectives about the AIDS epidemic. Most were written by overseas writers whose primary purpose was to critique, evaluate, or explicate the responses to HIV/AIDS according to their utility, meaning or outcome. Among the gay writers offering critiques of the responses were Crimp,[10]

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6 Brandt, A. (1) *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880,* 1985 (2) *AIDS: From Social History to Social Policy,* 1988

7 Fee, E. *Sin Versus Science: Venereal Disease in Twentieth-Century Baltimore,* 1988

8 Musto, "Quarantine and the Problem of AIDS" in *AIDS: The Burdens of History,* 1988

9 Risse, G. "Epidemics and History" in *AIDS: The Burdens of History,* 1988

10 Crimp, D. "AIDS: Cultural Analysis/Cultural Activism" in *Cultural Analysis/Cultural Activism,* 1988

Kramer,[11] Watney,[12] Patton,[13] Altman[14] and Weeks.[15] These writers were among the first to articulate the concerns and activities of the USA's gay community with respect to HIV/AIDS. Other writers such as Lupton,[16] Treichler,[17] Perrow & Guillen[18] offered critiques of media, medical and public health responses to HIV/AIDS. These critiques derived from feminist traditions, or were developed according to the authors' expertise in either the media or the public health sector.

## 1.5 New Zealand Research about HIV/AIDS

Most scholarly literature about HIV/AIDS in New Zealand appears as journal articles in *The New Zealand Medical Journal* and *Sites,* or as unpublished academic papers and theses. The articles fall into two main categories. They centre on survey research undertaken by local academics, social scientists and epidemiologists (the list of survey researchers includes

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[11] Kramer, L. *Reports from the Holocaust - The Making of an AIDS Activist,* 1989

[12] Watney, S. (1) *Policing Desire,* 1987 (2) "The Spectacle of AIDS" in *Cultural Analysis/Cultural Activism,* 1988

[13] Patton, C. *Sex and Germs: The Politics of AIDS,* 1985

[14] Altman, D. (1) *AIDS in the Mind of America,* 1986 (2) *Power and Community: Organizational and Cultural Responses to AIDS,* 1994

[15] Weeks, J. (1) *Sexuality,* 1986 (2) *Sexuality and its Discontents,* 1985 (3) *Sex, Politics and Society,* 1989

[16] Lupton, *Op cit.*

[17] Treichler, P. (1) "AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification" in *Cultural Analysis/Cultural Activism,* 1988. (2) "AIDS, Gender, and Biomedical Discourse: Current Contests for Meaning" in *AIDS: The Burdens of History,* 1988

[18] Perrow, C. & Guillen, M. *The AIDS Disaster: The Failure of Organizations in New York and the Nation,* 1990

Chetwynd, Plumridge, Dickson, Skegg, and Paul) or on AIDS discourse as explicated by academic theorists (eg: Worth, Alice, Ryan, White and Gavey). In 1992, an overview of New Zealand's organisational response to HIV/AIDS was limited to a single published paper: "The Gay Community and the Response to AIDS in New Zealand" in *The New Zealand Medical Journal.*[19] The only book published about the 'facts' of HIV/AIDS in New Zealand was Paul Goldwater's *AIDS: The Risk in New Zealand.*[20] It was evident that New Zealand's scholarly literature abut HIV/AIDS was largely restricted to socio-behavioural, epidemiologic and theoretical papers, and that a multi-focus, organisational or socio-historical analysis about the HIV/AIDS epidemic had not yet been attempted. Appendix II of this thesis provides a descriptive background for analysis of New Zealand's responses to HIV/AIDS.

## 1.6 Developing a Research Topic

My review of local literature about HIV/AIDS concluded that a study of New Zealand's responses to the epidemic would fill a gap in national research. A sociological study could also build on the insights and analyses offered by local research scientists and theorists. My decision to write the thesis was made with the intention of filling a research 'gap', and of contributing valuable social knowledge about HIV/AIDS. The decision to structure the thesis around a discursive framework was made after I explored the importance of epidemiologic discourse (especially

19 Parkinson, P. & Hughes, T. "The Gay Community and the Response to AIDS in New Zealand", *New Zealand Medical Journal,* 100 (817): 1987

20 Goldwater, P. *AIDS: The Risk in New Zealand,* 1986

understandings about 'sexual' women and 'feminised men') in shaping global responses to HIV/AIDS.

## 1.7 Theoretical Frameworks

A number of theories were investigated for their utility in providing a framework for this thesis. My decision to use the work of activist-theorists[21] such as Altman, Crimp, Gilman, Watney and Weeks as a conceptual basis rather than, say, the theories of organisational analysts (eg: Perrow and Guillen) or of socio-semioticians (eg: Baudrillard)[22], arose from the centrality of activist-theorists in defining political, moral and medical issues in the HIV/AIDS epidemic. These writers also addressed the blame and 'Eve' related issues I wished to explore in this thesis.

Most theorists explicating the HIV/AIDS epidemic have written with a sense of urgency, if not outrage, about its impact on sexual freedoms, the gay community, and sexual discourse. Much of their work focuses on the present and future, so that few of the writers have reflected on lessons or themes from history. Many have confined their theories or perspectives to the construction of AIDS discourse in the media or medical

21 I have coined the term 'activist-theorist' to denote the involvement of (usually) gay intellectuals and writers in developing theoretical perspectives on political aspects of HIV/AIDS. These aspects involve 'discourse production' as a means of challenging hegemonic ideas about 'homosexuality' and 'sexual disease', and those relating to civil rights issues, health care and strategies for HIV prevention. I discuss the production of 'reverse discourse' (also called 'perverse discourse' or 'discourse of resistance') more fully in Part II of this thesis.

22 Baudrillard, J. *In the Shadow of the Silent Majorities,* 1983

profession, with little reference to these themes as produced in prior epidemics (eg: Lupton, Watney, Treichler, Grover). An exception is Susan Sontag who wrote in *AIDS and Its Metaphors* about the stigmatising outcomes of the bubonic plague, leprosy, syphilis, cholera and the twentieth century epidemics and their meaning for HIV/AIDS.[23] Sontag's study is used in this thesis to provide links between the epidemic past and present with respect to common themes, discourse and outcomes.

After considering other theorists who addressed discursive themes in terms of their historic and political significance to HIV/AIDS, I drew upon the work of two writers, both of whom were concerned about the development, utility and effects of 'sexual' discourse. The first, Sander Gilman wrote a chapter titled "AIDS and Syphilis: The Iconography of AIDS" in *Cultural Analysis, Cultural Activism.*[24] He demonstrated how popular images about PWAs were recreated from pre-twentieth century notions about syphilitics. Gilman's insights provide the conceptual basis for understanding how responses have been constructed around the popularised images (iconography) of PWAs. The second writer, Michel Foucault, offered a broader basis for understanding the nature and history of 'sexual' discourse and its utility for AIDS organising in New Zealand. He did this by exploring in *The History of Sexuality: An Introduction* the evolution of sexual discourse, and the methodology of discursive power.[25] These theoretical frameworks were chosen because of

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[23] Sontag, S. *AIDS and Its Metaphors*, 1989

[24] Gilman, *Op. cit.*

[25] Foucault, M. *The History of Sexuality: An Introduction: Volume I*, 1978

their complementarity (links could be made between iconography and discursive power), and because their authors acknowledge the centrality of discourse in conceptualising and responding to disease.

## 1.8 Iconography and Power in New Zealand's HIV/AIDS Epidemic

Issues of power and iconography in New Zealand are explored in three case studies about media, parliamentary, and community responses to HIV/AIDS. In each case study, discourse emerges as a central theme of power in the political arena. Deborah Lupton emphasised the importance of discourse when she wrote that

> discourses are powerful, and they have political functions, because 'they define, describe and delimit what it is possible to say or not to say (and by extension - what is possible to do or not to do)' (Kress, 1985: 6). The criteria for distinguishing discourses as outlined by Parker (1992: 6-20), include the following: a discourse is realized in texts; a discourse is about objects, events, concepts or actions, e.g. an object such as a condom, a disease such as AIDS or an action such as sexual intercourse; discourses address the audience in a particular way, making us listen as a certain type of person; discourses are structured to persuade - they benefit or support some individuals, groups or institutions and oppress or attack others; discourses therefore produce power relations.[26]

Discourse also resides in publicity. For most New Zealanders, publicity about HIV/AIDS in New Zealand centred on a young HIV+

26 Lupton, D. *Op. cit.*: p. 29

girl, Eve van Grafhorst. The image of helpless, innocent Eve was popularised through numerous articles, especially in women's magazines. Willingly or not, the New Zealand public was obliged to 'listen as a certain type of person' to discourse that extolled Eve (but not the other AIDS icons such as gay men or injecting drug users). Media images about Eve van Grafhorst are presented in the photograph and montage overleaf to help illustrate how she was deified (iconised) in New Zealand. The image of New Zealand's 'innocent Eve' is contrasted with Gilman's 'sexual temptress' from the syphilis epidemic. I trace Gilman's 'sexual temptress' imagery to that of the biblical 'Eve', personified in this thesis as the female syphilitic, the African HIV+ prostitute, and as the 'feminised' male. This unifying theme explores links of how AIDS discourses 'benefit or support some individuals, groups or institutions and oppress or attack others; [thereby producing] power relations' in New Zealand and elsewhere.

This thesis approaches historical and discursive issues in their global and local contexts, and illustrates the continuity of 'Eve' in epidemiologic discourse. In Part I, an overview of the leprosy, bubonic plague, cholera, syphilis, poliomyelitis, influenza and HIV/AIDS epidemics is presented according to their themes and outcomes. In Part II, the perspectives of Gilman and Foucault are discussed, and case studies are presented to illustrate media, parliamentary and community responses in New Zealand as framed by discourse and the iconography of 'Eve'. Finally, organisational responses to HIV/AIDS are presented in two appendices as background perspectives for the major themes.

# EVE VAN GRAFHORST

THE PRESS, 14/4/93: 1

# Brave Eve

*'Angel' Eve van Grafhorst*

# ANGEL O COURAGE

**A brave little battler**

**She put a face to Aids**

**ittle Eve comes own with Aids**

**Her last words — 'I love you'**

A perfect gift for Eve

**VE - THE ANGEL OF COURAGE**

**ve van Grafhorst captured Z hearts with her courage**

This thesis is an exploration of AIDS discourse and response in New Zealand's HIV/AIDS epidemic. The academic nature of the exercise should not detract from the fact that AIDS is often about young or marginalised people who have been afflicted with a life-threatening condition. Their commitment to life, community and politics throughout this epidemic has given urgency to AIDS response and discourse. Their struggle is embraced in this thesis: it is juxtaposed with the power of epidemic and public health history, with the taint of moral judgements, and with HIV's reputation of being so much more than 'just a stupid virus'.[27]

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[27] Comment made by a bio-medical researcher on Cable TV (USA), April 1995

# PART I: 'PLAGUE' HISTORY

# INTRODUCTION

Part I of the thesis is a discussion of epidemic history up to, and including, the HIV/AIDS epidemic. Within Part I, Chapter 2 describes epidemics of leprosy, bubonic plague, cholera, influenza and poliomyelitis according to their social and political impact. Common themes and outcomes are identified, and the progress of public health responses from physical (segregation, quarantine) to 'suggestive' (educational) methods for disease control is charted. Chapter 3 describes the syphilis epidemic, as the disease most like HIV/AIDS in the way it was conceptualised and managed. New Zealand case studies about the influenza, poliomyelitis and syphilis epidemics are included in Chapters 2 and 3 to identify historical and discursive trends in local responses to epidemic disease. Chapter 4 addresses the HIV/AIDS epidemic, and includes a discussion about how popular ideas about HIV and PWAs were shaped by imagery from the syphilis and other epidemics.

The 'five plagues' were chosen specifically for their discursive value. They provide compelling insights into how risk groups have been created according to prevailing ideas about race (cholera, bubonic plague, influenza), sexuality (leprosy, syphilis), and social status (cholera, poliomyelitis). In particular, themes from the leprosy, syphilis and AIDS epidemic are notable for their iconographic impact; 'Eve' as prostitute or 'feminised man' has been sequentially framed as moral leper and degenerate

syphilitic. The powerful discursive legacy from the 'five plagues' has framed gay men, sex-workers and marginalised others as vectors of HIV/AIDS.

# CHAPTER TWO

## FIVE PLAGUES - A BACKDROP TO BLAME AND EVE ICONS IN THE HIV/AIDS EPIDEMIC

*These creatures of disease, thinks the heterosexual, so tenuously preserving his right to promiscuity, had it coming to them, for the way they looked, for the way they were. That the disease is shared by users of drugs, prostitutes, yes, and black men, puts power fair and square in the reins of the horsemen of the Apocalypse. Like all plagues, it gives work to liars and cowards and power to the bullies.*

\- *C. Williams*[1]

## 2.1 Objective of This Chapter

This chapter presents a Western history of plagues and epidemics prior to the HIV/AIDS epidemic. I focus on the themes and commonalities that have emerged from responses to major epidemic disease on the assumption that the historical precedent impacts on the way HIV/AIDS is being both conceptualised and managed. The themes relating to ideology, blame, language, and disease management are examined for ways in which such commonalities provide a framework for understanding the responses to HIV/AIDS.

The chapter outlines the discourses of blame for each of the 'five plagues'. It focuses attention on how public health authorities have reproduced and expanded these blame paradigms according to the 'sexual' or 'foreign' origin of the disease, or according to socio-political concerns of the day. The focus on

[1] Williams, *A Case of Knives,* 1988: p. 239.

public health responses appears in case studies about the influenza and poliomyelitis epidemics in New Zealand, largely because measures enacted during or after these epidemics have set the scene for the way HIV/AIDS has been managed by health authorities, the medical profession, and community activists.

### *2.11 Plague, Epidemic and Pandemic*

For the purpose of this chapter, the terms 'plague', 'epidemic' and 'pandemic' provide an understanding of the difference between infectious and contagious as applied to large scale disease.[2] Plague is defined in Webster's Dictionary as "any contagious epidemic disease that is deadly; specifically, the bubonic plague."[3] The emphasis here is on 'deadly'; ie: *automatically* deadly. A disease such as influenza which was responsible for countless deaths in the early 1900s was deemed an epidemic rather than plague because of the possibility of recovery for sufferers. Thus, 'epidemic' has a different meaning; it is a disease which has a rapid onset, which is not necessarily deadly, which spreads over a specific geographical area, and which has a finite lifespan in its epidemic form. Both influenza and polio were epidemics in the 1920s and 1950s respectively; although they had existed in sub-epidemic form, their epidemic history was characterised by sudden, severe and often fatal outbreaks of disease occurring more or less simultaneously.

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[2] Francois Delaporte, in his book *The History of Yellow Fever: An Essay on the Birth of Tropical Medicine,* 1991, defines infectious disease as 'indirectly transmissible' and contagious disease as 'directly transmissible' (p. 44).

[3] *Webster's Encyclopedic Unabridged Dictionary,* second edition: 1979.

The word 'pandemic', as an extension of 'epidemic', is used to describe epidemics occurring world-wide rather than in specific locations, and also denotes larger numbers (though not necessarily higher rates) of afflicted.[4] The word 'pandemic' has been used by a number of writers and the media to illustrate the global nature and rapid spread of AIDS, but probably can also be ascribed to widespread epidemics such as the bubonic plague. The meanings of both 'epidemic' and 'pandemic' have specific (scientific) applications, as separate from lay, or journalistic usage.

A salient feature of plague as opposed to epidemic disease is that the pathogens are highly contagious and are spread by means of direct or indirect contact. It is perhaps for this reason that AIDS has been called an epidemic rather than a plague, for while individuals who become infected with HIV are deemed infectious, they do not 'spread' HIV by touch or indirect contact, but rather, through the direct infusion of either sperm or blood. The word 'plague' was used in the early years of the epidemic because of widespread fear about the effects of a new, deadly, and rapidly spreading disease. In use, the phrase 'gay plague' has also been both sensationalist and perjorative. It reflected homophobia rather than epidemiological accuracy in the naming of disease.

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[4] Definitions of epidemic and pandemic in Webster's Dictionary are:

a) epidemic - a disease prevalent in a locality; an epidemic disease; also: the rapid spreading of such a disease.

b) pandemic - of all the people; prevalent over a whole area or country; universal; an epidemic over a large region.

However, it was also invoked in epidemiologic discourse; for example, in the initial naming of AIDS as Gay Related Immune Deficiency (GRID).

This chapter begins with a chronological overview of some specific catastrophic, chronic and recent epidemics, namely: leprosy, bubonic plague, cholera and the twentieth century influenza and poliomyelitis outbreaks. Case studies of the influenza and poliomyelitis epidemics in New Zealand are included to illustrate the contextual nature of responses to public health crises, and to set the scene for understanding New Zealand's rationale for dealing with HIV/AIDS. Although a discussion of the syphilis epidemic might have been included in this chapter, its particular character justifies a more detailed and separate analysis. In terms of a discourse about sexuality and gender and the outcomes of public health policy, the analysis of the social and medical history of syphilis is given a wider focus which, in turn, necessitates a different approach. The syphilis epidemic, therefore, is the subject of a separate chapter on sexuality and sexually transmitted disease.

## 2.2 Pre Twentieth Century Epidemics: Leprosy, Bubonic Plague and Cholera

### *2.21 Leprosy: Epidemic of the Unclean*

One of the first epidemics to be recorded was that of leprosy: the isolation of lepers, as recorded in the bible, was absolute. A

leper was compelled to

> [w]ear torn clothes and let the hair of his head hang loose, and he shall cover his upper lip and cry, "Unclean, unclean." He shall remain unclean as long as he has the disease; he is unclean; he shall dwell alone in habitation outside the camp.[5]

The isolation stemmed from fear about a disease that was believed (until recently) to be highly communicable. Sufferers were forcibly isolated on evidence of disfigurement to their limbs and faces. Such disfigurement also led to the belief that lepers must have deserved their affliction. Thus, in addition to being placed in quarantine[6], lepers were blamed for their disease. Musto writes that "it was not uncommon to believe that the loathsome disease was God's punishment for sin, particularly venereal transgressions."[7] Themes of blame and isolation were well established in terms of a disease that existed in epidemic form in biblical times, and until the end of the middle ages in Western Europe. Says Musto, "leprosy became a metaphor for heresy, moral turpitude, and unnatural and excessive lust for which the penalty was banishment or death." [8] Although direct notions of blame were later ameliorated by Christian doctrine, Musto writes that "thousands of individual or group asylums

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[5] Leviticus, 13:45-46. Revised Standard Version

[6] Quarantine is defined in Webster's Dictionary as being the isolation of people or animals to prevent the spread of contagious disease, or the curtailment of travel for the same reason. Ships are also quarantined, ie: retained in port if passengers or sailors are found to be ill.

[7] Musto in *AIDS; The Burdens of History,* 1988: p.69.

[8] *Ibid.*: pp.70-71 In the early days, syphilis and leprosy were often confused.

called leprosaria existed in the thirteenth century." [9] The last leper house in England was opened in 1472.[10] It was during this time that Kings Henry II of England and Philip V of France carried out extermination programmes in an effort to rid society of this 'pestilence'.

The biblical notion of leprosy as a sign of moral depravity declined during the eighteenth century, as did the influence of the Christian church. Instead, the assumption that leprosy was a disease of 'inferior' (non-white) people emerged after the discovery of the disease in parts of the world colonised by Westerners.[11] Capitalist expansion in the nineteenth century was soon accompanied by religious outreach in the form of missionary activity. Gussow notes how

> the expansion of European imperialism late in the nineteenth century was accompanied by a religious revival in England and by an intensification of missionary activity. Starting in the 1870s, missionaries began going abroad in large numbers. . . Systematic and focused attention on leprosy as an area of service formally began in 1874 with the formation in England of The Mission to Lepers.[12]

The missionaries involved in 'helping' the lepers soon revived

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[9] *Ibid.*: p.68

[10] Amory Winslow, *The Conquest of Epidemic Disease,* 1943: p.90 Leprosaria still exist: the Molokai (Hawaii) and Carville Leprosaria (New Orleans) were opened in 1865 and 1917 respectively, and operate today.

[11] Gussow, *Leprosy, Racism and Public Health,* 1989: 19

[12] *Ibid.*: p.20

ancient views about leprosy. However, they also promulgated the anglophiles' view that other cultures (the Chinese, Hawaiians, Pacific Islanders) were inferior to their own. The missionaries became ambassadors for western civilisation, aggressively setting about changing the social and cultural mores of other groups. Gussow writes that, for example,

> in several ways the goals of the missionaries in China were far more grandiose than those of traders, who sought profits and markets, or those of diplomats, who sought negotiating stances and favorable positions of power. The missionaries sought an absolute: the perfect conversion of heathens and pagans to Christianity, a conversion within which the concept of "civilization" itself was argued.[13]

The nineteenth century not only saw ancient notions about leprosy converge with racist ideologies, but also saw the reintroduction of enforced isolation for lepers in places like the Phillipines, Hawaii and the Pacific Islands.

Twentieth century beliefs about leprosy were shaped by the 'germ theory'. Ideas that leprosy was caused by a mixture of dirt, depravity and racial inferiority resulted in the continued segregation of lepers, and led to discriminatory practices such as the USA's refusal to accept lepers as immigrants. Gussow argues that western imperialism and colonialism, the germ theory of disease, missionary activity, fears about 'the yellow peril', and racism all contributed to the public's continued dread of

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[13] *Ibid.*: p. 118

leprosy.[14] This dread far exceeded that of other, fatal diseases such as tuberculosis, and kept alive outdated notions about a disfiguring, fatal disease despite its progression to a milder, chronic and often non-disfiguring condition.

## *2.22 Bubonic Plague - The First Pandemic*

Much has been written about bubonic plague, or Black Death as it is also known. According to Gregg, the first of the plague pandemics occurred in Egypt during the reign of Roman Emperor Justinian I in the year 531 CE.[15] The worst outbreaks of plague were experienced in the fourteenth century throughout Europe and Asia. Apparently, the disease spread so fast that within two years "all of Europe from Russia to Scandinavia (including such dependencies as Iceland and Greenland) was in the grip of plague."[16]. Black Death was so virulent that it decimated the populations of countries such as France, where according to one writer "it scarcely left a fourth part of the people."[17]

Reactions to plague were panicky and punitive. According to Risse (1988),

> privacy was invaded, suspects forcibly removed from their homes, lists of victims published, houses closed, relatives shut in, beggars expelled. [In the

[14] *Ibid.*: p. 24

[15] Gregg, *Plague: An Ancient Disease in the Twentieth Century,* 1985: p.7. CE (Common Era) equates to the Latin AD (Anno Domini).

[16] Musto, *Op cit.*: p.97

[17] *Ibid.*

> seventeenth century] violators of public health regulations were fined, summarily executed by firing squads, or hanged. . . Those committing serious crimes were actually torn apart, and their limbs publicly displayed. Informers usually received a third of the levied penalties.[18]

Risse writes that public health measures were a heavy-handed attempt to protect the long-term political and commercial interests of a wealthy elite. Scapegoats were sought and found, and invariably included members of groups who were social outcasts or outsiders. Jews in rural areas who were accused of poisoning wells with plague had their villages destroyed.[19] City-dwelling Jews were quarantined, where their death rates multiplied. Risse states that "the powerless, as usual, bore the brunt of the disease."[20] Cripples, also thought to have poisoned wells, were put to death. The poor, huddled in decrepit and overcrowded houses in the city areas, were unable to escape contagion, while wealthier elites who escaped the cities or who lived in better conditions, often survived. The plague therefore disproportionately affected the poor and marginalised. To add to this misery, citizens experienced public health measures that were often so harsh that "the remedy was the true illness, not the plague."[21] In the name of plague, prostitution was officially quashed, and in Rome, vendors, the unemployed and beggars were rounded up and made to work on construction projects.[22]

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[18] Risse, in *The Burdens of History,* 1988: p.39 Parenthesis has been added

[19] Gregg, *Op. cit.*: p. 27

[20] Risse, *Op. cit.*: p.40

[21] *Ibid.:* p.39 In the worst of these measures, people known to have been associated with plague sufferers were summarily executed.

Methods of plague control were invariably devised and executed by powerful groups such as the merchants of Rome.

Plague was believed to be spread by foreigners through commercial trade or military foray. As if to emphasise its 'foreign' origin, the bubonic plague was sometimes called 'oriental plague'.[23] Thus, the plague was believed to have come from Turkey by way of imported cotton[24] or by tainted silk ribbons from Naples.[25] The Italians blamed the French, the French blamed the English, the Spanish blamed the Portuguese, Europeans blamed the Asians.[26] The plague, it seemed, was an epidemic of 'blame your neighbour' despite (or because of) the reliance on neighbours for trade. Although plague was believed to have come from somewhere else, it was later found to be endemic to many areas, primarily because of infestations of plague-infested rats throughout Europe and the rest of the known world.

From about the fourteenth century, interested physicians and savants made a concerted effort to identify the causes and transmitters of plague. Despite or because of these efforts, responses to plague focused on sanitation or isolation as control measures. Goods, animals and people were quarantined, even though "quarantine, as practised in Mediterranean ports, was usually a costly farce." [27] In effect, while more effort went

[22] *Ibid.:* p.37

[23] Sontag, *AIDS and Its Metaphors,* 1989: p. 51

[24] Hirst, *The Conquest of Plague,* 1953.: p. 55

[25] Risse, *Op. cit.*

[26] Gregg, *Op. cit.*

into plague-tracing and isolation measures, public health responses to the plague were little different than those afforded lepers, except in degree. For both, there was the imposition of control measures ranging from quarantine to execution, in addition to the identification of social outcasts on whom the epidemic could be blamed. The social and cultural disparities that existed prior to the outbreak of plague were the yardstick by which the risk groups were created during this epidemiologic era.

### *2.23 Epidemic of the 'Other': Cholera*

Cholera as an epidemic was unknown outside the Far East until the nineteenth century. Sontag writes that there were four successive outbreaks in Europe "each with a lower death toll than the preceding one."[28] Rosenberg states that cholera killed half those it attacked, and was regarded as plague-like because of its rapid and dramatic spread.[29] However, Sontag suggests that cholera (rather than, say, the more virulent smallpox epidemic) earned plague status simply because of its non-European origin.[30]

The disease, believed to have originated in India, was

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[27] Hirst, *Op. cit.*: p.64 Some of the efforts to reduce contamination by outsiders were gargantuan. In Naples, there was an immediate suspension of trade, and city gates were closed. Boats were left at anchor, or in the case of trade along the Tiber river, blocked by chains. Shipping in some countries was disrupted by quarantine measures, as was land trade.

[28] Sontag, *Op. cit.*: p. 50

[29] Rosenberg in *AIDS: The Burdens of History,* 1988: p.18

[30] Sontag, *Op. cit.*

dubbed 'Asiatic Cholera' by Europeans. Its spread was attributed to pilgrims who immersed in the Ganges River before returning to their homes.[31] In the USA, Irish and other immigrants were blamed for bringing cholera from Europe to the New World, particularly in New York.[32] Cholera, as a water-borne disease, became epidemic in areas with poor sanitation: typically, the poorer immigrant suburbs. These areas were overcrowded, and in the case of New York, were said to be the Irish slums or Irish 'red light districts'.[33]

In the USA, blame for the cholera epidemic was attributed to "the dirty, the gluttonous, and the poorly nourished alike"[34] and "to the imprudent, the intemperate and to those who injure themselves by taking improper medicines [drug-taking]."[35] In London, cholera similarly was held to be "the result of poor diet and indulgence in irregular habits."[36] Contagion was therefore a contradictory affliction, being held to be the outcome of both 'excess' and 'insufficiency'. Because disease appended to moral values of the day, drinkers of alcohol (especially the Irish), prostitutes, and drug users were blamed for the epidemic, along with the poor. As Rosenberg suggests, this categorisation enabled the 'moral' middle classes to distance themselves from the fear of contagion, and from the necessity of helping the

31 McNeill, *Plagues and Peoples,* 1976: pp 46 and 107

32 Fee and Fox in *AIDS: The Burdens of History,* 1988: p.6.

33 Musto, *Op. cit.:* p. 74

34 Rosenberg, *Op. cit.:* p. 18

35 Musto, *Op. cit.* Parenthesis has been added.

36 Sontag, *Op. cit.*: p. 55

afflicted. As with other epidemics, blame resulted in quarantine or compulsory evacuation, despite "repeated pronouncements that they were useless and bad for business."[37]

Investigation of the causes of cholera was hampered by the disease's erratic epidemiological patterns.[38] It was not until the 1880s that the 'contagion theory' superseded 'miasma theory' following the invention of the microscope and the discovery of bacteria, including the bacillus that caused cholera.[39] In any event, the bifurcation of public health responses along the lines of the 'miasma' or 'contagion' theories resulted not only in clear cut differences in terms of disease control in different contexts, but in different social outcomes. Foreigners and 'risk groups' were the focus of the contagionists' controls, while 'risk behaviours' (which nevertheless were considered endemic to risk groups) were identified by officials and doctors adhering to the more reputable 'miasma' theory.

By the time medical science had produced a vaccine against cholera, public health boards had become a permanent fixture for the control and prevention of epidemic disease. Cholera, therefore, "provided the major impetus to improvements in urban sanitation and public health regulation."[40] Indeed, cities such as London and New York did not have effective boards of health until

[37] Risse, *Op. cit.:* p. 45

[38] *Ibid.:* p.45

[39] McNeill, *Op. cit.:* p. 267

[40] *Ibid.:* p. 265

the outbreaks of cholera in 1848 and 1866 respectively.[41] Thus, the scene was set for public health bodies to develop a permanent executive function in the control of epidemic disease. In later epidemics, this function was undertaken with the cooperation and advice of epidemiologists and the medical profession.

## 2.3 Epidemics of the Twentieth Century (1)[42]

### *2.31 Influenza*

The influenza epidemic claimed more than half a million lives in Europe and the USA between 1918 and 1919.[43] About twenty percent of the population of countries such as the USA died from the effects of influenza. [44] Sontag writes that influenza "would seem more plague-like than any other epidemic in this century if loss of life were the main criterion."[45] The epidemic struck during World War I, and seemed to single out soldiers and other young, fit adults.[46]

[41] *Ibid.*: pp. 271 and 273

[42] In presenting studies about influenza and poliomyelitis, I draw on the work of two contemporary New Zealand writers: Geoffrey Rice, who wrote *Black November: The 1918 Influenza Epidemic in New Zealand,* and Jean Ross, who presented an MA thesis titled: "A History of Poliomyelitis in New Zealand". In each, I discuss the social and organisational aspects of epidemic history in New Zealand.

[43] Fox and Karp in *AIDS: The Burdens of History,* 1988: p. 188

[44] Vaughan, *Influenza - An Epidemiologic Study,* 1921: p. 165 Death rates varied widely throughout the world. There were wide variations between cities and countries, with India and Alaska being two areas with the highest death rates. India reportedly lost a total of 500,000 citizens in the influenza epidemic.

[45] Sontag, *Op. cit.*: p. 56

[46] Rice, *Op. cit.*: p. 4 Men and women were affected in equal numbers worldwide, with the exception of New Zealand. New Zealand men in their thirties were twice as

Influenza was also thought to be of foreign origin, as is evident from the name "Spanish Flu". However, perhaps because of the mass movement of troops and ships during World War I, speculation about the origin of the disease was more muted than, say, during the bubonic plague. Media and political interest during the epidemic were reported as focusing far more on war activities than on the origins of a pandemic.[47] Medical interest, however, was such that "seemingly every life institution in the [USA] had dropped what it was doing to turn to influenza, many of them to produce with blinding speed absolutely useless vaccines."[48] The convergence of epidemic and war meant that, in the USA at least, suspicion for the virulent outbreak of influenza could be directed toward the Germans. Crosby (1989) writes that the virulence of anti-German fanaticism in 1918 was such that Bayer, a German pharmaceutical company, was accused of poisoning its tablets with influenza germs.[49] The rhetoric of war was adopted by the medical and scientific establishment. Excerpts such as the following appeared in newspapers and scientific journals:

> the American people, who had furnished fifteen billions to fight the Hun, will readily see the wisdom of properly financing the fight against the enemy,

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likely to die as women in the same age group. Rural men were particularly susceptible, probably because they had not been exposed to disease to the same extent as city dwellers.

[47] Crosby, *America's Forgotten Pandemic,* 1989: p. 77

[48] *Ibid.*: p. 313 Parenthesis has been added

[49] *Ibid.*: p. 216. The USA Public Health Service was obliged to test Bayer's products and pronounce them 'germ free' in order to alleviate public suspicions.

> disease, which in two months killed many times as many Americans as the Germans destroyed in a year.[50]

The military metaphor for epidemic disease became entrenched in medical discourse. As the quote suggests, it was used to help garner resources rather than to stigmatise certain individuals, and is indicative of a period in which a 'war effort' was required to 'mount campaigns' against 'invaders' at home and abroad. In any case, it seems that the citizens of countries such as England and the USA were too preoccupied with war with the Germans to stigmatise the sick and dying within their own borders. The lack of social stigmatisation for 'flu sufferers may also relate to the types of people who came down with it. As noted on page thirty-four, the 'flu seemed to strike mainly soldiers and other fit young men, groups who historically have been immune from social stigmatisation. Another factor might be the lack of historical associations between 'flu and dirt or odour; ie: 'flu was culturally a 'clean' disease, from which all members of society (not just the outsiders) were considered at risk.[51]

## *2.32 Influenza: A New Zealand Case Study*

In New Zealand, the influenza epidemic has been called "New Zealand's worst recorded natural disaster."[52] When influenza struck in 1918, it was the first epidemic recorded by the

[50] *Ibid.*: p. 312. This excerpt appeared in a 1918 copy of *The American Journal of Public Health.*

[51] Lupton, personal communication: 1995

[52] Rice, *Op. cit:* p. 1

European settlers.[53] New Zealand was particularly hard hit by influenza compared to other countries, for although the death rate of 5.8 per thousand for Pakeha was modest by world standards, the Maori death rate was actually seven times higher. An estimated four percent of Maori died in the last two months of 1918, a fact most Pakeha were unaware of at the time.[54] As elsewhere, the epidemic in New Zealand mainly affected adults between the ages of 20-45. Death rates for men were particularly high.[55]

News of the epidemic was greeted with panic in New Zealand. However, calls for a quarantine to help repel 'the invader' from overseas were ignored by public health officials and the government. After the crew from the overseas ship 'Niagara' came down with 'flu and had to be hospitalised in Auckland, quarantine became a null issue. The disease spread rapidly from Auckland, affecting most of New Zealand within a few weeks of its arrival. The absence of quarantine measures angered most New Zealanders. Many blamed Prime Minister Massey who had returned on the Niagara after inspecting troops overseas, accusing him of pulling strings to avoid having to be quarantined himself.[56]

[53] Maori had suffered epidemic outbreaks of diseases such as measles, influenza and diphtheria when Europeans first visited New Zealand.

[54] Rice, *Op. cit.*. Maori death rates were seriously underestimated in the official figures. Rice's revised figures doubled the death rates for Maori which then became "one of the highest known rates anywhere in the world." (p. 3).

[55] Worst affected among European men were soldiers in army camps, farm workers and Southland miners.

The response of government and public health bodies to the epidemic was reported as being tardy and inadequate. A commission was set up afterwards to investigate complaints. It was concluded that the Health Department had been caught napping, and had been unprepared for the outbreak of disease. Apparently, "delay characterised all the Department's responses, despite alarming reports from overseas."[57] Other criticisms centred on 'non-recognition or disregard' of the implications of the disease, the "department's stubborn insistence on the rather academic distinction between 'simple' and 'virulent' influenza", a lack of sound judgement, and a "crippling lack of coordination."[58] While 'flu was made a notifiable disease in New Zealand, this step had been taken late in the epidemic, and in the opinion of the commissioners, was further evidence of the department's neglect.

New Zealanders had not submitted quietly to the inadequacies of their public health service or government during the epidemic. Rather, concerns about the way the influenza epidemic was handled prompted them to agitate for major changes which resulted in far-reaching public health reforms. Rice writes that a 'thoroughly workable' Health Act was passed in 1920 which provided

> a sound structure for future development. The 1920 Act was so well-

[56] Rice, *Op. cit.:* p. 4

[57] *Ibid.:* 180

[58] *Ibid.*

> drafted that it survived with only minor amendments until the 1956 Health Act, which itself still followed the general pattern of the 1920 Act. At the time it was widely recognised as a model piece of health legislation, 'said to be the best of its kind in the English language'.[59]

The Act also "marked a very significant change in government policy toward Maori health."[60]

On a local level, responses were vigorous. The epidemic 'prompted an astonishingly rapid mobilisation of resources' in communities already mobilised due to the war effort.[61] One shortlived but determined measure was to close schools, theatres, businesses and shops. Around the country "coastal shipping came to a complete standstill, causing shortages of essentials such as coal and flour in some places."[62] Some of the measures were extreme, as in the case of Te Araroa where "locals set up roadblocks guarded by men armed with shotguns to make sure nobody went out or came in."[63] For the most part, local measures were mounted by district health officers independent of the centralised Health Department whose officials continued to dither throughout the epidemic. In a local initiative, the district health officer in Christchurch "had met with the mayor, the town clerk and the local health inspector to order a

59 *Ibid.*: p. 187
60 *Ibid.*: p. 180
61 *Ibid.*: p. 2
62 *Ibid.*
63 *Ibid.*: p. 96

general cleanup and disinfection of the city."[64]

Isolation was not practical, except in the rural areas. Inhalation centres were set up in the urban areas, usually at railway stations or post offices. Here, "batches of twenty to thirty [people] stood in a small room for about ten minutes, breathing in the clouds of zinc sulphate."[65] By November, 3,500 people in Christchurch were being 'processed' daily, and officials were being congratulated for having "devised an inhalation system far superior to that of any other city in New Zealand".[66] Other measures included the disinfection of buildings and streets with fluids such as sheep dip, the supply of gargle to school children, and the strict enforcement of by-laws against spitting in public. Tobacco smoking became popular as a 'flu retardant, as did alcohol and all kinds of antiseptics. After hygiene became a major concern with district health officers, local sanitary inspectors were appointed in the cities and towns.

From the outlays of energy and expense afforded hygiene, fumigation and sanitation measures or guidelines, it is clear that the viral nature of the epidemic was little understood. An underlying assumption of the response to the epidemic appears to be that fumigation, disinfection of public places and street cleaning could prevent contagion. This flurry of activity also suggests an attempt to ward off anxiety by 'doing something', rather than waiting for disease to strike.

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64 *Ibid.:* p. 72

65 *Ibid.:* p. 73 Parenthesis has been added

66 *Ibid.*

Scapegoating did occur during New Zealand's epidemic. At first, blame was attributed to the crew of the ship that ostensibly had brought the epidemic to Auckland. Later, other groups became the subject of official concern or censure. These groups were primarily the slum dwellers of Auckland and Wellington, including an unfortunate group of foreigners - Bengali Indian immigrants whose members had died in disproportionate numbers. Much to-do was made about urban slum dwellers, who lived in "old, dilapidated, worm-eaten, vermin-infested and rotten buildings".[67] Legislation was passed for the demolition of slum dwellings, even though it was acknowledged that the occupants had nowhere else to live. Nevertheless, the outbreaks of influenza were attributed as much to environment as to people, and even the 'shirkers' - men who were deemed medically unfit for the army - were not singled out except (erroneously) as 'weaklings' deemed susceptible to disease.

Perhaps the most striking aspect of New Zealand's response to the epidemic is the silence surrounding the plight of Maori. The occasional newspaper reports about Maori suffering were "written by Pakeha, many of whom were ignorant of, and or/unfortunately, unsympathetic towards, Maori culture."[68] Despite the silence, discrimination against Maori was rife. Hairdressers in the North Island were known to refuse to cut the hair of Maori clients, and in Christchurch, "railway officials were

[67] *Ibid.:* p. 182

[68] *Ibid.:* p. 108

under the impression that no Maori were to be allowed on the trains without a permit, and therefore refused to stop for Maori at wayside halts."[69] Indication of a not-so-subtle racism surfaced in official statements about Maori living in 'filthy' conditions in 'slum shanties', 'slums' and 'hovels' and in the ban on ceremonies such as *tangi* [Maori funeral rites].[70] Often, the official response to Maori suffering during the epidemic was euphemistic, so that the 'poor' and 'unhygienic' referred to Maori rather than middle-class Pakeha. Nevertheless, for the most part, Maori suffering was ignored. Discrimination was thus couched in 'void' rather than 'voice'. Such neglect is indicative of the cultural displacement of Maori in post-colonial New Zealand, where discrimination was expressed in terms of the almost wholesale suppression of Maori culture and concerns.

Rice writes that a national amnesia developed after the epidemic as New Zealanders "tried to forget the epidemic, along with all the other horrors of the First World War."[71] Like Crosby, Rice calls the epidemic a 'forgotten disaster', for which scarcely any memorials or reminders remained. As much as the amnesia suggests that New Zealanders were anxious to put bad times behind them, it indicates that this short-lived epidemic had considerably less symbolic value for New Zealanders than a

[69] *Ibid.*: p. 118

[70] *Ibid.*: p. 182 a) *Tangi* were blamed for the spread of disease in earlier times, too. b) Rice states that there was little mention of Maori in the Epidemic Commission's report despite the known heavy mortality in North Island districts. Further, "not a single Maori appeared amongst the [Commission's] 100 witnesses." Parenthesis has been added

[71] *Ibid.*: p. 1

war fought for 'freedom', 'race', 'right' and other lofty ideals of the age.

In summary, there are features of the influenza epidemic that distinguish it from other epidemics such as leprosy, bubonic plague or cholera. For instance, the influenza epidemic was remarkably short-lived. Instead of panic, blame and harsh measures, the epidemic was characterised by neglect and apathy on the part of public health officials and politicians whose energies were directed toward the war effort. In the USA, influenza had not even been declared a notifiable disease.[72] Further, disease manifestations of the epidemic were not grotesque - for unlike lepers, the victims' limbs did not rot, nor did 'flu sufferers break out into black boils like the victims of plague, or even die like cholera's 'blue-black wizened caricatures'.[73] Rather, victims died quickly from pneumonic complications of an 'ordinary' disease.[74] The similarities to other epidemics are evident only in the numbers of people affected, in the suddenness and virulence of outbreaks, in the mysterious abatement of the epidemic, and in the absence of a cure. Finally, there appears to have been no plague legacy left by the epidemic, except that of the military metaphor, nor, in countries such as the USA, was there the robust development of public health bodies that had characterised previous epidemics.

[72] *Ibid.*: p. 238.

[73] Sontag, *Op. cit.*: p. 39

[74] Rice, *Op. cit.*: p. 7 Victims of influenza did turn black after death, giving rise to fears of plague.

Instead, it seems that the influenza epidemic was an epidemic in fact only - its meanings, social discourse, unique manifestations and history having been buried along with its dead.

## 2.4 Epidemics of the Twentieth Century (2)

### *2.41 Poliomyelitis*

In its mildest forms, poliomyelitis mimicked the symptoms of influenza. Polio became known as infantile paralysis because of its prevalence among children.[75] Temporary or permanent paralysis marked more severe cases, and deaths were common. The epidemic years ebbed and waned from 1907 until the 1950s when the Salk and Sabin vaccines were distributed world-wide. The legacy of the polio years was visual as well as physical, and even now, one can see survivors in callipers or 'irons'.

Outbreaks of poliomyelitis were rare before the twentieth century. Risse writes that

> human actions contributed decisively to the creation of a favorable ecological setting for poliomyelitis. Ironically, the culprits were improved public sanitation and personal hygiene, slowly achieved after decades of cholera and typhoid fever. Such relative cleanliness presumably reduced the transmission of wild and ubiquitous polioviruses that had hitherto routinely infected most infants and young children without producing paralytic complications.[76]

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[75] Ross, *Op. cit:* p. 2 Adults were also affected, suffering paralysis more often than children.

The first of the world-wide epidemics occurred in the summer of 1916.[77] In the USA, health measures were comprehensive, speedy, and sometimes harsh. Health stations were set up in New York suburbs where the disease was first notified, and house-to-house searches were mounted to find sick children. Once discovered, "many children were promptly and forcibly removed from their parents."[78] Most measures were borne by immigrant and working-class families, believed to be the harbingers of disease.[79] All affected families were placed in isolation, and their premises marked with a yellow sign.[80] A vigorous street-cleaning campaign was undertaken in New York, and pamphlets were distributed to warn citizens against congregating in public places. Stray animals were collected and killed after flies had been erroneously identified as vectors. Travel in and out of New York City without a health certificate was banned, and children under sixteen were barred from movie theatres. Local health boards throughout the USA were granted "extraordinary quarantine powers."[81] These powers have been variously described as 'dramatic' and 'draconian'.[82]

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[76] Risse, *Op. cit.*: p. 48 Similar to the influenza epidemic, where the issue was resistance, or lack of resistance, to a particular strain of the virus.

[77] Poliomyelitis was known as the 'summer disease'

[78] Risse, *Op. cit.*: p. 50

[79] Fee and Fox *Op. cit.* p. 6 Italian immigrants were accused of bringing poliomyelitis into New York.

[80] Risse *Op. cit.* This marking of doors also took place during the bubonic plague.

[81] Rogers, *Dirt and Disease,* 1992: p. 5

[82] Ross, *Op. cit.*: p. 10

Rogers writes that the poliomyelitis epidemic of 1916 was called the 'epidemic of filth'. It was held that unsanitary conditions caused the disease, and public health measures of the day reflected this belief. In the USA, the prompt measures were facilitated by state government competency, a notifications register, and prior experience of the disease.[83] Preoccupation with war was not a factor in impeding the response, although it diverted attention from the epidemic's entry into the USA. Civil disobedience was common during the period of quarantine. Several thousand violations of New York's sanitary code were reported in the first months of the epidemic, immigrants and working-class families hid from authorities, fleeing middle-class families circumvented road blocks, and in one case, "irate fathers interrupted a town council on August 26 demanding the return of their children who had been removed to isolation hospitals."[84] In the wake of the epidemic it was admitted that while public health measures were forceful "none of the approaches was entirely successful."[85]

Outbreaks of the disease after 1916 were common and increasingly virulent.[86] Beliefs in environmental factors as causative agents began to lose ground in the 1920s. This shift was facilitated by scientific acceptance of the germ theory, and by the knowledge that 'sanitary', middle-class children were

[83] Risse, *Op. cit.*: p. 49 New Yorkers had experienced outbreaks of poliomyelitis in 1907 and 1910.

[84] *Ibid.*: p. 55

[85] *Ibid.*

[86] Rogers, *Op. cit.*: p. 165

more prone to infection than those from poor or immigrant families. Personal hygiene was still emphasised in public health campaigns, and patients continued to be isolated for lengthy periods of time. By the 1940s, victims of the epidemic were being afforded public sympathy rather than vilification. In the USA, the newly established National Foundation for Infant Paralysis "helped solidify the newly respectable image of the disease."[87] Poliomyelitis became the 'epidemic of innocents', in which "the spectacle of a brave but paralyzed little child, boldly attempting his [*sic*] first steps with steel braces attached to his [*sic*] legs was well-nigh irresistible."[88] In its mildest forms, the disease mimicked the symptoms of influenza. Poliomyelitis is the first epidemic in which harsh measures and blame gave way to fund-raising, sympathy, and the rehabilitation of its victims.[89]

## *2.42 Poliomyelitis: A New Zealand Case Study*

Over ten thousand New Zealanders were infected with poliomyelitis in the summer of 1916. Most suffered paralysis, and 123 people died.[90] Environmental factors such as hot weather, contaminated milk or poor drainage were blamed for the epidemic. Ross writes that "unlike the United States, the health

[87] *Ibid.*: p. 168 Poliomyelitis became respectable after it was known that middle class children were more susceptible to the disease

[88] *Ibid.*: p. 173 Parenthesis has been added

[89] In the USA, the transformation was facilitated by polio survivors such as Franklin D. Roosevelt.

[90] Ross, *Op. cit.*: p. 12

authorities here accepted from the beginning that the disease knew no social boundaries."[91] The public was less circumspect, however. Germans were singled out for suspicion, as were the children themselves.[92]

Public health responses emulated those of the USA. They included isolation at home or hospital, sanitation, and disinfection of homes and clothing. According to Ross, the measures were 'totally ineffective'. Methods for controlling outbreaks of poliomyelitis were formalised during New Zealand's second and worst epidemic in 1924. Wide-ranging powers granted District Medical Officers under Section 76 of the 1920 Health Act were invoked.[93] A nationwide quarantine was imposed on infected individuals and their families, schools were closed, and individuals were barred from public recreation and from travel between the North and South Island.[94] Businesses remained open. The only employees barred from employment were teachers or food-industry workers whose own children were infected.[95]

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[91] *Ibid.*: p. 75 Ross writes that the rate of infection was approximately the same for Maori and European (p.34). More infections occurred in rural than city areas (9:1,000 compared to 1:1,000).

[92] *Ibid.*. The writer did not elaborate on this point.

[93] Section 76 of the 1920 Health Act had been passed after the uproar over inadequate government responses to the 1918 Influenza epidemic

[94] Ross, *Op. cit.*: p. 20 Section 76 allowed District Medical Officers (DMOs) to take special steps such as quarantine and school closure to prevent the outbreak or spread of infectious disease.

[95] Exceptions were allowed on the misunderstanding that only children became infected with poliomyelitis. However, a desire not to disrupt the economy might have been a factor.

Most New Zealanders submitted to the demands of quarantine during the 1924 epidemic. However,

> while there seemed to be general acceptance for the principle of quarantine, there was considerable correspondence in the newspapers, and to the Health Department on its application. Initially, there was little concern expressed about the restrictions on schooling, but many asked for exemptions for their children to attend race meetings, picnics and picture theatres.[96]

The demands of quarantine created economic hardship for many families. Wage-earners lost income when they were quarantined together with their infected children. Some also lost their jobs, and could not find reemployment. Parents nursing children at home, or looking after school-age children during periods of school closure, complained of exhaustion. During the 1947-8 epidemic, "a very tired, worn-out mother expressed the feelings of many parents when she wrote to the Minister of Health, pleading that schools be re-opened for those who wanted to send their children."[97] School-age children kept at home were "roaming around [the Square, beach, streets] scarcely knowing what to do with themselves."[98] Maori were fined for holding *tangi*, and fines were meted out to parents whose children were found in movie theatres or the races. The 'massive quarantine effort' of 1924 was not repeated, and succeeding epidemics saw widespread, voluntary restrictions instead.[99] By the fifth

[96] Ross, *Op. cit.*: p. 23

[97] *Ibid.*: p. 50

[98] *Ibid.*: pp. 23-4 Parenthesis has been added

[99] *Ibid.*: p. 36

poliomyelitis outbreak in 1952, quarantine measures were imposed only on infected families and their contacts. A nationwide handwashing campaign was substituted for more restrictive measures during this outbreak.[100]

Children affected with poliomyelitis were often stigmatised. Ross writes that

> epidemic diseases that affect the whole community are more frightening than diseases like tuberculosis. An epidemic disease that kills its victims leaves a population to mourn its dead and then gradually to forget. But the community could not forget its polio victims. Most did not die: they lived, their wasted limbs, their callipers and their crutches a constant reminder of the fate which could befall anyone. In a society where the rights of the handicapped were non-existent, where the disabled were seen as a source of guilt and shame, death was even seen as a preferred outcome to being condemned to a lifetime of 'crippledom'.[101]

Children affected by poliomyelitis in New Zealand's earlier epidemics were a source of shame, and kept hidden from sight. Ross writes that families of infected children were treated like lepers.[102] The stigma attached to poliomyelitis did not begin to wane until the 1930s. Even so, hostility so marked the establishment of the Crippled Children's Society (CCS) in 1935 that people "walked out of public meetings and the organisers

100 *Ibid.*: p. 75

101 *Ibid.*: p. 77

102 *Ibid.*: p. 50

received abusive telephone calls."[103] By the 1940s, however, contributions to the rehabilitation of survivors were being made by organisations such as the Girl Guides and the New Zealand Swimming Association. Large donations to the CCS had been received from benefactors and members of the business community.

Suspicion had also marred relations between Protestant and Catholic, and between Pakeha and Maori during the poliomyelitis outbreaks of the 1924 and 1937. The Ratana Pa was closed on several occasions after concern was expressed about its 'sanitary conditions'.[104] Public dismay had been aired in the newspapers about Catholics who sent children to church and Sunday school during quarantine. [105]

The last poliomyelitis outbreak in New Zealand occurred in 1962. Poliomyelitis was never 'cured', but was made preventable after the discovery of the Salk and Sabin vaccines in the USA in the 1950s. By 1963, most New Zealanders (adult and child) had been vaccinated. Public acceptance of the vaccination programme was exceptional by world standards, and no cases of poliomyelitis have been recorded since 1963.[106] The efficacy of the campaign had the paradoxical effect of reducing public

103 *Ibid.*: p. 31

104 *Ibid.*: p. 23 Despite the rhetoric about poliomyelitis 'knowing no social boundaries', health officials looked askance at Maori living conditions (p. 34)

105 *Ibid.*: p. 22

106 Ross, *Op. cit.*: pp. 68 and 76 Vaccination is not compulsory in New Zealand. 90% of New Zealand parents agreed to have their children vaccinated in 1956 compared to 29% in England, 42% in Scotland, and 74% in NSW (p. 63)

participation in vaccination programmes, so that only about 70% of New Zealand's children are now vaccinated against poliomyelitis and other infectious diseases. In the post-polio period, survivors are often visible reminders of the 'children's epidemic', but its history and effects are being forgotten. Ross dubs this phenomenon "rapid collective amnesia".[107]

## 2.5 Five Plagues: Themes and Outcomes

Just as there are key differences in the manifestation and course of various the epidemics and in responses to them, there are themes common to all epidemics. For example, fear, xenophobia, scapegoating and ostracism have occurred throughout epidemic history. These themes form a basis for understanding the nature of responses to epidemic disease, and, in the context of this thesis, serve as historical markers for evaluating the response to AIDS. As remarked by Fee, events of the past have 'inescapable significance' for the present response to AIDS, particularly since "social, cultural, and moral values [are] embedded in the biomedical and epidemiological theories of disease itself."[108] They are also embedded in moral and theological bias.

The 'five plagues' were chosen for the insights they offer on the iconography of AIDS and for their value in explicating twentieth century responses to public health crises in New Zealand. Leprosy was associated with sexual transgression. Its

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[107] *Ibid.*: p. 76

[108] Fee, *Op. cit.*: p. 5 Parenthesis has been added

symptomology and discourse reappeared in the syphilis epidemic, which in turn, provided much of the discourse that served to shape understandings about HIV/AIDS (see Chapter 3). The bubonic plague and cholera were notable for xenophobia and the creation of 'risk groups', two common themes in the HIV/AIDS epidemic (see Chapter 4). The twentieth century epidemics, influenza and poliomyelitis, provide a useful contrast to discourse about the leprosy, bubonic plague and cholera epidemics because of the absence of iconography about 'risk groups' as vectors of disease.

A degree of xenophobia has characterised all epidemics since the bubonic plague. Suspicion of foreigners and outsiders has been evident in both the formal and informal responses to catastrophic disease. This suspicion resulted in the reification of xenophobia and justification for punitive controls on ethnic groups such as Jews (bubonic plague), West Indians (yellow fever), Africans (syphilis), the Irish (cholera) and Italians (poliomyelitis) in the USA. Most epidemics in the West have also had a foreign appellation. Names such as the 'Oriental Plague', 'Asiatic Cholera', 'Spanish Influenza' were common currency even when diseases were found to be endemic. Sontag writes that such eurocentric assumptions "reinforce the association of illness with the foreign: with an exotic, often primitive place."[109] The notion of foreignness has been used to justify extreme measures such as imprisonment, banishment and death.

The notion of 'risk groups' has surfaced in each epidemic.

[109] Sontag, *Op. cit.*: p. 51

Individuals from risk groups commonly are social outcasts such as immigrants and the poor. They are the creation of particular social or cultural systems whose norms reify caste or class differences. The presence of the risk group serves as a moral pointer for the powerful, underwriting or promoting their behavioural codes. In the leprosy epidemic, religious leaders benefitted from the focus on evil-doing, while in later epidemics such as the plague and cholera, class interests were served by identifying individuals who did not conform to racial or social norms. However, in a modern epidemic such as poliomyelitis, stigma was not appended to the usual 'risk groups' because it was not a disease of marginal people, but more commonly an affliction of middle class children.

Fear, evil, and banishment were intertwined in pre-twentieth century epidemic history. Hirst wrote that a fear of contagion and its association with evil meant that disease-bearers were isolated in biblical times, and that isolating victims of 'the evil eye' continued until modern times. The social outcomes for sufferers were therefore predicated on notions of evil-doing, either in acts committed or through the possession of evil spirits. Sufferers were excluded from meaningful social contact, or segregated in special areas outside city walls.[110] In the syphilis epidemic, as will be seen in Chapter 3, women syphilitics were deemed 'witches', and were burned at the stake.

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[110] Individuals with other ailments were ostracised, but were not subject to mass quarantine as were lepers and plague victims.

By the nineteenth century, blame had emerged as a major epidemic theme. Pre-Enlightenment notions of disease as divine retribution were being supplanted by a bourgeois ideology advocating individual responsibility for health and wellbeing.[111] Ancient notions about sin now co-existed with more 'rational' ideas about environmental co-factors of disease such as poor hygiene, apropos the 'germ theory'.[112] The convergence of old and new ideologies meant that divine retribution for disease was no longer seen to be mysterious or arbitrary, but meaningful in terms of its locus. Blame could be appended to individuals who abrogated health codes or social norms, particularly those who seemed unable or unwilling to exercise the new moral code. Categories of 'risk behaviours' were added to the 'risk groups' of ancient plagues, so that those who transgressed the moral lexicon of do's and don't's found themselves to be the new social outcasts of disease. Due to the Temperance movement, for example, imbibers of alcohol were singled out for censure, and composed a sizable number of the 'intemperates' classified for hospital admission during the cholera epidemic.[113] Notions of responsibility had the effect of reinforcing social norms, if only because fear of disease prompted compliance by the panic-stricken. Susan Sontag writes that, by the end of the nineteenth

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[111] Foucault in Volume One of *The History of Sexuality* (1978) wrote that eighteenth century bourgeoisie developed behavioural codes as a means of promoting the "vigor, longevity, progeniture and descent of the classes that 'ruled'" (p.123).

[112] Sontag, *Op. cit.*: p. 55

[113] Risse, *Op. cit.*: pp. 45-46 Coincidentally, most of the drinkers so classified were Irish. Risse cites the following: "Cholera victims were perceived to include 'the poorest class of Irish, many of them have for years (as they have themselves confessed) been almost daily intoxicated.'"

century, categories of blame had multiplied to the extent that

> interpreting any catastrophic epidemic as a sign of moral laxity or political decline was as common . . . as was associating dreaded diseases with foreignness. (Or despised and feared minorities).[114]

Twentieth-century diseases such as poliomyelitis and influenza did not became epidemics of the 'other' in terms of the extremes of blame directed towards certain types of people within, say, the USA, even though some groups, such as Native American Indians (influenza) and children (poliomyelitis) proved more susceptible to the disease than others.[115] Blame that existed was either muted or dissipated once medical science exposed the absurdities of scapegoating, say, army 'shirkers' during the influenza epidemic, and the 'unsanitary poor' during the poliomyelitis epidemic. Nevertheless, blame that existed followed predictable social and political patterns. Sontag argues that the relative lack of blame directed toward marginalised groups in the influenza and poliomyelitis epidemics is related to the fact that victims were held to be 'innocent': ie, soldiers ('the nation's best') or children. She argues that twentieth-century scapegoating is directed toward the victims of sexual disease whose actions are regarded as voluntary, self-indulgent, immoral and avoidable. These issues are revisited in Chapter 4.

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[114] Sontag, *Op. cit.:* p 54.

[115] Vaughan, *Op. cit.*: p.189 However, Maori experienced discrimination in New Zealand during the influenza epidemic (see case study, and overleaf).

As industrial nations democratised, extreme measures of disease prevention in the form of controls such as quarantine, forcible treatment, isolation, and fumigation fell into disrepute, and public 'voice' emerged to question such procedures and to plead justice for victims of epidemic disease.[116] Quarantine, as a prevention measure, had already declined in importance before the twentieth century. Thus, the more modern epidemics such as cholera saw quarantine being used mainly for goods and ships rather than to restrict the movements of individuals. Leprosaria, which had been so common in the middle-ages, had all but disappeared by the twentieth century. Measures for control and prevention of epidemics in the twentieth century soon evolved toward wide-spread, humanitarian controls such as mass education campaigns.

Responses to the poliomyelitis epidemic in New Zealand began with restrictions such as nationwide quarantine, and ended with public education campaigns. This shift followed overseas trends from physical to social methods of disease control. Medical advances helped promote this shift, especially when evidence was produced about the inefficacy of quarantine. Public activism was a factor in changing public health policy in New Zealand. Harsher measures had been tolerated until 1947 when "the general public too had become less tolerant of draconian regulations, and was much more assertive in its demands for different and better treatments."[117] Limited quarantine was in

[116] In a recent New Zealand example of public resistance to 'old' public health traditions, two individuals with tuberculosis were brought before the courts for refusing treatment for their disease.

effect until the last of the poliomyelitis epidemics in 1962.

New Zealand responses were marked by vigorous local strategies (fumigation, disinfection, travel restrictions) in the case of influenza, and full-scale national strategies (quarantine, isolation, school closures, bans on public recreation) in the case of poliomyelitis. The 1920 Health Act had provided the basis for public health measures during the poliomyelitis epidemics. Contextual factors such as political and racial homogeneity, informality and a small population enhanced the efficacy of local measures in New Zealand's influenza epidemic, and national measures during the poliomyelitis outbreaks. Collaboration between health officers, teachers, employers, the media and parents which marked the later poliomyelitis outbreaks set a precedent for dealing with HIV/AIDS.[118]

In New Zealand, fear and blame marked the history of both the influenza and poliomyelitis epidemics, giving rise to discrimination against 'disease-bearers'. Blame during the influenza epidemic was directed to social outcasts and ethnic groups (Maori, Bengalis), primarily because of popular beliefs about the role of dirt in the spread of disease. The stigma appended to children in New Zealand's poliomyelitis epidemics arose both from fear of contagion, and from the unprecedented sight of child disfigurement.[119]

[117] Ross *Op. cit.*: p. 51

[118] *Ibid.*

[119] *Ibid.*: p. 31

It is evident that all responses, whether epidemiologic, medical, governmental or social, are shaped by ideologies that create outcasts in the name of disease. This realisation prompted one physician to declare after the polio epidemic that "we have learned little that is new about the disease, but much that is old about ourselves." [120] Despite shifts in ideology, epidemics throughout history invariably have been characterised by fear, scapegoating and moral conservatism, all of which leads to the suspicion that notions about 'evil spirits' and sin still lurk behind the responses to much catastrophic disease. Such phenomena have given rise to the panoply of ideological prototypes which shaped responses to later epidemics. The material in this chapter has been presented in an attempt to illustrate how these prototypes have provided a backdrop to social and organisational responses to HIV/AIDS, and how we are once again learning 'much that is old' about responses to epidemic disease. In the following chapter, the distinction between responses to 'non-sexual' (contagious) epidemics like influenza and poliomyelitis, and 'sexual' epidemics (leprosy, syphilis, HIV/AIDS) is further clarified in a discussion about the syphilitic 'Eve'.

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[120] Tilney in Risse, *Op. cit.:* p. 55

# CHAPTER THREE

## SYPHILIS: THE REPRODUCTION OF EVE IN A 'SEXUAL' EPIDEMIC

## 3.1 Introduction

> *The history of venereal disease until the nineteenth century often reads like the history of one disease - syphilis.*
>
> *(Kehoe, 1988)*[1]

Described as 'the terror of the masses', the syphilis epidemic[2] probably most resembles AIDS in its manifestations, meanings and outcomes. The syphilis epidemic was different from other epidemics such as cholera, bubonic plague, yellow fever and influenza, but it was a clear precursor to AIDS - particularly in its discourse. The ideology surrounding syphilis centred on the control of disease and sexuality as a moral project. This focus led writers such as Quetel to state that syphilis was, like AIDS, "a social and cultural phenomenon extending far beyond the domain of health alone."[3] Brandt argues that perceptions of syphilis were not only shaped by moral debates more so than were other epidemics, but that the debates have now also shaped the way AIDS is being perceived and managed.[4] According to

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[1] Kehoe, "AIDS: Social and Historical Context", *Coping with AIDS, Lifestyles and the Social Order* (symposium), 1988. On p.8, Kehoe says "the history of venereal disease until the nineteenth century often reads like one disease, syphilis. This is probably due to the fact that it was generally believed that gonorrhea and syphilis were manifestations of the same disease." The terms 'syphilis' and 'leprosy' were also used interchangeably early in the syphilis epidemic.

[2] McNeill, *Plagues and Peoples,* 1976: p. 267. Syphilis was first reported in Europe (France and Italy) in the latter half of the 15th century and lasted in epidemic form until the twentieth century (pp 193 & 252).

[3] Quetel, *History of Syphilis:* 1990: p. 4

Brandt, 'syphilophobia' has apparently given way to 'AIDS-phobia', fueling the old debates about morality and sexually transmitted disease which had virtually lapsed after the discovery of antibiotics in 1943.

In this chapter, I discuss the history of the syphilis epidemic, its course and discourse, as a means of providing insights into old ways of conceptualising and managing a sexual epidemic. By 'syphilis epidemic', I refer to the sexually transmitted disease that apparently first appeared in Europe in 1494 (and worldwide since then) to produce a specific set of symptoms, most obvious of which were leprous-like skin lesions. I highlight those features of the epidemic most likely to be associated with AIDS. These features include the identification of 'risk groups', the naming of disease according to a foreign invader theme, the public health measures adopted for the management of syphilis, and a discussion of the moral panics surrounding both sexuality and sexually transmitted disease. Finally, I explore New Zealand's syphilis epidemic as a case study of this country's responses to sexually transmitted disease. In the study, I highlight the ways in which local methods for dealing with the syphilis epidemic might have set the scene for how medical, government and community organisations have responded to HIV/AIDS. In this chapter, I have focused specifically on syphilis rather than on the broader history of venereal diseases. On the one hand, sexually transmitted disease was ill defined and

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[4] Brandt, *No Magic Bullet*, 1985

understood before the twentieth century, but on the other hand, as Kehoe states, most venereal diseases were labelled 'syphilis' until, and including, the nineteenth century.[5]

## 3.2 Overview

Syphilis became widespread in Europe during the sixteenth century. It has been described as the third great plague after leprosy and the bubonic plague.[6] As with other epidemics, there is some dispute as to its source. Stokes maintained that syphilis was brought back from Haiti to Europe by Columbus in the fifteenth century[7], while Quetel states that the disease first appeared in France.[8] A common belief was that the disease was spread by Columbus' crew who were infected by native women in the Americas.[9] From the outset, syphilis was variously called 'the barbarian poison', 'mal de Naples', 'gallico morbo' (French Sickness), and 'Spanish pox'; its status as a foreign disease was inscribed in public consciousness, enabling

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[5] Kehoe, *Op. cit.*

[6] Stokes, *The Third Great Plague,* 1917: p. 11

[7] *Ibid.*

[8] Quetel, *Op. cit.*

[9] McNeill, *Op. cit.:* pp. 193-4 McNeill writes that "some competent experts continue to believe that syphilis came to Europe from America. . . The timing of the first outbreak of syphilis in Europe and the place where it occurred certainly seems to fit what one would expect if the disease had been imported from American by Columbus' returning sailors. This theory, once it had been promulgated in 1539, became almost universally accepted among Europe's learned until very recently, when the inability to distinguish between the spirochete causing yaws [leprosy] and that of syphilis in laboratory tests led a school of medical historians to reject the Colombian theory entirely." Parenthesis has been added

sufferers from other countries or places to acquire victim status or attribute blame. In Europe, syphilis' foreign tag continued through the centuries, so that immigrants to the USA, and foreign prostitutes, were believed to be the source of disease. By the twentieth century, says Brandt, syphilis and other venereal disease "had become, pre-eminently, a disease of the 'other', be it the other race, the other class, the other ethnic group." [10] Gilman describes the finger-pointing that occurred during the epidemic as "an obsession with discovering the origin of disease rather than the means of controlling it."[11]

Stokes described syphilis as a "blasting epidemic, which in the sixteenth and seventeenth centuries devastated Spain, Italy, France, and England, and spread into India, Asia, China and Japan" and made the claim that "there probably does not exist a single race or people upon whom syphilis has not set its mark."[12] Unlike other epidemics such as influenza and the bubonic plague, syphilis did not wax and wane in cyclical form. Syphilis remained fully epidemic until the discovery of antibiotics. By the nineteenth century, it was so widespread that one French writer stated "SYPHILIS. Everyone has it, more or less."[13]

In its early days, syphilis was confused with leprosy, because both diseases were chronic, 'carnal' and disfiguring. This

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[10] Brandt, *No Magic Bullet,* 1985: p. 23

[11] Gilman in Crimp, *Cultural Analysis, Cultural Activism,* 1988: p. 92

[12] Stokes, *Op. cit.:* p. 11

[13] As quoted in Sontag, *AIDS and its Metaphors,* 1989.: p. 22

meant that syphilitics were also called lepers and pox-bearers, a practice that continued at least until Shakespearean times in the sixteenth century. Although syphilis was deemed a venereal epidemic, 'blasphemers' and 'heretics' came in for particular censure during the early years of the epidemic. Rosebury explained that

> before the Reformation blasphemy and heresy were much more serious crimes than sexual transgression; blasphemy threatened the very power of the Church, and it was an open secret that the popes themselves could not resist the lure of the flesh.[14]

With the rise of Puritanism, blame for the epidemic shifted to individuals engaging in 'improper' sexual activity. Notions of sin and race were mixed with new ideas about sexuality, and a 'sexual science' evolved which "promised to eliminate defective [syphilitic] individuals, degenerate and bastardised populations."[15] Quetel writes that the incidence of syphilis was one reason that "the institution of marriage and the preservation of one's line became the stakes in an immense moral crusade which was to develop throughout Europe."[16] This crusade resulted in a code of sexuality which Foucault dubbed 'a programme of eugenics'. It exhorted individuals to restrict sexual activity for the sake of racial and personal health. The

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[14] Rosebury, *Microbes and Morals,* 1971: p. 168

[15] Foucault, *The History of Sexuality,* 1978: p. 54 Parenthesis has been added

[16] Quetel, *Op. cit.:* p. 6

theme of racial fitness continued well into the twentieth century, as is evident from World War One posters which link sexual health to fighting ability.[17]

## 3.3 Locus of Blame: Women as Risk Group[18]

A major theme of the syphilis epidemic was that of woman as vector of disease. Although both men and women were originally portrayed as victims in syphilis iconography, Gilman states that the (heterosexual) male "is portrayed as the primary victim of the disease, not as its harbinger."[19] Biblical notions of Eve and temptation are evident in early records of the epidemic, with 'leprous [syphilitic] woman' an epithet for 'carnal' woman by whom man is invariably tempted, then infected.[20] Gilman writes that by the eighteenth century, the 'innately corrupt female' had become 'corrupting female' in iconographic

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[17] Brandt, *Op. cit.:* p. 164 (particularly plates 16 and 18.) One poster bluntly states that "You can't beat the Axis if you get VD."

[18] In her essay "AIDS: Keywords" *(Cultural Analysis, Cultural Activism,* 1988*)*, Jan Grover writes that "the concept of *risk group* is an epidemiological one; its function is to isolate identifiable characteristics that are predictive of where a disease or condition is likely to appear so as to contain and prevent it." She points out that "the epidemiological category of *risk group* has been used to stereotype and stigmatize people already seen as outside the moral and economic parameters of 'the general population'." (p.27)

[19] Gilman, *Op. cit.:* p. 95

[20] Rosebury, *Op. cit..* Rosebury's book reproduces a tract written in 1754 repeatedly warning men of 'meddling' with harlots and 'leprous [syphilitic] women'. An excerpt from plates opposite p. 53 states "That a certain Countess ill of the Leprosy came to Montpelier, and was left under his Care; and that a certain Bachelor of Physic waited on her, lay with her and got her with Child, and became perfectly leprous." (Figure 2) Parenthesis has been added.

representations of syphilis, so that all victims of the disease were portrayed as being male, and all perpetrators, female. Feminised and/or 'hypersexual' men (fops, dandies) were also portrayed as vectors of STD during the syphilis epidemic. This iconography sets a frame of reference for the forthcoming discussion about gay men as HIV vectors.

The focus on women partly results from the often symptomless nature of syphilis in women in its early stages which 'fools' its male victims (the disease was often more visible in men). However, an underlying misogyny appears to characterise the framing of woman as vector since most of the literature on the topic depicts women as deceptive, opportunistic and corrupt. Sympathy was not directed toward women unless monogamously married. The blanket of silence surrounding the 'source' of syphilis for married women (their husbands) was maintained even by sympathetic medical practitioners because "it was in the interests of the social order."[21]

The theme of corrupt female was particularly apposite for the prostitute. Men were exhorted to "avoid the greatest dangers, beginning with prostitutes".[22] Prostitutes were given a raft of insulting names such as 'wench', 'harlot, 'rogue', 'streetwalker', 'street whore' and 'soldiers' whore', and were duly despised for their ability to infect men. The reverse was apparently never contemplated. Street-walkers were "the very dregs of

[21] Brandt, *Op. cit.:* p. 18

[22] Quetel, *Op cit.:* p. 66

prostitution, the source of the worst of syphilis", while professional and 'casual' prostitutes were held to have "wrecked havoc. . . doling out pox after pox to young men out for a binge."[23] Prostitutes were held to be a race apart, and regulation was mooted to ensure "that they remain in the marginal position appropriate to them."[24] Estimates put the rate of infection among prostitutes at seventy to eighty-five percent, and beliefs that all such women would become infectious in the course of their working lives were not uncommon among medical professionals. Such estimates signal the degree to which prostitution and disease had become 'cause' and 'effect' in epidemiologic mythology.

By the nineteenth century, concerns in England about links between syphilis and prostitution were so widespread that the Contagious Diseases Act was passed in 1864. Porter and Porter write that framers of the Act

> attempted to counter venereal disease by enforcing the compulsory medical inspection of streetwalkers in specified garrison towns and ports. Women suspected of common prostitution could be taken into police custody, subjected to medical examination, and if found venereally infected, detained during the course of treatment.[25]

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[23] *Ibid.:* p. 227

[24] Corbin in Quetel, *Ibid.:* p. 212

[25] Porter and Porter, *AIDS; The Burdens of History:* 1988: p. 106

Quarantine of prostitutes continued well into the twentieth century. During World War I, Sontag states that "some thirty thousand American women, prostitutes and women suspected of being prostitutes [were] incarcerated in detention camps surrounded by barbed wire for the avowed purpose of controlling syphilis among army recruits."[26] Sontag alleges that, contrary to expectation, the incarceration of women caused no drop in the military's rate of syphilis.

Images of disease, gender and sexuality had converged during the syphilis epidemic to produce an ideology of risk that focused on the sexual activity of women. Control of female sexuality was the overarching preoccupation, and women were deemed either 'good' (chaste) or 'bad' (promiscuous). Within this sexual paradigm, the married, syphilitic woman was portrayed as a victim along with her syphilitic husband (invariably infected by the corrupt woman, either seductress or prostitute). Images of the 'evil' diseased woman and the 'good woman' were again juxtapositioned in the sexual ideology of World War I. Posters of that time depict "pick-ups, good time girls, prostitutes" and even "clean-cut, all-American girls" as vectors of disease.[27] The all-American girl was portrayed as safe only when she was married, a mother, or the faithful girlfriend of an absent soldier. No such distinctions were made about men, nor were syphilitic men incarcerated. As much as this imbalance illustrates the double standards of the times, it is also indicative of the

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[26] Sontag, *Op. cit.:* p. 81 Parenthesis has been added

[27] Brandt, *Op. cit.:* figures 14, 18, 19, 20.

persistence of ancient notions about evil as embodied in women, particularly those who operated outside moral sanction. Images of Eve, temptation and divine punishment underwrote patriarchal notions of woman's sexuality as a male possession, producing an ideology of anti-desire and disease, for which syphilis became both anchor and marker in terms of its symbolic significance.

## 3.4 Measures, Medics and Medicaments

Isolation of syphilitics was a common response from the start of the epidemic, causing one victim to complain that "my very dear friends turned their backs on me as if some pursuing enemy had his sword at their throats, without giving a single thought to the obligation of human fellowship and friendship."[28] Quetel writes that physicians, too, were reputed to ignore their patients, although not their pockets, as they vied with charlatans for the sale of remedies and potions.

As in other epidemics, quarantine was used as an extreme measure of disease control, although only for women deemed promiscuous or prostitute. Early responses included the rash of witch trials that occurred after the sixteenth century, which Andreski states were directly related to the rapidly increasing numbers of women syphilitics.[29] In medieval European towns, public baths were often closed as a precautionary measure.[30] In

[28] *Ibid.:* p. 17

[29] Andreski, *Syphilis, Celibacy and Witch Hunts,* 1989: p. 77

[30] *Ibid.:* p. 42

Scotland, in 1497, demands were made that "all light women desist from their vice and sin of venery. . . on pain, else, of being branded with a hot iron on their cheek and banished from the town."[31] Later responses to the epidemic appear to have been more systematic, if not less emotive. Quetel mentions a "flood of regulatory measures that engulfed Europe in the first half of the nineteenth century."[32] Included was the proposal that infection be made a criminal offence. In the twentieth century, increased legislation continued the regulatory trend of the Victorian era. Compulsory notification of syphilitics was introduced, together with contact tracing and compulsory pre-marital blood tests in countries such as the USA.

During the nineteenth century, educational campaigns became an adjunct to legislation once authorities perceived the syphilis epidemic to be out of control. These campaigns became increasingly heavy-handed. During the interwar period of the twentieth century, "pamphlets, posters, radio, the theatre and the cinema were actively used to frighten people".[33] The measures caused mounting panic until the discovery of antibiotics in 1943 which resulted in "an instantaneous shift from a frenzy of fear to a complete lack of concern."[34]

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[31] Andreski in Fleming, "Fighting the Red Plague": *New Zealand Journal of History*, 1988: p. 56 Syphilis was known as the 'red plague' because a reddish rash often characterised the second stage of disease.

[32] Quetel, *Op. cit.:* p. 7

[33] *Ibid.*

[34] *Ibid.*

The flood of regulatory measures occurring during the nineteenth century in western countries generally focused on poor or immigrant women, and those deemed 'prostitute'. In England, the middle-classes provided refuges and patronage for destitute 'fallen women', while prostitutes and 'whores' were incarcerated if found to be infected, or jailed if they refused to undergo bi-monthly checkups.[35] Other laws were passed to close or regulate brothels, to register prostitutes, and to outlaw or suppress prostitution by means of vice squads. Control of disease therefore centred on the regulation of women's sexuality rather than treatment or control of syphilis itself. However, while legislation and regulation was imposed on certain categories of women, exhortation was employed in moral discourse for the rest of the populace in order to protect the ideals of family, class and race.

## 3.5 Ideology in the Syphilis Epidemic

In Europe, the links between sin and disease had originated during the leprosy epidemic (see Chapter 2). During the nineteenth century, the notion that syphilis was God's punishment for sin was replaced by the idea that disease was the outcome of 'risk behaviour'. An exploration of the ideology surrounding syphilis, and its emergence in terms of 'health prevention' during the

[35] *Ibid.*: p. 213. Prostitutes were also subjected to compulsory examination in France. Quetel states that the speculum, used by French doctors as an 'indispensable instrument of medical control', was dubbed 'the Government's penis' by women.

HIV/AIDS epidemic, is undertaken in the following sections of this chapter.

### *3.51 a) Pre-Industrial Era*

Before the eighteenth century, syphilis was invariably thought to be the outcome of sin because all "disease, particularly epidemic disease, was thought to be caused by God."[36] People suffering from venereal disease were "classified by the part of the body attacked and stood proof of contact with immorality and disorder."[37] This response to catastrophic disease in Europe continued unchallenged until the end of the syphilis epidemic, with minor variations according to cultural or political context.

Citizens in pre-industrial times were invariably located within discrete caste or class structures. Sontag maintains that, as a result,

> thinking of syphilis as a punishment for an individual's transgression was for a long time, virtually until the disease became curable, not really distinct from regarding it as retribution for the licentiousness of a community.[38]

In this, Sontag says, the response to AIDS is no different from that of syphilis. Individuals were blamed for their own disease, and were invariably categorised as part of a community or group

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[36]Patton, *Sex and Germs*, 1985: p 57

[37] *Ibid.:* p. 56

[38] Sontag, *Op. cit.:* p. 46

whose characteristics had 'created' the disease. The ideological shift which occurred in the nineteenth century focused responsibility for disease on individuals rather than on a community. This focus resulted in syphilitics and the healthy alike suffering not only from the old labels of, say, 'promiscuous woman', 'dissolute dandy' or 'fop', but from the now added burden of self-regulation as disease prevention. However, most were deemed to fail at self-regulation given the self-perpetuating 'characteristics' of their class or group.

### *3.52 b) Industrial Era*

Before industrialisation, it was held that individuals who operated outside powerful moral codes invoked the wrath of God, and that punishment for sexual transgression inevitably would be 'the pox'. By the nineteenth century, while moral codes were more secular and class-based, they were also more prescriptive. As stated, these codes were shaped, in part, by the fear of syphilis and other epidemic diseases. Such moral codes enabled the righteous to feel safe, the unworthy to accrue blame, religious codes to proliferate, and notions of 'foreignness' and 'pollution', sex and 'impropriety' to amalgamate into a potent ideology of disease. By such means, individuals became objects of a reiterative 'punishment as disease, disease as punishment' morality. Sontag exposes the paradox of this morality when she states that "a polluting person is always wrong [but] the inverse is also true: a person judged to be wrong is regarded as, at least

potentially, a source of pollution."[39] As much as such ideology illustrates the illogic of blame for epidemic disease, it is an apt example of Foucault's theory of power by which ideology, as a modem of power, reproduces and reiterates in order to maintain the status quo.[40]

None of the ideologies emerging during the syphilis epidemic had seriously challenged the central notion of disease as punishment for the transgression of religious or societal norms. Secularisation, the growth of science, and the discovery of the syphilis spirochete in 1905, all produced variations on a theme rather than a radical reconceptualisation of the link between society, sexuality and disease. In industrial Europe and the USA, absolutist ideas about God, sin and sexuality were juxtaposed with secular notions of individual responsibility for health, but the rules remained the same: 'excess' or 'deviant' sex would result in disease, shame, disfigurement, or death.

By the nineteenth century, sexuality's prescriptors had become doctors, educators, legislators and social purity feminists[41] as well as ministers of religion, all of whom

[39] *Ibid.:* p. 48 Parenthesis has been added.

[40] Foucault, *Op. cit.* (1978): p. 94

[41] Social purity feminists agitated for 'sexual purity' (married monogamy) for both men and women. They were opposed to regulations which targeted the sexuality of women, and they abhorred the Victorian double standard. 'Social purity' feminism was a force in the suffrage movement in Britain, the USA, and commonwealth countries such as New Zealand. It championed women as morally superior. 'Social purity' feminism was only one strand of feminism that existed in the nineteenth

propounded 'social hygiene' according to their particular philosophy. As society secularised, control of sexuality seemed to become more urgent. According to writers such as Patton, sexual diseases such as syphilis served as a powerful code. Although syphilis was now 'wilfully contracted' (thus, actively rather than passively acquired), moral discourses still reiterated old notions of sexual diseases serving "simultaneously as symptoms of evil and punishment in themselves."[42]

## 3.6 Syphilis as Legacy in the AIDS Epidemic

Writers such as Crimp, Gilman, Sontag, Fee and Brandt argue that discourses about sexuality and disease that surfaced during the syphilis epidemic powerfully influence the way AIDS is conceptualised and managed today. Conversely, Kehoe states that, "the AIDS pandemic has provided enormous impetus for the socio-historical study of venereal disease, and in particular, syphilis, which, as Brandt (1988) points out, historically had much in common with AIDS."[43] AIDS has brought a re-examination of the history of syphilis, as the plethora of recently published books and articles on the subject attests.

While the identification of risk groups according to the notions of 'guilt' and 'innocence', and the upsurge in public health measures are common to all epidemics, syphilis' legacy in the

century.

[42] Patton, *Op. cit.*: p. 59

[43] Kehoe, *Medicine, Sexuality and Imperialism*, 1992: p.3

AIDS epidemic is the ideology of sexual disease. Sontag writes that in the AIDS epidemic, this ideology is, once again, the discursive province of professional fulminators "who can't resist the rhetorical opportunity offered by a sexual disease that is lethal."[44] Such ideology anchors ancient notions of religion while serving as a powerful method of social control among secularised individuals. The persistence of this ideology is evident from the fact that, although debates about control of sexually transmitted disease lapsed after the discovery of antibiotics in 1943, they resurfaced powerfully during the HIV/AIDS epidemic, bringing with them old ideas about 'risk groups' and 'risk behaviours', as well as a management methodology centred on such sexual restraints as celibacy, heterosexuality and monogamy. The resurfacing of this ideology was contingent on the fact that AIDS could not be cured.

A feature of the syphilis epidemic (absent in other epidemics) that provided a model for the community response to AIDS was the growth of grass roots movements (feminism, civil rights). The feminist movement of the nineteenth century employed and promulgated the discourse of sexual disease in order to promote gender equity. Their self-defined role as 'moral guardians of the nation' eventually earned women the vote, on the basis that they would be society's rule-keepers. The feminist and civil rights movements provided inspiration for other community groups such as those representing gay men and women. The

[44] Sontag, *Op. cit.*: p. 60

subsequent politicisation of the gay community has evolved to become a potent force in the HIV/AIDS epidemic.

Before AIDS, syphilis was the last of the great epidemics to be called 'plague'. Sontag writes that the discursive shift that differentiated epidemic and plague came out of twentieth century advances in microbial science which put paid to the old notion that sin caused disease. The discovery prompted a reduction in overtly moral responses to twentieth century epidemics such as influenza and poliomyelitis, although not for syphilis as 'the sexual epidemic'. Instead, the discourse of sexual disease was inflated by moral panics which kept alive the notion of syphilis as plague. The discourse of sexual disease, as a cornerstone of moral ideology, was underscored by the chronicity of syphilis which made the disease appear less 'epidemic' than 'indictment'. It is this legacy which continues in AIDS narrative, particularly as HIV (showing no signs of abatement) is labelled another chronic, sexually transmitted disease.[45]

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[45] In his essay, entitled "20+, HIV+" in *The New York Times Magazine*,17/4/94, p. 52 Stephen Beachy writes "Nothing to lose. Actually, that's a blatant lie. We've probably got years ahead of us without any symptoms, and by that time, so we're told, AIDS will have developed into a chronic, manageable disease." (p. 52). Also, Parker in *Sexuality, Politics and AIDS in Brazil* says on p. 151; "Above all, it is necessary to be convinced that while AIDS is still incurable (in the sense that HIV cannot be eliminated from the body), it is increasingly a treatable disease." Like AIDS, syphilis was mostly fatal when it first appeared in Europe.

## 3.7 The Syphilis Epidemic in New Zealand - A Case Study

### *3.71 Overview*

In nineteenth century New Zealand, syphilis was often called 'the red plague', probably because the rash of secondary syphilis gave sufferers a reddish appearance (see footnote 31, this chapter). Fleming describes the disease as "as amongst the first 'gifts' of European civilisation to be brought to New Zealand by the earliest settlers. The Maori people were soon to discover its virulence and ferocity."[46] Not much later, Europeans blamed Maori women for being 'reservoirs of the disease'. The blame, says Kehoe, sprang from "new fears, specifically connected with the encounter with unknown cultures [that] surfaced as a result of the British imperialist advance."[47] The fears were inherently racist: they were organised around notions of Anglo-Saxon superiority over Maori and other 'savages'. As usual, there was a need to attribute blame for the disease to 'others' from non-hegemonic groups.

Kehoe writes that British physicians who immigrated to New Zealand in the nineteenth century were

> heir to a long and persistent tradition of thought, enshrined both in ecclesiastical and medico-moral discourse, in which woman was portrayed as

[46] Fleming, *Shadow Over New Zealand,* 1989: p. 10

[47] Douglas (1986; 1970) in Kehoe, *Op. cit.* Parenthesis has been added

> the 'poison-damsel', whose sexuality, if unrestrained, could bring disease, disorder and death to mankind *[sic]*.[48]

In this vein, Fleming states that it was the control of prostitution rather than the incidence of syphilis *per se* that proved the catalyst for New Zealand legislation such as the 1869 Contagious Diseases Act. The lack of statistical information about venereal disease in New Zealand lends weight to the argument that the rhetoric of syphilis was more important than its reality.[49] Fleming notes that some doctors "were [by] no means convinced that venereal disease constituted the major threat which politicians and some other members of their profession [had] portrayed."[50] Debates about sexuality and the control of sexual disease therefore existed as separate from the 'facts' of the syphilis epidemic. Kehoe argues that this separation existed because "the subjugation of women was vital to upholding the prevailing patriarchal order."[51] As the epidemic progressed and it became evident that the 'old' traditions were shaping New Zealand's response to the epidemic, women's groups began to campaign against anti-syphilis legislation.

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[48] Kehoe, *Op. cit.*

[49] Tolerton, in *A Life of Ettie Rout,* 1992: p. 93, writes that: "No one knew what the figures [for syphilis] were in New Zealand. Figures of those who actually died of syphilis were recorded until 1908, when the system of categorisation was changed. In the years that followed, New Zealand did not want to change its system back lest its figures look higher than those of other countries." Parenthesis has been added

[50] Fleming, *Op. cit.*, 1989: p. 103 Parenthesis has been added.

[51] Kehoe, *Op. cit.*

The debates about syphilis[52] in New Zealand were fierce, polemical and Eurocentric. In part, the intensity of debate sprang from a belief in New Zealand's role as a new society which "presented its [Pakeha] inhabitants with a unique opportunity to avoid the ills of the 'old' world and to forge a clean, healthy, and vigorous society."[53] New Zealand was held to occupy "a special place in the world [because] our isolation by 1200 miles of ocean protects us from dangers other lands find so hard to protect against."[54] The portrayal of New Zealand as a special place spurred a number of medical, social and economic initiatives. As in Britain, eugenics concerns shaped the initiatives for population growth and the control of social problems, including sexually transmitted disease. But while rhetoric elevating European New Zealanders was commonplace, Maori were excluded from debates which eulogised the racial superiority and fitness of Europeans.

A raft of legislation passed during the syphilis epidemic in New Zealand, while echoing that of countries such as Britain, was indicative of the new colony's energy and social progressivism. In this, New Zealand's image had become that of "brave social pioneer in the fields of welfare and government intervention."[55] After the recommendations of the Committee of Enquiry into Venereal Diseases were published in 1923, London's newspaper,

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[52] I could have used the more generic term 'venereal disease' in this section of the chapter, but decided to name syphilis as the 'real' STD because, according to Tolerton (*Op. cit.*: p. 93) gonorrhoea was ignored in the nineteenth century.

[53] Fleming, *Op. cit.*,1989: p. 60 Parenthesis has been added.

[54] *Ibid.* Parenthesis has been added.

[55] *Ibid.*

*The Morning Post* praised New Zealand's "daring and innovative approach to such issues." New Zealand policy-makers, keen to maintain New Zealand's reputation as 'the land of brave social experiments', had put forward wide-ranging measures to combat syphilis and other sexually transmitted diseases in the committee's report. The tradition of social reform was facilitated by a simplified (single house) parliamentary structure which proved less obstructive than the legislatures of countries such as Britain, Australia and the USA. This tradition of social reform has continued in New Zealand's HIV/AIDS epidemic, whose responses overseas commentators again herald as 'innovative, progressive and egalitarian.'[56] New Zealand's social-progressive tradition in relation to the HIV/AIDS epidemic is discussed further in Chapter 5 and Appendix II.

### *3.72 Methods of Control*

Hopes of ridding the country "of the consequences of venereal disease for the race and for national efficiency"[57] primarily centred on the infamous Contagious Diseases Act of 1869 and its amendments. As in Britain, the Act subjected prostitutes and other sexually active women to medical examination and detention if found to be syphilitic. Later, the risk category of the 'common' prostitute was widened to include the 'casual

[56] For example, Debra Lebron (Education Coordinator at the West Alabama AIDS Outreach Center (WWAOC), USA) spoke favourably to me about New Zealand's response to AIDS.

[57] Fleming, *Op. cit.*, 1989: p. 28

prostitute', or 'young woman at risk'. Health Patrols, composing 'respectable matrons' or plain-clothes women police, were formed. Their brief was to prevent the casual prostitute from attending night clubs and movie theatres, or from consorting with servicemen in public parks.[58] Other legislation was passed, such as The Medical Defectives Act of 1911. This Act legalised the detention of 'female degenerates and imbeciles' whose 'unrestrained sexuality' was believed to result in widespread syphilis and racial degeneration. More legislation targeted individuals, mainly prostitutes, who 'wilfully or knowingly' infected others, as well as that outlawing brothels and 'one woman brothels'.[59] Overall, the type of anti-syphilis legislation passed in New Zealand demonstrates the power and particularity of the sexual 'double standard'. All the legislation was directed at the sexual activities of women. There were no parallels for men.

While much legislation for the control of sexual disease was passed in New Zealand, still more was thwarted through the activism of women's groups such as The Auckland Women's Political League, The Women's Christian Temperance Union, the Country Women's Institute, and the National Council of Women. The women's groups deplored moves to introduce anti-syphilis

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58 *Ibid.:* p. 97 Fleming writes that the Auckland Chapter of the WCTU "involved themselves in night work in parks and streets to render assistance to girls and women under the influence of drink and in danger of molestation."

59 *Ibid.* In New Zealand's HIV/AIDS epidemic, legislation regarding 'wilful infection' was used to charge HIV+ Kenyan, Peter Mwai (see Chapter 6 for comment).

legislation which targeted women. Their conservative manifesto had long outlined ideals for the sexual purity of both men *and* women based on celibacy or married monogamy. This manifesto was promulgated in opposition to Victorian sexual norms.

Some attempts were made to educate the public about syphilis. Pamphlets and lectures about prophylactic techniques for the prevention of syphilis were provided, but mainly for New Zealand's expeditionary forces during World War One.[60] The pamphlets, issued by Government, religious and philanthropic bodies, "reflected the prevailing attitudes towards venereal disease: its use as an incentive to morality and a punishment for wrongdoing and the rejection of medical prophylaxis."[61]. A nationwide system for clinic-based treatment of syphilis and other sexually transmitted diseases was established by military and health authorities during wartime. Condoms were advocated for and supplied to soldiers by the social reformist Ettie Rout during World War One, but were not officially mandated until World War Two.[62] It is difficult to escape the conclusion that

[60] Of the pamphlets cited in Fleming's 1989 PHD thesis, only one, entitled "Social Diseases, what women should know about them - and why" (published by the YWCA in 1917), was for women.

[61] Fleming, *Op. cit.*,1989: p. 29 Physical (medical) prophylaxis included early treatment of syphilis and the supply of condoms. However, both were often opposed by physicians and moralists alike. Tolerton, *Op. cit,* states that "an eminent doctor [said] that prophylactics did not work and that only discredited members of the medical profession recommended them." (p. 184) The issue of condom efficacy has been raised in the AIDS epidemic. Parenthesis has been added

[62] Tolerton, *Op. cit.* According to Tolerton, eugenicist and social reformer Ettie Rout was the *bete noir* of social purity feminists in New Zealand. Ettie supplied physical prophylaxis to the expeditionary forces on the basis of 'racial fitness' and

efforts to educate the public about syphilis were a war-time contingency for men only. Similarly, the provision of physical prophylactics such as condoms and early treatment for men were undertaken to protect the fighting ability of the expeditionary forces, with 'family protection' (for wives back home) a secondary consideration. With few exceptions, sexual education and physical prophylaxis for women remained taboo throughout the syphilis epidemic. According to Fleming, the supply of condoms to women was 'unthinkable'.

### *3.73 Activism and Ideology*

As in Britain, protagonists in New Zealand's debates about syphilis were often mutually opposed, but their underlying philosophy was the same - a belief in the superiority of the Anglo-Saxon 'race', and a desire for its active maintenance. This belief and desire surfaced in myriad ways, most powerfully intersecting in the discourses of race, gender, sexuality and disease. Central to eugenics concerns was the control of women's sexuality, for "woman's racial duty is obviously to act as the guardian of the torch of life, to light it anew with every generation."[63] The concern with sexual control prompted Dr Truby King, eugenicist and founder of The New Zealand Plunket Society, to write

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humanitarian ideals, much to the outrage of women who believed that she was encouraging men's vice.

[63] *Ibid.*: p. 102

> it should also be borne in mind that sexual precocity and sexual irregularity present the greatest difficulties for any civilisation which regards self-control and continence as essential in early life. . . Nothing tends to sap, undermine, and stunt individual and racial development and progress more than precocious sexuality and sensual irregularities and perversions. [64]

Paradoxically, the emphasis on 'sexual regulation' de-emphasised sexual knowledge, causing politicians to "bemoan the veil of prudery which surrounded the topic [of syphilis]."[65] It was this prudery, in part, which had hampered moves to control syphilis and other sexually transmitted disease in New Zealand.[66] Rather than advocate an 'unveiling' in the interests of women's sexuality, the challenge mounted by social purity feminists re-emphasised celibacy, monogamy and the sexual innocence of both men and women in the interests of a racially superior society. In this, New Zealand social purity feminists replicated the moral project of their sisters in Britain and the USA.

The feminists who mounted political campaigns during the syphilis epidemic were dubbed 'anti-regulationists' because they sought the abolition of legislation which made vice safer for men. Long after their successful fight for the repeal of the Contagious

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[64] Truby King, *Picture Shows*, 1924 ( in Fleming,1989: p. 165)

[65] Fleming, *Op. cit.*, 1989: p. 29 Parenthesis has been added.

[66] In her 1991 'Life History', my ninety-three year old great-aunt commented on the prudery surrounding sexuality and contraception in the 1920s. Women were unable to purchase condoms, although men 'knew where to get them.' In any event, the purchase of condoms was always surreptitious. (Lichtenstein, Life History Project, University of Canterbury: Soci 312, 1991)

Diseases Act in New Zealand, women's groups "remembered well how long it had taken to eradicate the Act from the statute books and they were determined that similar legislation would never get its foot inside the legislative door."[67] As a result of their sustained activism, the women's anti-regulation efforts continued to be successful after the repeal of the Contagious Diseases Act. Fleming gives the example of proposed legislation for the "compulsory notification, compulsory treatment and the compulsory examination of suspected [syphilis] sufferers", which, due to vociferous opposition from women's groups during World War One, was completely abandoned.[68]

The political campaign mounted by women's groups was a partisan response to anti-syphilis measures which focused on prostitutes and unmarried, sexually active women in terms of a male-defined 'risk group'. Some of the beliefs and arguments promulgated by spokeswomen from women's groups have re-emerged in the AIDS epidemic. Then, as now, there was a belief that "the introduction of punitive measures such as compulsory examination, detention and notification. . . would drive [syphilis] underground and discourage sufferers from seeking treatment."[69] Instead, there was a call for free VD clinics and health promotion techniques, although physical prophylaxis, in the form of early treatment or condoms, was spurned on moral grounds. The

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[67] Fleming, *Op. cit.*, 1989: p. 52

[68] *Ibid.:* p. 39 This legislation had been framed in the 1920 Social Hygiene Bill. Parenthesis has been added

[69] *Ibid.:* p. 53 Parenthesis has been added

women's groups believed that blame was being unfairly attributed to one group in society, which was subsequently the focus of punitive measures such as segregation and quarantine. These concerns, echoed by community activists and others in the AIDS epidemic, prompted women to strive for substantive change in the management of syphilis and other sexually transmitted disease. Their success is indicative of a tradition of strong community action during times of epidemic and social crisis in New Zealand. Likewise, the government's response was (in part) an outcome of that action. Today, the lobbying skills, activism, and ideological purpose of the women's groups has been replicated by gay activists and others in the AIDS epidemic, whose efforts have scored similar gains. However, the legislation framing prostitution in New Zealand remains, and has hampered efforts by the New Zealand Prostitutes' Collective (NZPC) to educate members about HIV/AIDS.[70]

## 3.8 Summary

Syphilis was a chronic, sexually transmitted disease that existed in Europe for about 500 years from 1494-1943. Until this century, syphilis was believed to have been 'imported' by Columbus after his journeys to the Americas. The disease spread to the USA and British colonies during the eighteenth and nineteenth centuries. Racial stereotypes were appended to syphilis ideology during capitalist expansion in the nineteenth

[70] NZPC Submission to Parliament, July 1990.

century, so that Irish prostitutes and African-American slaves in the USA, and other indigenous groups deemed inferior to British colonisers, became the icons of disease.

Syphilitics were both male and female. However, women were mostly blamed for the epidemic. This ideology of blame resulted in punitive measures such as incarceration, burning at the stake, exile, or enforced medical examination for many women syphilitics, especially prostitutes. Notions about 'good' and 'bad' women that proliferated during the latter phase of the syphilis epidemic were used during the nineteenth century by members (men and women) of the upper classes to impose bourgeois ideals on working class women employed as prostitutes. The imagery about syphilis created syphilophobia in middle-class women which was marked by sexual and physical inhibition. This retreat served as a re-affirmation of traditional notions of sexuality which further dichotomised women in their roles as either mother/wife or the sexually corrupt 'Eve'.

New Zealand's response to syphilis was marked by debate and shaped by eugenics concerns as expressed in discourse about race, class, sexuality and gender. In blaming Maori and working class prostitutes for the disease, the response demonstrates a male, middle-class and European bias. Like Britain, New Zealand's response was marked by nineteenth century legislative change instituting proscriptive measures for a single group of citizens ('promiscuous' women), rather than the formulation of

health measures for the entire populace. Official and community responses to the syphilis epidemic advocated moral rather than physical prophylaxis in the absence of a cure. The legislation to control women's sexuality was vigorously protested by feminist groups such as the WCTU, Country Women's Institute and the National Council of Women, and their activism often met with success. However, some of the legislation remained on the statutes. This legislation has been challenged by sex-workers and others during New Zealand's HIV/AIDS epidemic (see Appendix II). Responses to syphilis in New Zealand set the scene for the way sex-workers were conceptualised and managed in the HIV/AIDS epidemic. A discussion of this public health paradigm and its meaning for community activism in the HIV/AIDS epidemic is included in Chapter 5.

# CHAPTER FOUR

## AIDS: THE EPIDEMIC AND ITS THEMES

*Everything about this epidemic has been utterly predictable, utterly, utterly and completely predictable, from the very beginning, from the very first day. But no one would listen.*

*- Dr Mathilde Krim, AmFAR*[1]

## 4.1 Introduction

Perhaps no other epidemic has generated as much literature as HIV/AIDS. In part, this phenomenon is the outcome of medical and popular concern about the sudden appearance of a modern-day plague. It is also a by-product of the 'information' age. As stated by Sills, "the sudden appearance and rapid spread of AIDS has spawned a sometimes bewildering spate of articles, books and press commentaries that, taken together, provide an enormous amount of information about this disease and its social impact."[2]

Most of the literature about HIV/AIDS is about a particular aspect of the epidemic such as its treatment, epidemiology or politics. Many writers have attempted to explore the nature or politics of AIDS as a means of controlling its effects and outcomes. A few writers such as Shilts[3] and Sills[4] have

[1] Krim in Kramer, *Reports from the Holocaust*,1989: p. xviii - Dr Mathilde Krim made this statement as co-chair of the American Foundation for AIDS Research (AmFAR)

[2] Sills, *The AIDS Pandemic*, 1994: p. vii

[3] Shilts, *And the Band Played On*, 1987

written an overview of organisational or other aspects of the epidemic. No writer has systematically attempted to cover every aspect of HIV/AIDS. Writing an overview of the HIV/AIDS epidemic for this chapter posed similar problems of reducing thematic 'spread'. Thus, only a brief and descriptive overview of the AIDS epidemic from 1981 to 1994 is provided in this chapter. It was believed that an overview of New Zealand's AIDS epidemic and its themes warranted a fuller discussion: this overview is provided in Chapter 5.

The section of this chapter titled "'Constructing Blame in the HIV/AIDS Epidemic" expands on issues surrounding AIDS iconography and discourse. This section analyses the concept of the 'other' in the AIDS epidemic (the foreigner, the social outcast and the sexual 'deviant') according to 'new' and 'old' typologies. The three categories chosen for case studies are a) the gay man, b) the injecting drug user and c) the African prostitute. Individuals composing these categories have been iconised as HIV vectors, either in Western countries or Africa. All were marginalised members of their own societies before HIV/AIDS.

This chapter includes the work of gay activist-writers who maintain that AIDS is a socially constructed disease. Writers such as Crimp, Watney, Weeks and Altman, for example, argue that AIDS was conceptualised according to moral, racial or social concerns about 'others' such as gay men, Haitians and injecting drug users. Delaporte in Crimp offers the theoretical rubric for

[4] Sills, *Op. cit.*

this representation by saying that AIDS "does not exist apart from the practices that conceptualize it, represent it, and respond to it. We know AIDS only in and through these practices."[5] The following overview is a presentation of the socio-political context of HIV/AIDS.

## 4.2 Conceptualising the HIV/AIDS Epidemic

### *4.21 Naming a 'New' Disease*

The first cases of AIDS among gay men in the USA were documented in 1979. HIV/AIDS was classified a 'new' epidemic once scientists had determined its incidence and origins.[6] The spread of HIV from the USA to other countries around the globe ended the complacency that had existed after the virtual elimination of such diseases as syphilis, smallpox, poliomyelitis, cholera and yellow fever in their epidemic form. The appearance of a deadly 'new' disease undermined certainty about scientific omnipotence, renewed fears about human susceptibility, and led

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[5] Crimp, "Cultural Analysis, Cultural Activism" in *Cultural Analysis, Cultural Activism*: p. 3 I expand on the 'disease is social praxis' concept in the section titled 'HIV/AIDS: Disease and Praxis' in the Conclusion of this thesis.

[6] Fee and Fox, "AIDS, Public Policy, and Historical Enquiry" in *AIDS: The Burdens of History,* 1988: p. 1 Sontag (AIDS and its Metaphors, 1989: pp. 16-17) writes: "Strictly speaking, AIDS - acquired immune deficiency syndrome - is not the name of an illness at all. It is the name of a medical condition, whose consequences are a spectrum of illnesses. In contrast to syphilis and cancer, which provide prototypes for most of the images and metaphors attached to AIDS, the very definition of AIDS requires the presence of the illnesses, so-called opportunistic infections and malignancies. But though not in *that* sense a single disease, AIDS lends itself to being regarded as one - in part because, unlike cancer and like syphilis, it is thought to have a single cause."

to a search for viral and human culprits in an attempt to control the spread of HIV/AIDS.

AIDS took the form of a syndrome, with characteristics so unusual that medical scientists speculated that the virus had 'jumped' a species.[7] It became apparent to medical researchers early in the epidemic that the syndrome was expressed in different ways - through opportunistic diseases such as Karposi's sarcoma, pneumocystis carinii, cytomegalovirus (CMV), toxoplasmosis and the virulent forms of thrush, herpes and hives. It was also apparent that HIV (the Human Immune-deficiency Virus) had a long latency period, and that it was fatal once the disease had progressed to AIDS.

Although HIV soon appeared in other countries, and was deemed African in origin, it was dubbed 'the gay plague' because its first USA 'victims' were homosexual men from self-defined gay communities in San Francisco, Los Angeles and New York.[8] Dennis Altman writes that

> [t]he very first report on the new outbreak from the CDC [Centers for Disease Control] stressed the homosexuality of those affected: "In the period October 1980-May 1981", read the report, "five young men, all active homosexuals, were treated for biopsy-confirmed P.C.P. [a virulent type of

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[7] Connor and Kingman, *The Search for a Virus,* 1988: p. 28 The authors write "One theory was that the disease resulted from a new strain of Africa swine fever virus, which infects pigs. . . The theory was that the swine fever virus had mutated and infected humans." The African green monkey is another species thought to have 'passed' HIV to certain tribes in Africa through use in tribal ritual.

[8] Altman, *AIDS in the Mind of America,*1986: p. 31

> pneumonia] at three different hospitals in Los Angeles". A month later the CDC reported that KS [Karposi's sarcoma] had been diagnosed in "26 homosexual men".[9]

According to Treichler, the Centers for Disease Control's *Morbidity and Mortality Weekly Report* dated 5 June 1981 specifically linked 'homosexual lifestyle' to AIDS. The report stated that

> the occurrence of pneumocystosis in these 5 previously healthy individuals without a clinically apparent underlying immunodeficiency is unusual. The fact that these patients were all homosexuals suggests an association between some aspect of a homosexual lifestyle or disease acquired through sexual contact and *Pneumocystis* pneumonia in this population.[10]

The way the epidemic was linked to a lifestyle set the scene for the way HIV/AIDS has been perceived and managed in the USA. Altman writes that AIDS was inevitably classified as a sexually transmitted disease (STD) because "except for syphilis before the discovery of antibiotics, no life-threatening illness has had the potential of AIDS to be linked so clearly to sexuality and personal behaviour."[11]

Due to its early association with gay men in the USA, AIDS was given the name "gay-related immune deficiency", or GRID, by

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[9] *Ibid.*: p. 32 Parenthesis has been added.

[10] Treichler, "AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification" in *Cultural Analysis, Cultural Activism*,1988: pp. 52-53

[11] Altman, *Op. cit.*: p. 14

the scientific community. The syndrome was later and more neutrally renamed AIDS, but the link between male homosexuality and AIDS had become firmly established as an epidemiologic entity. ('AIDS' became 'HIV infection' or HIV/AIDS once the difference between asymptomatic and symptomatic stages emerged). This 'first-world' conceptualisation of the new epidemic as a gay man's disease continued even after it was known about HIV transmission among heterosexuals in sub-Saharan Africa. Most Western literature about HIV/AIDS has focused on the idea of male homosexuality as locus of the epidemic, whether as an assumption or as a point of argument.

Concern about the sexual behaviour of gay men was expressed as political vilification, media hyperbole, and socio-behavioural interventions. While moral concern centred on the nature of homosexuality and its perceived threat to health and social order, socio-behavioural interventions were predicated on the notion that sexual behaviour could (or should) be changed. Like syphilis before it, HIV/AIDS soon emerged as a 'sexual' epidemic in terms of its politics and management.

An outstanding feature of the management of AIDS has been a focus on 'risk *groups*' rather than 'risk *factors*', as a means of tracing, monitoring and controlling the disease. From the outset, the emphasis has been on surveillance, monitoring and 'probablistic reasoning' that is the realm of epidemiologists.[12]

[12] Grace, "The Marketing of Empowerment and the Construction of the Health Consumer: A Critique of Health Promotion in New Zealand", 1989: pp 106-7 Black in Treichler, *Ibid.:* p. 60 states that 'AIDS is an epiderniologists' dream; a mystery

That AIDS became an 'epidemiologists' epidemic' is emphasised by writers Oppenheimer and Altman. Altman writes that "signs of a new illness were picked up by the Centers for Disease Control in Atlanta [which] reflect[s] its sophisticated monitoring of the nation's health".[13] Oppenheimer describes how

> epidemiology played a key role in the AIDS epidemic [through] the Centers for Disease Control (CDC) in Atlanta. . .the CDC is responsible for, among other things, monitoring morbidity and mortality trends in the United States and for responding to acute outbreaks of disease - infectious disease in particular.[14]

Investigation of the new disease by epidemiologists meant that 'risk groups' other than gay men (most particularly injecting drug users and Haitians) were also identified by the CDC by means of "case reports, surveillance, and epidemiological investigations."[15] According to Treichler, the focus on risk groups by the CDC was instrumental in HIV/AIDS becoming known as the epidemic of the 4 H's: Homosexuals, Haitians, Heroin Addicts and Haemophiliacs.[16] Even now, incidence of HIV/AIDS in the USA is charted in terms of 'risk groups' by the CDC[17], although the fastest growing identifiable group in states like Alabama is

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disease that is fatal.'

[13] Altman, *Op. cit.*: p. 31 Parenthesis has been added.

[14] Oppenheimer, "In the Eye of the Storm: The Epidemiological Construction of AIDS", in *AIDS, the Burdens of History,* 1988: p. 268. Parenthesis has been added.

[15] *Ibid.*

[16] Treichler, *Op. cit.*: p. 44 . According to Treichler, the term '4 H's' was coined by the CDC, who 'only reluctantly' expanded its list of categories in 1986.

[17] Taken from the CDC quarterly, "HIV/AIDS Surveillance Report", March 30, 1994.

reported to be white, middle-class 'general population'.[18]

### *4.22 A Partisan Epidemic*

The number of People with AIDS (PWAs) in the USA grew exponentially from 120 in September 1981[19] to 361,509 as at December 1993.[20] Gay men account for approximately half the number of PWAs in the USA (54%), with intravenous drug users the next largest category at 31%.[21] Heterosexuals (non IV drug users) account for six percent of cases, with women outnumbering men by two to one.

In the USA, the demography of AIDS has changed significantly since the early days of the epidemic. While gay men were first to feel the impact of the epidemic, the epidemic is said to be increasingly an affliction of "segments of society already at a disadvantage - communities of color, women and men grappling with poverty and drug use".[22] African-Americans and Hispanics now account for 47 percent of all PWAs in the USA, although they compose approximately 17 percent (12 and 9%

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[18] From an interview with Debra Lebron, Education Coordinator, West Alabama AIDS Outreach, in May 1994. The incidence of HIV infection among the African-American population is still much higher than for Whites.

[19] Kramer, *Op. cit.*: p. 8

[20] CDC Quarterly HIV/AIDS Surveillance Report for period ending 31/12/93

[21] Mann, "Global Effects of AIDS" in *Green Left*, 28 April 1993: p. 14 Prof. J. Mann was director of the World Health Organization's Global Program on AIDS until March 1990

[22] Glass, "Living with AIDS": an interim report of the National Council on AIDS. Tulane University (USA) 1993: p. 1

respectively) of the population.[23] Women appear to be the fastest growing 'risk group', not the least because they are more susceptible to HIV infection than men.[24]

HIV transmission (whether heterosexual or homosexual) around the world has been linked to poverty, marginalisation or powerlessness. Mann argues that "a decade of work against AIDS has shown us that the central societal lesion which underlies AIDS and ill health worldwide is discrimination."[25] For gay men in Western countries such as the USA, the discrimination implicit in the absence of government action to contain the epidemic (and from their sometimes illegal status) has resulted in countless unnecessary deaths.[26] The position of injecting drug users is even more invidious given their extreme marginalisation and lack of politicisation.

In countries where AIDS is prevalent in the heterosexual population, efforts to contain the epidemic are hampered by

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[23] Sills, *Op cit.*: p. 64

[24] This finding is supported by various writers. Sills writes "The ratio of men to women with HIV infection, as measured by seroprevalence tests, is dropping rapidly; recently, only three men to every one woman have become infected." (p. 62) *Time* (August 3, 1992: p. 34) reports "In many AIDS clinics in New York and San Francisco, 30 to 50 percent of all new patients with HIV are women". Caldwell and Caldwell in their paper "The Nature and Limits of the Sub-Saharan AIDS Epidemic: Evidence from Geographic and Other Patterns" in the *Population and Development Review* (December 1993) state that heterosexual transmission generally is "perhaps as low as one in 1000 from females to males and one in 300 from males to females." (p. 817)

[25] Mann, *Op. cit.*: p. 15

[26] Krim in Kramer, *Op. cit.*: p. 150; and Perrow and Guillen, *The AIDS Disaster*, Yale University Press, 1990.

poverty, politics, and social systems in which women, in particular, are subjugated. The link between women's subjugation, their economic inequality, and HIV, is evident in the way girls who a) are sold into prostitution (Thailand), b) sell sex in order to buy basic necessities (Africa), and c) engage in sex work in India, have all experienced an 'explosion' of HIV sero-prevalence.[27] This point is made in a United Nation's newsletter which states that "the major [mode] of AIDS transmission [in Asia and the Pacific] is now heterosexual behaviour, often involving poor, very young and grossly exploited prostitutes."[28] Mann argues that "reforms of laws governing property and divorce may be much more important in helping to prevent HIV infection than increasing the distribution of brochures or condoms."[29] He writes that women who are unable to make life decisions with regard to marriage, property distribution or income are also rendered powerless in their sexual lives. This powerlessness is exacerbated by women's inability to insist on condom use during sexual intercourse. Women become susceptible to HIV and other 'social' diseases through a lack of employment alternatives to sex work, and through sexual and economic subordination to men. Mann concludes that "male dominated societies are a threat to public health."[30]

The incidence of HIV/AIDS increasingly reveals social,

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[27] Mann, *Op. cit.:* p. 14

[28] From the United Nation's Economic and Social Commission on Asia and the Pacific (ESCAP's) "Social Development Newsletter", October 1993: p. 5 Parenthesis has beenadded.

[29] Mann, *Op. cit.*

[30] *Ibid.:* p. 16

cultural and economic schisms. While in a homogeneous, secular and relatively well-to-do society such as New Zealand the epidemic is said to be 'contained' by virtue of a well-funded and coordinated response[31], heavily populated countries in which poverty is endemic (such as those in sub-Saharan Africa), have seen AIDS "threaten the economic and social fabric of their societies".[32] Mann maintains that HIV/AIDS is rapidly becoming an indicator of the poverty gap between "not only rich and poor countries, but the rich and poor within countries."[33] To Mann and other writers, AIDS has become a symbol of inequality. While inequality featured in other epidemics such as cholera and the bubonic plague, it might have greater consequences in the HIV/AIDS epidemic for countries already struggling with endemic poverty, famine, war and fractured social systems.

## 4.3 Constructing Blame in the HIV/AIDS Epidemic

The following section explores one of the central themes of this thesis: blame in the HIV/AIDS epidemic. This theme is discussed with respect to gay men, injecting drug users and African prostitutes. The focus on these 'typologies' illustrates thematic links between HIV/AIDS, its social context and prior epidemic discourse. A fuller exploration of AIDS iconography is undertaken in Part II.

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[31] Peggy Koopman-Boyden, former chairperson of the New Zealand National Council on AIDS: interview, March 1993.

[32] Sills, *Op. cit.:* p. 42

[33] Mann, *Op. cit.:* p. 14

## *4.31 Gay men*

*God's plan was for Adam and Eve, not Adam and Steve*

*- William Dannemeyer*[34]

True to precedent in earlier epidemics, notions of an 'other' have marked responses to HIV/AIDS. Gilman writes that from the first, "the idea of the person afflicted with an STD, one of the most potent in the repertory of images of the stigmatized patient, became the paradigm through which people with AIDS were understood and categorised."[35] In this context, the creation of 'other' in the AIDS epidemic was heavily underscored by the perception that the principal icon (the gay male PWA) was 'promiscuous' and 'already diseased' in terms of his prior association with STDs and 'abnormality'. The gay man, standing outside mainstream morality on three counts - orientation, disease status, and sexual practice - was cast in the same mould as the "isolated, visually recognizable by his signs and symptoms, and sexually deviant syphilitic".[36] In the HIV/AIDS epidemic, notions about non-heterosexual masculinity were also contaminated with ideas about disease, so that Karposi's Sarcoma lesions proclaimed the AIDS isolate, his orientation, and his fate.

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[34] Attributed to USA congressman William Dannemeyer during a debate on a homosexual rights bill (quoted in Langone, *AIDS: The Latest Scientific Facts*, 1991: p. 29)

[35] Gilman, "AIDS and Syphilis: The Iconography of Disease" in *Cultural Analysis, Cultural Activism*, 1988: p. 90

[36] *Ibid.:* p. 93

Gilman argues that the blame meted out to disease victims is always an attempt to "isolate those we designate ill."[37] In the case of the gay male PWA, his isolation had come about, in the first instance, through nineteenth century medicalisation in which the homosexual was cast as a sub-species, an 'abnormal' sexual variant.[38] The struggle for gay rights in the 1960s and 1970s, was, in part, a challenge to the medical-scientific discourse that had constructed homosexuality as 'sick'. However, homosexuality was remedicalised in the AIDS epidemic by the focus on sexual practices, and the diseases assumed to accompany the 'gay lifestyle' - "venereal diseases, hepatitis, herpes, cytomegalovirus, amoebas and several other tropical pathologies."[39] In effect, categorisation of the homosexual 'sub-species' of the nineteenth century (a notion captured by gays and reworked to become 'gay identity' in the 1970s) had turned full circle once gay men were classified as 'AIDS patients' and 'AIDS carriers'. Even psychopathology was reintroduced, this time appearing as depression or dementia in the later stages of AIDS.[40]

The re-isolation of gay men during the HIV/AIDS epidemic was, in part, an outcome of epidemiologic enterprise which sought to link high STD rates in the (male) gay community to

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[37] *Ibid.*: p. 107

[38] Foucault, *The History of Sexuality: An Introduction,* 1978: p. 43

[39] Leibowitch, *A Strange Virus of Unknown Origin,* 1984: p. 6

[40] *Ibid.*: pp 104-105 According to Watney in Crimp ("The Spectacle of AIDS" in *Cultural Analysis, Cultural Activism,* 1988: p. 79), the homosexual's 'pathology' is still touted even in the absence of AIDS with bio-medical references to the 'softening of the brain' of the 'habitual homosexual'.

AIDS. As Altman notes,

> [i]t is ironic that the very success of the gay [male] movement in claiming legitimacy for its 'lifestyle' affected - and probably distorted - early research on AIDS. Instead of assuming that the culprit was a specific organism, researchers looked for factors in the 'gay lifestyle' to explain what was going on.[41]

words such as 'immune overload', 'immune fatigue' and 'life in the fast-lane' were used to describe the environment in which AIDS 'flourished'. As stated by Leibowitch, misleading perceptions about AIDS arose from the use of extravagant metaphors that eschewed reason and fanned public fear about 'other' lifestyles. In 1984, Leibowitch wrote "the homosexual 'life style' is so blatantly on display to the general public, so closely scrutinized, that it is likely that we never will have been informed with such technico-phantasmal complacency as to how 'other people' live their lives."[42]

Publicity about the 'gay lifestyle' in the AIDS epidemic has resulted in reports of violence against gay men. One report told how teenage males "were chasing the gays with sticks and stones and shouting 'unclean'".[43] This scenario evokes images of past

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[41]Altman, *Op. cit.:* p. 33 Parenthesis has been added.

[42] Leibowitch, *Op cit.:* p. 3 Scrutiny of 'other' lifestyles is evident in papers such as Hickson, Davies, Wych and Project Sigma's "Brief Encounters: Characteristics and Sources of Casual Sexual Partners among Gay and Bisexual Men" in *AIDS: Facing the Second Decade*, 1993: pp. 83-97. Gay men's sexuality is described in detail in this paper.

[43]Altman, *Op. cit.:* p. 69

epidemics such as leprosy in which violence, isolation and fear marked responses to epidemic disease.[44] While the purpose of this anti-gay discourse is victimisation, it has afforded unprecedented political, legal and social opportunities for gay men and women during the HIV/AIDS epidemic, as discussed in Part II.

### *4.32 Injecting Drug users*

Injecting drug users, also cast as 'other' in the AIDS epidemic, are the target of a long-standing moral crusade against 'substance abuse' in the USA. This crusade has resulted in their acute stigmatisation, along with an increased risk of death from HIV infection. A demographic breakdown of HIV+ drug users highlights some of the dynamics involved in the stigma=death dyad. Drug-related HIV infection often occurs in the ghettos of large cities such as New York. Injecting drug use is increasingly linked to unemployment, poverty and racial and urban despair; AIDS is thus said to have become a disease of the poor and marginalised in the USA.[45] However, marginalisation is not the only factor relating to high rates of HIV infection among injecting drug users. There is little doubt that the phenomenon is linked to moral conservatism in the USA. Politicians, legislators and moralists have blocked the implementation of effective HIV prevention measures such as needle exchange. In New Zealand, IDUs have been protected from HIV infection by needle exchange

[44] Freiberg in Altman, *Op. cit.:* p. 70

[45] Mann, *Op. cit.:* p. 14, and Sills, *Op. cit.:* p. 97

and a more inclusive public health policy. Injecting drug users comprise only 4.2% of the number of PWAs in New Zealand and slightly fewer (4.1%) of the known HIV infections.[46]

An article in the USA newspaper *The Washington Post*, titled "Scarcely a Dent In The AIDS Menace",[47] outlines the failure of community efforts to slow HIV infection among the city of Washington's 16,000 injecting drug users. IDUs currently compose a third of the city's new PWAs. Writer of the article, Rene Sanchez, believes that the council-sponsored needle exchange programme was so restrictive as to be a 'complete flop'. Its limited scope followed opposition from political and religious leaders, who feared that 'harm reduction' in the form of a needle exchange scheme would encourage illegal drug use. Few needle exchanges exist in the USA, and most are hampered by similar moral, fiscal and political constraints.

Illicit drug users (labelled 'drug abusers' in official USA literature) have long been represented as a 'socially disorganised minority.' In particular, IDUs have been constructed as 'dangerous urban deviants'. In the HIV/AIDS epidemic they are believed to cause the death of 'innocent' partners and children, and to be undermining America's social fabric. Identification of an AIDS 'risk group' on the basis of illicit drug use has prompted politicians and religious leaders alike to renew their call for harsher measures in the 'war against drugs'. The absence (or timidity) of preventive health measures for IDUs in the USA

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[46] *AIDS New Zealand:* Issue 24, February 1995.

[47] *Washington Post*, 18/4/94: pp A1 and A8

demonstrates a belief that drugs, not HIV, must be eliminated for *moral* purposes, rather than for a sub-culture's *physical* survival.

Gilman argues that although opposition to IDUs is constructed on the basis of 'sociopathy' (so defined because of the illegal drug user's refusal to eschew practices considered dangerous to self and society), societal approbation stems from the iconography of syphilis and other STDs through a convergence of images about disease, sexuality and immorality.[48] He states that this image is constructed around a stereotype - that of African-American injecting drug users in the USA, who are deemed hypersexual as well as sociopathic in terms of their practices. An illustration of the sex-drugs imagery is the African-American woman who is said to exchange sex freely for drugs.[49] 'Sex-drugs' parties among minority groups are commonly noted in the literature on AIDS. Further, in a well-publicised case, sports icon 'Magic' Johnson (the African-American superstar of USA basketball) is stated to have acquired HIV infection through self-proclaimed heterosexual promiscuity. The publicity surrounding 'Magic' Johnson's confession about his HIV status prompted King to argue that Johnson's 'hypermasculine' stance is indeed "promoting myths about African-American hypersexuality and other naturalized constructions."[50]

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[48] Gilman, *Op. cit.:* p. 104

[49] Debra LeBron, *Op. cit.*

[50] King, "The Politics of the Body and the Body Politic: Magic Johnson and the Ideology of AIDS" in *Sociology of Sport,* 1993, No. 10: p. 271. On p. 279, King

Gilman writes that the USA's history of linking STDs to 'others' is evident in the Tuskegee experiment where it was assumed that African-Americans had greater immunity to syphilis.[51] Smith in King argues that the creation of 'others' such as the hypersexual, drug-using African-American allows the problem of HIV infection and its devastating effects on minority communities to be viewed (and dismissed) "through the selective lens of age old bigotry."[52] The 'otherness' of injecting drug use and HIV infection helps conceal the stratified nature of the AIDS epidemic in countries like the USA. This realisation prompted Sills to write that

> in its ultimate impact the U.S. epidemic will resemble the flu epidemic of 1918 [because] many of its most striking features will be absorbed in the flow of American life, but, hidden beneath the surface, its worst effects will continue to devastate the lives and cultures of certain communities.'[53]

A focus on African-American 'behaviours' during the AIDS epidemic (particularly those behaviours relating to injecting drug use) reveals a modern form of stigmatisation in which the

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discusses "Johnson's announcement of his HIV status and. . . his claim of (heterosexual) promiscuity."

[51] Gilman, *Op. cit.:* p. 101 On p. 100, Gilman writes about the "horrors of the Tuskegee syphilis experiment, in which blacks infected with the disease were observed, without any medical intervention, until their deaths."

[52] Smith (1991) in King, *Op. cit.:* p. 282.

[53] Sills, *Op. cit.:* p. 98 Here, Sills quotes from a report titled "The Social Impact on AIDS" (1993), produced on behalf of an advisory panel of social scientists and other experts. Parenthesis has been added

(white) middle-classes can safely discriminate against 'others' on the basis of their behaviour, rather than by virtue of race or class. In the case of injecting drug users, the dynamics of stigmatisation are best understood through demographic analysis of illegal drug use in the USA. As noted by Gilman, a 1981 investigation into the nature of illegal drug use indicated that "it was not the yuppies with their drug of choice, cocaine, who [were] infected, but the blacks of Harlem and the South Bronx, shooting heroin with shared needles."[54] The opposition continues to underpin what Gusfield described as 'status control' by 'cultural fundamentalists', whose links to the 'old middle class of the nineteenth century' replicate a racist agenda against immigrants, Blacks and the working class.[55] The irony of this Black-White dichotomy with respect to the AIDS epidemic is that many African-American organisations have been vociferous in their opposition to needle exchange schemes. This opposition is, in part, due to a reluctance by African-American organisers to admit 'otherness' as exposed by the drug problem. It is also an expression of their fears about 'racial genocide' in the wake of the Tuskeegee experiment. However, the moral crusade against illegal drug use has also been adopted by middle-class African-Americans, who have incorporated the status values of a white majority. This agenda places African-American organisations in direct opposition to those in their own communities who are often powerless, stigmatised through poverty and drug use, and in need of life-saving strategies. Indeed, 'racial genocide' is evident in America's refusal to allow life-saving techniques like

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[54] Gilman, *Op. cit.:* p. 104 Parenthesis has been added

[55] Gusfield, *Symbolic Crusade,* 1963: pp. viv, 147 and 140.

needle exchange for drug-afflicted minority populations.

### *4.33 The African 'Eve'*

Although the first outbreaks of HIV infection were labelled a 'gay plague', AIDS was also conceptualised as an African or Haitian disease because of its putative origin. Gilman states that "this presumed origin is, of course, very much in line with the white American notion that blacks, being inherently different, have a fundamentally different relationship to disease."[56] Both Gilman and Fee[57] maintain that the racism inherent in this belief is a hangover from colonial times in which syphilis was linked to the presence of African slaves in southern parts of the USA.

True to historical precedent, the notion of AIDS as 'foreign' soon appeared in popular and medical literature. It was proclaimed by Shilts in his widely-read book about the AIDS epidemic, titled *And The Band Played On.* In the opening pages, Shilts wrote that "the microbe's first victims were largely linked to Africa."[58] He underscored the emerging 'African origin' hypothesis by alluding to 'strange and exotic ailments' whose 'deadly microbes' the "tropics so efficiently bred."[59] USA writers Connor and Kingman and French immunologist Dr Jacques Leibowitch also postulated the 'African Origin' theory.[60] From

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[56] Gilman, *Op. cit.:* p. 100

[57] Fee, "Sin versus Science: Venereal Disease in Twentieth-Century Baltimore" in *AIDS: The Burdens of History,* 1988: p. 127

[58] Shilts, *Op. cit.*: p. 35

[59] *Ibid.:* pp. xxii and 5

[60] Connor and Kingman, *Op. cit.,* and Leibowitch, *Op. cit.* The back cover of

the outset, Dr Robert Gallo (co-discoverer of HIV), had speculated about the origin of HIV, saying that he could not "conceive of AIDS coming from elsewhere into Africa".[61]

As publicity about the presence of AIDS in Africa emerged in the West, so too did the realisation that the epidemic in those countries was a heterosexual (rather than homosexual) phenomenon. Treichler writes that "the World Health Organisation (WHO) confirmed what many had suspected: AIDS was devastating the populations of at least four African countries, where half of those with AIDS are women."[62] Packard and Epstein state that when medical researchers first began studying AIDS in Africa, they found "the ratio of male to female [AIDS] cases. . . in Africa was nearly 1:1."[63] Caldwell and Caldwell point to the fact that, in 1992, "sub-Saharan Africa accounted for over six-sevenths of the world's heterosexual transmission."[64]

Soon after the discovery of women as 'equals' in the African epidemic, the imagery of the PWA underwent radical re-conceptualisation. Old images relating to women and syphilis

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Leibowitch's book states that "as a consulting immunologist for AIDS at the World Health Organisation, he had the opportunity to develop his arguments in favor of an African origin to the AIDS virus."

61 Treichler in Crimp, *Op. cit.:* p. 56

62 Treichler, "AIDS, Gender, and Biomedical Discourse: Current Contests for Meaning" in *AIDS: The Burdens of History,* 1988: p. 193

63 Packard and Epstein, "Medical Research on AIDS in Africa" in *AIDS: The Making of a Chronic Disease,* 1992: p. 350 Parenthesis has been added

64 Caldwell and Caldwell, *Op. cit.*: p. 818

were resurrected. This time, the images were touted as being 'natural' to the African 'race'. Overnight, says Treichler, the contention that "there is no need for female representation in the AIDS saga because gay men are already substituting them as the Contaminated Other"[65] became redundant for African women "whose exotic bodies, sexual practices, or who knows what are seen to be so radically different from those of women in the USA that anything can happen in them."[66] Out of this reconceptualisation, the 'African Eve' emerged as the exotic, diseased, and hyper-sexual female transmitter of HIV.

The image of African woman as AIDS vector is invariably constructed around notions of 'the prostitute'. Female sex work in sub-Saharan Africa ('The AIDS Belt'[67]) is said to be commonplace, ostensibly because of the social and demographic changes (eg, migrant labour) wrought by Christianity and nineteenth century colonialism.[68] African women are often portrayed as multi-partnered, or pre- and post-maritally promiscuous. As sex-workers they have been labelled 'pervasive vectors' and 'a major reservoir of the AIDS virus' because they 'have literally hundreds of contacts a year'.[69] Some African women (notably those from the non-clitoridectomising Haya tribe

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[65] in Treichler in Fee and Fox, *Op. cit.:* p. 217

[66] Treichler in Crimp, *Op. cit.:* p. 46

[67] Caldwell and Caldwell, *Op. cit.:* p. 818. The zone is described by the authors as a "contiguous belt stretching from Uganda and Rwanda southward to Zambia, Malawi, and Zimbabwe (and increasingly parts of South Africa), a belt of countries inhabited by only 2 percent of the world's population."

[68] Lambkin (1906) in Packard and Epstein, *Op. cit:* p. 349.

[69] Packard and Epstein, *Ibid.:* p. 352 and Treichler in Fee and Fox, *Op. cit.:* p. 208

of Northwest Tanzania) are said to be so interested in sex that "they constitute a disproportionate number of Nairobi's commercial sex workers."[70] Treichler argues that, in the iconography of sex work, prostitutes are portrayed as being so contaminated that their bodies are "'always dripping,' virtual laboratory cultures for viral replication."[71] In the case of the African prostitute, this image is reinforced by the fact that in the West she is already 'other' in terms of race and exposure to 'exotic disease'. Further, she comes from a culture that views sex as being enjoyable for its own sake, and as "a source of good health and even good fortune."[72] This ideology promotes an image in the West of the libidinous African sex-worker, who becomes both 'predator' and 'vector' in the Westernised iconography of HIV/AIDS.

The African woman's alleged amorality and "high background levels of viral, parasitic, and bacterial infections"[73] helped cast this Eve as the female, heterosexual equivalent of the gay male 'fast-laner'. Packard and Epstein argue that this first-world construction is the outcome of a "predisposition to look for 'deviance' in an African setting."[74] It is also a search for an

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[70] Caldwell and Caldwell, *Op. cit.*: p. 824

[71] Brandt *No Magic Bullet* (1985), as included in footnote 79 of Treichler in Fee and Fox, *Op. cit:* p. 251. A 1910 publication entitled *Lavinia Dock's 1910 Nursing Manual* is quoted thus on p. 196: "Prostitution is now as certainly the abiding place and inexhaustible source of. . . venereal disease, as the marshy swamp is the abode of the malaria-carrying mosquito, to the polluted water supply of the typhoid bacillus."

[72] Caldwell and Caldwell, *Op. cit.:* p. 834

[73] Packard and Epstein, *Op. cit.:* p. 371

'other' who resides in some dark, mysterious and dangerous place. A research focus on 'risk behaviours' rather than social factors has reinforced Western notions about sexual promiscuity being culturally determined, and the heterosexual nature of the African AIDS epidemic is thus believed to be "simply a product of the peculiarities of African behaviour".[75] For the African woman, the refocus on female sexuality has given rise to an assumption that she is not only Africa's principal AIDS icon, but she is the highly infectious *vector* of a raging epidemic. This assumption persists despite a disclaimer by researchers such as Caldwell and Caldwell to the effect that the epidemic in Africa is confined to specific areas, and that 'differential rates of transmission or susceptibility to infection by sex' indicate 'the likelihood that women are more often exposed to infected men than men are to infected women.'[76]

Surveys, such as the one conducted by Neequaye & Neequaye, Osei, Mingle, Ankra-Badu, Bentsi, and Asamoah-Adu, give a telling example of the African woman-as-vector thesis. The researchers focus on the activity of female 'commercial' sex-workers, drawing a now-familiar conclusion that HIV infection was brought to Ghana by 'foreign-based prostitutes' from neighbouring countries, some of whom (to demonstrate the extent of women's venality) had even been 'actively recruited by older women'.[77]

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[74] *Ibid.*: p. 353

[75] *Ibid.*: p. 356

[76] Caldwell and Caldwell, *Op. cit.*: p. 818

[77] Neequaye, Osei, Mingle, Ankra-Badu, Bentsi, Asamoah-Adu and Neequaye, "Dynamics of Human Immune Deficiency Virus (HIV) Epidemic - the Ghanaian Experience", *The Global Impact of AIDS,* 1988: p. 14

The parallels with the homophobic notion of gay man as 'recruiter' of young boys appear obvious.

The focus on woman-as-vector in the HIV/AIDS epidemic in Africa has given rise to survey data like the above in the name of AIDS research, and has re-stigmatised women according to the iconography of syphilis. Indeed, the image of the 'syphilitic' African woman might not have changed, because her co-existent STD status had prompted venereologists and epidemiologists to classify this Eve as the most efficient transmitter of HIV. In addition, the notion of African hypersexuality still leads (Western?) researchers and writers to construct the African woman in terms of vice, not only because of her so-called 'primary' role in the African HIV/AIDS epidemic via sex work, but because most women are perceived to be involved in sexual interchange throughout their sexual lives. The African woman, as principal actor in a sexual merry-go-round, is held to be either the 'travelling' prostitute who 'services' a migrant (male) labour force (thereby acting as a sexual substitute for absent wives), or the non-commercial sexual partner of many men on home territory.

The notion of promiscuous African woman as source of social pollution is often perpetuated without due examination of the complex social, political and economic conditions that have given rise to the women's sex work and sexual exchange.[78] This neglect is evident in a narrow focus on African sexuality and its

[78] Caldwell and Caldwell, *Op. cit.:* pp. 822-824

'difference' by researchers. It identifies a need by some researchers to define the sexual 'otherness' of an already stigmatised group in the hope of understanding the mysteries surrounding a new epidemic. The focus on 'other' sexuality has meant that the behaviour of African prostitutes has been described, quantified and analysed, just as it was for gay men in the USA. Unlike gay men, however, African prostitutes have failed to gain a voice in terms of AIDS discourse, so have been unable to demand treatment regimens or foster self-empowerment strategies for HIV prevention.

It could be argued that the shift in research focus from gay men to African women was inevitable, given the heterosexual nature of HIV/AIDS in Africa and misogynist perceptions that shape notions about STD. The 'woman-only' emphasis of AIDS discourse in Africa certainly gives rise to outrageous comments about women's role in 'spreading' HIV. For example, the Zimbabwe MP, Chief Mutoko, is reported as saying that "if a pregnant woman is found to have AIDS, she should be killed so that the AIDS ends there with her. . . You should not only terminate the pregnancy, because the women would still continue to spread the AIDS."[79]

Running counter to the 'female sex-worker as vector' theory of African AIDS is the argument that cultural practices, poverty and economic factors have contributed to the high rates of HIV infection in sub-Saharan Africa. Caldwell and Caldwell

[79] News Item "Kill pregnant AIDS sufferers, says MP", *The Press,* 10/3/94.

argue that female prostitution *per se* is not the conduit for HIV infection. Rather, they believe that HIV is endemic to areas where men are uncircumcised, and where one or both sexual partners have genital ulcer disease (GUD).[80] They conclude that

> [t]he ecological evidence, together with Kenyan and Ugandan medical studies, seems to place beyond doubt the fact that lack of male circumcision puts both individuals and whole societies at greater risk of genital ulcer disease and consequently, and probably separately as well, of HIV/AIDS.[81]

The writers' emphasis on male circumcision shifts the focus somewhat away from the 'promiscuous' woman to that of cultural praxis and its implications for sexually transmitted disease. It also brings into focus heterosexual man, an often silent partner in the AIDS epidemic in both African and Western countries. However, it is doubtful that the image of African Eve will shift from that of 'polluter', 'pervasive vector', 'contaminated other' and 'AIDS reservoir' to the (arguably) less stigmatising 'PWA'. If the traditions of the syphilis epidemic hold true, stereotypes about African hypersexuality, disease and cultural otherness will persist in the absence of a cure for HIV/AIDS, as will the age-old iconography of Eve.

Iconography surrounding the African PWA has surfaced in AIDS discourse in New Zealand, most particularly in the Peter

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[80] Other writers support this claim. Connor and Kingman *Op. cit.:* p. 222 state that men with genital ulcer disease and "uncircumcised men were also at higher risk of HIV than circumcised men", as does Leibowitch, *Op. cit.*

[81] Caldwell and Caldwell, *Op. cit.:* p. 840 GUD rarely occurs in Western countries.

Mwai case (see case study in Chapter 6). Here, an African man was charged with 'wilfully infecting' a number of white New Zealand women. Images of the atavistic, hypersexual African surfaced in reports about the case, as did notions of 'white vulnerability', particularly 'white women's vulnerability'. Publicity surrounding the case presented the New Zealand woman as foolish victim, rather than the 'promiscuous Eve'. Thus, the dichotomy between 'good' and 'bad' women was maintained because of a focus on white women's innocence and passivity, and her enthrallment with a dangerous (read 'African') man. As Gilman argues, this construction is the outcome of fear, and the urgent need for boundaries between 'vectors' and 'victims' in the AIDS epidemic. Warnings issued to New Zealand women by public health authorities were also explicit, telling of the dangers of engaging in sexual intercourse with men from countries where there is a high level of heterosexual infection.[82] Innocent 'white' New Zealand women were thus placed in counterpoint to iconography about the 'African Eve'. Other configurations of 'Eve' in the New Zealand context appear in Part II, most notably in the three case studies about the media, parliamentary discourse and sex workers.

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[82] Health Reseacher, personal communication, 1995

## 4.4 Conclusion

### *4.41 Reviewing the Epidemic....*

At first, the AIDS epidemic appeared unique in that white, middle-class gay men in the USA were its first 'victims'. The focus on gay men, although titillating, was met with scepticism by scientists such as Leibowitch who stated that "AIDS is not a disease linked to the homosexual condition - and never has been. Viruses, even in 1984, cannot recognize their homosexual victims as such, and no one in biology has ever regarded such a thing as conceivable."[83] Leibovitch has been proven right, but the epidemic manifests in selective ways and percolates to vulnerable populations rather than to whole societies. AIDS thus mimics other epidemics such as cholera and the bubonic plague in terms of its prevalence among outsiders such as the poor, the immigrant, and the 'social outcast'.

The discourse of AIDS is most akin to the rhetoric surrounding syphilis. Its focus on sexual praxis is similarly framed in terms of 'moral culpability' or 'sexual abnormality'. As stated by Fee, this discursive coupling has occurred because

> [b]oth diseases can be transmitted by sexual contact; both can also be transmitted nonsexually. The social perception of each disease has been heavily influenced by the possibility of sexual transmission and the attendant notions of responsibility, guilt, and blame. In each case, those suffering from the disease have often been regarded as both the cause and embodiment of the

[83] Leibowitch, *Op. cit.*: p. 4

> disease, and have been feared and blamed by others who define themselves as more virtuous.[84]

The link with syphilis ensured that AIDS was construed as an STD.

By the mid twentieth century, epidemics were believed 'conquered' or 'conquerable' due to the wonders of modern medicine. Sontag writes that "for decades, it had been confidently assumed that such calamities belonged to the past."[85] In 1984, Robert Gallo articulated the scientist's incredulity when he wrote "just at a moment when prominent medical scientists were predicting the end of the great human infectious epidemics, AIDS entered the most technologically advanced societies in a manner stranger than science fiction".[86] Old concerns about 'sexual' disease re-emerged to leap-frog the decades separating syphilis from HIV, suggesting that the rhetoric surrounding epidemics is more resistant to 'cure' than perhaps the microbes themselves.

To paraphrase Dr Mathilde Krim of AMFAR (American Foundation for AIDS Research), much about the AIDS epidemic has been predictable.[87] Krim refers to the neglect, denial and stigma afforded PWAs. This response replicates that of prior epidemics such as cholera and the bubonic plague. Each epidemic is shaped by the nature of disease, and its course is dictated, like that of

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[84] Fee, *Op. cit.:* p. 122

[85] Sontag, *AIDS and its Metaphors,* 1989: p. 60

[86] Gallo in Leibowitch, *Op. cit.:* p. xi

[87] See footnote 1, this chapter

wartime influenza, by its social context.

Gay activists (both men and women) have defied epidemiologic tradition by rejecting the traditional images of 'sufferer' and 'isolate'. By attempting to reverse the notion of vector-as-victim in the HIV/AIDS epidemic, activists reframed the age-old discourse about sexuality and disease. Such reframing has afforded new meaning to the concept 'principal icon', so that the PWA's image is that of rhetorician as well as 'abject victim' of Gilman's syphilis iconography. The result has been increased health care, funding, and political clout for PWAs and the gay community. This outcome is unique, perhaps even more than 'the new epidemic' itself.

### *4.42 ...and its Icons*

A central task of this chapter has been to illustrate how prior discourse has shaped responses to AIDS. As discussed, gay men, injecting drug users and the 'African Eve' have experienced re-stigmatisation according to the 'social outcast' or 'foreigner' paradigm of other epidemics. The discourse surrounding the sexually active African woman or prostitute seems little changed from that of the syphilis epidemic. The discourse of syphilis (and of the African 'other') has also prompted research into the sexual mores of African men. Gilman suggests that this focus is indicative of western phobia about African sexuality, a fact obviated by the dearth of research into, say, the sexual behaviour of heterosexual men in the West. It appears that concepts about

the African PWA are anchored in mythology about Africa as the 'dark continent' which produces hypersexuality along with 'evil' and exotic diseases. Such concepts are measured against Western ideology which posits a 'constrained' sexuality as guard against social disorder, racial disintegration and the ravages of disease.

Prior discourse has also shaped imagery about the injecting drug user in the AIDS epidemic. This icon, multiply constructed in terms of race, hypersexuality and drugs imagery, is aligned with the African (cultural) model of HIV carrier rather than with 'sexual' icons such as gay men. The injecting drug user is thus cast as 'urban sociopath' or 'racial other' rather than 'AIDS victim' or 'carrier'. Discourse about STD appears to have had little impact on the image of the injecting drug user, despite the advent of AIDS. Instead, the reverse has occurred, with AIDS serving to shape and endorse the moral discourse on drugs.

The gay man's image is much broader, carrying with it baggage about sexual abnormality as well as that about class, race and disease. The HIV+ gay male is often assumed to be middle class, white, and politically astute. Like the African-American male or the female prostitute, however, he is constructed as being hypersexual and, therefore, diseased. This icon's image has evolved more powerfully than that of the abject syphilitic, or of the less politicised 'African Eve' and injecting drug user. The re-emergence of the gay community as a political force in the 1980s is a particular feature of the HIV/AIDS epidemic.

The fluid iconography surrounding gay men, injecting drug users and African sex workers during the HIV/AIDS epidemic is not just the dynamics of a 'new' disease. Rather, as Delaporte's thesis suggests, it was grounded in pre-existing ideas and contexts which categorised 'homosexuals', 'drug abusers' or 'prostitutes' according to different pathologies or 'types'. AIDS iconography has thus stemmed from prior social or cultural assumptions that created risk groups according to moral or social hierarchies. In this, the process of creating 'otherness' and its outcomes in the AIDS epidemic is little different from 'old' afflictions such as leprosy, that most ancient of the chronic diseases. The basis of analysis of this process, and its meanings for response and activism in New Zealand's HIV/AIDS epidemic are presented in Part II.

# PART II: THEORISING EVE:

# CASE STUDIES AND CONCEPTUALISATIONS

# INTRODUCTION

To most New Zealanders, the story of Eve in New Zealand's HIV/AIDS epidemic has been about an Australian-born girl who died from the complications of AIDS in 1993. Eve van Grafhorst's story was celebrated in the popular media, and it provided an insight into the mysteries of HIV/AIDS for many New Zealanders. Eve van Grafhorst, however, was not the only 'Eve' to emerge in AIDS discourse. Theorists such as Sander Gilman argue that sexual imagery has resurfaced from the leprosy and syphilis epidemics to shape the way HIV+ individuals are both perceived and stigmatised. Part of this imagery incorporates the biblical notion of Eve. In Part II of the thesis, I examine the concept of 'Eve' in the HIV/AIDS epidemic in New Zealand and overseas, and explore the ways in which notions about 'Eve' in a sexual epidemic have shaped local media and public health responses, and in turn, how such notions have been shaped by local factors.

Chapter 5 ("The Appearance of Eve in New Zealand's Response to HIV/AIDS") includes a discussion about iconography, power and discourse in the local context. This chapter summarises AIDS organising in New Zealand, for which background material is provided in Appendix II. The theme 'AIDS is a gay man's disease' is presented as an organising theme for AIDS activists, government and the health sector. The

empowerment of gay men, sex-workers and injecting drug users through government-sponsored HIV prevention programmes is seen as dependent on AIDS iconography. The momentum and challenges of these public health paradigms reflect the activists' reframing of 'Eve'.

Gilman's iconographic constructs, developed from visual and textual representations of sexual epidemics such as syphilis and HIV/AIDS, are explored and elaborated upon in Chapter 6 ("Images of Eve in the HIV/AIDS Epidemic"). To illustrate how iconography has developed in the HIV/AIDS epidemic, a case study ("Icons of AIDS - the Media and Popular Culture") is included that draws on iconographic material presented in the popular media in New Zealand and overseas. Particular reference is made to Eve van Grafhorst, as New Zealand's principal AIDS icon. An analysis of the way in which media presentation of Eve both reifies and challenges AIDS iconography forms the basis of this study.

In the following paragraphs, I provide an overview of the theoretical frameworks used in the analysis of media, parliamentary and community responses to HIV/AIDS in New Zealand. This overview focuses on power relations and on discourse as a means of conceptualising or resisting notions about AIDS. I use the theories of Gilman and Foucault to examine how discourse and the exercise of power are inextricably linked in the way HIV/AIDS in New Zealand is both conceptualised and

managed.

To understand the cultural and socio-political context in which Gilman's iconography was developed (and its relevance for power relations in the HIV/AIDS epidemic), I draw upon Michel Foucault's genealogy of power and sexuality as outlined in his book *The History of Sexuality: An Introduction.* In Chapter 7 ("An Epidemic of Discourse?") the nexus between power relations and gay activism in the HIV/AIDS epidemic is analysed, drawing on Foucault's notions of resistance and strategy. In Chapter 8 ("Foucault and The Life Project in the HIV/AIDS Epidemic"), I discuss Foucault's journey into the construction of sexuality in Western Europe as a means of understanding the discursive context of a 'Western' nation such as New Zealand. In this latter chapter I demonstrate how sexual discourses can both confine and empower individuals during a 'sexual' epidemic such as HIV/AIDS. In particular, I analyse the activities of the NZPC for their contribution to the development of sexual discourse during New Zealand's HIV/AIDS epidemic.

Both Gilman's and Foucault's work were developed out of historical analyses of responses to health and reproductive issues. Gilman's analysis centres on the construction of notions about 'disease bearers' from the leprosy and syphilis epidemics. Gilman, in his chapter "AIDS and Syphilis: The Iconography of Disease" *(Cultural Analysis, Cultural Activism*), argues that

disease typologies are the outcome of blame directed at certain 'risk groups' during a major health crisis. While Gilman provides an historical overview of the development of such typologies, his analysis is restricted mostly to the deconstruction of visual images (pictures, photographs and media imagery) and their stigmatising outcomes. Gilman's focus on the visual and textual aspects of disease iconography omits an analysis of the power relations which invoke such image-making. I incorporate Foucault's insights into power and sexuality to broaden the analysis and to provide an understanding of how the exercise of power operates to both construct and reproduce iconography according to pre-existing social categories and methods of disease prevention. Foucault's insights are particularly useful for examining how Gilman's iconography has been utilised or produced in organisational power relations both in the syphilis and HIV/AIDS epidemics. An exploration of the notion of 'resistance' according to the insights offered by Foucault is included in the case study "Gay Activism in the HIV/AIDS Epidemic".

Case studies are also presented at the end of Chapters 7 and 8. For these studies, material already referred to in the thesis is used to explore the nature of AIDS iconography in New Zealand. Foucault's insights about power and sexuality are integrated with Gilman's iconography, so that each study is an exploration of epidemiologic image-making in New Zealand according to an historical, organisational or discursive context. In each, I

discuss the meaning of image-making for the politics of AIDS organising in New Zealand, and examine how power is utilised or produced within the 'iconographic' text. The topics chosen for discussion are a) "A Case Study of AIDS Discourse: Parliamentary Debates about Homosexual Law Reform and the 1993 Human Rights Amendment" and b) "Reframing Eve: Sex-Workers, Legitimacy and 'Life'".

The three case studies were chosen for their illustrative and practical value. Each study is an exploration of the 'iconography of Eve' concept in New Zealand's response to AIDS. First, analysis of the news media's portrayal of Eve van Grafhorst facilitates an exploration of local discourses about sexuality, race, and gender. Second, the study of parliamentary discourse about Homosexual Law Reform and the Human Rights Amendment Bill highlights the particularity of AIDS iconography, and its links to biblical myths about Adam and Eve. Third, the case study about New Zealand sex workers discusses the iconography of Eve in the workplace both in terms of prostitutes' roles as HIV educators and as activists who seek a reversal of long-term discourse that frames them as venal and disease-ridden.

The case studies were chosen, in part, on the basis of available data from library and agency records, news items and the Hansard debates. The material for the first two case studies had broad applicability, was a matter of public record, and could

be analysed for its general impact on the New Zealand public. Material from or about the New Zealand Prostitutes' Collective was specific and had limited coverage, but was unique in its development of an activist discourse during New Zealand's HIV/AIDS epidemic.

The case studies are arranged according to their level of generality. The first case study represents the greatest level of generality; the New Zealand media reaches many New Zealanders, its subject matter is drawn from multiple and international sources, it covers a wide range of topics, and it purports to represent the various conflicting, contradictory or competing understandings about a particular topic. Within this context, the story of Eve van Grafhorst offers a singular perspective. Eve's story is valuable for the way it both disrupts and reaffirms AIDS iconography according to gender, sexuality and racial stereotypes in the local context. In the second case study, the parliamentary context is specific in its locus and structure. Nevertheless, the politicians also offer a general perspective; their debates about local concerns are often anchored in a broad moral discourse that has its roots in Judeo-Christian history. In the third case study, blame of prostitutes in the HIV/AIDS epidemic is the product of long-standing discourse about women's sexuality. However, the activist discourse developed by New Zealand sex-workers is not only occupationally specific, but its existence and vigor represents a particular cultural phenomenon.

# CHAPTER FIVE

## THE APPEARANCE OF EVE IN NEW ZEALAND'S RESPONSE TO HIV/AIDS

## 5.1 Introduction

This chapter about responses to HIV/AIDS in New Zealand builds on the examination of epidemics in Part I, and serves as a segue to the discussion of power, iconography and discourse in Chapters 6, 7 and 8. It includes an introductory perspective on the media's coverage of AIDS, for which a more detailed analysis follows. Legal and religious activities relating to the epidemic are not covered here; although they are part of New Zealand's 'integrated' approach to HIV/AIDS, their role has not been particularly influential. This chapter, then, highlights selected roles that organisations play in HIV prevention as well as in common understandings about 'risk groups.' A background overview of community, government and medical sector responses to HIV/AIDS is included separately in Appendix II.

A central argument of this thesis is that the discourse of 'Eve' has shaped public health responses to HIV/AIDS in New Zealand. 'Eve' is manifested in New Zealand's AIDS epidemic as 'the gay man's disease' with implications for legislative reform, health measures, and community activism. As noted earlier, this discourse is framed by iconography from previous epidemics, particularly 'sexual epidemics such as leprosy and syphilis. Its appearance in New Zealand is the outcome of local understandings about 'sexual' women and 'sodomists' (a legacy of British socio-medical discourse about syphilis), and of overseas media, moral

and medical discourse about HIV/AIDS.

## *5.11 Background*

New Zealand is a small Pacific nation, populated by people of mainly British, Maori and Pacific Island descent.[1] In 1991, New Zealand's population was about 3,500,000 of whom the majority (79.1%) claim British or European heritage. [2] Like Canada and Australia, New Zealand was once a British colony. The country's style of government has traditionally been modelled on that of Britain. Strong personal, historical and political ties remain to Britain and British-style institutions.

Political responses to health care in New Zealand have been hailed as progressive since moves to stem the syphilis epidemic in the nineteenth century. In 1938, a comprehensive 'cradle-to-grave' health care system was introduced by a social-progressive Labour government. Since 1990, this once-vaunted health care system has been eroded by market-based health reforms. True to the social-progressive tradition, the recently implemented health-sector changes are reported to have been more rapid and comprehensive than any of their overseas models.[3]

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[1] *The 1994 New Zealand Yearbook* lists New Zealand's population as 79.1% European, 3.8% Pacific Islander, 9.7% Maori, 4.7 % mixed ethnic origin and 2.7% 'other' (p.94). Statistics relate to the population census conducted in 1991.

[2] *Ibid.*: p. 80. The exact figure, as calculated from 1991 census data, is 3,434,950.

New Zealanders had encountered several epidemics before HIV/AIDS. In the early days of New Zealand's European settlement, diseases such as measles, diphtheria and the common cold (which were introduced by the early settlers) affected Maori in epidemic form, causing severe population losses.[4] Susceptibility to disease continues for Maori, resulting in lower life expectancy than for most European New Zealanders.[5] One of the first epidemics to affect both Maori and European (syphilis) saw a raft of legislation directed at controlling women's sexuality in the interests of 'race' (see Chapter 3). The influenza epidemic of 1918 was managed vigorously at a community level, but reluctantly by government officials. Public outrage over government neglect in the influenza epidemic gave rise to the 1920 Health Act. This Act laid the foundation for a widely admired public health system. Regulations brought in during the polio epidemic of 1924 according to the provisions of the Health Act were 'extraordinarily wide in scope' (see Chapter 2). The foundations of a comprehensive and responsive public health

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[3] Fougere, "The State and Health-Care Reform" in *A Leap Into The Dark: The Changing Role of the State in New Zealand since 1984*, 1994: pp107-124.

[4] Pool, *Te Iwi Maori: A New Zealand Population Past, Present and Projected*, 1991: pp. 82-5

[5] *Ibid.*: p. 175 For example, Maori suffer disproportionately from diseases such as cancer, diabetes and heart failure. 1987 statistics from *New Zealand Now Maori*, 1994: p. 7 indicate that Maori cancer rates are 12% higher than for Pakeha, deaths from circulatory disease are 41% higher (35% for men, 47% for women) and that adult deaths from respiratory diseases are about 25% higher (Figure 2.6). More recent data were unavailable.

system in New Zealand were laid well before the HIV/AIDS epidemic.

## *5.12 HIV/AIDS in New Zealand*

Eleven years into New Zealand's HIV/AIDS epidemic, there were 473 notifications for AIDS, with 997 individuals testing positive for HIV.[6] In 1992, AIDS notifications stood at 10.4 per 100,000 total population, compared to rates of 79.7 for the USA, 20.1 for Canada, 8.5 for Britain and 21.2 for Australia.[7] New Zealand's rate therefore compares favourably with that of countries such as the USA, Canada, and Australia. Maori compose about ten percent of New Zealand's total, which approximates their overall numbers in the population. Maori are therefore not disproportionately represented in New Zealand's AIDS statistics.[8] Figure 5.1 sets out, in graph form, AIDS notifications in New Zealand from 1984 to 1994 in yearly and cumulative totals. A reading of the graph indicates a sharp increase in notifications prior to 1990, followed by a significant

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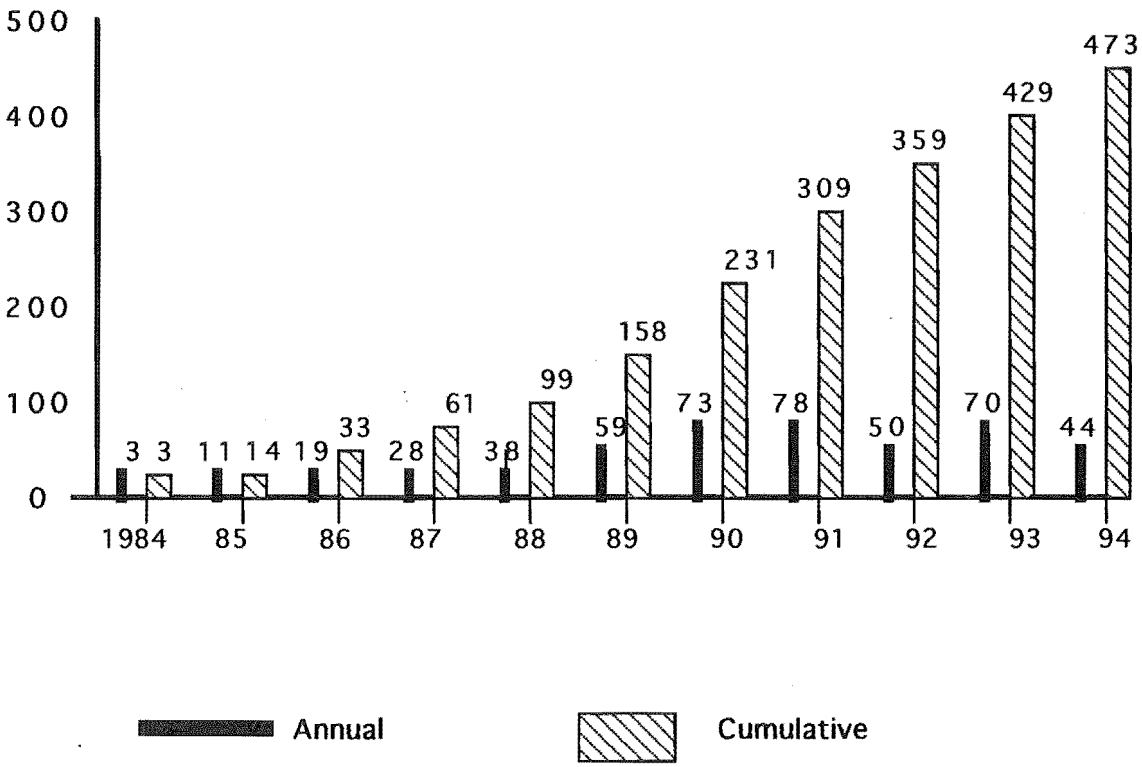
[6] *AIDS - New Zealand,* Issue 24: February 1995. The data relate to 1983-94

[7] (a) WHO report, "AIDS in the Western Pacific Region": July 1993 for Australian and New Zealand rates, and (b) *AIDS - New Zealand,* Issue 12, February 1992 for Canadian, British and US rates. New Zealand's AIDS notifications were listed as 14.5 per 100,000 population in *AIDS - New Zealand,* Issue 25, May 1995. An increase in AIDS notifications has also been noted in the US, Canada, Australia and Britain.

[8] *AIDS - New Zealand,* Issue 25, May 1995. This figure is disputed by Rex Pererana, director of Te Roopu Tautoko (Maori) who states that Maori comprise 89% of AIDS notifications for individuals aged between 21-25. (Mana News, 3/11/1994).

FIGURE 5.1 AIDS NOTIFICATIONS IN NEW ZEALAND: 1984-1994




Source: AIDS - New Zealand: Issue 24 - February 1995

levelling off. AIDS is a notifiable disease in New Zealand, so the data gathered are more reliable than for HIV notifications, for which information is gathered on a voluntary basis. Figure 5.2 depicts the fluctuations in AIDS notifications in New Zealand from 1984-1994. Gay men compose a large majority of PWAs. The first AIDS notifications were for gay men, who still compose a majority of new HIV infections (see Appendix II for further details).

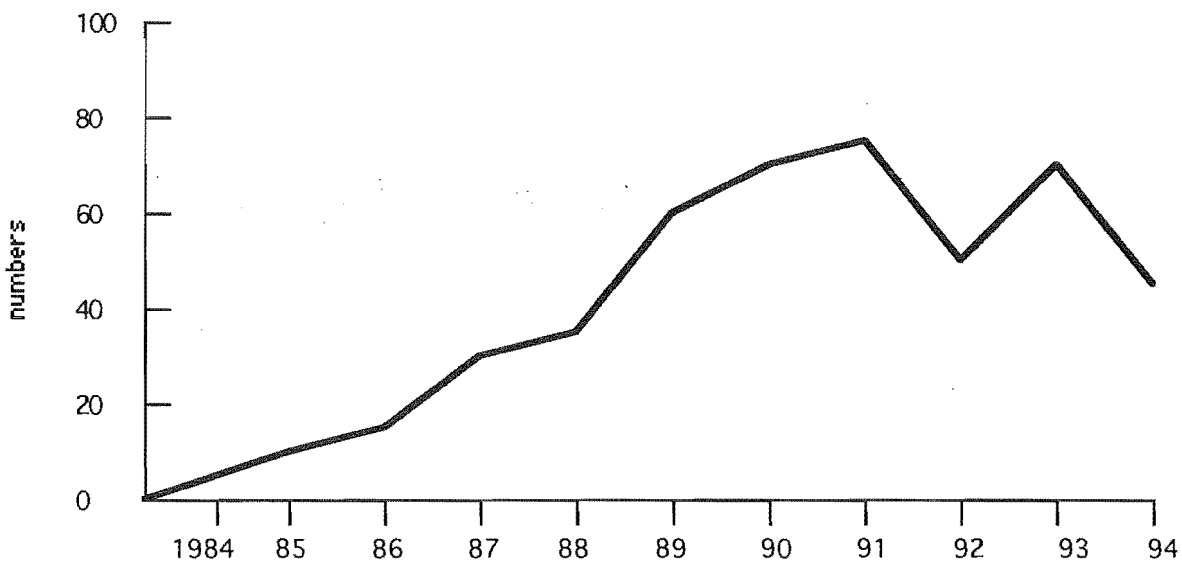
## 5.2 Community Responses to HIV/AIDS

In September 1981, before the syndrome had been named in the USA, a story about AIDS was published in the New Zealand gay community's news magazine *Pink Triangle*.[9] This speedy action heralded the beginning of New Zealand's organisational responses to HIV/AIDS. As in other western countries, efforts to deal with a 'new epidemic' were initiated by members of the gay community. Parkinson writes that, "the gay community here and elsewhere has a well-established tradition of health reporting, and gay community health programmes were already in operation before the AIDS crisis arose [in New Zealand]."[10] This tradition was forged by 'gay rights' activism during the 1970s. Members of

[9] Cited in Parkinson & Hughes, "The Gay Community and the Response to AIDS in New Zealand. *New Zealand Medical Journal*, 1987: p. 77. Phil Parkinson is a gay activist. He has served on the National Council on AIDS, is administrator of the Lesbian and Gay Rights Resource Centre, and is the curator of The Lesbian and Gay Archives of New Zealand (LAGANZ).

[10] *Ibid.* Parenthesis has been added

FIGURE 5.2 AIDS NOTIFICATIONS IN NEW ZEALAND BY YEAR: 1984-1994




Compiled from data in 'AIDS New Zealand', Issue 24 - February 1995

the gay community had developed political and social networks that could be used in a health crisis like HIV/AIDS. They had also gained media experience during prior attempts to de-criminalise New Zealand's sodomy laws.

One of the moves to prevent an impending epidemic "saw the National Gay Rights Coalition come out of recess to promote blood donor self-deferral as requested by the Blood Transfusion Service, and to conduct seminars on HIV/AIDS for the gay community."[11] Other moves included setting up STD clinics, creating an AIDS support network, producing HIV/AIDS awareness and safer-sex pamphlets, running an AIDS roadshow, and undertaking community outreach.[12] The response was spearheaded by Bruce Burnett, a New Zealand PWA with first-hand experience of HIV/AIDS community organising in the USA.[13] A discourse of crisis characterised these early measures, largely in response to news about the devastating effect of AIDS on gay men in the USA. The discourse constructed AIDS as 'the gay man's holocaust'. The sense of urgency engendered by the discourse enabled AIDS activists such as Burnett to rally support and funds

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[11] Lichtenstein, "An Initial Investigation into the New Zealand Response to AIDS", Sociology Honours paper, 1992. Self-deferral refers to the process by which gay men were asked to take responsibility for protecting New Zealand's blood supply by voluntarily ceasing to donate blood.

[12] Parkinson & Hughes, *Op. cit.:* pp 77-79 and Lindberg, "New Zealand National Strategy", Australian AIDS Conference, 1988. By 1985, the gay-run and supported AIDS Support Network had branches in six urban centres (Heeringa, "The Ailing Foundation" *Metro,* 1994: pp 80-81).

[13] *Ibid.:* p. 78 Burnett died in 1985.

from gay communities for HIV prevention.[14] The discourse also provided an impetus for homosexual law reform, and for wider lobbying of health department officials, members of the medical profession, and the media for coverage, funds and other resources.[15]

## 5.21 *'AIDS is a Gay Man's Disease'*

New Zealand's first AIDS 'case' was recorded in 1983, two years *after* the gay community began to educate its members about HIV. As stated in *The New Zealand Medical Journal,*

> in May 1983 a New Zealander who had been on holiday in San Francisco presented with an illness that was later recognised as an acute HIV infection. During the next two years, several patients with AIDS were diagnosed in New Zealand and nearly all had travelled overseas. AIDS was made a notifiable disease in August 1983.[16]

From 1983 to 1985, all PWAs in New Zealand were gay men. This phenomenon convinced the gay community that AIDS was 'their' problem, but one which required wider support to prevent a health crisis such as had occurred in the USA.

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[14] *Ibid.*

[15] The Department of Health became the Ministry of Health in the 1990 reforms, after which its orientation changed from a 'programmes' to 'policy' approach.

[16] Carlson, Skegg, Paul & Spears, "Occurrence of AIDS in New Zealand: The First Seven Years", *New Zealand Medical Journal,* 10 April 1991: p.131

Department of Health officials were reluctant to pursue HIV reduction programmes because of perceived links between AIDS and a then 'illegal' homosexuality.[17] Thus, New Zealand's first voluntary AIDS organisers and public health officials shared the perception that AIDS 'belonged' or was limited to gay men. Parkinson notes that the then Minister of Health, Mr A.G. Malcolm, publicly promoted the idea that AIDS was a gay man's disease.[18]

The fourth Labour Government was elected in 1984. This political change heralded a number of reforms, including a pro-active approach to HIV prevention. Following the advice of AIDS activists, medical professionals and some health officers, the new Government allocated $100,000 for the establishment of the New Zealand AIDS Foundation (NZAF). The organisation is run by gay men and provides HIV/AIDS support, counselling and prevention services. This move 'delegated' much of the

[17] Parkinson & Hughes, *Op. cit.*: p. 79. 'Homosexual acts' were deemed illegal in New Zealand until the Homosexual Law Reform Bill was passed on July 11, 1986. Before then, the New Zealand government had been reluctant to adopt pro-active AIDS policies and programmes, in part, because it meant dealing with law-breakers. The Act "removed a basic contradiction in the fight against AIDS in New Zealand - that a group of outlaws was being allocated large sums of taxpayers' money and government-funded resources." (Lichtenstein, *Op. cit:.* p.47) In their paper "AIDS Policy Response in New Zealand: Consensus in Crisis" *(Health Care Analysis,* 1994) authors Plumridge and Chetwynd write that a few health department officials also lobbied government. The authors state that "[B]y the end of 1984, a small cadre of senior figures within the Department had become as convinced as the AIDS Support Network [precursor to the AIDS Foundation] that there was a crisis in regard to AIDS, and was heavily influenced by the Network's analysis of the crisis" (p. 288). Parenthesis has been added

[18] Parkinson & Hughes, *Op. cit.:* p. 77

responsibility for AIDS prevention and support to the gay community, and illustrates the power of iconography in shaping responses to HIV/AIDS.[19]

By 1984, beliefs about HIV/AIDS being confined to a specific risk group in New Zealand had also emerged as a political statement in support of gay visibility. In particular, gays and others who believed that legalised (visible) homosexuality would help contain HIV made renewed attempts to have New Zealand's sodomy laws repealed.[20] By early 1985, the Homosexual Law Reform Bill was being debated in parliament, and despite an 800,000 signature petition against decriminalisation, the bill became law in 1986.[21]

Government funding did not guarantee political success for reformers seeking legislative change. Du Chateau cites

[19] A segment of the first major HIV/AIDS public awareness campaign in 1985 was also 'delegated' to the gay community, (*Ibid.:* p. 79). However, the DOH increasingly undertook responsibility for public awareness of HIV/AIDS and coordinated campaigns on an annual basis from 1985-89 (Crofts et al, "Involving the Communities: AIDS in Australia and New Zealand", *AIDS in Asia and the Pacific,* 1994.: p. 45). In 1986, "The New Zealand Department of Health produced the first government-sponsored television promotion for condoms in the world" (Lindberg, *Op. cit.:* p.: 9)

[20] Du Chateau, " Aids - Apocalypse How?" *Metro:* November 1990: p. 78

[21] New Zealand was the first country to reform sodomy laws relating to homosexuality *because* of the threat of HIV/AIDS (CIVDURG Manager, interview: 8/12/93). This action is indicative of New Zealand's 'health measures' legislation during the HIV/AIDS epidemic. See Parliamentary Case Study (Chapter 7) for analysis.

contributing reasons, such as the political savvy of gay lobbyists. She writes: "the gays made a formidable lobby group: smart, energetic, and with a great deal at stake. They were also brilliant at networking and had excellent contacts in the media."[22] To gain maximum political leverage, the necessity for law reform as a form of HIV prevention was orchestrated by gay lobbyists, politicians and other policy-makers, all of whom focused on the idea of reform as necessary for 'health purposes', rather than a means of gaining equality for its own sake.[23] This pragmatic approach ensured that political discourse surrounding HIV/AIDS continued to reiterate the notion of AIDS being a 'gay man's disease'. The premise was not contradicted by a focus on 'health measures' rather than 'gay-rights' in HIV-related legislation after 1985, primarily because most of the changes made were either activated by the gay community or were in support of its concerns.

In publicising the issue of AIDS and homosexuality within the framework of law reform, the local gay community gained considerable political leverage. Several commentators agree that, unlike similar groups overseas, local gays had "used the disease [*sic*] to legalise homosexuality."[24] AIDS activists in

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[22] Du Chateau, *Op. cit.*: p. 78

[23] Luke, "Gay Law Passes Easily After it Becomes a Health Issue", *The Christchurch Press:* 31/7/93: p.22 In introducing the Human Rights Amendment Bill, Katherine O'Reagan stated that "if discrimination against gays or HIV sufferers was allowed to continue, such people would not be prepared to risk identification by seeking treatment, counselling, or testing [for HIV]" (Luke, 29/7/93: p. 6) Parenthesis has been added

New Zealand were, and still are, at pains "to point out that AIDS is almost exclusively a gay disease."[25] Their insistence comes at a time when funding for gay HIV-related services is contracting, competition for AIDS funding has increased under the National Party's health reforms, new HIV notifications for gay men have declined as a percentage of the total, and women's HIV groups and others pose a challenge to allegedly male-focused HIV/AIDS programmes provided by the AIDS Foundation.

Sex-workers, IDUs, lesbian women, PWAs and gay men have been at the centre of AIDS organising, often interchangeably as clients and staff. Although the staff of community agencies are mostly women or gay men, the clientele is often more diverse. For example, HIV/AIDS outreach and counselling is directed or available to all New Zealanders as a matter of policy, and injecting drug user groups and the sexual health clinics have equal numbers of heterosexual men in their clientele.[26] This staff/client gender disparity highlights the 'feminisation' of AIDS organising in New Zealand. The belief that HIV/AIDS is confined to gay men still holds sway even as the syndrome itself becomes more feminised in New Zealand.[27] Thus, well-

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[24] Informant, interview: 9/3/92. Also, Du Chateau, *Op. cit.:* pp. 78-80 Parenthesis has been added

[25] Du Chateau, *Ibid.:* p. 78

[26] Injecting drug users are more likely to be male, while new clients at the Christchurch Sexual Health Centre are equally male and female. (Estimates based on CIVDURG and the Christchurch Sexual Health and STD Centre figures for 1993).

[27] *AIDS - New Zealand,* Issue 22: August 1994. In the second quarter of 1994,

entrenched beliefs about gay men and their relationship to HIV serves to deflect any meaningful challenge to the male-focused agenda of organisations such as the AIDS Foundation. In this instance, the rubric 'AIDS is a gay man's disease' serves to privilege gay men, albeit in a marginalised context.

## 5.3 Government Responses to HIV/AIDS

The Labour Government's recognition that effective control of HIV depended on the cooperation and involvement of gay men, sex-workers and IDUs resulted in significant funding to the major 'risk groups' after 1985. However, according to Du Chateau, the aim of government actions was to protect the 'general public' from risk rather than to protect the major 'risk group' from HIV infection.[28] Thus, the theme 'AIDS is a gay man's disease' emerged in official responses which framed 'Eve'-surrogates (gay men, sex-workers) and IDUs as polluters of the heterosexual population.

Du Chateau maintains that the government's belief in an impending heterosexual epidemic was prompted by African-based data promulgated by WHO and by media reports about the African origin of AIDS.[29] The WHO's warnings about the spread of AIDS

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five women and sixteen men were notified as being HIV+. While these figures should be interpreted with caution due to fluctuations in quarterly figures (and because of inconsistencies in the HIV database), they indicate increased numbers of HIV+ women.

[28] Du Chateau, *Op. cit.*: p. 80

was based, in part, on perceptions about the 'African Eve' as HIV vector. The African Eve was thought to be particularly infectious because of her prior STD status. Government's adoption of World Health Organisation recommendations was viewed by gays as inappropriate for Westerners, where links between STD and HIV were arguably tenuous. Thus, gays refuted the epidemiologic links between the African Eve and gay men. However, the iconography of Eve represents the 'African' and gay men in strikingly similar ways. A specific reference to the African connection is made in the case study within Chapter 6 that analyses media representation of 'promiscuous' white gay men such as Liberace and 'Vincent', and the 'hyper-sexual' African male, Peter Mwai.

Public health responses to HIV/AIDS began to contract with the re-election of the National Government in 1990 (see Appendix II). This contraction has resulted in a refocus on the 'AIDS is a gay man's disease' theme. As much as this thematic recycling is the unintended outcome of health reform, gay men reinforce it by insisting that AIDS 'belongs' to them. This stance is a political project, and while based on the reality that most PWAs are gay men, it is fueled by increasing uncertainty about funding under a contractionist regime. The motif is actively promoted by the newly-formed (1994) activist group, Gay Men Fighting For AIDS. This group seeks to reverse the PHC's funding policy for HIV prevention programmes for gay men.[30] The notion that gay men

[29] *Ibid.*: p.76 WHO's predictions about a heterosexual epidemic were based on data from sub-Saharan Africa.

infect the 'general population' was reiterated by spokesman Callum Sawyer, who tacitly acknowledged the increasing numbers of HIV+ women in New Zealand when he stated that "if the funding is decreased that spells danger, because most women infected with HIV are infected by men who have sex with other men."[31]

## 5.4 Medical Responses

AIDS research in New Zealand involves socio-behavioural research rather than clinical drug trials or vaccine development. This focus has resulted in a number of studies aimed at ascertaining the knowledge, attitudes and sexual practices of 'risk groups' and 'the general population'.[32] Much of this research has been generated by social scientists in medical and university settings.

Research endeavours, such as those undertaken by members of the AIDS Epidemiology Group, try to identify potential sites of HIV infection in New Zealand.[33] The group has conducted sentinel testing at sexual health clinics and needle exchanges, a process involving the collection of anonymous blood and saliva samples for HIV testing.[34] The pro-active, epidemiologic

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[30] News item, National Radio: 22/9/94

[31] Wharemate-Sadler, "Funding Attack Planned", *Man to Man, 18/8/94*: p.4

[32] Abstracts of these studies are contained in the HRC's 69 page document: *Social Research on HIV/AIDS in New Zealand - A Bibliography 1984-1993.*

[33] Dickson, Paul, & Herbison, "Adolescents, Sexual Behaviour and Implications for an Epidemic of HIV/AIDS Among the Young", *Genitourinary Medicine,* 1993.

approach to HIV/AIDS research and enquiry by medical professionals has prompted Dr Jane Chetwynd to comment that "we are totally on top of where major infections are occurring in New Zealand."[35] The medical/scientific AIDS research shifted from HIV surveillance in the early days of the epidemic to the eclectic focus on 'risk sites' (STD clinics, methadone programmes).[36]

Researchers at the Department of Public Health, Christchurch School of Medicine have collaborated with some members of the New Zealand Prostitutes' Collective (NZPC).[37] The partnership has been more interactive than might have been expected from the traditional scientist/research subject

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[34] (a) Dickson, Paul, Austin, Sharples & Skegg, "HIV Surveillance by Testing Saliva from Injecting Drug Users: A National Study in New Zealand" in *Journal of Epidemiology and Community Health*, in press, and (b) AIDS Epidemiologist, interview: 20/5/93.

[35] Dr Jane Chetwynd is Professor of Public Health and General Practice, Christchurch School of Medicine. The comment was made on 24/8/94 at a public lecture about HIV/AIDS research.

[36] Compulsory testing for HIV/AIDS is illegal in New Zealand. Researchers have thus engaged in creative ways of obtaining blood, saliva and other samples to test for HIV.

[37] Some collaborative efforts include the following: "Report on pilot study of knowledge and practices concerning HIV/AIDS amongst a sample of sex workers in New Zealand" (Chetwynd, Report to the New Zealand Prostitutes Collective, 1991), "Report on SIREN readership survey - 1991" (Chetwynd, report to the New Zealand Prostitutes Collective, 1991), and "The New Zealand Prostitutes Collective - a process evaluation of its formation and operation" (Chetwynd, report to the New Zealand Prostitutes Collective, 1991). A number of collaborative studies were also undertaken by members of the gay community and medical researchers (see *"Social Research on HIV/AIDS in New Zealand - A Bibliography 1984-1993:* pp 11-23).

paradigm. While social-behavioural researchers had first sought to investigate the sexual practices and attitudes of the gay community and the wider public, members of the NZPC initiated the research on their own organisation and clients. The efficacy of the NZPC and its HIV prevention magazine *Siren* reflects research initiated by sex-workers and mutually explored by researchers and the NZPC.[38] This collaborative effort has also produced a pilot study on the knowledge, attitudes and activities of sex-workers' clients, rather than on sex-workers themselves.[39] The concerns of NZPC members are now intertwined with the interests of socio-behavioural researchers in the medical and university sectors. The impact and meaning of this symbiosis on the iconography of HIV/AIDS in New Zealand are discussed later.

In the clinical sector, venereologists have attempted to incorporate HIV prevention into their sexual health programmes with increasing success. In 1989, the Labour Government

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[38] Dr Jane Chetwynd, personal communication: 28/9/94. Nevertheless, published results of the surveys conducted omit the names of the sex-worker/research assistants, perhaps for reasons of anonymity. In the acknowledgements of one study, the researchers note that: "We would normally have included our interviewer as an author on this paper but for reasons of confidentiality she preferred not to be named.": Chetwynd & Plumridge, "Knowledge, Attitudes and Activities of Male Clients of Female Sex Workers: Risk Factors for HIV" in *New Zealand Medical Journal,* 14/9/94. Altman (1994) is sceptical about the notion of collaborative research, maintaining that "'collaboration between social researchers and community organizations all too often means no more than providing researchers with a better opportunity to recruit subjects for study" (p.126).

[39] Chetwynd & Plumridge, *Ibid.:* pp. 351-353

allocated extra funding which effectively "doubled the service of the Christchurch STD Clinic."[40] In 1993, the PHC created an advisory committee on STDs and HIV/AIDS (see Appendix II), thus paving the way for integration of HIV/AIDS with existing sexual health services. The move toward integration has been promoted by government officials, venereologists, WHO and overseas policy-makers from countries such as Britain and Australia, as epidemiolgic discourse has proliferated about STD serving as a 'marker' for HIV infection.

## 5.5 Publicising AIDS

In 1983, *The Press* published its first news item about HIV/AIDS ("AIDS Could Exist in New Zealand").[41] The gay community had already published its first story about HIV/AIDS in 1981.[42] While the general media's response to HIV/AIDS seems tardy, it compares well with the USA where the epidemic was given little coverage in the print and electronic media until 1985.[43] In the early years of New Zealand reporting about the HIV/AIDS epidemic, the public was treated to alarmist stories about an impending health disaster.

Specialist journals such as the *New Zealand Medical Journal* (NZMJ) and *Health* have been major contributors to

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[40] Christchurch Sexual Health Centre Informant, interview: 13/10/93

[41] *The Press*, 1/11/83: p. 4

[42] See footnote 9, this chapter.

[43] Shilts, *And The Band Played On*, 1987

medical/scientific information about HIV/AIDS. Both were publishing factual articles about HIV/AIDS by 1985.[44] In the general print media, glossy magazines such as *More*, *North and South* and *Metro* were alerting readers about HIV/AIDS by 1987, although the latter was also sensationalising the 'gay life-style' through articles such as "Vidi Vici Veni: The Memoirs Of A Sex Maniac."[45] Women's magazines such as *The New Zealand Woman's Weekly*, and *New Idea* published factual and human-interest stories about HIV/AIDS. Their focus has been on HIV+ children and their families, rather than on gay men.

The theme 'AIDS is a gay man's disease' was often ignored or implicit in mainstream media coverage about the epidemic during the crisis period. Items were headed "The Truth About AIDS", "AIDS: The Facts", and "The Panic Versus The Facts" in an attempt to alleviate heterosexuals' fears.[46] As the epidemic progressed, there was a shift away from 'facts and figures' reportage to a broader concern with social issues or personalities such as Eve van Grafhorst. 'Angel Eve', as Eve became known through the print and electronic media, was given star billing,

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[44] The *NZMJ* published its first three articles about HIV/AIDS in 1983; *Health* published its first article in 1985.

[45] *Metro* articles focusing on the 'gay lifestyle' include "The Death That Dare Not Speak Its Name (*Metro*, 6 (70) 1987:pp. 88-90) and "Vidi Vici Veni:The Memoirs Of A Sex Maniac" (*Metro*, 6 (70), 1987: pp.78-86 ).

[46] (a) Westaway, "The Truth About AIDS", *The New Zealand Woman's Weekly*, 18/2/85: pp17-19, (b) Calvert, "AIDS: The Facts", *Broadsheet*, May 1985: pp36-7, (c) Bryan, "The Panic Versus The Facts", *More*, 20/5/85: pp.15-20

particularly by the editors of some women's magazines. The meaning of 'soft-focus' journalism on Eve van Grafhorst and her family for AIDS iconography in New Zealand is analysed in Chapter 6.

Print media responses to HIV/AIDS from 1983 to 1994 suggest a link between public health responses to HIV/AIDS and print media coverage. The early years of the epidemic in New Zealand were characterised by few articles or news items on HIV/AIDS. *The Press* published only two items during 1983 ("AIDS Could Exist In New Zealand": 1/11/83 and "New Zealand Man In Australia Has AIDS": 21/11/83). Coverage of HIV/AIDS increased during the crisis period, with the number of items peaking in 1989 as complacency about a 'heterosexual' epidemic set in. The decline in public health responses to HIV/AIDS in New Zealand is mirrored by a decrease in the number of items published in newspapers, magazines and journals between 1990 and 1994. The nature of articles about AIDS also changed from topics reflecting 'local panic' during the crisis period (for example, "AIDS: a race against time" and "A time for urgency")[47] to 'overseas news' (for example, "Needle swap scheme aims to cut Baltimore's AIDS Cases", and "'Safe' AIDS vaccine mutates").[48] Several of the 1994 news items in *The Press* reassured heterosexuals that the panic was over (for example, "Heterosexual AIDS myth undone": 5/1/94, and "'One in 1000'

[47] a) *Health*, Spring 1987: pp 3-4, and b) Fry, *The Listener*, 18/4/87: p. 5

[48] *The Press*, (a) 19/9/94:11, (b) 30/9/94:14).

chance of HIV from unprotected sex":10/6/94). Figure 5.3 depicts media responses to AIDS from 1983 to 1994 (see overleaf). Some caution should be used in interpreting the chart because of errors in the database.[49]

## 5.6 Conclusion

Organisational responses to HIV/AIDS in New Zealand began in the gay community in 1981. The efforts of AIDS activists centred on educating gay men about HIV/AIDS, a response led by Bruce Burnett, one of New Zealand's first PWAs. The gay community's early prevention strategies parallel those in other countries such as the USA, Canada, Britain and Australia (see Appendix I). In these countries, efforts by gay organisers preceded government measures to control HIV/AIDS. AIDS discourse focused on gay men as AIDS vectors, and was accepted by members of the gay community in an effort to secure funds for HIV/AIDS prevention and support. In New Zealand, then, gay men are victims, activists and stakeholders. Their role in AIDS organising has been pivotal in shaping government and health sector responses to HIV.

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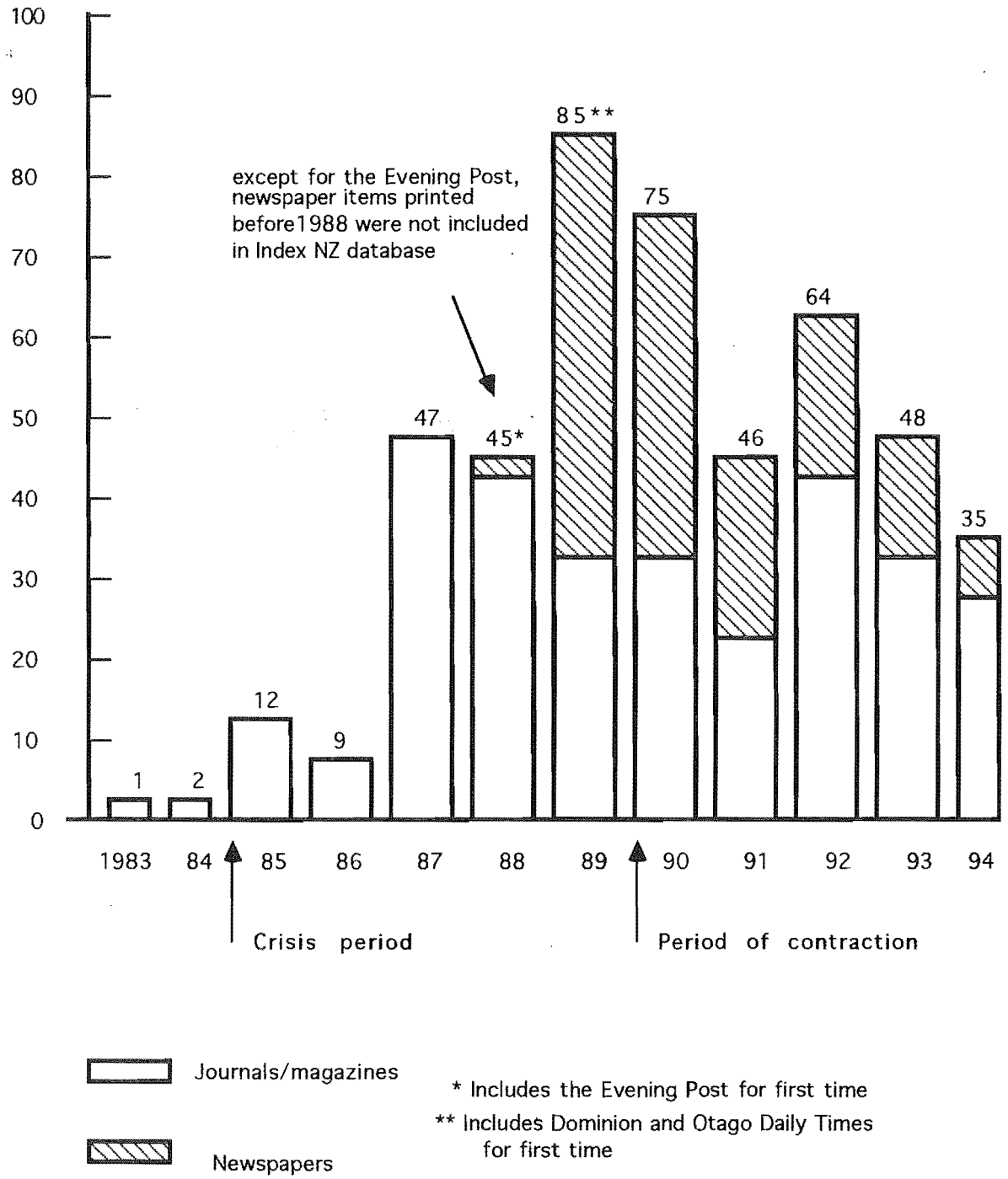
[49] The database, Index New Zealand, was presented in three different forms (bound volumes, microfiche and computerised listings) from 1983-94. An analysis of the data revealed inaccuracies such as double entries, omitted items, and later additions to the data source from newly included newspapers and specialist magazines. NINX, the computerised database for newspaper items, began in 1990 and was therefore of limited use. However, for the period between 1990-93 inclusive, the trend in NINX data mirrored INNZ's reduced number of items published about AIDS and related topics.

Figure 5.3 Newspaper, Journal and Magazine Articles Published on AIDS and Related Topics in New Zealand: 1983-1994 *




* Compiled from Index New Zealand database (1983-94). Only the major newspapers (Dominion, Evening post, Independent, National Business Review, NZ Herald, Otago Daily Times, Press, and Sunday Times) were included in the database.

The iconography of Eve is paradoxically apparent in government's neglect of gay men in the early years of the epidemic, and in crisis funding to gay men, sex-workers and IDUs after 1985. If the plight of gay men was ignored by government in the early years of the AIDS epidemic, so were the occupational hazards faced by New Zealand sex-workers who could become HIV infected, and the personal risks faced by IDUs who shared infected needles. This neglect reflects a long-standing bias against the activities of 'disreputable' women in New Zealand, and of 'self-abusing' IDUs. It also reflects the invisibility of gay men in traditional public health discourse. This invisibility, it was said, had been promoted by the enforcement of 'sodomy' provisions as set out in the 1961 Crimes Act. Likewise, the activities of sex-workers and IDUs have been criminalised and often rendered invisible through laws relating to soliciting, brothel-keeping, and illicit drug use. Disreputable identities were thus marginalised in New Zealand by way of legislative fiat. These 'identities' were invariably constructed as being female (female sex-workers) or feminised (gay men, male sex-workers). The norms of male heterosexuality in New Zealand have rarely been challenged. However, the bridging activities of 'invisible bisexuals' or hyper-sexual 'others' have forced attention on some forms of masculinity in the HIV/AIDS epidemic. This attention is invariably connected to Eve; in the case of bisexual men, through contact with 'feminised' gay men, and in the case of the African man, through 'otherness' and 'hypersexuality' as embodied in

discourse about the African Eve.

After 1985 'Eve' in New Zealand's AIDS context was well-funded in the interests of public health. Gay men, sex-workers and IDUs received budgets, support, expertise and professional opportunities from public health officials and some medical professionals. This outcome is consistent with New Zealand's tradition of responding to public health crises on a comprehensive basis. HIV prevention centred on drawing 'sexualised' or 'invisible' identities into mainstream public health discourse and methodologies to control HIV/AIDS. This move had unexpected outcomes for both government and activists. For government and health sector officials, the inclusion of marginalised individuals resulted in access to formerly invisible sexualities and practices. On the other hand, the 'Eve'-surrogates were provided with a springboard for activism, reform, and legitimation. In the case of gay men, this iconography had been both a personal cost (death) and community gain (employment, social and political status, visibility). For sex-workers, the costs and benefits are less tangible, and less catastrophic. Few, if any, female sex-workers in New Zealand have been infected with HIV. However, their political gains are circumscribed by an iconography of Eve that punishes women who operate outside the norms of respectability. The entrenched nature of this iconography contributes to sex-workers' difficulties in seeking legislative reforms relating to prostitution. IDUs are less successful still, and their continued ignominy clearly reflects moral panic about illegal drug use. The

following chapters explore AIDS activism and discourse in New Zealand's media, community and parliamentary responses to HIV/AIDS. This exploration takes place within the context of power and strategy as exercised by important actors who seek to 'manage', 'define' or 'respond' to HIV/AIDS in New Zealand.

# CHAPTER SIX

## IMAGES OF EVE IN THE ICONOGRAPHY OF AIDS

AIDS iconography is about image-making.[1] Creating images about HIV risk groups is the process of establishing or revisiting commonly-held beliefs about people with sexually transmitted disease, and those at risk of becoming infected with HIV. These images are not only an epidemiologist's tool: they are a means of establishing a 'comfort zone' for individuals who fall outside such categories. AIDS iconography traverses other epidemics and diseases; the need for establishing epidemiologic certainty about risk and safety has been longstanding. Sander Gilman explains that

> [I]cons of disease appear to have an existence independent of the reality of any given disease. This 'free-floating' iconography of disease attaches itself to various illnesses (real or imaged) in different societies and at different moments in history. Disease is thus restricted to a specific set of images, thereby forming a visual boundary, a limit to the idea (or fear) of disease. The creation of the image of AIDS must be understood as part of this ongoing attempt to isolate and control disease.[2]

In this chapter, I discuss the nature of AIDS iconography, its meanings and its outcomes for either image-making or invisibility during the 'sexual' epidemic of HIV/AIDS. Where appropriate, I comment on the re-emergence of images from other epidemics such as leprosy and syphilis. Although Gilman's

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[1] See Chapter 1 (Introduction) for definition.

[2] Gilman, "AIDS and Syphilis: The Iconography of Disease" in D. Crimp (ed) *Cultural Analysis/Cultural Activism*, 1988: p. 88

analysis is broader (for example, he theorises about the racism implicit in AIDS iconography), the focus here is on *sexual* categories which form the basis of New Zealand's organisational response to HIV/AIDS. While issues of 'race' have been excluded from analysis in this chapter, they were explored in Chapter 4 with respect to injecting drug users in the USA, and the re-emergence of the 'African Eve' in sub-Saharan Africa. So far, 'race' has not been a critical factor in New Zealand's HIV/AIDS epidemic. In part, this phenomenon is due to the fact that Maori are not disproportionately represented in AIDS statistics; in part, because New Zealand's 'hard drugs culture' is not linked with 'ethnicity' as it is in the USA. In New Zealand, AIDS iconography was publicly linked to 'race' only during the trial of Peter Mwai, a Kenyan charged with infecting New Zealand women with HIV. This incident is discussed in counterpoint to the image of (white) 'Angel Eve' in the case study: "Icons of AIDS: The Media and Popular Culture".

## 6.1 The Emergence of 'Eve' as a Disease Icon

Organisational responses to HIV/AIDS in New Zealand emerged from 'risk group' iconography (gay men, sex workers, IDUs). Such iconography was constructed around gay men as the 'group' not only to bear the brunt of AIDS, but to garner resources to help contain HIV in the absence of government interventions. Initially, the image of the gay man as principal AIDS icon emerged in the USA, where gay communities had been the first to encounter HIV.

Therefore, the iconography of AIDS which centred on the gay man in New Zealand has its historical roots in the AIDS iconography of the USA and other western nations such as Britain, France, Canada and Australia.

Gilman maintains that AIDS iconography is, in fact, much older than AIDS itself. He argues that the iconography of AIDS has been borrowed from that of other diseases such as leprosy, or syphilis which existed in epidemic form until the twentieth century (see Chapters 2 and 3). Gilman writes that notions about women syphilitics, for example, drew on pre-existing beliefs about the "innate corruption of the female" which later translated "to her potential for corrupting the male."[3] This image, in which "woman was shown as both seductive and physically corrupt"[4] meant that women in the middle ages were cast as the vectors of disease, with men as their victims. Thus, the 'exemplary syphilitic' was portrayed as another 'Eve', temptress and corrupter of an unsuspecting Adam. So pervasive was this image that "in his great atlas of skin diseases in 1806, Jean-Louis Alibert, one of the founders of modern dermatology, represents all of his syphilitics as women."[5]

The misogynist image of woman as the vector of sexually transmitted disease bears little relation to the reality of the disease (both men and women were/are syphilitics, both 'caught'

[3] *Ibid.:* p. 96 Also, see discussion in Chapter 3, pp. 67-68

[4] *Ibid.:* p. 95

[5] *Ibid.:* p. 96

syphilis from one another), but much to pre-existing sexual iconography. The image of the syphilitic often emerged from gender archetypes as much as by transmission of disease. The syphilitic Eve was framed in terms of deceit and artifice, in which her "beauty only serves as a mask for corruption and death."[6] It was little acknowledged (known?) that, in women, syphilis (like HIV) is often symptomless, or that it is transmissible other than by sexual activity.[7] The iconography of syphilis was therefore socially constructed, conflating pre-existing images of sexuality, gender and morality (biblical notions of sin), at a time when characteristics of the disease were poorly understood.[8] By the nineteenth century, prostitutes in several countries, including Britain, had been incarcerated to prevent the spread of STDs to soldiers during wartime, and the idea of the promiscuous woman as vector of disease had become firmly established (see Chapter 3).

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[6] *Ibid.* This imagery persists in the HIV/AIDS epidemic. An advertisement about HIV/AIDS in the British press depicted a beautiful woman who is used to sell the idea of safer sex to heterosexual men. Her role is described thus: "the beautiful face, the long hair, the jumper which falls off the shoulder are all signs of woman as a lure, as a seductress who is out to attract men (an old theme). The advert makes us aware that she is (possibly) the dangerous harbourer not only of disease, but of certain death. Beauty can be a mask that conceals all that is rotten." (McGrath, cited in Kitzinger "Visible and Invisible Women", *AIDS: Setting a Feminist Agenda,* 1994: p. 104.)

[7] Dastur, *Sex and Diseases,* 1989: p. 81

[8] *Ibid.:* p. 82 For example, until the discovery of the syphilis spirochete in 1905 it was believed that syphilis and gonorrhoea were one and the same disease.

## 6.2 Creating AIDS Iconography

### *6.21 Gay Men*

The notion of a gay plague came about after the first reports of people with AIDS indicated that the syndrome had been sexually transmitted among members of the USA gay community. Soon, in the USA, the phenomenon of AIDS (a new disease requiring definitions, categories, meanings) was categorised as an STD, and with it were appended the discourses that had constructed the iconography of STD in terms of immorality, prostitution and promiscuity. The pre-existing iconography of STD which, according to Gilman, had "left our culture with a series of images of mortally infected and infecting people suffering a morally repugnant disease"[9] alighted on the homosexual man and began to shape the PWA in terms of "the promiscuous gay male body" on the basis of "early reports [which] noted that AIDS 'victims' reported having as many as 1,000 sexual partners."[10]

The moral panic which followed underscored the image of the promiscuous gay man as the principal icon of AIDS. Further, this man was not just promiscuous; he was effeminate. As 'effeminate man' (and sexual predator), he resembles the corrupt female of the syphilitic middle ages whose activities undermined

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[9] Gilman, *Op. cit..*: p. 98

[10] Treichler, "AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification" in *Cultural Analysis, Cultural Activism*, 1988: p. 42 Parenthesis has been added

and infected the 'innocent' male population. Gilman writes that this AIDS icon is seen as

> both victim and cause of his own pollution. Already feminized in the traditional view of his sexuality, the gay man can now also represent the conflation of images of the male sufferer and the female source of suffering traditionally associated with syphilis.[11]

Like the male syphilitic, the PWA is cast as "the suffering, hopeless male, shown as depressed and marginal".[12] He is depicted as being an isolate by virtue of his sexual orientation and of his disease status. In 'society''s view, his ignominy is both deserved and inevitable because of his role as 'polluter' and harbinger of disease.

### *6.22 Prostitutes*

Soon after the CDC's construction of the gay man as principal AIDS icon (see Chapter 4 for discussion), others were similarly viewed once they had been categorised into 'risk groups'. Individuals in these groups were held to be at risk of acquiring HIV if they were recipients of blood products, Hispanic, or if they were intravenous drug users. Placement of such PWAs into epidemiologic 'risk groups' served to distance them from other individuals, because the 'groups' by nature of their practices,

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[11] Gilman, *Op. cit.*: p. 99

[12] *Ibid.*

composition, or ethnicity, were held to pose little threat to the larger (white, middle-class, heterosexual) population. The activities of prostitutes, however, did not. Ancient images about 'good' and 'bad' women soon re-emerged, so that while ordinary women, with their 'rugged vaginas' were portrayed as "inefficient transmitters of AIDS",[13] the prostitute was believed to have a vagina which "functions merely as a reservoir, a passive holding tank for semen that becomes infectious only when another penis is dipped into it - like a swamp where mosquitoes come to breed."[14] Images of dirty, illicit sex via prostitution created the fear of imminent spread of HIV infection into the heterosexual population. Biblical images of sin=death, of woman as corrupting temptress, were not far away. Such iconography was evoked in cartoons such as one in *The San Diego Tribune* (1987) which "depicted the source of heterosexual transmission as a group of prostitutes proferring death - 'Death for Sale.'"[15] According to Gilman, "this shift - from male victim to female source of pollution - clearly repeats the history of the iconography of syphilis".[16] The image of prostitute as source of infection is contradicted by the fact that female sex-workers in countries such as New Zealand and Australia commonly engage in safer sex, and might be better protected than other women.[17]

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[13] Treichler, *Op. cit.:* p. 49

[14] *Ibid.*

[15] in Gilman, *Op. cit.:* p. 107

[16] *Ibid.*

[17] a) Chetwynd, "Report on Pilot Study of Knowledge and Practices Concerning HIV/AIDS Amongst a Sample of Sex Workers in New Zealand", Report to the New

## *6.23 The Promiscuous Woman*

The old idea of woman as polluter and source of infection is also evoked by the image of the 'promiscuous' (non prostitute) woman. Such women are those who have had multiple partners, who presumably infect their male partners (although not the reverse), and who are "considered to be outside the limits of social respectability."[18] Notions of the dichotomised 'good' and 'bad' woman are evident here, a misogynist and divisive concept pre-dating AIDS or the iconography of syphilis itself. Such beliefs persist in the HIV/AIDS epidemic, despite evidence to suggest that male to female transmission of HIV is almost three times more likely than the reverse.[19] Notions of female prostitution and promiscuity are conflated in AIDS discourses, and the monogamous or celibate woman emerges as the only 'safe' woman in terms of the transmission of STDs. The image of the pure, celibate woman is presented by Amie Beth Dickinson (Miss USA, 1994) who proclaimed that her no-sex-before-marriage stance

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Zealand Prostitutes' Collective, 1991. The study found that women sex-workers in New Zealand insist that their clients use condoms. However, condom use among New Zealanders and Australians is highly variable (Hodges, "Passion Killers - Issues Related to Low Condom Use", New Zealand Department of Health report, 1992.) b) In her article, "Condomed to death" (*Metro*, May 1994: p.92), Nicola Legat quotes nurse educator Diane Wilson of the Auckland Family Planning Association as saying "In fact, prostitutes are very good at keeping themselves healthy and STD-free, because they have to... I tell men that they have more of a chance of contracting an STD by sleeping with a woman they meet at a party."

[18] Gilman, *Op. cit.:* p. 107

[19] Caldwell & Caldwell,"The Nature and Limits of the Sub-Saharan African AIDS Epidemic: Evidence from Geographic and other Patterns" in *Population and Development Review,* 1993: p. 817

gave her moral superiority along with "freedom from disease, freedom from worry and freedom from pregnancy."[20] The counterpoint of this discourse on sexual purity or innocence is that non-celibate or non-monogamous women can be held accountable for 'spreading' AIDS.

As Treichler suggests, internalised notions of sexual propriety surface in medical and non-medical literature on AIDS. In a New Zealand study which makes the claim that "a disturbing finding was that women with more partners tended to be less likely to use condoms"[21], notions about 'polluting' and 'promiscuous' women are coupled in terms of the good/bad woman dichotomy. This conflation is played out against a backdrop of sexual responsibility which is assumed to be the woman's (ie: that women are responsible for initiating 'safer sex') - even though it is clear that while women cannot wear condoms[22], men can. Thus, the imagery of AIDS is skewed, masked and driven by perceptions of gender, intertwined with biblical notions of good/evil and of disease (the leper), and stamped with the history of epidemiology. It is orchestrated by a fearful public attempting to place as much distance between individuals in the 'infected'

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[20] Worthy, "Crowning Glory", *Tuscaloosa News*, 10//11/94.

[21] Dickson, Paul & Herbison, "Adolescents, Sexual Behaviour and Implications for an Epidemic of HIV/AIDS Among the Young" in *Genitourinary Medicine*, 1993: pp. 133 -140

[22] However, female condoms are being trialled in the USA (informant: Bonnie Carew, Project Manager for 'Female Condom Trial', University of Alabama at Birmingham, USA: May 1995) They are reported by users as being 'smelly', 'thick' and 'revolting'.

and 'non-infected' categories as can be ideologically achieved. Gilman, in commenting on "our desire to distance and isolate ourselves from those we designate as ill", argues that AIDS icons are "proof that we are still whole, healthy and sane; that we are not different, diseased, or mad."[23] The imagery of AIDS, therefore, can be understood to be deeply discriminatory. Of this, Treichler says, "we need to resist, at all costs, the luxury of listening to thousands of language tapes playing in our heads, laden with prior discourse, that tell us with compelling certainty and dizzying contradiction what AIDS 'really' means."[24]

### *6.24 Bisexual Men*

One of the contradictions alluded to by Treichler is evident in the notion of bisexual man as polluter of the 'good' (heterosexual, monogamous) woman. In a sideways shift from woman as polluter of man (the imagery of syphilis) to homosexual as feminised source of infection (the imagery of AIDS), the bisexual emerges as both feminine and masculine by virtue of his (assumed to be male) cross-sexual practices. As such, the bisexual man is dangerous, hard to categorise, and hard to detect, perhaps masquerading as the heterosexual, safely-married man dabbling in surreptitious, man-to-man sex. This image of the 'bisexual' man as elusive source of HIV infection is one currently inflated by the media and AIDS literature. The image sits uneasily between the concrete imagery of feminised man (the homosexual)

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[23] Gilman, *Op. cit.:* p. 107

[24] Treichler, *Op. cit.:* p. 70

and polluter of heterosexual populations (the prostitute) by virtue of its slippery and indeterminate status, and by the elusive nature (or absence) of a 'bisexual community'.

The logic of the bisexual man as AIDS icon becomes more apparent, and less contradictory, if seen in terms of the good/bad woman dichotomy in which the 'polluter' (the promiscuous woman, the prostitute) is placed at one end of the scale, with the 'good' woman (monogamous wife of bisexual man, female partner of male injecting drug user) at the other. By this means, the bisexual man can be cast as polluter of the 'good woman', while the 'bad' woman remains the 'polluter' of heterosexual men. The position of bisexual men thus emerges from the intersection of discourses about gender and morality as these have merged in the discourses of AIDS. This discursive convergence is apparent in the play-off between notions of 'good' women and the traditional role of men in their lives. The bisexual man exists in AIDS discourse as both feminised 'polluter' and 'failed masculine protector' of the 'good' woman by virtue of his deceit and risky sexual double-dipping. The belief in moral reward for 'good' women, together with the puzzlement or outrage felt by those who discover that bisexual men have failed in their masculine role as protector, is evident in the following statements by New Zealand women with AIDS:

> I'm angry because men aren't responsible. I was the least promiscuous person around. Why me?

> We have three women in the group who were infected [by bisexual men] in long term monogamous marriages.
>
> We'd been married for thirty-six years and as I said to the doctor, he was the only male I'd had sex with in my life.
>
> He was a wonderful husband and father. My children are still thinking "How did he ever find time to do it?" I mean, he probably just went out one night. . not thinking and picked it up like that. We'll never know because he didn't talk about it.[25]

## *6.25 Bisexual Women*

The bisexual woman is not dichotomised as 'good' or 'bad' woman: she is not included in the iconography of AIDS. This neglect is symbolic of a patriarchal discourse in which women's homo- and bisexuality is rendered invisible, perhaps because it is deemed unthinkable, minimal, or 'safe' in terms of the 'vector' theory. The bisexual woman's exclusion from AIDS iconography in New Zealand has undoubtably been justified on the basis of findings in which "there have been none [reported incidences of HIV/AIDS] among bisexual women."[26] The invisibility of bisexual women,

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[25] Quotes from Brander and Norton, *Women Living with HIV/AIDS: Issues and Needs Confronting Women with HIV/AIDS and Women Who Care for People with HIV/AIDS,* Ministry of Healthy, 1993. Quotes I and II are from page 62, quote III from page 38, and quote IV from page 64. Parenthesis has been added.

[26] Chetwynd, "Bisexuality in New Zealand" in *Bisexuality and HIV/AIDS,* 1991: p. 134. Parenthesis has been added.

at least in terms of a gender-specified 'risk group', has thus continued because of the apparent correlation between the 'group' and its lack of HIV infection.

The only published data on bisexual women presenting for an HIV test in New Zealand indicate a high level of STDs. An extract from the study states that

> [m]edical histories of sexually transmitted diseases showed that among bisexual women, 28 percent reported genital herpes; 24 percent, genital warts; 16 percent, gonorrhea; and 12 percent, chlamydia. These rates were considerably higher than those among the lesbians in the sample and somewhat higher than the heterosexual women.[27]

Given the proclaimed link between STDs and AIDS, it seems surprising that bisexual women are still omitted from epidemiologic investigation in New Zealand, if only because the sexual behaviour of *all* bisexuals might be thought to be open to scrutiny. The link between STDS and AIDS, after all, was the apparent basis for elevating African prostitutes and gay and bisexual men to the status of AIDS icon, so such invisibility for bisexual women reveals a contradiction, a curious lack of concern

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[27] *Ibid.:* p. 136. The data were gathered from a number of people attending the AIDS Foundation clinics in New Zealand by MacFarlane (1984). Chetwynd writes "The study of people attending the AIDS Foundations Clinics provided extensive information on the health levels and health practices of the bisexuals in that sample." Note: This sample is inevitably biased: the incidence of STDs etc. for those individuals *not* presenting at clinics is almost certainly lower.

by researchers and epidemiologists. Bisexual women's continued exclusion from the iconography of AIDS (or from epidemiologic investigation), therefore reflects their invisibility in terms of the discourses on gender and sexuality, if only because links between STDs and HIV infection for bisexual women are rarely considered. This exclusion underscores gender power imbalances, and demonstrates the power of Treichler's 'prior discourse' in the construction of AIDS imagery. Not that exclusion would necessarily be hailed as bad news for bisexual women in this context. However, it is bad news for the bisexual man who continues to be singled out on the basis of his risk status. Male bisexuality has become an irredeemable 'risk category' in relation to HIV/AIDS, even in countries where male bisexuality has long been an unproblematised 'norm'.[28]

### *6.26 Lesbians*

Despite the involvement of lesbians in the AIDS story, the lesbian is no more an AIDS icon than the bisexual woman, a neglect perhaps based on the heterosexual man's assumption that she poses little threat to him in terms of STD. This Eve is no temptress of Adam, but spurns Adam. Not for her, then, "the innate corruption of the female [with] her potential for corrupting the male"[29], for her 'corruption' is meaningless to the heterosexual man when used in the seduction of woman. In an

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[28] In Brazil, for example, male bisexual activity was so commonplace that it was *assumed* rather than *named* in the pre-AIDS era (Daniel & Parker, *Sexuality, Politics and AIDS in Brazil,* 1993: pp. 133-140)

[29] Gilman, *Op. cit.:* p. 96 Parenthesis has been added

ironic twist, this outcome suggests that the lesbian has become, in a sense, a symbol of 'purity' - a notion underscored by the fact that she is often believed to be risk free in terms of HIV. Such thinking also suggests that the sexual typography of STDs and AIDS centres on misogynist notions of who *can* have sex, which is assumed to be penetrative, ie: penis-centred in relation to man-woman or man-man sex. According to this view, lesbian sex is not 'real sex': it is more like same-sex foreplay. The lesbian, then, can be dismissed in terms of AIDS iconography as it has been constructed on the basis of prior discourse. After all, if she does not have 'real' sex, then she cannot acquire HIV.

### *6.27 'Monstrous' Icons: Gay and Bisexual Men*

Male bi- and homosexuality are considered synonymous in an epidemic in which homophobia has become 'full blown' as a symptom of heterosexual fear. The imagery surrounding both is, as Gilman says, that of the "hysterically feared abnormal."[30] In Gilman's view, the bisexual/homosexual icon now represents the 'fearful fantasy' of an entire nation following the advent of HIV/AIDS.[31] While Watney contends that "AIDS commentary does not 'make' gay men into monsters, for homosexuality is, and always has been, constructed as intrinsically monstrous"[32] Gilman's thesis suggests that Watney has missed the point, for

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[30] *Ibid.:* p. 100

[31] *Ibid.:* p. 99

[32] Watney, *Policing Desire*,1987: p. 42

the gay/bisexual man is seen as infinitely more monstrous, precisely because of his status as AIDS icon. Since the advent of AIDS, he is both sinner and vector, a cataclysmic symbol of a far deadlier STD than syphilis, and his moral burden has doubled. Thus, *he* is deadlier than before. In the eyes of the homophobe, AIDS is a fitting epitaph.

### *6.28 The HIV+ Child*

Gilman's analysis of AIDS iconography also extends to the HIV+ child, and by definition, to notions of family - an institution already iconised (deified), partly as a result of the debates staged in the 1970s by moral conservatives.[33] The HIV+ child is depicted as being innocent, and usually, female. In New Zealand, this icon was Eve van Grafhorst who died of AIDS in 1993. Her story was predicated on notions of family, and was constructed in the popular media according to the 'innocent victim' icon. The following case study ("Icons of AIDS: The Media and Popular Culture"), includes the story of Eve van Grafhorst as presented in the New Zealand media. In it, the image of the 'pure' HIV+ child as framed by 'the family' or 'caregiver' is juxtaposed with that of the gay PWA as 'polluter' and 'isolate'. Other AIDS icons have been well theorised by Gilman and other writers, in apparent contrast to iconography about the HIV+ child. Thus, the focus in this case study is on publicity surrounding Eve van Grafhorst as a means of understanding the nature of AIDS iconography in New

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[33] Weeks, *Sexuality and its Discontents,* 1985: p. 35

Zealand, and of exploring the implications of such image-making in relation to issues surrounding family, gender and race.

## 6.3 Case Study: Creating AIDS Icons: The Media and Popular Culture

### *6.31 Introduction*

The media have played a significant role in publicising AIDS in New Zealand and overseas. An AIDS iconography, constructed by way of focus on risk groups, is reproduced through newspapers, television, and popular magazines. Lupton writes that "the ways in which the phenomenon of AIDS has been represented in the entertainment and news mass media have played an important role in the development of shared cultural meanings about AIDS."[34] Media images of the PWA first centred on the gay man in the USA, but as the epidemic progressed, such images were extended to include injecting drug users, individuals from non-white ethnic groups, and sex-workers. The focus on 'risk groups' rather than 'risk behaviours' resulted in the creation of AIDS icons, an HIV+ stereotype perceived to be both victim and vector of a deadly disease. AIDS icons were invariably associated with the 'five H's': homosexuals, Haitians, haemophiliacs, hookers and heroin addicts (see also Chapter 4).[35]

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34 Lupton, *Moral Threats and Dangerous Desires,* 1994: p. 9

35 Prostitutes were dropped from the list once it was obvious to epidemiologists at the Centres for Disease Control (Atlanta) that they did not constitute a 'risk group'.

This case study is about the media's role in shaping AIDS iconography in the local and overseas context. Selected newspaper items and magazine articles are analysed to identify how iconographic images have been created or reproduced, both in New Zealand and overseas. The evolution of AIDS iconography in New Zealand is charted, with particular reference to Eve van Grafhorst, the HIV+ child who emerged as New Zealand's principal AIDS icon during the 1980s.

### *6.32 AIDS and the Media*

The ways in which PWAs have been represented in the media have interested a number of writers. Watney writes that media images about 'AIDS carriers' are the legacy of eugenics theory in which 'society' is believed to be at risk from the activities of those deemed social outcasts. Watney believes that the print and electronic media have inflated historic concerns about marginalised individuals during the HIV/AIDS epidemic. For Bersani, Alice and Watney, media images about the HIV/AIDS epidemic also reflect notions about the family which posit the 'AIDS sufferer' (usually homosexual or prostitute) as being anti-social. Watney and Bersani believe that the media have recycled traditional views about the effects of STDs on family and social health, and that these views constitute a moral panic in the HIV/AIDS epidemic. Lupton concurs. She argues that the popular media have an integral role to play in the regulation of deviant sexualities, and are replacing the church as guardian of public

morals. Crimp, Alice and Gilman use historical models to explain how PWAs are portrayed in the popular media. Gilman writes that AIDS image-making has its precursors in the leprosy and syphilis epidemics. Like Watney, Gilman argues that links between STDs and promiscuity were made according to gender and racial stereotypes. Of the writers reviewed, Gilman's analysis as outlined in "AIDS and Syphilis: The Iconography of Disease" *(Cultural Analysis, Cultural Activism)* is the most compelling in its exploration of image-making in popular culture and the media. Gilman's exploration of iconographic links between syphilis and HIV/AIDS is acknowledged in Chapters 3, 4 and 6 of this thesis.

Gilman's focus on icons in the HIV/AIDS epidemic has been paralleled by a number of writers, who also maintain that 'history repeats itself' in terms of ascribing blame.[36] Gilman builds on Delaporte's thesis that blame is meted out to social outcasts during a time of epidemic, and that iconographic 'risk groups' are created from beliefs about the moral, racial or social 'inferiority' of such individuals.[37] Gilman's brief in re-presenting this argument is so that "we can at least be aware of the regularity with which it recurs historically'.[38]

### *6.33 Toward a Comparative Analysis: The USA and NZ*

Analysis of AIDS iconography in New Zealand's popular media

[36] See Lupton (1994), Watney (1987), Treichler (1988) and Brandt (1988).

[37] See Introduction of Chapter 4, and Conclusion.

[38] Gilman, *Op. cit.:* p. 88

called for making comparisons about the content of local and overseas publications about HIV/AIDS. In New Zealand, the media's role in publicising AIDS largely imitates that of the western nations referred to earlier in this thesis.[39] In this particular case study, items from the popular press are examined for ways in which the gay man is presented as principal AIDS icon in the USA and New Zealand.[40] Individuals from other 'risk groups', such as sex-workers and injecting drug users, have received less attention in the popular press and, in fact, have been invisible in the longer term. They will not be discussed in this case study. News items relating to Eve van Grafhorst are also analysed for their iconographic content, and contrasted to the publicity (or otherwise) about other PWAs in New Zealand.

For the New Zealand analysis, items about HIV/AIDS from the major South Island newspaper (*The Press*) were reviewed over a three year period from 1991 to 1993. Magazine articles

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[39] However, Lupton notes that compared to Australia a remarkably low level of coverage has been given to AIDS issues in the New Zealand press (written communication, 1995).

[40] Gay men are not presented as a homogenous group in AIDS iconography. Issues of 'race' often underscore textual representations of gay men *and* 'others' such as injecting drug users, Haitians etc.. Gilman (1988) points to a *Newsweek* article "in which the editorial intent was to change the image of the typical person with AIDS from male to female in order to stress the risk for the "general population". Accompanying this essay were three photographs of PWAS: all of them are of men, and all are shown in the traditional guise of the isolated male sufferer that dominated the early history of images of syphilis. The first image the reader sees upon opening this cover story is not only male but also black. The black gay man thus becomes the icon of the PWA even in the context of a story that explicitly stresses the potential widespread heterosexual transmission of disease." (Gilman, *Op. cit.*: p. 106).

about HIV/AIDS from general interest magazines such as *Metro, North & South, Listener, New Zealand Woman's Weekly*, and *New Idea* were also collected over this time. Items about HIV/AIDS from several US newspapers such as *The New York Times, Washington Post* and *Tuscaloosa News* were collected for comparison.

Photographs presented in this case study were selected from texts, popular magazines and newspapers in New Zealand and the USA on the basis of their iconographic content. In his chapter, "AIDS and Syphilis: The Iconography of Disease", Gilman's analysis of AIDS iconography was restricted to twentieth-century photographs and cartoons about HIV/AIDS from the print media of Europe and the USA. In line with this strategy, items from TV or radio programmes were not included for analysis. The local articles selected for this case study are representative of stories published about PWAs in New Zealand, and are notable for their impact on the popular imagination.

Once a picture emerged of the ways in which PWAs were portrayed in the print media in New Zealand and the USA, the material was tested against Gilman's concepts. In particular, news items were examined for how they "both reflect and work to shape the public image of the person with AIDS."[41] This analysis used some iconographic 'cues' identified by Gilman, such

[41] *Ibid.:* p. 87 Gilman did not develop this concept of 'power' in AIDS image-making. See Chapters 7 and 8 for analysis, using Foucault's insights into the mechanisms of discursive power.

as pictorial or textual references to 'marginalisation' (with respect to ethnicity, sexual orientation or social status), 'isolation' (with respect to visual or physical barriers evident in photographic representations), or to markers of respectability, such as the inclusion of furry animals or family in stories or photographs about HIV+ children.

### *6.34 Early AIDS Icons: The Gay Man as Polluter*

In 1987, the story of 'Patient Zero', an HIV+ Canadian airline steward, appeared in newspapers such as *The New York Times* ("Canadian Said to Have Had Key Role in Spread of AIDS"), *The New York Post* ("The Man Who Gave Us AIDS") and *Time* ("The Appalling Saga of Patient Zero").[42] Many of these stories conflated images about promiscuity and AIDS. These images were embodied in Gaetan Dugas, a gay man reputedly bent on inflicting a scourge on his sexual partners. Public fascination with Dugas was such that "'People Magazine' made Patient Zero one of its 25 most intriguing people of '87, together with Ronald Reagan, Mikhail Gorbachev, Oliver North, Fawn Hall, Princess Diana, Vincent van Gogh, and Baby Jessica."[43] Patient Zero became an AIDS prototype, with his image signifying the 'sexual polluter' with respect to traditional iconography about blame for sexual disease.

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[42] Crimp, "How to Have Promiscuity in an Epidemic" in *Cultural Analysis, Cultural Activism,* 1988: p. 242

[43] *Ibid.*

In New Zealand, the image of the gay man as AIDS polluter has been advanced by glossy magazines such as *Metro.* An article, "Vidi, Vici, Veni: The Memoirs of a Sex Maniac", is an *expose* of the 1970s 'gay lifestyle'. James Allen, in self-revelatory mood, writes that

> I and the hundreds of other gay men I saw cruising Auckland, Sydney, London, New York, Los Angeles, San Francisco - all over the world - during the late 1970s and early 1980s, centre[d] our lives around the relentless celebration of our sexuality... Love was the drug, and everyone was constantly on the lookout for a quick fix. Our motto could have been Vidi Vici Veni- I saw, I conquered, I came. Why did we do it?[44]

The writer of this article revives popular images of the gay man as progenitor of 'sexcess' in the interests of gay liberation. Allen's remorse about his 'relentless sexuality', and his contention that the advent of AIDS has resulted in less and safer sex among gay men, confirms the perceived link in the reader's mind between promiscuity and disease. Allen reinforces the idea that monogamy based on the heterosexual model is the ideal for both romantic love and STD prevention.

Sexual deviance, disease and gender are commonly conflated in news items about AIDS. This conflation occurs only if sexual 'otherness', other than the male, heterosexual norm, is presented. The AIDS icon is also constructed around a gendered norm. In the

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[44] Allen, "Vidi, Vici Veni - The Memoirs of a Sex Maniac", *Metro* 6 (70): p. 79

USA, where most PWAs are gay men, the principal AIDS icon is the non-heterosexual male, while in African and Asian countries (where AIDS is deemed 'heterosexual') AIDS iconography is constructed around the female sex-worker (see chapter 4).

The gay man's counterpart in the syphilis epidemic is the 'fop' (effete, or feminised man) - associated in German myth with sexual excess and deviance. Gilman writes that in pictorial representations the fop invariably "wears an enormous, plumed hat; an abundant cloak; broad-toed, slashed shoes; and long, flowing hair".[45] His flamboyant dress and style marked him out to be non-heterosexual, and therefore suspect in terms of sexually transmitted disease. The fop's likeness appears in stories about 'AIDS victims', such as one featuring the entertainer, Liberace. The item is headed "Exclusive! Liberace and Pal Who Died of AIDS", and the entertainer is depicted in fur coat, bouffant hairstyle and make-up (see Figure 6.1 overleaf). The caption of this news item reads "Pals at a party. . . fur-coated Liberace with lover Wyman and flamboyant Christopher, soon to die."[46] Here, images about homosexuality, and sartorial and sexual excess are constructed around a fatal, sexually-transmitted disease. As if to prove the link, Liberace, as both 'victim' and 'cause' of his own pollution, is photographed holding hands with his soon-to-die pal.

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[45] Gilman, *Op. cit.:* p. 92

[46] The item about Liberace was printed in *The Sun,* a British newspaper (Watney, 1988).

FIGURE 6.1 "EXCLUSIVE! LIBERACE AND PAL WHO DIED OF AIDS"

THE SUN Friday January 10 1992 7

# EXCLUSIVE! LIBERACE AND PAL WHO DIED OF AIDS

Hand in hand . . . Liberace and Christopher

## Gay night out before tragedy

From WENDY LEIGH in NEW YORK

● THIS was Liberace's gay life before it turned sour—enjoying himself at a swell party with two homosexual pals. But now one of them, songwriter Christopher Adler, is dead from AIDS and Liberace himself is dying of the disease.

● There were no such worries when Liberace and his lover Carey James Wyman joined Adler at the Limelight Club in New York to mark actress Shirley MacLaine's fiftieth birthday. But just months after those exclusive pictures were taken, Christopher was complaining to Shirley: "I am having ghastly pains."

● Christopher, 30, told her: "I have a high fever and no energy at all." Friends revealed afterwards that he had died from a lymph disease brought on by AIDS. Now, two years later, Liberace is close to death at his millionaire mansion in Palm Springs, California.

● The 67-year-old master showman is being treated round the clock by a team of doctors. Close friends visit him every day and hundreds of get-well messages have been sent by fans. Last night a friend said: "There is no change in Liberace's gravely-ill condition despite the vigorous efforts of his doctors."

● In his 30-year career as one of the most successful personalities in showbiz, Liberace is reported to have averaged earnings of more than £3 million a year and has built up a fortune in jewellery, paintings, a string of lavishly decorated homes, a museum, 20 cars and 18 pianos.

Pals at a party . . . fur-coated Liberace with lover Wyman and flamboyant Christopher, soon to die

Source: *The Sun* as reproduced in "The Spectacle of AIDS" by Simon Watney in D. Crimp (ed), *Cultural Analysis, Cultural Activism*, p. 80

The New Zealand media have lacked such flamboyant entertainers as Liberace to publicise with respect to the 'perils' of HIV/AIDS. However, in 1987, *Metro* published a story called "The Death That Dare Not Speak Its Name" in which notions about gender, sexual deviance and disease were woven into the text as a means of informing the reader about the stigma associated with HIV/AIDS. James Allen writes that the HIV+ character he calls 'Vincent' is reputedly so effeminate that "many people looked upon him as a physical freak, an abomination to their perceptions of the ordained order of things. On the bus, the street, wherever, they'd talk about him as if he was deaf, feeling free to say the most insulting things."[47] 'Vincent's' 'extreme effeminacy' also affects his career prospects because his

> refusal to disguise his sexual orientation, his desk cluttered with plants, small bijoux, framed snaps of his mother, the latest Mr Right, Diana Ross and Dusty Springfield, and his flamboyant choice of clothing did not encourage his superiors to think of him as executive material.[48]

Like the syphilitic fop, 'Vincent' is deemed a rank outsider, an 'isolate' whom Gilman describes as being typical of the suffering, hopeless male. Stigma stalks 'Vincent' by virtue of his effeminacy and later, his HIV+ status. 'Vincent' represents a conflation of images about the male sufferer and the female source of suffering traditionally associated with syphilis. His dilemma (extreme isolation) exemplifies the dual stigma

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[47] Allen, "The Death That Dare Not Speak Its Name", *Metro* 6 (70): p. 89

[48] *Ibid.*

experienced by such PWAs, which results in ignominy in death as well as life. For 'Vincent' and other gay men who "start off life being told we can't love right, we can't live right", now, with the advent of HIV/AIDS, they are told they "can't die right" either.[49]

The New Zealand media's role in shaping the AIDS icon according to the 'feminised man' is also apparent in a *Listener* article about former rock and football star, Lew Pryme[50] (See Figure 6.2 overleaf). The writer of "Telling All" refers to a 1965 story about Lew, and a confession that

> he owned - and used - a "blow-waver" for his hair. That was not all. In an article under a heading screaming "Pop Star Tells All", Pryme was reported as saying: "And if the kids want to know whether or not I bleach my hair - tell them, 'Yes, I do.' " Pryme revealed that he also used "hair lacquer: when you get worked up in a number, you need it to keep looking tidy." He went even further. "I also use makeup - but only for my eyebrows."[51]

Pryme's confession resulted in his being "a frequent target of late tackles on the rugby field".[52] The ensuing publicity meant that "he never revealed to more than a few close friends that he was gay."[53] His confession is resurrected in the *Listener*

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[49] *Ibid.*: p. 90

[50] Stirling, "Telling All", *Listener and TV Times*, 27/8/90: p. 89. The 'Lew Pryme Story' was also the subject of a TV documentary.

[51] *Ibid.*

[52] *Ibid.*

[53] *Ibid.*

FIGURE 6.2 LEW PRYME: "TELLING ALL"

Source: P. Stirling, "Telling All" in *The Listener*, 27/8/90: p.88

article only in the context of his HIV+ status. Here, Pryme's construction as AIDS icon in terms of 'femininity' rather than macho 'masculinity' serves to reassure heterosexual readers that HIV/AIDS is not their concern.[54]

In "Telling All", the problems faced by Lew as closeted gay man, as football star and as Executive Director of the Auckland Rugby Union are used as evidence of pre AIDS homophobia. The iconographic sub-text of this article continues even as the writer's focus shifts from Lew's flamboyance to his 'incredibly close' relationship with Jeffrey. The writer states that "life became easier for Jeffrey [Lew's partner] and Lew after the Homosexual Law Reform Bill, and people were more willing to accept a gay couple."[55] But it is apparent that assumptions about sexually transmitted disease, promiscuity and 'fopishness' which shaped attitudes about the HIV/AIDS epidemic also form the basis of this article. The references to Lew's past, his flamboyance and secret life-style under the rubric "Telling All" suggest that, after all, there *was* something titillating to tell.

Sentimental notions about romantic love, monogamy and life-long commitment, such as that experienced by Lew and Jeffrey, are posited as ideals which transcend HIV/AIDS. While

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[54] Lew Pryme's presentation as both a gay man and a rugby football player is contradictory in that, in New Zealand, rugby football players are considered the epitome of 'real' (ie: macho, heterosexual) men. Rugby lore is replete with songs, jokes etc. celebrating this 'real' (singular) masculinity, and rugby denigration refers to 'wimps', 'queers', 'girls', 'poofters' etc..

[55] Stirling, *Op. cit.*: p. 89 Parenthesis has been added.

such ideals emerged from the syphilis epidemic as behavioural interventions for disease prevention, here they serve to make the suffering associated with AIDS more acceptable to the heterosexual reader. Thus, Lew Pryme dies "just a week apart" from his lover, Jeffrey, who had a "blinding fear. . . that he would die first and not be there to care for Lew."[56] This iconographic device allows images of the corrupt, feminised man to be framed and tempered by heterosexual norms, and for sympathy to be evoked for the plight of gay lovers infected with HIV. The text goes on to read that, like the perfect 'wife', Jeffrey "just wore himself out caring for Lew. I mean, what greater love . . . ".[57] In return, Lew chooses the song 'Perfect Love' to be played at his own funeral.

### *6.35 The Child as AIDS Icon: 'Angel Eve' and the Making of a New Zealand Icon*

The iconography of HIV/AIDS also frames the HIV+ child. Gilman argues that the dying child is usually constructed in terms of the 'exemplary innocent': he cites examples of Dickens' Little Nell, and Eva Beecher Stowe's Little Eva. HIV+ children, in contrast, are seen as stigmatised through their association with a 'dirty' and devastating disease. As evidence, Gilman points to events in the USA in which several schools were boycotted following admission of HIV+ children, and where the home of three HIV+

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[56] *Ibid.*

[57] *Ibid.*

haemophiliac siblings was razed. Efforts to rescue the HIV+ child from such imagery results in

> many images of children with AIDS show[ing] the child in the family setting, which contrasts radically with the imposed isolation of the gay man or IV drug user with AIDS. The presence of the family serves to signal the 'normality' of the child and the low rate of transmission, in spite of the child's radical stigmatization. The media wishes to maintain society's image of the pure, dying child. But such an iconographic device is rarely sufficient to overcome the stigma of AIDS.[58]

Conflicting images of 'the polluted disease-bearer' and 'the pure, dying child' are used to publicise information about women and HIV/AIDS in the USA. A photograph of 'Eleana and Rosa' (see Figure 6. 3 overleaf) is representative of the way HIV+ children (especially girls) are depicted in the popular media.[59] In the photograph, Eleana, HIV+, is shown with an adult carer named Rosa. Rosa's protective mien and proximity to Eleana serves as a reminder that the child is an innocent victim whose ability to transmit HIV is minimal. The subjects' sadness is framed by their isolation; they are photographed from behind a metal fence, away from onlookers. The viewer's sympathy is sought by the use

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[58] Gilman, *Op. cit.:* p. 105 Parenthesis has been added.

[59] The photograph of Eleana and Rosa was included in a photo-essay by A. Meredith as published in *AIDS: The Making of a Chronic Disease.* The accompanying text reads: "Eleana is a child with AIDS. Of [US] children affected with the virus, 70 to 80 percent are black, 10 percent are white, and 10 percent are Hispanic (Public Health Hearing on Women and HIV sponsored by the San Francisco Public Health Department; San Francisco, California; June 1987). Parenthesis has been added.

FIGURE 6.3 ELEANA AND ROSA

Source: A. Meredith, "Until That Last Breath: Women with AIDS" in E. Fee and D. Fox (eds) *AIDS: The Making of a Chronic Disease*,1992: p. 233

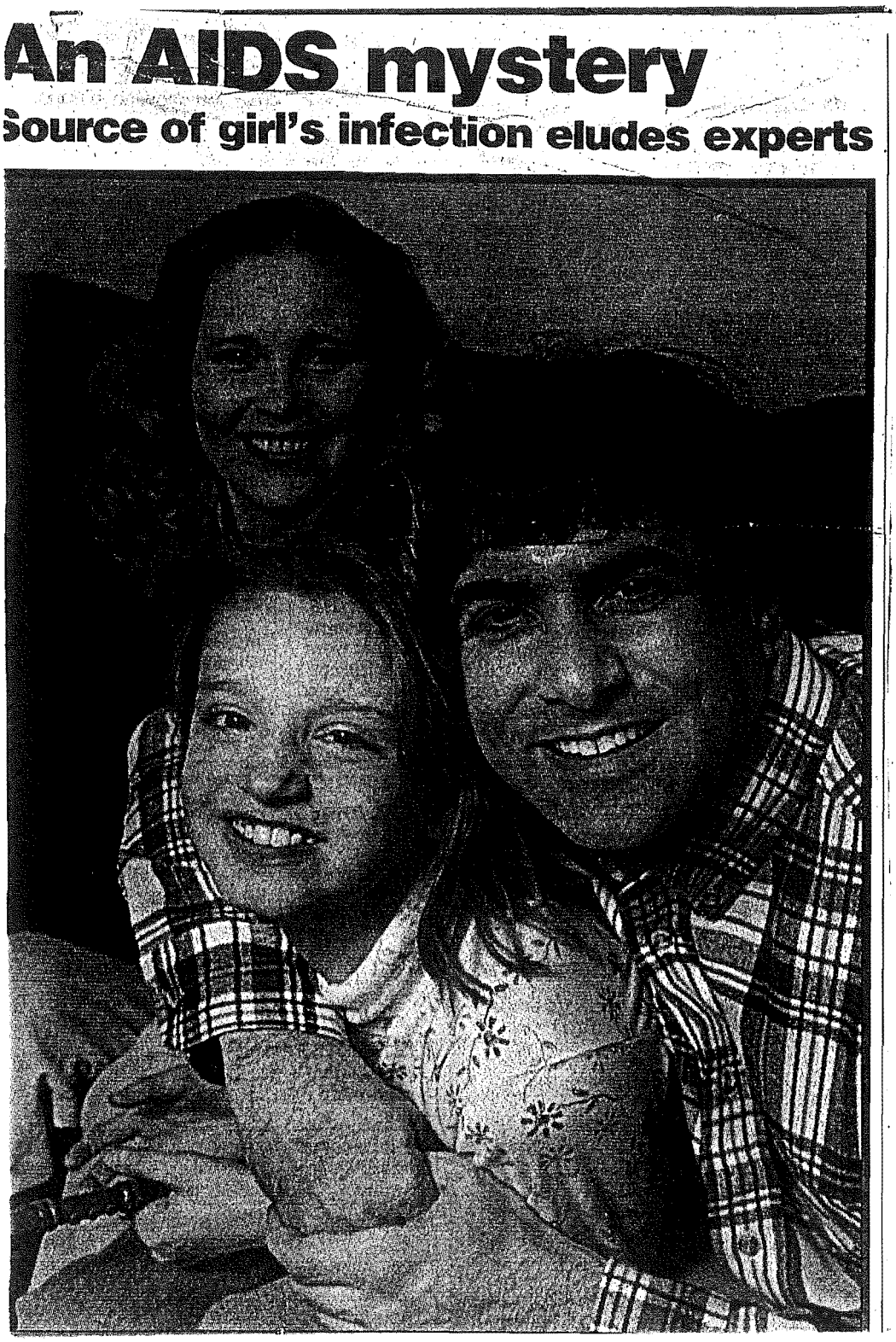
of dual images about the 'innocent child' and 'AIDS victim'. The outcome of such iconography is that the viewer is left in no doubt about Eleana's plight (illness, stigma) and the outcome (premature death).

The unhappy portrait of Eleana and Rosa can be compared with that of Whitney Williams and her family (see Figure 6.4 overleaf).[60] The picture presented of this smiling, all-American family is marred only by the knowledge that Whitney was 'mysteriously' infected with HIV.[61] The image of the pure, dying child is offered here in terms of normality; the reader cannot guess from the photograph alone that Whitney has AIDS. As Gilman argues, the presentation of this normalised image is a means of separating children like Whitney from other, less innocent PWAs such as gay men. But as the normal (white) all-American girl, Whitney can also be compared to less fortunate individuals such as Eleana, who was depicted as abnormal in terms of ill health, parental absence, and (importantly) ethnic origin. Efforts to evoke normalising images about Whitney are evident in the text. Here, Whitney introduces "a menagerie of stuffed bears and serv[es] tea made by her mother." The framing of the HIV+ child in terms of family, cuddly toys and 'normal' activities is, as Gilman suggests, a device to protect the child from being branded a 'polluter' instead of an 'innocent victim'. The device also protects Whitney from being labelled 'other' in

[60] Painter, "An AIDS Mystery: Source of Girl's Infection Eludes Experts", *USA Today*, 8/3/94: p. 1

[61] Eleana's mode of HIV transmission was not stated (see footnote 59 above).

FIGURE 6.4 WHITNEY WILLIAMS: "AN AIDS MYSTERY"




Source: K. Painter, "An AIDS Mystery: Source of Girl's Infection Eludes Experts" in *USA Today*, 8/3/94: p. 1

terms of the fourth world realities of HIV/AIDS in the USA.[62] The image of the family as a white, middle-class, two-parent ideal is likewise protected from association with 'real' HIV/AIDS.

The media's role in shaping the image of the HIV+ child in New Zealand is evident in the story of a young girl, Eve van Grafhorst. The emergence of Eve as an HIV+ media star first occurred in Australia, where she was born. The family had sought publicity after Eve was banned from attending a day care centre in NSW for being HIV+. Their decision to immigrate to New Zealand was made once they had found allies in "the people of New Zealand who characteristically opened not only their hearts but their pockets, to help bring the beleaguered family back home to New Zealand."[63] After Eve's arrival in 1986, the New Zealand media made Eve their 'wee darling'.[64] Stories about Eve appeared in newspapers and mainstream women's magazines until her death in 1993.[65]

One of the first articles about Eve van Grafhorst in the New Zealand print media outlines her experience of entering the NSW day care centre ("From Eve's mother - Thank You, New

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[62] The term 'fourth world' is used to describe the way in which HIV/AIDS is increasingly associated with ethnicity and urban dislocation in the USA (Altman, 1994).

[63] Sims, "From Eve's Mother - Thank You New Zealand", *New Zealand Woman's Weekly*, 28/7/86: p. 8

[64] Bell, "Smiling Eve Dies Peacefully", *Sunday Times*, 21/11/93: p. 25.

[65] Eve van Grafhorst also appeared on New Zealand TV, and was a special guest on 'The Paul Holmes Show' on several occasions.

Zealand").[66] Echoing Gilman's contention that HIV+ children and their families are subjected to hostility and stigma, Eve's mother reports that attempts to live openly with her daughter's HIV+ status in Australia meant that "people have hassled me, spat at me, thrown lighted cigarettes at me."[67] In photographs accompanying the article, Eve is pictured with her mother and three 'new-found playmates' (see Figure 6.5 overleaf). Like Whitney and her family, Eve and her mother are smiling. In the second photograph, the presence of Eve's friends serves to reinforce the notion that the HIV+ child is both normal and safe. This representation contrasts with the text, where there is a focus on stigma, the family's isolation, and fear experienced by parents of children at the NSW day care centre after Eve bit a 'friend' on the arm.

Eve van Grafhorst's star billing in New Zealand has been the product of media and public fascination, and of Eve's mother's quest to publicise AIDS through her daughter.[68] Eve's story was most often presented through her mother in a wide range of media (women's magazines, newspapers, TV), and in terms that emphasised the place of family, friends, and the pursuit of 'normal' activities such as school and play. For Eve, images of disease and otherness were averted by this focus on normality, and on everyday events. Nevertheless, images of the 'other' (adult

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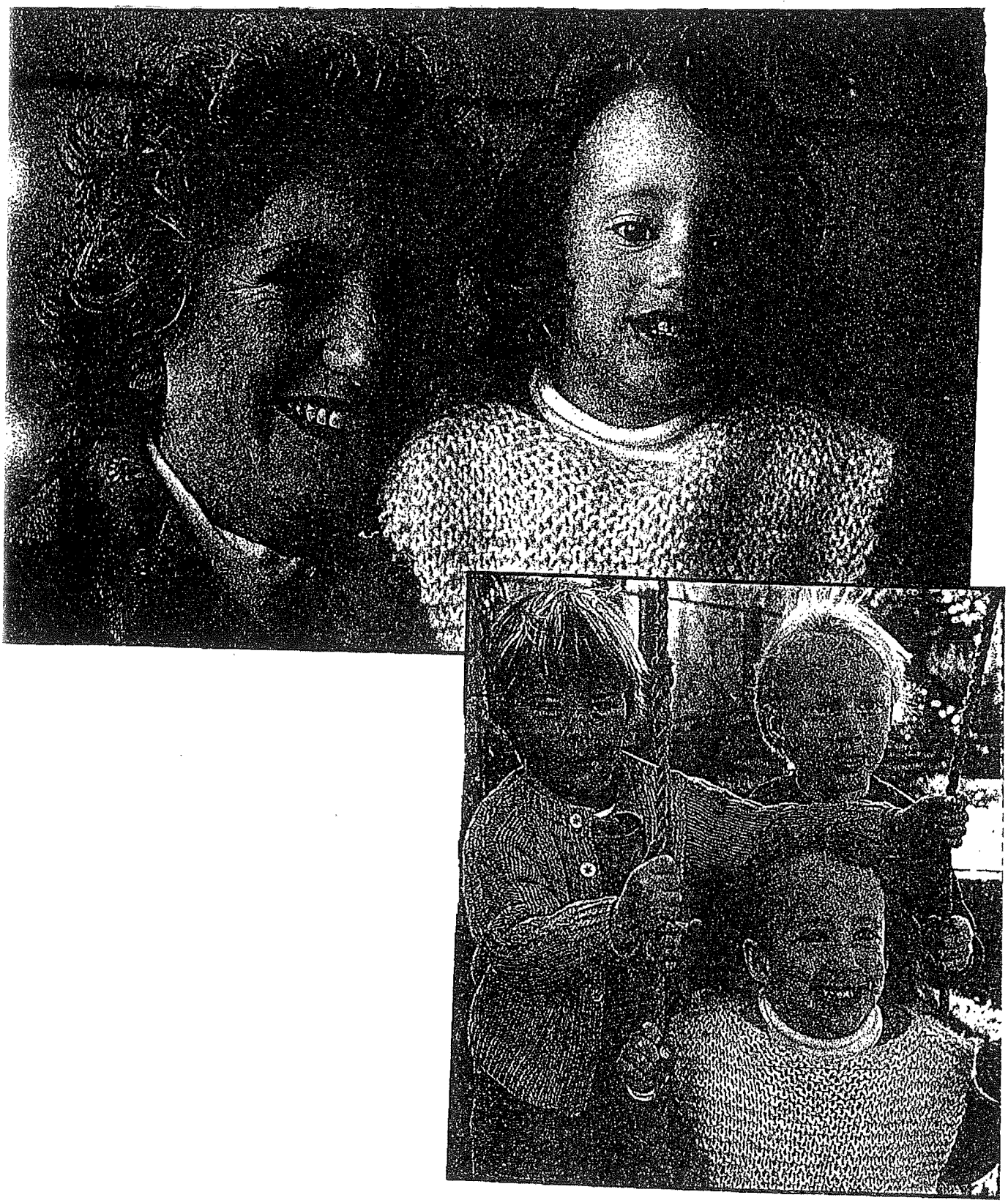
[66] Sims, *Op. cit.*

[67] *Ibid.:* p. 9

[68] As stated by Eve's mother (Gloria Taylor) on the TV programme "Angel Eve", TV3: 7/6/94

FIGURE 6.5 EVE VAN GRAFHORST: "THANK YOU NEW ZEALAND"



Source: J. Sims, "From Eve's Mother - Thank You, New Zealand" in *New Zealand Woman's Weekly*, 28/7/86: p. 9

PWA) as polluter are present in the sub-text of Eve's story. In an article entitled "12-year-old makes brave resolve"[69], Eve is reported as saying "when they ask me I say that it [HIV] is a very bad thing that you can get from adults." Here, the notion of the innocent child is recreated through Eve in her self-proclaimed role as AIDS educator, and the notion that adults are the 'culprits' is perpetuated by the child herself. 'Victims' and 'culprits' thus become part of the iconography of AIDS which dichotomises PWAs according to their age, as well as to their social, ethnic or gender status.

Notions about 'pollution' are also evident in reports about Eve's HIV+ friend, Jeremy Miller.[70] One report quoted his caregiver as saying "We've told Jeremy gradually and hope he handles it [AIDS] OK. We tell him it is not his fault, and he is not a dirty person because he has it."[71] Like Eve, Jeremy is often pictured with celebrities and animals. Despite such iconographic buffers, it could be argued on the basis of this media presentation that Jeremy's 'pure' status is tenuous and needs reinforcing to persuade the reader that he is pure while being infected with a dirty disease.

During the nine years she lived in New Zealand, Eve van Grafhorst's image evolved from that of the normal child to one of

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[69] Wright, "12 Year Old Makes Brave Resolve", *New Zealand Woman's Weekly*, 6/1/92: p. 9

[70] Jeremy Miller died on 27/5/95

[71] Wright, *Op. cit.* Parenthesis has been added.

'a special [magnificent, amazing] little girl'.[72] From photographs of Eve as presented in the popular media, her physical decline was matched by efforts to present her as extraordinary to the New Zealand public. The media's presentation of 'Amazing Eve' became more evident toward the end of her life. Eve's image was constructed around other icons: the bride, the princess and, lastly, the angel. While notions of gender underlie such image-making, the progression from normal (albeit, HIV+ child) to the supernatural icon is indicative of a need to disassociate this HIV+ child from AIDS imagery and notions of pollution. However, Eve's ascendence to supernatural status in New Zealand might have been wrought at the expense of PWAs such as gay men, whom the general interest media often ignored.[73]

Eve's transcendence to 'Angel Eve' status was capped by a photograph in the *Sunday News*[74] which showed her in white 'princess' gown and gold tiara, holding a bouquet of flowers (see Figure 6.6 overleaf). According to the caption, the white gown was "a satin dress - embroidered with pearls - that was made for her funeral." Eve's pre-funeral appearance in flowing white represents a gallant attempt to transcend the finality of death,

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[72] Bell, *Op. cit.* Parenthesis has been added.

[73] Deborah Lupton writes: "The overt homophobia of the early years of AIDS reporting had given way to an equally discriminatory silence about the mounting number of deaths of gay men, as simultaneously the deaths of a tiny minority of children with AIDS were publicly mourned." (Lupton, *Op. cit.*: p. 124).

[74] No author listed, *Sunday News*, 21/11/93: p. 1

FIGURE 6.6 EVE VAN GRAFHORST: "ANGEL OF COURAGE"

Source: (no stated author), "Angel of Courage: Brave Eve Loses Fight for Life", *Sunday News*,21/11/93: p. 1

as well as the stigma of a sexual disease. It was also an effort to show that *her* death (as opposed to other AIDS-related deaths) could be deemed 'pure' because it was constructed within the notion of 'virginal innocence'.

Eve's death was afforded national coverage on TV, radio and in the print media. To many, she embodied the virtues of love, selflessness and courage. A public trust was created in her memory, and a rose, called "Patio Rose Angel Eve", was named after her.[75] The image of Eve as New Zealand's 'little saint' is not permitted to wane, or lose its potency. Eve's icon status has been kept alive by reports of family memorabilia in which "her ashes, angels and a greenstone [are arranged] on a special table ringed by candles burning in her memory."[76]

### *6.36 The Media, the Public and Eve*

The effect of Eve's image-making on the New Zealand public has been the showering of personal tributes, gestures of goodwill, and a demonstration of love probably not afforded HIV+ children elsewhere.[77] A measure of Eve's popularity can be gained from

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[75] According to a flyer from 'Greenworld', the rose was "dedicated to AIDS campaigner Eve van Grafhorst." The caption reads "Delightful new patio rose with large soft shell pink blooms which flower profusely all year long."

[76] Rule, "Keeping My Promise to Eve", *New Idea*, 12/7/94: C9. Parenthesis has beenadded.

[77] A news item in *The Press* stated that "more than 10 years after Eve van Grafhorst was ostracised from a New South Wales town because she was HIV positive, another little girl is suffering a similar fate without even having the virus." (No author listed, "Baby girl cast out by AIDS Fear", *The Press*, 31/10/94: p. 9).

reading lines such as "Eve's greatest wish was to be an angel. So many people believe she was just that because she changed so many people's lives."[78] Public support for Eve is evident from such events as a sponsored trip to Disneyland, and the campaign to establish a publicly-funded Angel Eve house for terminally-ill children.[79]

While the love-affair with Eve was amply fuelled by media hype and sentiment, Gilman's thesis suggests a closer examination of her story and its meaning for AIDS iconography in New Zealand. By utilising his analysis, it could be surmised that the public's sympathy for a 'pure, dying child' was also an expression of outrage about how an 'innocent' child (particularly a female child) could be polluted by an STD as deadly as AIDS. Undertones of homophobia are evident in this outrage, which is also suggested by the lack of celebratory status and media coverage afforded other PWAs in New Zealand. Likewise, it could be argued that homophobia underlies the way public attention has been diverted from the starker 'reality' of HIV/AIDS in New Zealand to a focus on such AIDS trivia as statues, costumes, roses, kittens named Angel, celebrity promotions, and fairy tale trips to Disneyland. A similar story emerged in Australia after another HIV+ girl, 'little' Holly Johnson, had been elevated to angel status by the press. Lupton argues that

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[78] Rule, *Op. cit.*

[79] Despite $300,000 in public donations, the Angel Eve house was shelved (no author listed, "Eve Hospice Shelved", *The Press* 23/12/93: p. 3).

> it took the death of a blonde and pretty Australian child to emphasize these aspects [that HIV was not a 'sleazy virus']: the death of yet another gay man or injecting drug user or even a 'promiscuous' heterosexual would not have sufficed. Indeed the deaths of many hundreds of Australian gay men from AIDS since the disease first appeared in Australia in 1982 may have received attention in terms of the number of articles appearing in the press, but have never occasioned the same rhetoric of sentimentalism and tragedy.[80]

The stigma existing in New Zealand for members of marginalised groups during the HIV/AIDS epidemic is evident from the results of a nationwide survey that indicated an increase in blame directed towards prostitutes who contracted certain 'diseases'.[81] In New Zealand, as elsewhere, popular notions about polluters are framed by societal norms, and results of this survey show how norms are reinforced during epidemics by the need to blame the perceived harbingers of disease. For this purpose, notions about safety and family in terms of heterosexuality, monogamy and children are placed on one side, while unsafe (non-reproductive) homosexuals, sex-workers and injecting drug users are placed on the other. The HIV+ child is buffered by the existence of family, whose media portrayal in New Zealand and elsewhere has usually been framed by the monogamous, heterosexual ideal.

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[80] Lupton, *Op. cit.:* pp. 102-3 Parenthesis has been added.

[81] Chetwynd, "Changes in Sexual Practices and Some HIV Related Attitudes in New Zealand: 1987-9", *New Zealand Medical Journal,* 24/6/92: pp. 237-239. 67% of respondents blamed prostitutes for 'catching diseases' in 1989, up from 60% in 1987. The margin of error was not stated in the discussion of survey results.

The coupling of family with the image of the pure, dying child highlights a basic contradiction in AIDS iconography. Gilman suggests that notions of purity cannot withstand the obvious: that a child has HIV or AIDS (however blamelessly acquired), and that 'polluters' themselves comprise and are themselves the products of family. In a well-orchestrated attempt to escape this contradiction, the New Zealand public, rather than raze the van Grafhorst home or ostracise a family, took Eve under their wing of moral concern, glorified her image, and donated money in her name. Later, in an ironic and perhaps desperate twist, Eve became the Angel, embodiment of the image of the 'pure, dying child' supported by loving family and community in New Zealand. The media represented a pre-celestial Eve who was reported to have died, at home, "peacefully in her mother's arms".[82] Eve's celebrity status was the outcome of an effort to escape Gilman's 'stigma of association', and the reason she was pictured at all times among the famous, her family, community, friends and furry animals. However, the martyred icon of Eve serves further to highlight the stigma of AIDS, and throws the homophobic nature of Eve's deification ('the Angel' versus 'the Isolate') in New Zealand into sharp relief. More particularly, other AIDS icons are not portrayed as 'angels' by either the public or the popular media.

The image-making surrounding Eve's story is an example of how individuals can be 'relentlessly exploited' by the popular

[82] *Sunday News*: 21/11/93: p.1

media.[83] It is also indicative of how AIDS iconography can change through media representation. In New Zealand, Gilman's typology of the depressed, isolated PWA, and the stigmatised HIV+ child has been contradicted: the 'Angel Eve' configuration emerged to be celebrated by media and public, and to be deified through association with such fairy tale icons as princesses, brides, angels and saints. It remains to be seen whether this creation is aberrant in terms of AIDS iconography, or whether Eve's image affects the way other PWAs are presented by the popular media. It seems likely that this image would only be attributed to HIV+ *girls* (such as Eve van Grafhorst, Holly Johnson or Whitney Williams) who emanate a kind of beauty which emphasises the feminine: frailty in a boy or man is not seen as a cause for admiration or celebration.[84] Thus, it could be argued that, Eve's construction is inherently gendered. James Allen, writer for *Metro,* is certainly sceptical about a flow-on of sympathy or publicity to male PWAs, especially for gay men. In "Reclaiming AIDS", he writes:

> Gay men dying of AIDS doesn't work for the media. Tom Hanks might call them angels in his Oscar acceptance speech but the media prefer to cannonise "innocent" victims, preferably children, such as Ryan White [USA] and Eve van Grafhorst. . . Media worldwide can't and won't deal with "guilty" gay men.[85]

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[83] Du Chateau, "aids - apocalyse how?", *Metro.:* p. 82 Eve's mother, Gloria Taylor, also 'promoted' her daughter (see footnote 68, this chapter).

[84] To my knowledge, no photographs were published of Jeremy Miller looking 'frail'.

A flow-on of sympathy for PWAs was certainly not afforded Peter Mwai, an HIV+ Kenyan convicted of grievous bodily harm for infecting New Zealand women through unprotected sex.[86] Peter Mwai was portrayed as polluter of New Zealand women, one who "systematically and deliberately set out to lure women into having sex with him while he was touring with his band." [87] In contrast to the adoration afforded Eve, the Peter Mwai story prompted public outrage for the activities of a 'promiscuous African' who 'knowingly' infected (white) women with HIV.[88] But in the *Metro* article titled "Sleeping with the Enemy", writer Jan Corbett asks "Why was Peter Mwai the one to end up in court? The simple answer is that he is a black man who infected white women and it coincides with a push to educate women about the dangers of HIV."[89] The Peter Mwai story highlights Gilman's thesis about the racist images surfacing in AIDS iconography, because discourse about 'the carnality of Africa' was so explicit in media reportage. The discourse revolved around the primitive, excessive sexuality of the black African man, and was counterpointed to the need to protect the 'innocent' white women

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[85] Allen, "Reclaiming AIDS", *Metro,* November 1994: p. 48 Parenthesis has beenadded.

[86]a) No author listed, "HIV Accused Refused to Use Condom", *The Press,* 7/12/94: p. 27 and b) Corbett, "Sleeping with the Enemy", *Metro,* February 1995: p. 53

[87] Wakefield, "The Peter Mwai I Know and Still Love", *New Zealand Woman's Weekly,* 26/12/94: p. 15

[88] Not all the women were Pakeha: one witness at the Peter Mwai trial was a self-defined Maori (Corbett, *Op cit.:* p. 52)

[89] *Ibid.*: p. 53

of New Zealand.

If juxtaposed with the 'Angel Eve' story, the Peter Mwai case highlights one aspect of AIDS iconography unexplored by Gilman; namely, that the 'pure' image of the HIV+ child is also constructed in terms of 'race'. This construction is apparent in the story of Angel Eve, whose ethnicity was reinforced by her (white) bridal gown and her blond, angel image. It could be argued that if Eve had been Maori, this 'angel' image might not have been created or celebrated.[90] In the USA example, the Whitney Williams story is constructed around her 'mysterious infection', and her identity is posited as the 'pure' white child from the 'ideal' family. This image starkly contrasts to that of Eleana, who is depicted as a homeless, dejected and obviously ill 'child of colour'. Eleana's source of HIV infection is not mentioned: Whitney's 'source of infection' (and her family's puzzlement) *is* presented, as the basis for publicising her story and as affront to her now-compromised 'purity'.

## 6.4 Conclusion

The material presented in this case study contributes to an

[90] The absence of the New Zealand media's coverage of stories about Maori PWAs, or their concerns in relation to HIV/AIDS, could also be construed as racist, not unlike media responses in New Zealand's influenza epidemic which were couched in 'void' rather than 'voice' (see Chapter 2). Racism in the popular media's response to HIV/AIDS, which has been *explicit* in the case of the black African man, is thus *implicit* with respect to Maori.

understanding of how the popular media play a significant role in shaping public perceptions about PWAs. The media also play a selective role in terms of the stories presented to the public about HIV/AIDS. Such representations are often drawn from pre-existing stereotypes about gender, sexuality and disease. The media can shape AIDS iconography according to opportunity and context, so that individual AIDS stories emerge to either challenge or reinforce these stereotypes. The media's important role in this epidemic has been enhanced by technological advance, so that now, as in no other epidemic, news about these events can instantly be relayed world-wide. The media, therefore, constitute an increasingly powerful institution through which attitudes of the public and PWAs alike will be determined. If, as Gilman suggests, the syphilis epidemic with its spiralling panic about 'sexual disease' and 'risk types' is epidemiologic cousin to HIV/AIDS, then pre-conceived notions about risk groups in the HIV/AIDS epidemic will continue to be generated by the media until (or if) there is a cure for AIDS. The example of Eve van Grafhorst illustrates how an AIDS story has been constructed and celebrated, while the iconography on which it is based remains fixed on pre-HIV/AIDS stereotypes about polluters and sexually transmitted disease.

This case study was based on Gilman's methodology used in the chapter "AIDS and Syphilis: The Iconography of Disease". Thus, a critique or departure from his perspective has been constrained by my adherence to identical methodological

parameters. Nevertheless, a challenge to Gilman's AIDS=stigma paradigm has partially been achieved with the presentation of a contextual analysis (the Eve van Grafhorst story). To some extent, this exception underscores the differences in AIDS reporting in New Zealand and the USA.[91] It also demonstrates the limitations of Gilman's methodology, as evident in his focus on 'the AIDS victim' (rather than 'AIDS activist'), and in his utilisation of newspaper cartoons or photographs as sole subjects for analysis. Other writers, such as Lupton, undertake a textual analysis of AIDS reporting, and extend Gilman's paradigm to include AIDS themes ('gay plague', 'AIDS crime') in order "to show the broader patterns in AIDS reporting."[92]

Gilman's selectivity is, in part, the outcome of his concern about the nature of AIDS reporting, which Lupton claims was 'overtly homophobic' until the mid 1980s.[93] It was also a reflection of the *time* he did his research, and the outcome of his desire to demonstrate discursive correlations between the syphilis and AIDS epidemics. That Gilman sought to demonstrate an 'outcome' by selective, longitudinal analysis is true to the nature of a perspective which is "regarded from a particular standpoint or point in time".[94] Thus, Gilman's perspective should be appreciated within the context of its limitations. It is

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[91] Heather Worth from the NZAF maintains that the New Zealand's popular press is relatively unbiased in its reports about AIDS and related matters.

[92] Lupton, *Op. cit.:* p. 33

[93] *Ibid.:* p. 124 Gilman wrote "AIDS and Syphilis: The Iconography of Disease" in 1987.

[94] *Ibid.*

not a complex theory, nor is it an ahistorical content analysis of all AIDS news items published about HIV/AIDS. Rather, it is a thematic exploration of epidemiologic events according to a specified discursive paradigm. Notwithstanding these limitations, Gilman provides a tool for understanding the nature of discourses about HIV/AIDS. By focusing on icons, he offers a perspective on how ideas and stereotypes are recreated and reproduced; he draws attention to the power of images and the particular role of those who appropriate the images (in this case, the popular media) in shaping and perpetuating discourses about AIDS.

The case study in Chapter 7 explores another source of AIDS imagery which has been of particular importance in the New Zealand story, namely, that of the New Zealand parliament.

# CHAPTER SEVEN

## AIDS AND FOUCAULT - AN EPIDEMIC OF DISCOURSE?

## 7.1 Introduction

The debates about sexuality, disease and power (access to, 'rights', legislation) in New Zealand's response to HIV/AIDS are invariably interconnected, but can also be competing and contradictory. A central task for the thesis, then, was to develop a theoretical framework that provided an understanding of the complexity of power in relation to discourse and praxis as they co-exist in New Zealand's AIDS context. The available material appeared amenable to applying the ideas of Foucault, primarily because he offers a multi-faceted perspective rather than a unitary theory, and because a range of insights about power relations might thereby be developed about responses to HIV/AIDS in New Zealand.

For Foucault, power is in constant flux, in ceaseless activity across all social forms. This power is 'produced' or 'constructed' through purposeful action. Foucault argued that multiple forms of power arise through the diversity of human interaction and activity as framed by culture, politics and history. Foucault's analysis offers an understanding of the complex ways in which power is exercised; hegemonic social formations are maintained and reproduced through discourse about, say, sexuality, on the one hand, and through the bureaucratisation of medical and institutional praxis on another. A less flexible approach to power than Foucault's could restrict a

full exploration of what he terms 'distributions' of 'multiple and mobile power relations'.[1] A unitary approach to power might, for example, encourage a one-way picture of power diffusion, rather than a systematic exploration of the multiple strategies employed by the various social, cultural and economic players who pursue dominance under the rubric of AIDS politics and HIV prevention.

The issue of power (its exercise and manifestations) is central to the sociological analysis developed in Part II of this thesis. The issue of power is apparent in, say, organisational responses to HIV/AIDS, because of the reliance on, and competition for, access to government resources. The relationship between government and community organisers therefore gives rise to issues of power with respect to dependency or control. The changes that occurred during, or as a result of, the HIV/AIDS epidemic are also indicative of what Foucault described as "the strategic field of power relations".[2] Some of the changes relate to legislation and national health reforms, others to activism or media representation.

The tensions, conflicts, and co-operative efforts that have marked the response to HIV/AIDS in New Zealand, as elsewhere, give rise to the fluid, constant modifications to discourse and praxis that occur through the exercise of power. For Foucault, the nexus of these tensions, conflicts, etc. are 'matrices of

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[1] Foucault, *The History of Sexuality: An Introduction,* 1978 : pp 98-99

[2] *Ibid.*: p.96

transformations'[3], because of the potential for change. The conceptualising of social change as 'transformative' seems particularly apposite to the AIDS epidemic in which both disease and people have transformed the social landscape. It is my belief that such analysis is the key to understanding the contextual outcomes, meanings and discourse of New Zealand's response to HIV/AIDS.

## 7.2 Socio-Political Background to Foucault's Analysis

In developing his theory of the *structure* of power in his books *The History of Sexuality: An Introduction* and *Discipline and Punish*,[4] Foucault sought to make the exercise of power transparent by a) analysing institutional practices and b) developing a critique of hegemonic discourse as it developed from the eighteenth century. In his text, *Discipline and Punish*, Foucault outlined the rules and regulations, architectural layout and disciplinary procedures of the 'modern' European prison.[5] He gave a schematic overview of the maintenance and reproduction of power, and demonstrated how 'the body' was subjected to disciplinary measures as a means of placing individuals under the surveillance of prison authorities. This process marked a shift in the constitution of subjectivity, in which systemic control became internalised, so that the 'regulation of the body' that had existed in pre-eighteenth century

[3] *Ibid.*: p.99

[4] Foucault, *Discipline and Punish: The Birth of the Prison*, 1977

[5] Marshall (ed), *The Concise Oxford Dictionary of Sociology*, 1994: p. 186

Europe was superceded by 'regulation of the soul'.[6] Here, Foucault illustrated how, as a result of socio-political changes during the industrial revolution, 'juridico-legal' power underwent a shift away from the more violent forms of punishment (eg: public hangings) toward incarceration of the 'body', and to surveillance as a form of social governance. Foucault also illustrated how power is maintained and reinforced by bureaucratic minutiae: the routines, record-keeping, and practices which help instil and bolster this hegemonic system by way of a 'code of praxis' comprising specified rules, regulations and guidelines which act on the 'body' through *method* (explicit instructions, or modes of operation) and *surveillance* (in, say, school or taxation records). In *The History of Sexuality: An Introduction,* Foucault again described how particular forms of power-knowledge were institutionalised, this time with respect to the social practices of European bourgeoisie. Here, Foucault analysed the sexual code of a dominant class, the rules and regulations of which were designed to enhance the bourgeoisie's health and economic power. Foucault detailed the shift from 'power over death' to 'power over life' by way of these explicit socio-sexual codes.

In both *Discipline and Punish* and *The History of Sexuality: An Introduction*, Foucault gave the reader an hermeneutic view of power in which he analyses the 'parts' (ie: the micro-physics of power)[7] in order to understand the 'whole'. His analysis is a

[6] Foucault, *Op. cit.* (1978): p. 187

conceptual ordering of social and institutional behaviour which enabled him to identify ideological shifts or discrete cultural themes as they are located in history. The outcome of his analysis is a *general* theory of systemic power which can also be applied to *specific* systems of dominance such as those relating to gender or race.[8] The insights provided by Foucault in his text *The History of Sexuality: An Introduction,* that focus on the analysis of discursive strategies instituting the medicalisation of sexual behaviour, appear particularly suited to an analysis of responses to an epidemic disease. The following section follows this discussion of Foucault's theoretical ideas from his text *The History of Sexuality: An Introduction,* as they relate to material in this thesis. In particular, I examine Foucault's ideas about power as 'strategy', with an exploration of gay activism in the USA and New Zealand as a means of connecting theory with data. In the case study which follows ("A Case Study of Parliamentary Discourse: Parliamentary Debates About Homosexual Law Reform

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[7] *Ibid.*

[8] However, some feminists maintain that Foucault's theory is seriously deficient in relation to gender analyses. Janet Holland *et al* (in "Desire, Risk and Control: The Body as a Site of Contestation" in *AIDS: Setting a Feminist Agenda,* 1994) write that "Foucault's work also raises problems for feminist conceptions of patriarchy and women's liberation. In his view we cannot understand power as a possession which can be held by a group or groups in society. As there is no such possession, then there cannot be patriarchal power held by men and opposed by women. . . Foucault has largely ignored feminism" (pp. 62-63). While Foucault certainly argued against the subject/object binary implicit in certain feminist notions about male dominance/female subjugation, and made little reference to 'feminist issues' other than through statements about the 'hysterization of women's bodies' (Foucault, *Op. cit.* (1978): p. 121), I believe his theory allowed for an exploration of power relations with respect to gender. I have used his perspective to explore gender issues in the section 'Gay Activism in the HIV/AIDS Epidemic', this chapter.

and the 1993 Human Rights Amendment"), I integrate Gilman's iconography of AIDS with Foucault's analysis of power by drawing on parliamentary records (Hansard), and on relevant material from Part I and Appendix II of this thesis.

## 7.3 Foucault on Power

For Foucault, power exists as a multiplicity of mechanisms, strategies and techniques criss-crossing through time and space in "a dense web that passes through apparatuses and institutions without being exactly localised in them."[9] For Foucault, then, "power is everywhere."[10] He maintained that there is no one mode of domination or subjugation, for power is manifold - a force that shifts and changes according to locus, history, and political exigency. It is never unitary or fixed but rather contingent, contextual and accretional. Nor is power solely the province of interactions between institutions and groups: since power is everywhere, it is interpolated through discourse, evident in architectural styles, organised into methods of accounting, and popularised by ideas or practices. In all its forms, power is relational. It resides in, and is produced by, the social upon which it depends.

For Foucault, power is also an incremental process, one which

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[9] *Ibid.*: p. 96

[10] *Ibid.*

> through ceaseless struggles and confrontations, transforms, strengthens, or reverses them;. . . thus forming a chain or system, or on the contrary, the disjunctions and contradictions which isolate them from one another; and lastly, as the strategies take effect, whose general design or institutional crystallization is embodied in the state apparatus, in the formulation of the law, in the various social hegemonies.[11]

As this quote suggests, dominant discourses and techniques of power have a history, gain momentum over time, and become institutionalised. But the schisms created by confrontation, struggle and change mean that power is in constant flux. Because it is in flux, power is forced back on itself. It becomes reflexive, subject to alteration through incorporation, challenge and change in terms of established ideas or praxis. Thus, by its dependence on the relational, power becomes transformative - not only of the subject, but of itself.

Foucault created the concept of 'knowledge-power', which he says is "an ordered system of knowledge".[12] He argued that an 'ordered system of knowledge' about sexuality developed during the eighteenth and nineteenth centuries, along with institutionalism as a means for social control. What is significant about Foucault's coupling of power and knowledge, is that 'power' and 'knowledge' are fully implicated in one another; that power is productive of knowledge, and that knowledge does

[11] *Ibid.*: p. 93.

[12] *Ibid.*: p. 69

not exist in the absence of power. His conceptualisation also contests the notions of objectivity etc. that characterise positivist scientific discourses.

Sexuality came to be 'scientifically' studied and named: forms of behaviour were categorised 'normal' and 'abnormal' according to eugenics and other concerns of the day. Scientific findings about sexuality with respect to 'moral' or physical disease were promulgated by 'the expert' (doctor, scientist, educator) in a constantly expanding discourse, so that "the nineteenth-century grouping, made up of the father, the mother, the educator, and the doctor, around the child and his [*sic*] sex, was subject to constant modifications, continual shifts." [13] The 'new' behavioural paradigms were based on notions about racial and reproductive health and welfare, rather than sin. This shift related to the productive rather than repressive technologies of power that Foucault argued featured at this time. The implications for, say, gay men who were categorised as 'abnormal' during this period (and beyond) are explored in the section below.

### *7.31 Power of the 'Norm' in a Post-Modern Epidemic*

At first glance, the HIV/AIDS epidemic invites the onlooker to view the discourses constructing interpretations of AIDS in terms of binary oppositions such as health/disease,

[13] *Ibid.*: p. 99 Parenthesis has been added.

moral/immoral, heterosexual/homosexual, safe/unsafe. The divisions (posing as opposites) although constructed in prior discourse, appear as given, natural and immutable. Since the 'norm' is a hegemonic referent which *delineates* and *defines*, the PWA[14], say, is constructed as diseased, immoral and homosexual. Thus, the PWA is presented as (ab)normal at all points of convergence in the medley of AIDS discourses. From such a viewpoint, marginalisation is a feature of binary oppositions, for which the 'norm', as a definitive category of behaviour, has been created as a socio-medical yardstick by powerful groups to facilitate opportunities for social governance. The 'normal/abnormal' binary that has emerged is self-reproducing, and paradigmatic. Its creation allows unacceptable behaviour, ie: behaviour that diverges from an established norm, to be categorised, named, and made deviant.[15] An outcome of this process is one in which the binaries evident in sexual

[14] The term PWA has become the popular usage for a person with AIDS. Other terms such as PWHIV (person with HIV) or PLWA (person living with AIDS) are also used, primarily to denote that individuals are living with, rather than dying of, HIV disease. The terms were coined by AIDS activists in response to media and medically-inspired labels such as 'AIDS patient' or 'AIDS sufferer' which denote helplessness in the face of death (Grover, "AIDS: Keywords" in *Cultural Analysis/Cultural Activism*, 1988: p. 18). The use of PWA throughout this thesis thus parallels that of activist writers, rather than that of clinicians or the popular press.

[15] As sexuality became the object of scientific study in the nineteenth century, individuals deemed sexually deviant were labelled homosexuals, hermaphrodites, pederasts, adulterers, rapists, sodomists, sexual inverts and degenerates. Sub-categories included Rohleder's auto-monosexualists, Krafft-Ebings's zoophiles and zooerasts, mixoscopophiles, gynecomasts, presbyophiles, sexoesthetic inverts, and dysparunist women (Foucault, *Op. cit.* (1978) : p. 43). By this labelling, deviance was placed at an ever greater distance to the norm.

categories such as heterosexual/homosexual, moral/immoral, angel/whore, monogamous/promiscuous, frame the individual as deviant, rather than the act itself. In this way, people 'become' the act. It is this framing that gives rise to marginalisation of individuals, who are grouped, socially isolated, denied rights of citizenship, and further categorised into 'risk groups' in the event of epidemic disease.[16]

What, then, to make of Foucault's statement that power relations are not constituted through dichotomy?[17] Foucault answered by saying that

> [P]ower comes from below; that is, there is no binary and all-encompassing opposition between rulers and ruled at the root of power relations, and serving as a general matrix - no such duality extending from the top down and reacting on more and more limited groups to the very depths of the social body.[18]

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[16] a) The creation of socio-sexual categories was not standardised across cultures. In the book *Sexuality, Politics and AIDS in Brazil* (1994), Richard Parker writes about the 'relatively fluid and open-ended nature of sexual contacts, particularly among males of Brazilian society' (p. 20). Men in Brazil commonly engage in sex with other men, but before the AIDS epidemic such behaviour was both normal and unnamed. Instead, masculinity depended upon whether a man was the active (masculine) rather than passive (feminine) sexual partner. Bisexuality as a category in Brazil was created only recently through Western models of disease. Likewise, Western categories denoting 'homosexual' and 'heterosexual', adopted by Brazilian physicians and psychoanalysts in the mid-twentieth century, had limited influence before the AIDS epidemic (pp. 69-70).

b) In an effort to desexualise male-to-male social relations (a move in which sexual categories are coincidentally discarded), Eve Kosofsky Sedgwick, in *Between Men: English Literature and Male Homosocial Desire* (1985), posits the idea of homosocial rather than homosexual behaviour.

[17] Foucault, *Op. cit.* (1978): p. 94

Here, Foucault indicated that power is not a simple matter of subject/object, ie: of dominance/subjugation. Rather, it is the outcome of individual, collective or institutional will "exercised from innumerable points, in the interplay of nonegalitarian and mobile relations."[19] Thus, because power is a force that is relational (ie: dependent on human interaction), binaries emerge as part of the *process*, say, of formulating discourse. For Foucault, binaries about sexuality emerged as hegemonic concepts during the growth of science (power-knowledge) in the nineteenth century. These binaries became fixed in discourse, and in the case of sexuality, acted as referents in categorising individuals according to a newly-established norm.

If, as Foucault argued, binaries are constructed in discourse, they can be challenged on the basis that they are 'historical' constructs rather than 'natural' entities: so can the hegemonic systems which create them. This view is propounded, and acted upon, by PWAs themselves. Grover writes:

> The [USA] Advisory Committee of People with AIDS, forerunner of today's National Association of People with AIDS, issued the following statement: "We condemn attempts to label us as 'victims', which implies defeat, and we are only occasionally 'patients', which implies passivity, helplessness, and dependence on the care of others. We are 'people with AIDS'."[20]

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[18] *Ibid.*

[19] *Ibid.*

[20] Grover, *Op. cit.:* p. 26 See footnote 14, this chapter. Parenthesis has been

Grover writes that, in 1987, "PWAs from all over the USA took the naming of their condition one step further, announcing that they are 'people living with AIDS'."[21] She states that the binaries and keywords such as 'AIDS sufferer' or 'AIDS patient' are primarily the property of the powerful, and that the activists' re-naming of a socio-medical category forces not only an examination of common assumptions, but is an attempt to give notice to physicians, the media and others that they are a dynamic, even powerful, group.

### *7.32 Creating a Project for 'Life'*

Foucault maintained that the creation of social categories and divisions was an outcome of a 'racist' (class- and culture-specific) project formulated by the bourgeoisie as they gained economic and political ascendency in Europe during the eighteenth century. Its roots, he maintained, are in the Catholic confessional, where penitents were required to describe sexual transgressions in detail, and from which a 'discursive knowledge' was developed. In appropriating this knowledge, the bourgeoisie sought to promote the longevity and prosperity of their class through the encoding of socio-sexual behaviour.[22] Foucault called the process of 'understanding', labelling and regulating sexual behaviour a 'sexual technology'. The 'technology' included

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added.

[21] *Ibid.*

[22] Foucault, *Op. cit.* (1978): p. 127

proscriptions against certain types of sexual behaviour such as adultery, extramarital relations, relations with a person prohibited by blood or statute and other 'illegitimate' acts.[23] Prescriptions advocated healthy sexual behaviour based on self-restraint, sexual exclusivity, and vigilance over the control of children's sexuality, emerging as an 'ideology of the family'. By such means, a code of sexuality was promulgated for the purpose of enhancing bourgeois reproductive superiority.[24] This code was inscribed by medical practitioners and other 'experts', whose power-base expanded due to the interdependence of (expert) knowledge and (class) praxis in the expansionist project of the European bourgeoisie.

During the nineteenth century, this socio-sexual code was extended to the proletariat as a means of controlling their social and sexual (reproductive) behaviour during a time of industrial growth. Foucault maintained that the code, as expressed through discourse, became

> [A]n entire social practice, which took the exasperated but coherent form of a state directed racism, furnishing this technology of sex with a formidable power and far-reaching consequences.[25]

It was a 'sexual technology' that became widespread in

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[23] *Ibid.:* p. 107

[24] This technology was also designed to promote (white) racial superiority over the populations of colonised countries.

[25] Foucault *Op. cit.* (1978) *:* p. 119

Western societies by the twentieth century. In part, it had been a response to the ravages of epidemic disease such as syphilis, cholera, and influenza, as well as a bourgeois attempt to create a stable, competent and malleable labour force.[26] It required the creation of a moral lexicon, the bureaucratisation of socio-sexual behaviour, and the intensification of social schisms as a means of legitimating the sexual and social mores of a dominant class. Its method was discursive, regulatory and exhortative. As Foucault suggested, where once it had been the Life Project[27] of a ruling class, by the mid-nineteenth century it had broadened into a general 'technology of governance' in its extension through geo-political time and space. It is this Life Project which shapes the meanings and outcomes of epidemic disease, and which serves as discursive legacy in the AIDS epidemic.

## 7.4 The Life Project in the AIDS Epidemic

### *7. 41 Life for its Own Sake*

In terms of a technology of sex beginning as a whisper in the confessional and culminating in a full-blown discursive roar in the AIDS era, the PWA seemingly represents, as the embodied

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[26] *Ibid.:* p. 126

[27] In this chapter and in Chapter 8, I refer to the categorisation and regulation of sexuality that emerged during the eighteenth century as the 'Life Project' to denote its importance to the European bourgeoisie with respect to their moral, economic and racial advancement, and to link this 'governance of the body' with the shift to a generic 'health promotion' in the late nineteenth and twentieth centuries.

subject, the farthest point as measured against the norm. The 'AIDS victim', as a socio-medical category, thus seems fixed as 'death object' in a hegemonic discourse that has enlarged in scope as a result of the AIDS epidemic. But even a cursory understanding of the AIDS story demonstrates a far more complex and contextual interplay of power through discursive struggle, not the least in reconceptualisation of the 'life project' by its former outcasts. As stated, the struggle is expressed, in part, by members of the gay community and by AIDS activists through such abbreviations as PWHIV and PLWA. By such means the notion of PWA as 'death object' is challenged, and the conceptualisation of 'life' as a project in AIDS discourse is reworked. Of this, Daniel wrote

> [C]ertainly, the disease leads us to discover something fragilely different, with a certainty that is anchored in our most intimate depths: life continues. That is, life continues now. There is no death before death - despite the fact that they may already be preparing our funeral, despite the condemnations repeated in the official propaganda. Much remains to be said about this death before death called AIDS, according to the most prejudiced and discriminatory definitions. To speak about it is to shout, "Long live life!"[28]

In his writing, Daniel referred to the 'racist' (discriminatory) outcome of AIDS discourse which creates social outcasts who experience civil death in the name of 'life'. He also challenged the assumptions of a life project whose methodology centres on

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[28] Daniel in Daniel and Parker, *Op. cit.:* p. 142. Herbert Daniel died of AIDS in 1992.

regimens for disease-prevention and reproduction (whose disease-free outcomes require self-denial, or a deferred or 'specified' pleasure) rather than life itself. In writing about life and disease as a daily dualism, Daniel challenged the notion of life as merely a conduit for the future existence of an individual, class or race, as outlined in pre-existing discourse. Instead, life becomes the celebration of the 'now' which "beats like a heart."[29]

### *7. 42 Life for Sexuality's Sake*

The technology of sex has expanded in the AIDS epidemic, bringing with it new attitudes toward the Life Project. As stated by Foucault, "the technology of sex with a formidable power and far reaching consequences"[30], in its accretional journey, (its sinewy operations), not only acquires its oppositions but is remoulded by them as it gains momentum and control. Such reflexivity has been demonstrated by the gay community which has sometimes sought access to 'life' through the celebration of the 'body beautiful' and a diverse sexuality. Here, the concept of a technology of sex is undisputed by individuals who challenge its discourse. Instead, these individuals seek to change, or 'remould' the technology. Thus, gays who engage in Foucauldian 'plaisir de resistance', seek legitimation and incorporation into the Life Project through a reverse or, as Foucault also calls it, 'perverse'

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[29] *Ibid.*: p. 154

[30] See footnote 22, this chapter.

discourse.[31] As Foucault suggested, this action does not undermine the power of the Life Project, but rather, increases it by way of 'garrulous' challenge which reiterates the norm as a social paradigm. The outcome for 'life' is an enhanced technology for which a greater number of citizens (as power objects) have been 'acquired' through the acceptance and promulgation of techniques such as celebratory (frequent and varied) safer sex.

### *7.43 Expansion of 'Life' Expertise*

The Life Project has expanded in other ways. Although marginalised individuals (and others) are now exhorted to restrict expression of their sexuality to an acceptable but increasingly narrow set of practices, they are also actively incorporated into the AIDS prevention/health promotion discourse. This shift represents the cross-referencing of power: its pushes and pulls in full play as activists seek to expand their base or influence.[32] The alliance between officials and activists

[31] The use of a 'perverse' discourse by both gays and sex-workers is apparent during the HIV/AIDS epidemic, as outlined in the case studies following Chapters 7 and 8. For gays, the concept of a celebratory safer sex is central to HIV prevention campaigns, while sex-workers promulgate the 'perverse' notion that *they* are 'safer' (than non sex-workers) with respect to the 'spread' of STDs.

[32] D. Rayside and E. Lindquist, 'AIDS Activism and the State in Canada", *Studies in Political Economy* (1992) write about how ASOs have influenced AIDS policy in Canada. They outline ways in which "A number of [community groups], particularly those with roots in gay and lesbian activism, have developed skills not only in the provision of services, but in direct action and media relations, augmenting their capacity to extract resources and concessions from state agencies." (pp.37-77). Parenthesis has been added.

has been formalised in New Zealand: thus, officialdom is no longer the sole or primary discursive agent in the Life Project, even as it seeks to educate, monitor, and exhort for the purpose of disease prevention. For example, sex-workers, who now disseminate information to their own and other communities (high schools, business groups etc.) in their role as AIDS educators, have gained visibility and a degree of legitimation. For them, the process of organising a viable HIV prevention group has engendered politicisation of its members, and a desire to influence the party politic in terms of legislative power (see case study "Reframing Eve: Sex Workers, Legitimacy, and 'Life'" for discussion). To a lesser extent, members of other ASOs such as the National People Living with AIDS Union (NPLWAU) and IV drug user groups in New Zealand have done the same. Thus, as marginality becomes more popularised and more muscular, so does the Life Project as its 'referent'. To be true, it is a process by which marginality, in its nascent visibility, becomes accessible to normalising codes. But in the interplay of power, just as knowledge is imposed on the newly accessed body with respect to safer sex practices and information about health and disease, so the 'body' gains a voice through the acquisition of knowledge, and is able to rework the discourse on what constitutes marginality and thereby, the norm.[33]

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[33] Evidence of more liberalised 'norms' in New Zealand might be discerned from the results of surveys about public attitudes on a variety of social issues (eg: the 1992 McNair Survey titled "Awareness of and Attitudes to Discrimination on the Grounds of Sexual Orientation and HIV/AIDS Status"), although it could be argued that surveys are an unreliable means of gauging public opinion, or, more especially, of differentiating between 'response' (to the question) and actual behaviour. (refer

### *7.44 Power, Discourse and Community Activism*

Foucault's theoretical paradigm emphasises the fluidity of power, and its manifestation through discourse and praxis in the current era. For Foucault, power becomes hegemonic only when specific forms of social organisation are historically reproduced in many ways by multiple actors. Thus, rather than power being "something that is acquired, seized, or shared, something that one holds on to or allows to slip away"[34], Foucault views hegemonic power as an accretional process marked by 'reiterative' discourse which is always subject to challenge. His contention that power is the nexus of all response, and that the nature of resistance relates to pre-existing 'non-egalitarian relations' (giving rise to discursive challenge) is examined in each of the following case studies. The strategies employed by gay activists in the USA, and by parliamentarians and lobbyists in New Zealand during homosexual law reform, are analysed in each case study, with the view that the interplay of discursive strategies between government and community agencies is representative of 'the exercise of power from innumerable points.' Power relations in the HIV/AIDS epidemic are thus explored to render a picture of AIDS organising that is not simply one of dominance/subjugation, but one that has unique expression

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Cameron, "Notions of Biology in Value of Children Research: Application of an Interpretive Perspective to a Demographic Problem", Conference Paper, Australian National University Population Conference, 1984).

[34] Foucault, *Op. cit.* (1978) : p. 94

in terms of challenge, strategy and incitement as shaped by local history and context.

## 7.5 Case Study: Gay Activism in the HIV/AIDS Epidemic

The gay community has become a site for the exercise of power, both with respect to gaining a 'voice', and as a means for transforming socio-sexual behaviour. For if, according to Foucault, power is "the name that one attributes to a complex strategical situation in a given society"[35], then the gay movement (its juxtapositioning and resistance, its confrontation with moralists, and its lobbying for legislative power and funding) neatly fits this model of power relations. As a minority group, the gay community has devised multiple strategies to gain a political foothold in the USA, Canada, and England on a number of fronts (political, demographic, sexual). Today, the gay lobby is recognised as a powerful force, and in areas in which gays are demographically or politically concentrated, they are courted by politicians, given prominence by news media, and funded by governments for AIDS and safer sex projects. In New Zealand, while strategies mounted by gay activists are less publicised than in the USA, they are at least as successful. 'Homosexual activity' in New Zealand has become legal, and discrimination against gays in employment and housing etc. is now illegal. Other barriers to visibility are crumbling. For instance, in 1994, New Zealanders witnessed the appointment of their first openly gay

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[35] *Ibid.*: p. 93

member of parliament.[36] Thus, in New Zealand, (as in other Western capitalist nations) gay activists strive for "a directly productive role"[37] in the nexus of power relations. Challenges by the gay activists continue to be mounted on legislative controls, societal norms and discourses about sexuality and disease.

A central tenet of HIV prevention, especially that promulgated by the gay community and New Zealand's NCA, is that a 'visible' marginality + AIDS education = HIV prevention. This message has been so compelling that legislators have sanctioned gay rights even while invoking hegemonic ideals about the family, sexuality, and the norm (see: "AIDS Discourse: Parliamentary Debates About Homosexual Law Reform and the 1993 Human Rights Amendment"). In New Zealand, then, the desire by politicians to stem the AIDS epidemic without being seen to give license to 'deviant' behaviour has produced ideological strain rather than the veto of AIDS funding or 'health' legislation. This strain is evident in the intensity and length of debate during the 1986 Homosexual Law Reform Bill, and in the number of 'personal belief' speeches about homosexuality which preceded the Human Rights Amendment in 1993.[38] By such means, the legislative

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[36] News item, *The Press*, January 1994.

[37] Foucault, *Op. cit.* (1978) : p. 94

[38] The Human Rights Amendment Act of July 1993 was passed by a large majority. 'Personal belief' speeches are those in which speakers declared their own moral viewpoint about homosexuality (usually negative, or qualified) before voting 'Aye' to the legislation. In excerpts from a 'personal belief' speech, member of parliament for Northern Maori, Dr Bruce Gregory stated "I am not necessarily proposing the view that we should encourage homosexuality, nonetheless, I point out to the House

process produces renewed dialectic, incitement, even furore in defence of ideals which are then reiterated to the populace. This process underscores Foucault's belief that even as hegemony is challenged, it subverts and reproduces its dominant discourse. The discourse reproduced in debates surrounding New Zealand's Homosexual Law Reform Bill, for example, re-emphasised 'family values', 'heterosexuality', 'morality', and 'monogamy', all of which were placed in opposition to homosexual 'orientation' or 'lifestyle'.

The Information Age with its sophisticated techniques for disseminating information has ensured that discourse is increasingly both a distributor and locus of power. Thus, as AIDS decimated the (male) gay community during the early 1980s, there was a sudden shift in gay political focus from sexual/political liberation to HIV prevention and a corresponding re-emphasis on discourse as a mechanism of power. But as gays challenged popularised ideas about homosexuality (ideas they believed have a negative influence on gatekeepers to resources

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that homosexuals are human. . . The problem that faces the House and many people is not the question of homosexuality, but the question of sodomy. I do not condone sodomy. I am also opposed to the idea. It is an abhorrent practice. . . if it is a question of sodomy, certainly I would be opposed to it. But if it is a question of homosexuality - not with a component of sodomy in it - who am I to judge or disapprove of them? On the basis of what I have attempted to say, I have no doubt that the law must not discriminate in any way against an individual because of his sexual orientation, but it must not encourage it by other means [by condoning sodomy]. It is important that we maintain the majority or the normal range of heterosexual practice in a wide space in relation to our society." *(NZPD,* 27/7/93, pp. 16949-16950) Parenthesis has been added

such as health care, employment, legislative protections, and sexual rights) a flurry of 'unbalanced heterogeneous, unstable and tense force relations'[39] ensued in which oppositional or tangential interests sought to influence legislature, funding authorities and the hearts and minds of the populace. Thus, religious groups such as the Moral Majority made mileage out of a 'gay plague'; educational authorities sought greater control of children's sexuality through pedagogical technique; government departments (ever in contradiction) became beneficent misers; all as the gay community and other marginalised individuals tried to carve their own ideological niche.

In the interstices of power following the AIDS epidemic, a discursive paradox emerged. The gay community's sexual practices became a hot topic, there were surveys and articles, papers and fulminations. Sexual practices were exposed as the populace was subjected to a Foucauldian 'intensification of the body'. Thus, as a modem of power, an enhanced sexual repertoire became available to all as a kind of 'gay sex' which was incorporated into mainstream sexual knowledge (praxis?) by way of an incited discourse. Conversely, existing hegemonic ideas about sexuality were reimposed on the gay community as soon as AIDS was classified as a sexually transmitted disease. Gay men were expected to refrain from anal intercourse and to engage in non-penetrative safer sex. Medical and public health authorities also recommended monogamy or celibacy. Thus, gay men were subjected to 'normalisation' of their erstwhile 'aberrant'

[39] Foucault, *Op. cit.* (1978) : p. 93

sexuality, and despite the freedom campaigns of the 1960s-70s, fear of becoming infected with HIV meant that many complied.[40] The access to, and visibility of gay men during the AIDS epidemic ensured that the 'distributions of power' in terms of the Life Project reached, influenced and changed the behaviour of many gay men.

The exercise of power, with respect to "transformations, realignments, redistributions and homogenizations"[41] was sought by gay activists during the heady days of the 1960s and 70s, with efforts gaining momentum after the advent of HIV/AIDS. But as well as seeking to normalise homosexuality as a means of gaining a degree of *acceptability*, gays also sought to enter or contribute to mainstream society as a means of gaining *respectability.* Gay men and women who were members of mainstream choirs, sporting and cultural clubs, political parties and religious organisations 'came out' in terms of publicly declaring their sexual orientation.[42] Ironically, in New Zealand,

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[40] This shift in sexual behaviour is noted in the results of a number of studies. For example, in the Social Aspects of the Prevention of AIDS (SAPA) Project in 1986/7, gay men "reported that since the advent of AIDS, they had adopted a wide range of strategies that they believed enabled them to avoid transmitting HIV and avoid HIV infection." Cited in *Sustaining Safe Sex: Gay Communities Respond to AIDS,* 1993: p. 89

[41] Foucault, *Op. cit.* (1978): p. 94 For Foucault, 'major dominations' are the prevailing ideas and praxis that constitute 'social governance'.

[42] Gays also formed their own sporting and culture clubs, as was evident from many of the floats and displays at the Vancouver Gay Pride March (August 1993). At time of writing (1995) there was at least one self-proclaimed lesbian hockey team in Christchurch

increased success towards normalisation through legislative change (in particular, The Homosexual Law Reform Act of 1986 and the Human Rights Amendment of 1993) has seen a decline in political activism within the gay community, so that it has become increasingly difficult to attract volunteers for HIV/AIDS prevention and support work.[43] If this is the homogenisation of which Foucault speaks, then it is an ambivalent process, one in which there are both costs and benefits for all players in the struggle for power. It is also one of convergence, whereby the gay community and normalising codes as evident in the technology of sex meet, mix, and become partners in a power hybrid of resistance, appropriation and mutual reinforcement.

The activists' political agenda also underscores the nature of dominant discourses. Since the gay community aspires to equality in terms of employment, housing and health care as often as it resists or encompasses hegemonic sexual ideals, some interesting contradictions occur. For example, the most politicised sector of the gay community often comprises white, educated men, who seek power and status not only from within their own communities but also in politics, academia, the media and other places of influence. Thus, in a curious but constant doubling up of resistance and affirmation of status codes, gay men are often in the forefront of reinforcing what Foucault refers to as 'major dominations'[44], as they seek educational, political and economic advancement according to mainstream (hegemonic)

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[43] Manager: NZAF Ettie Rout Clinic: Interview, December 1993.

[44] Foucault, *Op. cit.* (1978): p. 94

values. Further contradictions with respect to power and resistance are evident in gender relations between gay men and women. For instance, the success of gay men is often at variance with that of say, lesbian women, who (like heterosexual women), may be less qualified or well paid than gay men[45] although they are just as energetic in campaigning for gay rights. This disjunction perpetuates (or is based on) a power imbalance between men and women as generalised across society which overrides imbalances due to sexual preference, and is perhaps an example of Foucault's 'force of power' (its spread, multifariousness and persistence) in terms of a "general line of force that travels the local oppositions and draws them together."[46] In terms of gender, 'local oppositions' here refers to disparate cultures, social groups or sub-discourses which are linked to a general or hegemonic discourse through a common practice or outcome. In this case, the unifying force between mainstream and marginalised groups is the subordination of women. Lesbian activism in the HIV/AIDS epidemic is often unacknowledged, as is the lesbian's risk of HIV[47], or contribution with respect to support and care of HIV+ men. This neglect reinforces women's traditional invisibility, and underscores Foucault's contention that, even as hegemonic power is being subverted by gay activists (men and women), the 'major dominations' as evident in status values and gender inequalities are still 'gaining momentum and control'.

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[45] News Item, *Vancouver Gay Community Newspaper,* August, 1993.

[46] Foucault, *Op. cit.* (1978)

[47] Patton *Last Served? Gendering the HIV Pandemic,* 1994: pp 71-2

## 7.6 Case Study: AIDS Discourse in Parliamentary Debates About Homosexual Law Reform and the 1993 Human Rights Amendment

### *7.61 Introduction*

The passage of the Homosexual Law Reform Bill (1986) and the Human Rights Amendment (1993) in New Zealand was based on concerns relating to the HIV/AIDS epidemic. The impetus for both 1986 and 1993 reforms had been provided by WHO, gay activists and public health workers on the basis that statutes outlawing 'homosexuality' in New Zealand contravened basic human rights and prevented access to gay men with respect to HIV/AIDS education and prevention. For this reason, the Homosexual Law Reform Bill was designed to legalise 'sodomy' between consenting males over the age of sixteen, while provisions of the 1977 Human Rights Act were extended to gay or HIV+ individuals as well as to pregnant women, racial minorities and the disabled.[48] The material in this study is presented as an analysis of the debates surrounding this legislation as framed by the theoretical insights of Gilman and Foucault. Official records

[48] The Human Rights Act was first passed in 1977. It outlawed discrimination on the basis of race and religious, political or ethical beliefs. Later amendments outlawed discrimination on the basis of age, gender, sex, employment status, family status, marital status, disability, sexual orientation and 'the presence of disease organisms in the body'. (Linda Beck, Complaints Officer, Human Rights Commission, Christchurch).

from Hansard (verbatim written accounts of parliamentary debates in New Zealand's House of Representatives) serve as raw data for the purpose of analysis.

The focus on AIDS icons proved more intense and prolonged for the 1986 and 1993 reforms than for parliamentary debates about any other matters relating to the HIV/AIDS epidemic in New Zealand. The passage of the Homosexual Law Reform Bill, in particular, was marked by dispute, bipartisanship, tactical delays, and numerous references to Old Testament morality as a means of maintaining the status quo. Such references increased in number as the Bill went through its first, second and third readings in an attempt by some opponents to apply moral pressure to the outcome. The Homosexual Law Reform Bill alone occupied almost 200 pages in Hansard between October 1985 and July 1986. The acrimony that followed the Bill's introduction prompted one parliamentarian to declare that it had "divided New Zealand as few Bills have the power to do."[49] Parliamentary debates relating to these reforms centred on issues of morality. This focus yielded a rich source of material about discourse and ideology whose meaning could be explored with the insights offered by Gilman and Foucault.

### *7.62 The Parliamentary and Legislative Context*

New Zealand's parliament is uni-cameral. Its ninety-seven

[49] From a speech by Geoffrey Braybrooke (Labour), *Parliamentary Debates* (PD), 8/10/85: p. 7208

members comprise a single House of Representatives as opposed to the bi-cameral lower and upper house system of other Commonwealth countries.[50] At time of writing, there were two major political parties in New Zealand, with members belonging either to the Government or Opposition party.[51] These political bodies, traditionally split between the 'left' and 'right' of the political spectrum, are known as the Labour and National parties. All New Zealand citizens over the age of eighteen years are entitled to vote for the party of their choice, and to make representations to parliamentarians (MPs) about their political viewpoints or concerns. Citizens thus expect elected officials to represent the views of the 'electorate' or local constituency in parliament. These views are usually presented in debate about new legislation or amendments to older laws. New legislation is introduced to parliament as a 'Bill' to the debating 'Chamber', and its progress is marked by debate from both sides of the 'House'. Bills might be referred to a Select Committee for change or advice after the first or second readings. Select Committees also attend to petitioners' concerns in the pre-legislative stage, and make recommendations on legislation to parliament. Once a Bill is passed by a majority vote after first, second and third readings, it becomes an Act of Law.

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[50] From 1969-1987, the number of MPs increased from 84 to 97. Further changes are expected under the newly introduced 'proportional representation' system (MMP) (Ringer, *Introduction to New Zealand Government,* 1991: p.118)

[51] This two-party arrangement may change under MMP which is due to take effect after New Zealand's next parliamentary election.

The HIV/AIDS epidemic in New Zealand has been characterised by legislative reforms aimed at protecting public health and promoting HIV/AIDS awareness. In general, these reforms were mooted by Labour parliamentarians whose majority during the HIV/AIDS 'crisis years' helped ensure the passage of new legislation through the House of Representatives.[52] Partisanship was most pronounced during the passage of the Homosexual Law Reform Bill, perhaps because the Bill was considered ground-breaking in nature. Later reforms such as the 1993 Human Rights Amendment extended legal protections to a greater number of individuals.[53] Nevertheless, final voting for the Law Reform Bill (and interim voting for the 1993 Amendment) was divided between 'left' and 'right' in terms of party politics.[54] Parliamentarians who supported Old Testament views made much of an 835,000 signature 'people's petition', and their constituents' concerns about moral standards. The Bill's supporters often referred to secular (scientific) research about 'genetically-determined' homosexuality, while claiming that humanitarian principles guided their position on reform.

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[52] Labour's 'party vote' (block voting) tradition also facilitated the passage of new legislation.

[53] The vote was almost evenly split in the Homosexual Law Reform Bill (49 Ayes, 44 Noes). The Human Rights Amendment was passed more convincingly (48 Ayes, 26 Noes). Source a) *Journals of the House of Representatives of New Zealand,* 1986-7: p. 191, and b) Peter Luke, *The Press* (31/7/93): p. 22

[54] PD, 9/7/86: p. 2823 The vote was sharply divided between Labour and National parties for the Homosexual Law Reform Bill. Only three National MPs (G. Gair, K. O'Reagan, I. McLean) voted for reform, while 35 voted against. Voting patterns for the 1993 Human Rights Amendment are discussed later in this case study.

## *7.63 The Iconographic and Discursive Context of AIDS*

In July 1994, New Zealand's Parliamentary Speaker[55] Dr Peter Tapsell was quoted as saying "women have had an influence on standards since Eve. Adam picked the apple but Eve was generally held to have had some part in the fiasco. She encouraged him to do it. . . the instinct of women is to make themselves as attractive to men as possible and lead them on."[56] The biblical theme of 'Eve' had emerged in relation to Dr Tapsell's concern about women's sexual and social responsibilities. The theme, as Gilman suggests, is one "we can at least be aware of [because] of the regularity with which it occurs historically."[57] Its re-emergence in the HIV/AIDS epidemic demonstrates the potency of Old Testament imagery, and how it can be sustained over time. As is evident from the iconography of the syphilis and HIV/AIDS epidemics, the biblical theme of Eve is at its most powerful when it has been associated with 'femininity' with respect to sexually transmitted disease. In the case of debates about homosexual law reform in New Zealand, Gilman's premise that male homosexuality is often associated with effeminacy is supported by the comment that "Dr Armand Nicholai of Harvard University recently said 'I have treated hundreds of homosexuals. None of them deep down thought he was normal. Simulating eating is not

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[55] Parliamentary Speakers in New Zealand act as adjudicators of parliamentary debate.

[56] Rudman, "Speaking His Mind", *Sunday-Star Times,* 10/7/94: C9

[57] Gilman, "AIDS and Syphilis: The Iconography of Disease" in *AIDS: Cultural Analysis, Cultural Activism,* 1988: p. 88 Parenthesis has been added

eating; simulating being female is not being female; simulating sex is not sex.'"[58]

Moral issues are often utilised for political advantage, especially during 'sexual' epidemics such as syphilis and HIV/AIDS. The 'biblical Eve' theme had surfaced in parliamentary debate in New Zealand's syphilis epidemic over the issue of women's sexuality, and legislation was enacted to control the sexual activities of 'nefarious' women such as prostitutes. During New Zealand's HIV/AIDS epidemic, parliamentary debate centred on the sexual activities of the gay man, whom Gilman framed in terms of an epidemiologic successor to 'Eve' because the public believes him to be both effeminate and promiscuous.[59] Unlike the syphilis epidemic, however, parliamentary debate about the HIV/AIDS epidemic in New Zealand centred on whether to change legislation which restricts the open expression of 'divergent' sexuality, or to further legislate for its control.

In moral debates, there is invariably tension between advocates for change and defenders of the status quo. This tension is expressed as discourse about the parameters of social and sexual behaviour. Defenders of the status quo in New Zealand, such as Dr Tapsell, adhere to the notion of 'basic values' or an immutable 'moral baseline' in speeches about social behaviour. For politicians like him, desire for social change must always be negotiated and measured against an inviolable set of norms.

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[58] PD, 6/11/85: p. 7794

[59] Gilman, *Op. cit.*: p. 99

Foucault referred to the moral baseline as a set of 'regulated truths' derived from the 'great evolutionist myths'.[60] Truths about sodomy, for example, and its regulation, comprise part of this moral core. For Foucault, attempts to either impose or change the moral baseline are often expressed in discourse.

Foucault maintained that 'regulated truths' gave rise to tensions between ideal and practice only after historical shifts occurred in the way behaviour was managed by ruling interests in the eighteenth century. He wrote that

> on the one hand, there was an extreme severity (punishment by fire was meted out well into the eighteenth century, without there being any substantial protest expressed before the middle of the century), and on the other hand, a tolerance that must have been widespread (which one can deduce indirectly from the infrequency of judicial sentences.)[61]

While Foucault was pointing to inconsistencies between ideal and praxis in this example, it is apparent that the 'moral baseline' remained despite societal and judicial ambivalence. As Foucault argued, this baseline was transformed into a set of regulations whose efficacy relied on techniques such as exhortation, reiteration and supervision rather than threat of dire physical punishment.

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[60] Foucault, *Op. cit.* (1978): p. 54

[61] *Ibid.* p. 101

Dr Tapsell's statement about traditional gender roles is indicative of the way ancient dogma is paradigmatic even for modern power-brokers. Politicians often reiterated their beliefs in 'regulated truths' during moral debates about HIV/AIDS in parliament. Anthony Friedlander (National) used this paradigm by stating that

> there has been ample evidence over the years to show that laws we have set in Parliament are based upon the great moral laws that have come to our civilisation over thousands of years. Those laws were originally set to ensure the survival of tribes and civilisations. There is ample evidence to show that those laws are as valid today as they have ever been.[62]

The moral furore which marked parliamentary discourse during New Zealand's HIV/AIDS epidemic is indicative of what Foucault calls 'incitement to discourse'. For Foucault, sexual behaviour in the modern era became subject to incitement in the form of a

> multiplication of discourses concerning sex in the field of exercise of power itself: an institutional incitement to speak about it, and to do so more and more; a determination on the part of the agencies of power to hear it spoken about, and to cause *it* to speak through explicit articulation and endlessly accumulated detail.[63]

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[62] PD,13/11/85: p. 8066 This speaker referred to 'standards', while others spoke of an 'imaginary code or line of moral conduct.' (*Ibid.:* 6/11/85: p. 7804)

[63] Foucault, *Op. cit.* (1978): p. 18 Italics in original

Here, Foucault referred to the way secular discourses multiplied after the rise of capitalism. The tendency of some 'Old Testament' parliamentarians toward 'explicit articulation' during, say, the Homosexual Law Reform Bill supports the argument that moral discourse has become a modern-day method for managing sexuality in the absence of physical punishment.[64] Competing or complementary discourses (religious or secular) can thus serve to reiterate the moral baseline, and to keep ideas about right and wrong firmly established as societal norms.

Foucault's 'explicit' method has traditionally been employed by conservatives in parliamentary debate. Graham Lee's (National) speech is a case in point. He stated that

> the practices of homosexuality are: anal intercourse - fucking; oral sex - sucking to the point that the semen is swallowed, or stopping before the semen is actually swallowed; indulging in water sports - that is, urinating on each other, rimming - tonguing the anal area, which brings the mouth into contact with faeces - or, indeed, even seeking to enter the anal opening; the sharing of sex toys; fisting, which is to use the fist and arm to enter into the rectum and right up the body of the partner, or to use other devices that we do not need to hear about (*sic*).[65]

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[64] Old-time methods were 'coercive', ie: physical, in which corporal and capital punishment rather than moral exhortation was meted out (see discussion in section titled 'Socio-Political Background to Foucault's Analysis' earlier this chapter).

[65] PD, 9/10/85: p. 7269 Lee's speech is reminiscent of Foucault's statement that "Sex was driven out of hiding and constrained to lead a discursive existence." (Foucault, *Op. cit.* (1978): p. 33)

Some parliamentarians used 'reiteration' as a discursive device, prompting the Speaker to place limits on debate during the Homosexual Law Reform Bill. The Speaker announced that

> when the motion was last put before the House I did say that I would be guided by the degree of repetition. I then heard two speeches in which new material was raised almost consistently, but the repetition has come back into the debate and I am not disposed to allow it to continue much longer merely to repeat arguments, contrary to the requirements of the House.[66]

It is clear from the Speaker's comments that 'reiteration' as a technique[67] was well understood and practised by some parliamentarians. The Speaker's statement had followed a speech by John Banks (National) in which the word 'moral' had been mentioned thirteen times in the context of a debate about family and social standards as measured against 'deviant' homosexuality.[68]

Both Gilman and Foucault contended that the moral baseline was substantiated upon evolutionary myths. Gilman states that biblical imagery was used to link notions about sexuality and disease in the syphilis epidemic, so that in pictorial representations "arrows signify the martyrdom of the victims, who suffer as a consequence of Adam and Eve's fall."[69] That

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[66] PD, 13/11/85: p. 8059

[67] Foucault, *Op. cit.* (1978): p. 34

[68] PD, 13/11/85: pp 8057-9

[69] Gilman, *Op. cit.:* p. 93

biblical imagery resurfaces in the HIV/AIDS epidemic is not surprising given that HIV is often sexually transmitted, and that sexual truths in western nations are derived from the Judeo-Christian tradition. More surprising, perhaps, is the ferocity such imagery provokes in defenders of the status quo, and how the restatement of moral truths is surfacing even in highly secularised societies such as New Zealand. This new conservatism is partly caused by fear about the impact of HIV/AIDS, but other factors, including widespread beliefs about social chaos, and its apocalyptic effects, cannot be discounted.

Gilman and Foucault's premise about the discursive nature of power and its iconographic outcomes is analysed in the following sections of this chapter. Here, the content of the Homosexual Law Reform Bill is examined according to moral discourse employed by 'Old Testament' politicians seeking to maintain the status quo. Since power is a salient factor in shaping AIDS iconography, Foucault's insights into the ways in which power relations are evident in discourse are incorporated to give a broader understanding of the debates. Speeches about the Human Rights Amendment are analysed separately and comparatively with the 1986 Homosexual Law Reform Bill.

### *7.64 The Homosexual Law Reform Bill*

Parliamentary debate became anchored to biblical notions about 'sodomy'[70] in New Zealand's HIV/AIDS epidemic once the

Homosexual Law Reform Bill was introduced by Fran Wilde (Labour) as a Private Member's Bill.[71] Prior to this event, parliament's approach to HIV/AIDS was characterised by enquiries about HIV testing, protection of the blood supply, and about AIDS research, funding and education. The Bill was only partly prompted by concerns about the HIV/AIDS epidemic. Its introduction had followed two earlier (pre-AIDS) attempts at reform, including Venn Young's 1974 Private Member's Bill that was defeated 'by only seven votes' in the House.[72]

### *7.65 Discursive Tactics*

Trevor Mallard (Labour), introduced the Justice and Law Reform Committee's report on Homosexual Law Reform to the House. He alerted politicians to the Bill's potential as a vehicle for moral incitement by saying that "the strongest thrust against the proposals in the Bill came from people who based their arguments on some Old Testament biblical passages."[73] He added that

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[70] The Concise Oxford Dictionary (1990 edition) defines sodomy as buggery, or anal intercourse. Sodomy became a crime after New Zealand had acquired Dominion status. It was framed as 'anal intercourse' in a sub-section of the Crimes Act, 1961. Like conservative MPs debating the Homosexual Law Reform, Foucault conflated 'sodomy' with 'homosexuality' when he stated that "Homosexuality appeared as one of the forms of sexuality when it was transposed from the practice of sodomy onto a kind of interior androgyny, a hermaphrodism of the soul. The sodomite had been a temporary aberration; the homosexual was now a species." (Foucault, *Op. cit.*: (1978) p. 43).

[71] The Bill was introduced in March 1985. Where legislation is not initiated by government as a 'Government Bill', MPs are entitled to introduce a 'Private Member's Bill'.

[72] PD, 9/7/86: p. 2810

"under cross-examination those people were shown to be selective in the passages they thought were applicable to modern criminal law."[74] In short, while Old Testament dictates about 'sodomy' were propounded, New Testament ideals were ignored. Fran Wilde (Labour) thought that many opponents espousing Old Testament views were homophobic.[75] Jim Anderton (Labour) reflected on the nature of 'Old Testament' arguments, then asked

> [I]s it the job of politicians to pass laws that deliver moral judgments on members of our society? Some Christians quote the Bible as the source of saying "Yes", but the Bible is a dangerous document from which to quote - it may be quoted back. Christ did not have a high regard for either lawyers or lawmakers: "Unless your justice gives fuller measure than the scribes and the Pharisees you shall not enter the Kingdom of Heaven." For those amongst us who are anxious to rush forward to judge the behaviour of others He made the mob of his day an offer that it refused. He said "Let he who is without sin cast the first stone."[76]

Thus, it was evident from the outset that polemics would mark the progress of the Homosexual Law Reform Bill through parliament. As it transpired, while Old Testament moralists railed against liberals and New Testament humanists; notions about the bible (new vs old) were used to anchor both sides of the debate.

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[73] *Ibid.*: 8/10/85: p. 7204

[74] *Ibid.*

[75] *Ibid.*: p. 7209

[76] *Ibid.*: 9/10/85: p. 7267

Submissions from congregants in the mainstream protestant churches (Baptist, Methodist, Anglican and Presbyterian) supported the Bill, and were not in favour of revisiting Old Testament moral dictates.[77] Individuals from the more 'fundamentalist' religions or those holding similar views invariably used biblical imagery to support their arguments. Their discursive efforts to retain sodomy as a homosexual crime may be interpreted as what Foucault called the exercise of 'bio-power' which is "an explosion of numerous and diverse techniques for achieving subjugation of bodies and the control of populations."[78] The use of moral discourse as a technique enabled opponents such as Norman Jones, John Banks and Graeme Lee (National) to create an atmosphere of fear about homosexuality and its effects on society with respect to HIV/AIDS.

Although Foucault wrote about the secular, multiple methodologies used by government or class interests to control social behaviour, the HIV/AIDS epidemic has seen a resurgence of 'religious techniques' such as the sexual abstinence programmes for youth. This resurgence challenges Foucault's belief in the steady progression toward secular, regulatory techniques whose proponents rely solely on education and self-control in the

[77] No mention was made of the Catholic Church's view of 'homosexuality' in debates about the Homosexual Law Reform Bill.

[78] Foucault, *Op. cit.* (1978): p. 140

exercise of bio-power. It also challenges ideas about self-regulation, if only because religious techniques involve perceptions about divine management for which notions of autonomy can be deemed irrelevant. Such notions are evident even among 'Naturists' (believers in a Law of Nature). Neil Morrison (Democrat) was an MP who used the Naturist argument in debate by claiming that

> nature has a gruesome way of demanding a penance in life. It always will and it always has done. There has been a rise in promiscuity among heterosexuals and homosexuals, and nature demands a balance. I do not say that this [AIDS] is some kind of divine retribution. It is not - it is the normal law of nature that when there are changes of attitude on the part of human beings that come, the laws of nature demand a balance. That is what they are doing now.[79]

Parliamentary debates about morality exemplify the divisions created in the name of bio-power. Pro-Bill debaters such as Helen Clark and Fran Wilde (Labour) defended their stance on humanitarian grounds, and for the sake of populations whose 'invisibility' made them inaccessible to health workers for the purpose of HIV prevention.[80] Moral conservatives, who opposed decriminalisation through a concept of bio-power as presided over by an external force ('God', 'The Law of Nature'), wielded the concept of 'disease' as a form of divine punishment or biological control. Struggles for bio-power and the resultant schisms were alluded to in debate by Geoffrey Braybrooke (Labour), who stated

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[79] PD, 13/11/85: p. 8054 Parenthesis has been added

[80] *Ibid.*: 8/10/85: p. 7212

that public wrangling over the Bill "has even divided the Christian churches, and that is not a good thing. It has divided political parties, communities, and even families. That is how serious the matter is."[81]

Moral anxieties and competing ideologies were most often framed in a rhetoric of freedom which emerged as a discursive sub-text, often in an attempt to restigmatise gay men. MPs such as Paul East (National) called on parliament to allow churches, police, prisons, armed services and organisations such as the Boy Scouts the freedom of choice to exclude gay men from employment.[82] Clive Mathewson (Labour) counter-argued for universal freedoms in the form of human rights. He revealed the paradoxical nature of the 'freedom of choice' rhetoric by saying

> I understand the reasoning of those who support the first part of the Bill but not the second. I understand their idea that personal freedom is the motivator - the freedom to hire whoever one likes, and so on. However, personal freedom must sometimes be curtailed. For example, we do not have the freedom to drive on the right-hand side of the road, for obvious reasons.[83]

Moralists commonly used the rhetoric of freedom to insist on the rights of citizens to a society which was 'free of

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[81] *Ibid.:* p. 7208

[82] *Ibid.:* 6/11/85: p. 7805 This exemption became known as the 'Exclusive Brethren Amendment'.

[83] *Ibid.:* p. 7810. Clive Mathewson's reference to 'danger' as a reason for road safety might be equated with the effects of discrimination being 'dangerous' to the health of gay men.

homosexual disease'. One method of obtaining this utopia was mooted by a visiting USA preacher, Reverend Sheldon, who recommended placing all homosexuals on an island.[84] Moralists invariably posited 'heterosexual' and 'homosexual' freedoms as being mutually exclusive. Their ideological stance was anchored to claims about a gay-inspired conspiracy to spread HIV/AIDS in society.[85] It was announced by Norman Jones (National), for instance, that gay activists had formed an "international homosexual conspiracy. . . to contaminate the world's blood banks to get money for AIDS research."[86] His announcement was designed to invoke public fear to an extent not evident in, say, the syphilis epidemic with its focus on individual 'disease-bearers' and 'victims' rather than on 'organised aggressors'. The theorising about a gay plot is evidence of how Gilman's iconography has become hyper-inflated in the HIV/AIDS epidemic through moral incitement in a conspiracy-conscious era.[87]

The bid to portray bio-power as biological warfare in the HIV/AIDS epidemic served to mask the moralists' own objectives for control by projecting this aim onto members of the gay community. As a result, the 'AIDS victim' was transformed into

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[84] *Ibid.:* 8/10/85: p. 7204

[85] Norman Jones (National) called HIV/AIDS "the homosexually induced venereal disease of AIDS." (*Ibid.:* 6/11/85: p. 7811)

[86] *Ibid.* Conspiracy theories were common in epidemics such as the bubonic plague where Jews were thought to poison village wells, and in the influenza epidemic of the USA where 'flu outbreaks were attributed to German biological warfare (see Chapter 2).

[87] See case study "Icons of AIDS: The Media and Popular Culture" in Chapter 6.

aggressor in an iconographic reversal not unlike that experienced by Jews during the Black Plague. No longer the passive victim, isolate or even corrupter of the syphilis epidemic, the new disease icon (gay man) was depicted as monstrous through his power to organise on a global scale. That the gay man is no longer perceived to be an atomised victim in the HIV/AIDS epidemic was evident in Geoffrey Braybrooke's declaration that "the gay community has shown it is out to get its own way come hell or high water."[88] Braybrooke also attacked the gay man's victim status by saying "anyone who genuinely believes that the gay community is passive, quiet, and gentle should have been at those public meetings [to discuss the Homosexual Law Reform Bill]".[89] Such attacks suggest that moralists fear the erosion of their own power base, either in terms of ideology or influence. By positing the existence of a conspiracy theory, moralists can act as purveyors of moral safety in the face of apocalyptic threat.

### *7.66 Political Strategies*

Parliamentarians using 'incitement' tactics to oppose homosexual law reform often referred to an 835,000 signature petition.[90] According to Graeme Lee (National), one of the organisers of the petition, its existence was evidence that the New Zealand public

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[88] PD, 9/10/85: p. 7259. Graeme Lee (National) also spoke about the 'militancy' of the gay community. (*Ibid.*: 8/10/85: p.7212).

[89] *Ibid.*: 9/10/85: p. 7259 Parenthesis has been added

[90] The number of signatures quoted varied from 800,000 - 880,000, although most MPs used the figure of 835,000.

had "come to understand, resist and register its concern about the unnaturalness, abnormality, and deviance of homosexual practices."[91] Other opponents drew on informal surveys or polls carried out in their local constituencies to support their anti-Bill views. Howard Austin (National) quoted from an 8,742 signature petition in his Bay of Islands constituency, while Richard Gerard (National) referred to a poll conducted among 600 of his Rangiora constituents. Winston Peters (National) drew attention to a survey in which 15,721 members of his Tauranga electorate had signed the petition, and Geoffrey Braybrooke (Labour) stated that 72% of his Napier electorate was opposed to the Bill.[92] Other MPs reported having 'consulted widely' among their constituents, while still others (usually in support of the Bill) quoted Heylen opinion polls which indicated that 62% of New Zealanders approved of homosexual law reform in 1985.[93] Ostensibly, the aim of such headcounting was to establish 'the will of the people', yet more often than not, this 'will' coincided with the opinions of conservative MPs.

To some politicians such as Clive Mathewson (Labour), tactics employed by anti-Bill campaigners often amounted to little more than moral blackmail. Mathewson recalled the presentation of the 835,000 signature petition to parliament, noting that

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[91] PD, 8/10/85: p. 7212.

[92] *Ibid.:* a) 6/11/85: p. 7804, b) 9/7/86: p. 2816, c) 16/10/85: p. 7244, d) 9/10/85: p.7259 Geoffrey Braybrooke was one of the few Labour MPs who voted against Homosexual Law Reform.

[93] From a speech by Fran Wilde (Labour), *Ibid.:* 9/10/85: p. 7257

> the boxes that were brought up the steps [of parliament] were not full. Why would the presenters of the petition bring a lot of empty boxes up the steps unless they were trying to impress people about the number of signatures collected? None of the boxes was even half full, and many of them had only an inch or two of paper in the bottom. Anybody can examine them and verify that. What was the reason behind that deception? If the petition had the force of reason behind it, it did not need to be made defective in that way. The presenters of the petition have threatened those who vote for the Bill with electoral defeat.[94]

Here, the mechanics of power, in the form of public display and rhetoric, are identified by one of the Bill's supporters. Such display was characteristically accompanied on both sides of the House by exaggerated claims, emotive reasoning, and a reliance on expert opinion obtained from Harvard scientists, theologians and ancient Greek philosophers.[95]

References to the petition, polls and surveys, mainly by conservative MPs, during the Homosexual Law Reform debates exemplify active attempts to establish control in the House through claiming a majority vote in the electorate. Not surprisingly, supporters of the Bill charged that the petition was invalid because it contained false signatures, including many

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[94] *Ibid.:* 6/11/85: p. 7807 Parenthesis has been added

[95] For example, in making her case against 'secular humanism' and the Homosexual Law Reform Bill, Tini Tirakatene-Sullivan (Labour) referred to Greek philosophers Plato, Socrates and Aristotle. (*Ibid.:* 13/11/85: p.8083)

from non-voters and children.[96] Supporters also argued for homosexual law reform on the basis of 'force of reason' rather than 'force of numbers'. The reference to force in this context is redolent of Foucault's "plurality of resistances [which] play the role of adversary, target, support, or handle in power relations."[97] The adversarial nature of parliament guaranteed that power operated in terms of a discursive struggle, and that resistance emerged in the form of disparate ideologies such as the 'Law of Nature', 'Old Testament laws' and 'Human Rights'. These ideologies not only served to delineate debate, but provided protagonists with a 'handle' in forming alliances with other colleagues. Thus, Naturists such as Neil Morrison and conservatives like John Banks could forge an alliance in an attempt to influence the final vote, even though they diverged on other occasions.

The survey as a social 'tool' has been theorised by Jean Baudrillard. In his book *In The Shadow of the Silent Majorities*, Baudrillard says that "everywhere the masses are encouraged to speak, they are urged to live socially, electorally, organisationally, sexually, in participation, in festival, in free speech, etc.."[98] He calls the survey the 'floating sign' and says it is 'intended for manipulation. . . because everyone knows the profound indeterminateness which rules over statistics. . . to

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[96] From a speech by Geoffrey Braybrooke, *Ibid.:* 9/10/85: p. 7259

[97] Foucault, *Op. cit.* (1978) : p. 95-6 Parenthesis has been added

[98] Baudrillard, *In the Shadow of the Silent Majorities,* 1983: p. 23

which again hardly any notion of 'objective law' corresponds."[99] The petition, as an indicator of the force of public opinion, was indeed 'intended to manipulate'. Likewise were threats of political defeat. As the Bill proceeded, threats of violence were commonplace. While the threats were aimed at liberals and conservatives alike, those uttered by fundamentalists were more strident.[100] These threats took the debate beyond mere 'incitement to discourse' to 'incitement to violence' in the interests of Old Testament morality. As Foucault pointed out, violence was the mainstay of absolutist rulers before moral discourse emerged as a means of regulating behaviour in Western societies. The position taken by some opponents of homosexual law reform is therefore reminiscent of ancient absolutism, but with a modern twist. The existence of violent threat was evidence that the 'power of the sword' lurked behind the 'power of the petition' in an attempt to elevate the petition (as word) into absolute Word as dictated through the will of the people.

During the second reading, supporters refrained from further debate. Of the sixteen speakers heard during debate in

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[99] *Ibid.*

[100] Fran Wilde claimed that she had been "the object of a bitter hate campaign" and had "experienced some of the hot breath of hatred that is breathed on gays and lesbians from the extreme homophobes in our midst." (PD, 9/10/85: p. 7254). Neil Morrison (Democrat) stated that "many people on both sides of the issue have received threats. I have received threats, and I find that most unfortunate. I commend the member of Wellington Central [Fran Wilde] for being brave enough to introduce the Bill into the House; it took some courage. I consider some of the abuse she has received from people who claim to be Christians to be totally despicable. Many people on both sides of the argument could do much soul searching." *(Ibid.:* 9/7/86: p. 2821) Parenthesis has been added.

November 1985, only two supported the Bill. No supporters spoke during the third reading. This silence was a deliberate attempt to offset the various delays created by the Bill's opponents in the House. Tactical delays included requests for Supplementary Amendments (to raise the age of consent to twenty years), proposals to re-refer the Bill to the Select Committee on the basis of allegedly substantial questions about procedure (such as hearing all 1,000 public submissions), and recommendations for postponement until a Royal Commission could report on the issue. Ironically, by not participating in debate, the Bill's supporters served to make the opponents' rhetoric appear more obstructive than otherwise might have been the case. Furthermore, the one-sided debate was not a sign of political disengagement, for supporters lobbied MPs outside the debating chamber either on a collegial basis or through the offices of the Select Committee. It is arguable, however, whether the outcome in favour of reform was wrought by political savvy, or by the singular fact of Labour's substantial parliamentary majority. Either way, the Homosexual Law Reform Bill became law, despite the fulminations of moralists whose much-publicised petition ("undoubtedly the biggest petition in New Zealand's history"[101]) failed to be the political coup they had anticipated. However, defeat was not one-sided. Political losses were incurred by the reformers, and Part II of the Bill relating to human rights had been abandoned in the face of certain defeat. Part II did not become a legislative item again until 1993, when it was packaged

[101] *Ibid.*: 13/11/85: p. 8063

with other provisions as an Amendment to the Human Rights Act, 1977.

### *7.67 The 1993 Human Rights Amendment*

The 1993 Human Rights Amendment was introduced during the National Party's term of office. In its final form, the Amendment was designed to protect individuals from discrimination on the basis of their sexual orientation, disability or HIV+ status in employment and housing, and in the provision of goods and services.[102] Other provisions of the Act, such as those relating to sex, race and gender were fine tuned in this Amendment.[103] Of several changes to the 1977 Human Rights Act (see footnote 48, this chapter), the most recent (in 1992) had been to ban age discrimination.

A Supplementary Order giving rights to homosexuals and PWAs was introduced during debate by Katherine O'Regan (National) and proceeded as a conscience vote in the House. While the Amendment's scope was much broader than the Homosexual

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[102] Specifically, the Amendment made it unlawful to discriminate against an individual on the basis of sexual orientation, disability or 'presence in the body of organisms capable of causing illness.' It also guaranteed rights of employment to such individuals, and their 'access to places and facilities, education, the provision of goods and services, land, housing and other accommodation'. (*Ibid.*, 27/7/93: p. 16905).

[103] Fine-tuning involved extending the provisions of the Act to voluntary workers, replacing the term 'gender' with 'sex' (which included pregnancy and childbirth), prohibiting 'unnecessary' questions on job application forms in relation to sex, marital status and age, and prohibiting 'racial slurs' to be published in the print media. (*Ibid.:* p. 16906)

Law Reform Bill with its focus on gay men, arguments about homosexuality dominated debates as soon as the Order had been introduced. This focus led to expectations that moral furore such as that experienced during homosexual law reform would recur. However, the Bill's impact was diluted by the way it was incorporated with other legislation, and by the feeling of *deja vu* that existed in the wake of Homosexual Law Reform.

Most arguments opposing the sexual orientation and disease status provisions of the Bill had been aired in 1986. Campaigners such as Graham Lee and John Banks (National) reiterated their beliefs about how gay men compromised youth, the family, and society.[104] The conspiracy theory was taken up by John Banks (National). His anti-gay statements were supported by colleagues who alerted the House to the existence of New Zealand's 'extremely powerful, very persuasive, and very well organised gay lobby'.[105] John Banks linked homosexuality with lifestyle in an effort to instil fears about the sexual predilections of gay men. In speeches about the effects of homosexuality on youth, family and society, he attempted to divert discussion away from sexual orientation (the focus of the Supplementary Order) toward sodomy as a yardstick for deviant, non-heterosexual (and therefore, destructive) behaviour.[106]

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[104] *Ibid.:* pp. 16916 & 16929. Parliament's most vociferous anti-homosexual law reform campaigner, National's Norman Jones, died before the 1993 Human Rights Amendment could be debated in parliament.

[105] For example, Hamish Hancock (National) included these statements in a speech opposing the 1993 Human Rights Amendment (*Ibid.:* p. 16930).

As in 1986, the results of petitions and surveys such as the Homosexual Law Reform petition, local polls, or larger surveys such as those conducted on a nationwide basis by McNair and The National Research Bureau were used to support views on both sides of the debate.[107] Statistics produced during debates about homosexual law reform, such as those about the levels of homosexuality in society, were re-presented.[108] Themes articulated during the 1986 Homosexual Law Reform Bill resurfaced in a number of ways, and were expressed in discourse about standards, freedom of choice, and the family; in the emphasis on scientific evidence about the levels of homosexuality in society; and in arguments about fundamental human rights versus Old Testament dictates.

The political fervour that had marked the passage of the Homosexual Law Reform Bill was less pronounced in 1993. Peter Luke in the *The Press* says that "in the end, the move to ban discrimination against homosexuals passed through Parliament with scarcely a hiccup."[109] There were no tactical delays, or large-scale petitions calculated to subvert reform. Moral debates

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[106] *Ibid.* p. 16917

[107] Results from the 1993 McNair survey (commissioned by members of the AIDS Foundation) demonstrated that most New Zealanders favoured open employment policies, even in the armed forces and the police, while those of the National Research Bureau (commissioned by the then Police Commissioner, John Banks) "showed that the public was clearly against or had mixed views about the prospect of openly homosexual police." *(Ibid.*: p. 16937 and 16945)

[108] For example, by Ian Peters (National) *Ibid.*: p. 16924.

[109] *The Press,* (31/7/93): p. 22

also lacked the intensity of 1986, so that the Bill's passage "clearly reflected a growing mood of tolerance if not liberalism over this issue."[110] The lack of discussion about other changes to the Human Rights Act, however, threw the iconographic nature of debate into relief. This neglect drew sharp comment from John Carter (National) who said

> I am disappointed that during the debate most of the parts of the Bill that refer to discrimination against those who are handicapped, and so on, have just whistled through the House and have not been debated. They have hardly been referred to, yet they are very important issues. Quite honestly, I do not think that any speeches were made about those particular provisions.[111]

Christopher Laidlaw (Labour) also remarked that "too much attention has been devoted right through the debate thus far to the whole question of sexual orientation and body organisms. I suspect that in twenty years or so we will look back and wonder what on earth the fuss was about."[112] Lianne Dalziel (Labour) tried to redress the balance. She said, "I am a little concerned that the debate on the issues in the supplementary order paper has led to little comment on the wider provisions of the Bill. Therefore I want to focus on those provisions at the outset."[113]

The attention given to homosexuality and AIDS in the

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[110] *Ibid.*

[111] PD, 27/7/93: p. 16978

[112] *Ibid.:* p.16919

[113] *Ibid.:* p. 16907

debates was, in part, an outcome of the way in which the Supplementary Order had been framed as a health issue. As quoted in *The Press*,

> Mrs O'Regan [National] had sold her proposal as a health measure rather than a human-rights reform. In essence, her argument was that to curb the spread of AIDS there must be a social environment in which homosexual people could feel secure in coming forward to seek medical treatment or advice. If discrimination on the grounds of sexual orientation or the presence in the body of disease-causing organisms had not been banned, such people might not risk the social stigma that could follow identification.[114]

Supporters had hoped that by framing the Supplementary Order as a health issue its prospects in the House would be advanced. The final vote in favour of gay rights suggests that this strategy was successful. However, at times it also resulted in 'fiery extremes of passion' reminiscent of homosexual law reform.[115] Dichotomous concepts about health and disease soon appeared in debate, so that while supporters such as Katherine O'Regan (National), Lianne Dalziel and Steve Maharey (Labour) praised the health aspects of the Order, opponents like Graeme Lee, Peter Tapsell, John Banks and Ian Peters (National) used apocalyptic imagery in an attempt to catastrophise the concept of 'homosexual' disease. Unlike the Homosexual Law Reform debates, however, their focus was on 'moral' rather than

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[114] *The Press*, (31/7/93): p.22 Parenthesis has been added

[115] *Ibid.*

'physical' disease. This discursive shift meant that homosexuality was posited as a perversion, and coupled with paedophilia, incest and sodomy as a threat to the health of society.

John Banks (National) polarised the debate further by challenging the reformers' 'gay health' rhetoric to suggest a causal relationship between homosexuality, paedophilia, and other sexual crimes involving children. Not only was he able to argue against extending human rights provisions to gay men by linking homosexuality with child abuse, but contrary to his stance in 1986, he could refrain from making explicit references to 'disease-bearing' gays.[116] This discursive shift was apparent to supporters such as Sonja Davies (Labour), who remarked that "the recent connections between sexual orientation and paedophilia are grossly ill-informed, as there has never been any correlation shown between homosexuality and child abuse. These wild claims are nothing more than homophobic scare tactics."[117] Nevertheless, John Banks' use of rhetoric had propelled the image of the gay man into that of a sociopathic predator, which transcended Gilman's 'disease' icon for whom sympathy (and human rights) could justly be afforded.

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[116] Apparently, lesbians were of little concern in either the 1986 or 1993 reforms, for according to Peter Tapsell, they were 'quite a different *psychological* phenomenon' to gay men (my italics). (PD: p. 16923) See the discussion about the invisibility of lesbian women in Chapter 6.

[117] PD, 27/7/93.: p. 16950

The decision to conflate 'homosexuality' with 'sexual predation' by moralists such as John Banks occurred at the height of public concern about child abuse in New Zealand (incest, domestic violence, school bullying). Intentionally or otherwise, conservative politicians thus reflected a wider discourse about sexual behaviour that effectively expanded pre-existing discourses about sexuality and STDs in New Zealand. Conservatives' renewed attempts to rally public and political opinion against gay rights meant that homosexuality could be reframed as morally and psychologically 'sick' in the context of wider concerns about social chaos.[118] By so doing, they hoped that political tolerance of gays would be called into question, or halted. Peter Tapsell (Labour) warned that

> [T]his law will not change one bit the public attitude in regard to the homosexual. Men will despise them and women will patronise them. What worries me most is that I foresee that the wheel will turn to the stage at which we will see brutal repression of homosexuality. If I were to guess, I would say that we will see that repression begin in the United States or Germany, then spread, and there again will be brutal repression of homosexuality. The irony of that is that those liberals who at this time promote homosexuality in 30 years' time will lead the march back, and they

[118] Peter Tapsell (Labour) and Ian Peters (National) were two politicians who referred to gay men as 'sick' or 'dysfunctional'. Ian Peters stated that "it is interesting to reflect that the three registered medical practitioners in the House will not vote for the supplementary order paper, and there must be a very good reason for that. . . I repeat that homosexuality is a dysfunction. It is also completely against being comfortable about one's health. At the heart of homosexuality is a health issue, and one of the reasons that I shall not support the Bill is that it is contrary to good health." (*Ibid:* p. 16925)

> will do it with the same fierce zealotry with which they have promoted this measure now.[119]

Gilman's perspective suggests that the discursive shift that occurred between 1986 and 1993 in New Zealand is evidence of a 'free-floating imagery about disease' that exists in society.[120] By free-floating, Gilman means that ideas about a particular disease remain constant, even while the discourse which frames them shifts according to cultural or historical context. Thus, while the discursive shift outlined here is indicative of changes to the way sexuality has been problematised in New Zealand, notions about AIDS remain firmly fixed on the 'polluting' image of the gay man. As Gilman points out, all such image-making "must be understood as part of [an] ongoing attempt to isolate and control disease."[121] His argument is supported by the fact that the Bill was framed in terms of a health issue, and that politicians on both sides of the House utilised the disease/health dichotomy in debate.

A focus on homosexuality and HIV/AIDS in 1993 meant that employment rights *per se* were often masked by the iconographic nature of the debates. The attention given to health in the HIV/AIDS epidemic also meant that the larger question of 'Whose

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[119] *Ibid.:* p. 16924

[120] Gilman, *Op. cit:* p. 88

[121] *Ibid.* Gilman argues that the boundaries drawn between 'diseased' and 'healthy' individuals act as a comfort-zone for the healthy (see Chapter 6). Parenthesis has beenadded

power?' in human rights issues was often ignored. Steve Maharey (Labour) alerted colleagues to the problem by saying

> I believe that it is very important to understand that the issues that we discuss here are about power: who has it, and who exercises it over others. That will become most apparent when we talk about the supplementary order paper. When we do talk about the supplementary order paper in relation to sexual orientation and organisms in the body, we must remember that, although we call this matter - in a somewhat joking way, I think - a conscience vote, and although we as individuals exercise our individual consciences, what we are doing is either defending the rights of people to oppress others or saying that that is not on and that people cannot oppress others.[122]

Here, Steve Maharey suggests that the parliamentary veto can be used in the exercise of hegemonic power. This prospect, however, had been taken into account prior to the introduction of the Supplementary Order according to Foucault's "interplay of nonegalitarian and mobile relations."[123] Reformers had devised a number of successful strategies such as flooding parliament with submissions in support of gay rights, linking the Supplementary Order with health concerns, conducting a more open-ended, national survey to counter the one commissioned by Police Commissioner John Banks, and packaging the Order between

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[122] PD, 27/7/93: p. 16914

[123] Foucault, *Op. cit.* (1978): p. 94 Foucault believed that hegemonic power is unstable, being constantly subjected to challenge from 'multiple sites'. By non-egalitarian relations, he meant that a state of disequilibrium is guaranteed by the friction generated through competition for status and control.

'goodwill' provisions designed for disabled individuals and pregnant women. By such means, reformers demonstrated their political acumen over an increasingly depleted cast of 'conscience-voting' moral conservatives. The veto feared by Steve Maharey was thus rendered inoperative. By means of the 'mobile relations' of power, moral hegemony had been subverted, and legislative objectives were achieved despite the obvious focus on AIDS icons.

The Amendment was passed in July 1993 by forty-eight to twenty-six votes. At that time, the ratio of National to Labour MPs in the House was more than 2:1 (sixty-three votes to twenty-nine). The Bill's passage was therefore not affected by National's more conservative majority, for according to Peter Luke of *The Press*, over half had also favoured reform (twenty-four votes to twenty-three).[124] Political strategies had undoubtedly influenced some conservative MPs. For example, National's Graeme Reeves, whose electorate is "generally regarded as being more conservative than many urban seats because of its elderly and Catholic population"[125] changed his vote after witnessing the number of Select Committee submissions in favour of reform. Cam Campion (formerly National) also voted for the Bill, "on the basis of written submissions to his electoral office."[126] Even

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[124] *The Press,* (31/7/93): p. 22 Luke attributes this phenomenon to urban-rural demographics, saying that Nationals from urban electorates favoured reform more than their rural colleagues.

[125] *Ibid.*

[126] *Ibid.*

such conservative stalwarts as John Carter, Brian Neeson and Alan Meurant (National), voted for reform. For Brian Neeson, the deciding factor had been the reformers' decision to package the Supplementary Order with other, 'goodwill' provisions. In a final speech, he said

> I voted against the amendment. We lost... So I have decided that I shall have to vote for the Bill because of the substantial parts in it that we just cannot ignore. As far as the homosexual amendment is concerned we have lost it, and I think that is where it will sit. Once again, I repeat to the homosexual community that I do not feel any malice towards anybody, and I certainly hope that through this measure things will not get worse for them rather than better.[127]

## *7.68 Conclusion*

Parliamentary debates about the 1986 Homosexual Law Reform Bill and the 1993 Human Rights Amendment proved useful for analysis with respect to Foucault's and Gilman's insights on power and discourse. For example, iconography relating to gay men appeared in the debates of both reforms. Opponents of the Homosexual Law Reform Bill used the image of the gay male disease-bearer as articulated by Gilman to argue against change to the status quo, while supporters argued for legalised sodomy on the basis of human rights and HIV prevention. In 1993, AIDS iconography emerged once the Supplementary Order had been

[127] PD, 27/7/93: p. 16979

presented as a health issue. Gilman's perspective thus proved central to gaining an insight into the iconographic nature of the debates. He also provided the historical context for epidemiologic image-making, so that the concerns of New Zealand moralists could be placed within the discursive history of STDs.

Issues of power were undeveloped until explored in terms of Foucault's analysis of power relations, especially in their discursive and material forms. As is evident from this case study, political strategy was integral to both the 1986 and 1993 reforms. Foucault's belief that tactical power is inherent to socio-political relations was well-suited to an analysis of New Zealand's parliamentary process as it related to HIV/AIDS. Major tactics included the presentation of a 835,000 signature 'people's petition' to parliament, and the artful packaging of the Supplementary Order within a number of provisions in the 1993 Human Rights Amendment. The writings of Foucault provided the theoretical means of exploring methods used by lobbyists and politicians by recognising that the 'production of power'[128] is not linear. Rather, it is a diffuse and multi-faceted process that can best be understood in terms of the active 'production' of discourse.

Some aspects of Foucault's theory were less suited to analysis in the case study. For example, Foucault's explanation of the development of systemic power did not readily lend itself to specific political events in New Zealand. The mismatch between

[128] Foucault, *Op. cit.* (1978): p. 101

theory and data was most apparent when details about parliamentary process failed to correspond to, or be illuminated by, Foucault's conceptualisation of power relations. At best, the theory provided an insight into the way ideology and praxis can become reiterative and hegemonic. At worst, local specificities were eclipsed by a perspective whose value lay in charting and explicating socio-cultural shifts that had resulted from the 'multiplying effects' of discourse and praxis. Where Foucault's work converged with Gilman's as an historical overview, however, the discursive patterns of the 1986 and 1993 debates were more satisfactorily explained. Both Gilman and Foucault provided analyses of events relating to eras of epidemic disease: both revealed patterns, systems and discourse as means by which sexuality was controlled in the interests of disease management and moral hegemony. Through this synthesis, the reforms could be viewed as one aspect of an evolutionary process whereby power was accrued in multiple ways through discursive praxis, and promulgated through specific discourses about sexually transmitted disease. This aspect of Foucault's work also provided insights into the way power is produced through the lens of cultural imperatives, so that responses to epidemics such as syphilis and HIV/AIDS could be explicated with respect to pre-existing discourses in their cultural context. In the theoretical section of Chapter 7, I outlined Foucault's perspective on how class interests in Europe had promulgated discourse about sexually transmitted disease as a means of securing economic (and racial) superiority. The links to this perspective, and the

debates surrounding the 1986 and 1993 legislation in New Zealand, are evident in the way, say, conservative politicians deemed homosexual behaviour a threat to societal (rather than individual) health, and how they placed 'non-reproductive homosexuality' in opposition to the ideal (reproductive) family.

The parliamentary debates discussed in this case study have, in both cases, ended in victory for reformers. From my analysis of the reforms, it could be surmised that party politics, ideology and epidemics are a potent mix in the production of social strategies for political advantage by liberals, conservatives and lobby groups of all kinds. The changes wrought by the reforms are, as Foucault suggests, open to challenge because of the constant juxtapositioning for power in economic, social and political life. At the political level, these challenges will continue to be expressed in parliamentary debate as framed by the rhetoric of fear, power, and moral destiny. The absence of legislation is also indicative of the exercise of power, ie: the power *not* to address issues, as has occurred with the reforms advocated by sex-workers in New Zealand. In the meantime, the AIDS icon sits uneasily between the axes of death, immorality or empowerment, awaiting the next twist in epidemic history in which protagonists will re-visit old and new discourses by way of strategy, tactic, method and resistance.

# CHAPTER EIGHT

## FOUCAULT AND THE LIFE PROJECT IN THE HIV/AIDS EPIDEMIC

## 8.1 Introduction

In his book *The History of Sexuality: An Introduction,* Foucault maintained that sexuality has a history - not only of practice, but of language or ways of talking about sex. According to Foucault, the language of sex that developed in Western countries is an outcome of particular historical, political and social factors which together have given rise to

> a steady proliferation of discourses concerned with sex - specific discourses, different from one another both by their form and by their object: a discursive ferment that gathered momentum from the eighteenth century onward.[1]

The 'language of sex' that has developed is what Foucault terms a 'garrulous' sexuality[2]; and 'a talking sex'[3]; a 'veritable discursive explosion. . . around and apropos of sex'.[4] This 'language' (or discourse) began in the Catholic confessional as a place in which the individual was impelled to divulge sexual transgression or erotic desires in return for absolution. Foucault argued that 'confession' as practice expanded during the eighteenth century, and was appropriated by medical and governmental authorities seeking knowledge and management of human behaviour. The behaviour of individuals, particularly those

1 Foucault, *The History of Sexuality: An Introduction , 1978* : p.18

2 *Ibid.*: p.127.

3 *Ibid.*: p.77

4 *Ibid.*: p.17

incarcerated in prisons or mental institutions, was monitored, and detailed accounts (confessions) were extracted. This body of knowledge played a key role in the subsequent 'categorisation' and 'measurement' of human 'typologies'.

Sexuality became a particular focus of the regulators' attention. Initially, rules for sexual behaviour were devised in an attempt to enhance the sexual (reproductive) health of the European bourgeoisie. Foucault argued that this Life Project[5] was enacted as a set of rules and regulations designed to promote the physical, economic and moral superiority of the upper classes. He argued that

> the body, vigor, longevity, progeniture, and descent of the classes that 'ruled'. . . has to be seen as the self-affirmation of one class rather than the enslavement of another: a defense, a protection, a strengthening, and an exaltation that were eventually extended to others. . . With this investment of its own sex by a technology of power and knowledge which it had itself invented, the bourgeoisie underscored the high political price of its own body, sensations, and pleasures, its well-being and survival.[6]

Thus, the bourgeoisie ensured the superiority of its class through specified codes of behaviour. These rules were later extended to the general public to promote worker health, economic

[5] See footnote 27, Chapter 7. The concept of a Life Project relates to Foucault's argument regarding the shift from a regime structured around the power over *death* to power over *life*.

[6] Foucault, *Op. cit.*, 1978: p.123

productivity, and to limit population size. Foucault maintained that this project was also a 'racist' one, in that its eugenics concerns justified capitalist expansion into countries in Africa, India and other non-white colonies.

Foucault argued that the Life Project was promulgated through medical, educative and scientific discourse. Attention was focused on the body, which was

> to be cared for, protected, cultivated, and preserved from the many dangers and contacts, to be isolated from others so that it would retain its differential value; and this, by equipping itself with - among other resources - a technology of sex.'[7]

The discourse of sexuality, therefore, emerged as a policy of exhortation, of measures taken for the purpose of longevity, and of practices and disciplines which would engender a healthy existence. There was to be sex within certain limits, a codified[8] and sanctioned sex, so that the body (in eugenic

[7] *Ibid.*: p. 17

[8] *Ibid.*: p.42. Here, 'codified' means a set of rules and regulations designed for 'healthy' sexual practice. For example, during the nineteenth century masturbation (onanism) was condemned and parents and teachers were exhorted to keep a watch on children at all times. Foucault wrote that, eventually, "an entire medico-sexual regime took hold of the family milieu." He maintained that the 'extraordinary effort' that went into the surveillance of children's masturbation in fact was designed to "proliferate the limits of the visible and the invisible." Thus, rules were not only created to regulate sexuality but to perpetuate a system of power in which longevity (achieved by behavioural constraints) was crucial to maintaining the superiority of a 'class.'

terms) would reproduce in ways that would enhance the superiority of class and race.

Foucault's 'garrulous sexuality', at once permissive and prescriptive, gained momentum in the nineteenth century as if snowballing through successive social, political and economic disjunctures. Thus, even the Victorian era witnessed an intensification of the discourse of sexuality - if only through the power of proscription, since a) "laws and structures that deny pleasure or desire [also] create that desire" [9], and b) proscription itself creates discourse because rules and prohibitions are promulgated through various media. This process was not without challenge from various sectors of Victorian society. Foucault argued, however, that each new challenge results in further 'incitement to discourse' because of the ensuing debates.[10] In a twentieth century example, the 1960s 'Age of Liberation' saw not only a challenge to existing ideas about sexuality, but an expanded discourse by virtue of that challenge. This expansion occurred primarily because of the publicity generated by the media, as well as by legislators, medical professionals and educators. Again, in the HIV/AIDS epidemic, discourse about 'alternative' sexual practices such as oral sex has emerged. In particular, proscription of one form of sexual practice (anal sex) has resulted in the discursive promotion of other sexual practices, now re-packaged as

[9] Patton, *Sex and Germs: The Politics of AIDS*, 1985: p.117. Parenthesis has beenadded.

[10] Foucault, *Op. cit.* (1978) : p.34

strategies for 'safer sex'.

## 8.2 AIDS and Sexuality: Convergence of Discourses

The discourse of sexuality, in its encounter with the HIV/AIDS epidemic, has not only become more garrulous in terms of Foucault's theory, but has had old meanings grafted onto new, incorporating language from other discourses such as those of disease (plague, STDs), gender and power. Thus, in an attempt to define, categorise, understand and contain HIV infection, there has been a convergence of discourses from which new meanings have emerged. The convergence of old and new is seen in the conjoining of a) pre-AIDS (and pre-antibiotics) medical and social discourses which conflated notions of sexuality and STD in terms of Victorian morality, and b) the liberationist discourse of 'free' sex. This discursive medley has produced some interesting juxtapositions. For example, while the necessity for 'safer sex' (eg: no casual sex) is promulgated by health authorities, activist writers such as Jeffrey Weeks, Simon Watney, Gaye Rubin and New Zealand's Allanah Ryan propose a 'celebratory sex' to offset the 'repressive' approach to sexuality.[11]

> Celebratory sex builds on the notion that the new gay identity was constructed through multiple encounters, shifts of

[11] Ryan, "The End of the Good Times? : 'Sexual Freedom' in an age of AIDS", *Sites*, Spring 1991: pp 101-111, and Bersani, "Is the Rectum a Grave" in *Cultural Analysis, Cultural Activism*, 1988: p.218.

> sexual identification, actings out, cultural reinforcements, and a plurality of opportunity (at least in large urban areas) for de-sublimating the inherited sexual guilt of a grotesquely homophobic society.[12]

While celebratory sex is described as varied, frequent and adventurous, its proponents still advise restraint: ie: they advocate the use of condoms, or other, 'non-penetrative' sexual practices. Activist writers thus depict the strain engendered by the discursive conflicts of AIDS epidemic, for while lamenting the "wholesale de-sexualisation of gay culture and experience encouraged by the AIDS crisis" and insisting on the "diversity of sexuality in *all* variant forms" so as to "maximise the mutual erotic possibilities of the body"[13], they nevertheless actively promote 'safer sex' which requires a degree of sexual restraint. While the activists' agenda for eroticism is in apparent contradiction to the 'safer sex = no casual sex' campaigns[14] of, say, the New Zealand government, the aims are similar, a reduction in HIV/AIDS. The contradictions are indicative of prior discourse: of a nineteenth century morality evident in government health promotion efforts, and of post-1960s notions of 'free sex' as advocated by gay activists. It is arguable which group is more successful in HIV prevention work (both groups address different audiences), but the outcome for discursive power is the same: the discourse of sexuality is expanded by its reference to a life-

[12] Watney in Bersani, *Ibid.*: pp 218-219

[13] *Ibid.*: p. 219

[14] Poster - "Ten Reasons For Saying NO To Casual Sex", Health Promotions, Christchurch, 1990

threatening disease. The urgency of disease has engendered this vastly expanded and cross-referenced discourse which has 'bled' into other areas of social life. The outcome is a hegemonic network of power relations which, as described by Foucault (with reference to a specific set of practices located in time and place) composes "circular incitements that have traced around bodies and sexes, not boundaries to be crossed, but *perpetual spirals of power and pleasure.*" [15] Thus, discursive power, in forming a coalition of pre-existing ideologies, multiplies its force by way of merger in the HIV/AIDS epidemic.

## 8.3 'Homosexuality' as a Life Project in the Age of AIDS

The AIDS epidemic has seen a sharp refocus on health, well-being, and the perceived capability of 'immoral sex' to undermine or deplete the health of a nation. The liberals' challenge to the 'old' sexual order during and after the 1960s has now faltered as a result of the HIV/AIDS epidemic, and the discursive furore which epitomises responses to AIDS is often heavily weighted towards re-imposing old-style sexual morality. However, this ideology of restraint is now under challenge from the people most affected by HIV disease (gay men). Gay activists are thus actively resisting the old-style morality with its emphasis on monogamous heterosexuality. This resistance takes the form of 'discourse production', a central aspect of which is that

[15] Foucault, *Op. cit.* (1978) : p.45 Emphasis in the original.

preservation of 'gay identity' (and life) depends on incorporating 'safer sex' practices into a 'celebratory' repertoire.

The gay community's[16] vigorous challenge to hegemonic sexual codes indicates the significance of 'voice' as a mode of resistance. This voice has emerged despite 'the homosexual', as created by early sexologists in the nineteenth century, being deemed a sub-species for whom 'voice' was denied on the basis that he (*sic*) existed only as an "indiscreet anatomy and possibly a mysterious physiology."[17] 'The homosexual' was placed outside discourse except for the purpose of making the norm visible and, therefore, sustainable.[18] Paradoxically, it was this early categorisation of a medical sub-species that enabled 'homosexuality' to become an identity in the twentieth century. Foucault wrote that, as much as the categorisation of homosexuality "made possible a strong advance of social controls into this area of 'perversity'",[19] it

> also made possible the formation of a "reverse" discourse: homosexuality began to speak in its own behalf, to demand that its legitimacy or "naturality" be acknowledged, often in the same vocabulary, using the same

[16] See footnote 3 in the Introduction for definition

[17] Foucault, *Op Cit.*(1978): p.43. Foucault says that in the nineteenth century the homosexual "became a personage, a past, a case history, and a childhood." Whereas prior to the nineteenth century the "sodomite had been a temporary aberration" according to prevailing religious philosophy, the Life Project now cast 'the homosexual' as a medical sub-species.

[18] This process was different for lesbians than for gay men on same, arguably important, counts. Lesbians are still often 'invisible' (see Chapter 6).

[19] Foucault, *Op. cit.* (1978): p.101

categories by which it was medically disqualified." [20]

It is this 'homosexual' identity that has come into sharp focus during the HIV/AIDS epidemic. It is an identity carved most forcefully during gay liberation in the 1970s, and one which strategically appropriated aspects of the discourses of the Life Project to demand funding and resources for HIV prevention and care. 'Identity' has been woven into gay life in terms of extraordinary suffering, and, as noted, has been promulgated by activist-writers as a means of preserving life through the 'celebration' of safer sex. Nevertheless, 'homosexuality' remains an identity which is constantly measured against the notion that heterosexuality is the norm.

Since the homosexual's 'reverse discourse' seeks legitimacy of difference and desire, it also exposes the underbelly of a Life Project for which desire must be repressed if it is to be valued, and for which difference is seen as pathological. Because gays were cast as a nineteenth-century sub-category, they have been well placed to develop their own 'life' strategies and discourses on sexuality, and to challenge a hegemonic Life Project that only served to marginalise them. Gays, as the politicised victims of medical discourse, have not only appropriated the medical language of AIDS, but have turned it to their advantage, invigorating it and demanding legitimacy on the basis of their knowledge about their 'body' and HIV disease. And if gays have

[20] *Ibid.*

become remedicalised by virtue of the HIV/AIDS epidemic, in counterpoint, 'homosexuality' has imposed its demands on medical science - challenging the medical establishment and drug companies in scientific language for prioritised consideration of PWAs and individuals from 'at risk' communities.

As gay communities are decimated by AIDS, homosexuality as 'identity' or 'category' is paradoxically enhanced through the politics of disaster.[21] As unlikely as it seemed a decade ago, 'biology' has re-surfaced and has been welcomed by gay activists and spokespeople as a *defence* for this identity. Genetic makeup is claimed by scientists to be a cause of homosexuality: decriminalisation of 'homosexual acts' is therefore recommended as the commonsense measure for disease control in the light of a scientific discovery.[22] The 'homosexual' thus has turned full circle, from being a nineteenth century medical sub-species and social outcast to becoming a re-medicalised entity, albeit one who demands legitimation on the basis of 'genetics'. The gay man's reclaiming of genetic identity in the HIV/AIDS epidemic is

[21] This prospect does not please everyone. Political conservatives in the USA, such as *Chicago Tribune* journalist Mike Royko, are of the opinion that "some AIDS education posters have far more to do with the promotion of homosexuality than with the prevention of disease." in Sills, *The AIDS Pandemic - Social Perspectives,* 1994: p.162.

[22] Gay activists (and others) contend that 10% of individuals are 'naturally' predisposed towards homosexuality with larger numbers participating in homosexual activities at some point in their lives. (PD, 27/7/93: p. 16924 and LAGANZ files, Alexander Turnball Library). The phenomenon of the 'rogue gene' being 'found' to explain all manner of 'ailments' such as anorexia and alcoholism etc., should be viewed in the context of *that* expanding discourse (and potential practice) and its intersection with HIV/AIDS and homosexuality.

indicative of the way a medically-defined 'category' has been captured, exalted as a 'life force', and politicised in a manner reminiscent of the expansionist ideals of the Life Project itself.

## 8.4 Bifurcation of the Life Project in the Age of AIDS

'Life' concerns seem to have split or polarised during the HIV/AIDS epidemic, giving rise to debates about 'sexual freedom' and the incidence of STDs. 'Old' ideas about *whose* health and well-being should be given priority during epidemics have also resurfaced, so that some governments and health authorities have been tardy in responding to HIV/AIDS. Thus, 'life-strategies' based on sexual difference have become a locus of concern for community activists in the face of perceived governmental apathy (see Appendix I). In the USA, groups such as ACTUP[23] stage protests to obtain funding for safer sex campaigns based on condom use rather than celibacy or monogamy. Such activists have also lobbied for IV needle exchange programmes on the basis that both needles and sex are being shared. However, moves to establish needle exchange programmes have met with such resistance from national, state and municipal governments that a clash of 'life' discourses in the USA has ensued. For example, the

[23] ACTUP - "AIDS Coalition to Unleash Power - a diverse, non-partisan group united in anger and committed to direct action to end the AIDS epidemic" - Bordowitz, "Picture a Coalition" in *AIDS - Cultural Analysis, Cultural Activism*, 1988: p.185. Bordowitz writes that ACTUP is a political group that stages regular protests in an effort to change legislation or policy which is disadvantageous to PWAs. Part of ACTUP's brief is to obtain greater resources for PWAs in the USA, including funds for HIV prevention.

activist agenda, which is based on concerns about civil rights *and* the health of marginalised people, has encountered the overtly moral discourse on drugs. The drugs discourse, with its focus on proscription and moral incitement is redolent of Foucault's bourgeois project whereby the body was to be "cared for, protected, cultivated, and preserved from the many dangers and contacts, to be isolated from others so that it would retain its differential value."[24] In the discourse on drugs, the body is to remain 'clean', ie: clean of addictive substances, and 'uncontaminated' in terms of contact with drug users. Through binaries that constitute the drugs discourse, (clean/unclean, good/evil, White/Black), drug users are placed outside decency, and therefore outside the concern of health authorities.

The force of this anti-drugs rhetoric is such that the activists, whose 'life' focus is pragmatic rather than moral, have been unable to counter the drugs discourse as it exists in the USA (see Chapter 4). As a result, HIV prevention strategies such as needle exchange programmes are often piecemeal and/or illegal operations.[25] This clash of 'life' discourses, as well as being illustrative of bifurcated responses in the HIV/AIDS epidemic, is

[24] Foucault, *Op cit.* (1978) : p.123. See footnote 8, this chapter.

[25] Anderson, "The New York Needle Trial: The Politics of Public Health in the Age of AIDS" in *AIDS and Contemporary History,*1993: pp157-181, and Sills, *Op. cit.:* pp 149-50. Needle exchange programmes offer injecting drug users clean needles and syringes in exchange for used ones. Injecting drug users therefore have access to a supply of clean needles at minimal or no cost. The benefits of this programme have become evident in countries like New Zealand and The Netherlands where few injecting drug users have been infected with HIV.

a salutary reminder of the ferocity of 'old' hegemonic ideals. This clash is particularly evident in the USA, and has racist overtones because of the way African-American 'drug abusers' have been targeted for blame.[26]

## 8.5 Sexuality and the Life Project in New Zealand

In the early days of the HIV/AIDS epidemic in New Zealand, gay activists lobbied the government for funds for HIV prevention programmes based on condom use rather than abstinence, monogamy or restricted sexual practice. As developed in Appendix II, the activists persisted in their attempts to gain funding, despite resistance from Health Department officials who refused to enter negotiations with a group of 'outlaws'.[27] As the numbers of PWAs rose in New Zealand, and fears were expressed of HIV infection spreading to the heterosexual population, the government instituted a crisis response (see 'Government Response' in Chapter 5). A unitary approach[28] to HIV prevention during this time was evident from budget allocations for 'life education' programmes in schools, and increased funding to

[26] Most injecting drug users in the major cities of the USA are Blacks and Hispanics who are also disproportionately poor and dispossessed. They are the focus of unilateral censure in terms of 'hegemonic norms' about deviancy and drug use (see Chapter 4).

[27] Parkinson & Hughes, "The Gay Community and the Response to AIDS in New Zealand" in *The New Zealand Medical Journal*, 1987: p.79. Homosexual acts in New Zealand were deemed illegal until the Homosexual Law Reform Act was passed in 1986.

[28] In this instance, 'unitary' means a centralised, even-handed approach to HIV prevention.

government agencies such as Family Planning Clinics and Sexual Health Centres,[29] as well as to the ASOs. However, the government's current move in favour of projects administered by *formal* health and education agencies appears to have been at the cost of some *community* programmes such as those developed by the AIDS Foundation (see 'Health Reforms' in Appendix II). This move has been commented on by at least one government health worker who said "I wonder if [the Co-ordinator of the College of Education HIV Prevention in Schools Programme] realises that the money she got was at the expense of the guys at Ettie Rout."[30]

The government's move to fund Colleges of Education for HIV prevention is an apparent attempt to target a large group of young New Zealanders, so that HIV prevention information is made available to those deemed the most malleable and also, the most sexually active. This focus suggests that the Life Project of old is alive and well, centring as it does on sexuality in terms of 'management', although in Foucauldian terms, there is evidence to suggest that desire can also be the by-product of such programmes.[31]

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[29] Information based on a) The AIDS POBOC (Payment On Behalf Of the Crown) funding report 1992/93 and b) interview with personnel at the Christchurch Sexual Health Centre on 13/10/93. Under a Labour government, the budgets of STD clinics in New Zealand increased. However, funding for the Christchurch Sexual Health Centre was cut by $40,000 in 1993 under National, probably in the name of 'health reform'. As one staff member remarked: "It represents someone's wage."

[30] Comment unreferenced to protect the anonymity of the informant. The Ettie Rout Clinic in Christchurch is a branch of the AIDS Foundation which offers HIV testing, counselling and support services. Parenthesis has been added.

[31] Owens, "Achieving Effectiveness in Intervention", 1992. Owen's study on sex education was commissioned by the New Zealand Family Planning Association. As

Some contextual twists to New Zealand's response to the HIV/AIDS epidemic are indicative of Foucault's 'distributions of power', whereby the reflexivity of power produces a doubling back or reiterative effect so that its 'force' is maintained or strengthened even as it undergoes challenge. In one example, AIDS education in a New Zealand school was undertaken by a government employee who incorporated gay ideology on sexuality into a high-school stage production about HIV.[32] In the production, a 'radical' approach to education was melded with the 'general' discourse on sexuality, although not without protest from some members of the school community.[33] While such blending challenges the notion of a dominant discourse, and certainly undermines notions of a unilateral approach to AIDS education in New Zealand, the discourse of sexuality itself gains in momentum by such means - if only because it becomes more visible through contestation, or has relevance for a larger group of individuals through its broadened educational scope.

Although attitudes towards sexuality were polarised at the start of the HIV/AIDS epidemic in New Zealand, no challenge was

part of a literature review, he included the findings of a USA study which stated that school children who had participated in a "Just Say No" programme subsequently engaged in more sexual acts than other children.

[32] Moore, *Playing Safe:*1991.

[33] Interview, Health Promotions Manager: 24/8/93. A report about this production was written by the manager in her role as health promoter for the government health unit 'Youth Futures'. The manager noted how some parents had objected to the play's exploration of issues surrounding gay sexuality and HIV/AIDS.

made to the Life Project itself, nor was there a de-emphasis on the 'sexuality and disease' dyad as its main focus. Such ideological continuity echoes the history of syphilis in New Zealand. During World War One, 'social purity' organisations such as the Wellington Social Hygiene Committee and the Women's Christian Temperance Union demanded celibacy from New Zealand soldiers in the interests of 'race'. Likewise, radical anti-VD campaigner Ettie Rout sought free condoms for New Zealand troops.[34] In both cases the Life Project itself was not in dispute, since each side rallied in the cause of a eugenics policy based on racial purity, a prime concern of the times.[35] Both sides focused on the issue of 'sexual life', in contrast to the (unstated) theme of 'death' as a project of war.[36] And if interest in sexual purity in New Zealand waned after the end of WWI, it was not because eugenics as a national policy became a hot issue but because the discovery of antibiotics resulted in a marked reduction in STD.

Discourse about sexuality, which had become so polarised during two World Wars, atrophied once New Zealand entered an

[34] Tolerton, *Ettie: A Life of Ettie Rout*, 1992: pp.13, 166-7.

[35] *Ibid.* Apparently the eugenicist's desire for disease-free soldiers centred not so much on concern for the soldiers as for the purity of race through monogamous, same-race sexual relations. "Foreign" women were perceived to be unclean, and miscegenation was deemed undesirable.

[36] According to Ettie Rout's biographer, war was also seen in terms of eugenics and the Life Project. Thus, soldiers ('our finest manhood') were sent to war for 'the success of our Army and the racial existence of our nation' (Tolerton, *Ibid.*: pp 143 and 155). A eugenics project whereby so much 'finest manhood' was sacrificed to racial imperatives was vigorously pursued by wartime propagandists, despite (or because of?) contradictions between reality and rhetoric.

economically regenerative phase. Later, the eugenicists' discourse was discredited when its racist intent was exposed during the civil rights and liberationist movements of the 1960s. Nevertheless, 'morality' as a national motif was only moribund, not dead. With the advent of HIV/AIDS there has been a marked increase in 'sexual' discourse and a re-polarisation of sexual ideologies. This time, however, the polarities have resulted more from tensions between conservatives and liberals (eg: during homosexual law reform) than from the lopsided battle between wartime allies (the church, social hygiene feminists, the military), and lone radicals such as Ettie Rout. But while the polarities of old are stark, their proponents are less certain of their terrain. Not only are the contenders more evenly divided, but a block of organisations with a single voice no longer exists: rather, there are many groups with different voices, each with their own discursive message. Policy-makers must thus navigate a number of discourses. They must also decide whether to reproduce the 'old' morality (which could lose both votes and lives) or advocate a more inclusive 'consensus' approach to HIV/AIDS, in an attempt to save lives while maintaining the status quo.

While the morality of old is still used as a referent by most policy-makers, the urgency of responding to the HIV/AIDS epidemic, the influence of overseas organisations such as WHO, and a more radicalised population have, in fact, ensured a less rigid approach to matters of sexuality. Thus, the moral agenda,

while firmly stated and reproduced through such forums as parliament and the popular media, is nevertheless also shaped by debate about 'what's best' with respect to disease control. Moreover, government responses to HIV/AIDS no longer presume sexuality as being normatively heterosexual, as is evident from 'targeted' HIV prevention programmes. For the purpose of HIV prevention, sexuality in New Zealand has become differentiated, ie: polarised into 'mainstream' (desirable) and 'other' categories. This semi-tolerance for 'difference' is evident, say, in the government's funding of a 'gay' organisation in The AIDS Foundation.[37] Sexual acts are thus still perceived as being either moral or immoral, but the fear of AIDS acts as both buffer and polariser in discourse. A 'moral' sexuality remains heterosexual (disease-free) while 'other' sexualities are tolerated and assimilated in the belief that 'marginality kills'[38] both gay men and the wider population through, say, the bridging activities of bisexual men and injecting drug users. The Life Project in New Zealand no longer focuses on eugenics (the propagation of race or class).[39] Instead, it is based on a non-

[37] The government's beneficence was built on the gay community's own initiatives for 'disease control'. The public's perception of the AIDS Foundation as a gay man's organisation is somewhat misleading. The organisation caters to both heterosexuals and gays, and is funded on this basis. Heterosexuals make up the vast majority of initial contacts in terms of HIV/AIDS counselling, while prevention and support services are offered to gay men and PWAs respectively.

[38] "Invisibility Kills" is the catch-cry of the New Zealand's gay community, which sought and helped achieve legislative changes such as the Homosexual Law Reform Act (1996) and the Amendment to the Human Rights Act (1993) on the basis that marginality = invisibility = unsafe sex practices = death from AIDS.

[39] However, resurgence of 'racist' discourse about sexuality and disease in New

partisan approach to sexual health as a 'life' guarantee, albeit for the ultimate benefit of the largely heterosexual population. Sexual purity as a moral agenda in New Zealand thus portrays post-epidemic sexuality in terms of what is 'pure' (heterosexual sex), 'clean' (safer sex) or 'dirty' (unprotected anal sex, shared needles, sex with prostitutes). Within this moral and medical framework, the discourse of sexuality flourishes through media incitement and public debate. The focus on sexual 'cleanliness' has given impetus to the move toward integrated STDs and AIDS programmes in New Zealand, although a WHO directive helped prompt this initiative.[40]

## 8.6 The New Zealand Prostitutes' Collective: The Life Project at Work

The emphasis on sexual health (cleanliness) in New Zealand is illustrated by the creation of organisations such as the NZPC. Here, the moral agenda implicit in government responses to HIV/AIDS is also evident, for sex-workers are again assumed to

Zealand was evident from media coverage of the Peter Mwai case, where an HIV+ African man was charged with various offences relating to unprotected sex with (white) New Zealand women (see Case Study, Chapter 6).

[40] Phil Parkinson of the AIDS Foundation states that the WHO data are specific to third world countries and should not be applied to New Zealand. Based on the data, WHO maintains that people with pre-existing STDs have a greater risk of contracting HIV. Parkinson argues that the WHO 'findings' relate to individuals in third world countries whose physical health was already compromised before they became HIV+ (Interview with Phil Parkinson at LAGANZ: 17 and 18 November 1993). See Chapter 5 for discussion

be vectors of 'sexual disease' according to the script which reads 'prostitute=immoral sex=venereal disease'. That the government's response to HIV/AIDS is based on concern about the activities of sex-workers is evident from the fact that government health officers approached sex-workers to set up an HIV prevention group in the 1980s.[41] There is little evidence to suggest that female sex-workers are HIV+, or that they are responsible for 'spreading' HIV into the heterosexual population. On the contrary, female sex-workers in New Zealand and Australia could be 'cleaner' than the non-sex-worker female population, according to recent data.[42]

With health officials operating on the assumption that 'deviant' sex = dirty sex, the Life Project of the HIV/AIDS epidemic is further revealed as a polarisation between 'pure' (heterosexual, non-casual sex) and 'safer sex' as an imperative for 'deviant' or 'rampant' sexualities. However, the government's programme of disease prevention through control of such sexualities is forcefully counterbalanced by the desire of sex-workers, gays and injecting drug users to control a *disease* rather than *sexual practice*, and further, by the government's own underwriting of community projects which eschew partner limitation as a safer sex strategy. Nevertheless, the

[41] The NZPC was formed at the end of 1987 when "a few sex workers were invited to meet with the AIDS Taskforce of the Department of Health." Jordan, *Working Girls*,1991: p.271

[42] Brander: Department of Health Protocol: *Women and AIDS*,1992. Also: Vitellone, "Why Condoms? Representations of Women and Safe Sex in an AIDS context", *Momentum*,1993: p.47

government's AIDS policy, which is based on a 'them' and 'us' approach to disease prevention, signals the underlying bifurcation of life strategies in New Zealand along the lines of 'normal' and 'other.' It appears that the epidemic has done little to change historical ways of thinking about sexuality and disease in New Zealand, despite the 'partnership' approach to HIV prevention.

The juxtapositioning of old and new sexualities in New Zealand's response to HIV/AIDS has produced the unusual outcome of sex-workers being employed as sex educators, not only for other members of the Collective, but for the general public as well.[43] This move indicates, however tacitly, that designated sex-workers are recognised as better educated about HIV prevention than the average citizen. Given their HIV- status, they could be deemed 'safer' (ie: better practitioners of safer sex) as well.[44] In New Zealand, designated sex-workers are employed as safer sex 'experts' in terms of a technology of sex which evolved primarily from community responses to HIV/AIDS. As noted, it is a technology which centres on barrier-protection in addition to non-penetrative sexual practices such as masturbation or oral sex.[45] Since the technology is deemed

[43] Interview: member of the NZPC, Christchurch: 29/9/93.

[44] This shift is unlikely to occur. According to a survey conducted by Dr Jane Chetwynd, as public knowledge about HIV/AIDS increased, so too did blame for the activities of sex-workers. Chetwynd, "Changes in Sexual Practices and Some HIV Related Attitudes in New Zealand" in *The New Zealand Medical Journal,* 1992: p. 238

[45] Joycelyn Elders, former USA surgeon-general, was sacked from her post after she suggested that masturbation could be viewed as a form of safer sex for the young.

suitable for 'hyper' sexualities, its diluted form is extended to the young, considered in need of protection from their own desires.[46] Sex-workers from the NZPC are thus being funded by the government to teach school children the mechanics of HIV prevention. This move is indicative of what Foucault called the "almost unspoken strategies which coordinate the loquacious tactics whose 'inventors' or decision-makers are often without hypocrisy."[47] The Government, with its often 'unspoken strategies' combined with 'loquacious tactics' (such as media campaigns) seeks to protect young heterosexuals in terms of both 'pure' *and* 'clean' aspects of the Life Project. Sex-workers, although resistant to dominant moral codes, do the same. The young, as beneficiaries of safer sex education, inadvertently gain knowledge of practices once denied them, and accrue an expanded repertoire for the expression of desire. By such means, sexuality as both power-knowledge and desire gains momentum, demonstrating the mechanisms by which power becomes

> a general line of force that traverses the local oppositions and links them together [bringing] about redistributions, realignments, homogenizations, serial arrangements, and convergences of the force relations. [48]

If the winner is HIV prevention, so too, are the discursive strategies of protagonists who promulgate either 'old' or 'new'

[46] Sex-workers from the NZPC are asked to speak to student groups at high schools or Polytechnics. (Interview with NZPC educator: 29/9/93)

[47] Foucault, *Op cit.* (1978): p.95

[48] *Ibid.* Parenthesis has been added

sexual ideologies. The protagonists are the instigators of discursive incitement and convergence in what is proving to be an intricate and accretional dance through an era now designated 'AIDS history'.

In the following case study: "Reframing Eve: Sex-Workers, Legitimacy and 'Life'", the discursive power of the survey is discussed according to its use as a political strategy by New Zealand's sex-workers. Through surveying their clients, sex-workers re-present ideas about prostitution and challenge the bourgeois ideals and norms of the Life Project. The sex-workers' 'project' is presented as a means of counteracting the 'old' in order to "undermine and expose it, render it fragile and make it possible to thwart it."[49] The case study illustrates how the re-presentation of prostitutes as health workers in New Zealand's HIV/AIDS epidemic contradicts images about the disease-bearing 'Eve', and how the NZPC's 'production of discourse' creates new iconography in which sex-workers become *vanguards* of public health.

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[49] *Ibid.*: p. 101

## 8.7 Case Study: Reframing Eve: Sex-Workers, Legitimacy and 'Life'

*Clearly all disasters, or an enormous proportion of them, are due to the dissoluteness of women.*

*Leo Tolstoy, 1900*[50]

### *8.71 Introduction*

The case study presented in this section is about the political activism of sex-workers[51] in New Zealand's HIV/AIDS epidemic. An overview of prostitution in New Zealand is presented, and the theories of Gilman and Foucault are discussed according to the perspectives they offer on AIDS iconography and community empowerment. Topics for discussion include a) sex work, gender

[50] From Leo Tolstoy's diary, cited in Starr, *The Natural Inferiority of Women, 1991:* p. 78

[51] 'Sex work', as used in this case study, replicates feminist usage which a) differentiates between 'prostitution' as non-voluntary labour in, say, third world countries and sex work as voluntary (?) employment in some Western countries, and b) seeks to eliminate the term 'prostitute' because the "misapplication of early epidemiology [of HIV/AIDS] resulted in increased policing and harassment of women identified as 'prostitutes' in many locales around the world" (Patton, *Op. cit.*: p. 53). Parenthesis has been added. Where possible, 'sex work' and 'sex-workers' are used in this case study as part of this 'discourse of resistance'. (Note: Some feminists also use the terms interchangeably - see Sullivan, "Rethinking Prostitution" in *Transitions: New Australian Feminisms*, 1995; Patton, *Op. cit.*; and Jordan, *Op. cit.*) The NZPC uses 'sex work' rather than 'prostitution' because "'Prostitute' equals 'dirty' and can lead to lower self-esteem - gives a criminal label. 'Sex worker' implies that a person sells his or her services." (NZPC service sheet, 7/8/95).

and the ideology of self-control, b) the role of the New Zealand Prostitutes' Collective (NZPC) and, c) methods of subverting the popular image of prostitutes as disease bearers in the HIV/AIDS epidemic. Empirical material for the study was obtained from NZPC personnel, interviews with scholars and members of the NZPC, articles from the *New Zealand Medical Journal* and *Siren,* a parliamentary address by the Hon. Maurice Williamson, texts such as *Working Girls* and *AIDS: Setting a Feminist Agenda*, and news items from two newspapers; *The Christchurch Mail* and *The Press.*

### *8.72 New Zealand's Sex Industry*

About 8,000 women work as prostitutes in New Zealand, most aged between eighteen and thirty years old.[52] By far the largest number of sex-workers is female, although there are some transvestites and transsexuals involved in street prostitution, and some escort agencies catering to gay men.[53] While women do operate as 'ship girls'[54], street workers, or escorts, most sex work is carried out in massage parlours owned or operated by men.[55] It is estimated that men, as non-clientele, comprise about 75% of the total sex industry operators in New Zealand.[56]

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[52] Based on NZPC estimates (from a speech by Maurice Williamson, Assoc. Minister of Health, 27/8/92) The number of male sex-workers is much smaller. Also: Jordan, *Op. cit.*:p. 9 According to this figure, about one in every 150 women in New Zealand between the ages of 18-40 is employed in some form of sex work.

[53] NZPC submission to parliament: July, 1990: p. 3

[54] Most ship girls are Maori or Polynesian (National Council on AIDS [NCA] minutes No. 9: p. 4) They are women who provide on-board, port-to-port sexual services to sailors.

[55] Jordan, *Op. cit.*: pp. 9-10

Prostitution is legal in New Zealand. However, soliciting is a crime under Section 26 of the Summary Offences Act, 1981. A number of other crimes relating to prostitution co-exist; they include brothel-keeping, pimping, procuring, and living off the earnings of prostitution.[57] Pimping in New Zealand is rare. NZPC organisers state that

> the New Zealand sex industry is different from that of many other countries in that prostitutes here have an internationally unusual degree of personal independence from the proprietors of sex businesses. Prostitutes do not have the status of employees and are not in general associated with pimps.[58]

Laws prohibiting brothel-keeping (SS107-109 of the Crimes Act, 1961) help ensure the non-existence of sex palaces in New Zealand.[59] It is also illegal for prostitutes to work from their homes. Sex-workers who work as escorts, street walkers, or in massage parlours 'own' their services because the law prohibits their earnings from being procured by pimps or managers of parlours. However, parlour operators often extract payment from sex-workers in the form of shift fees, laundry money, late fees, room rent etc.. Sex-workers working in parlours are paid directly by clients; massages are provided free.[60] While New Zealand

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[56] NCA minutes: *Op. cit.* The term 'sex industry' includes workers and other personnel such as massage parlour operators. It does not include the clients of sex-workers.

[57] *Ibid.*: p. 9

[58] NZPC submission to parliament: *Op. cit.*: p. 2

[59] Sex palaces are large-scale, sex-for-sale operations

[60] NZPC Submission: *Op. cit.*: pp. 3-4

sex-workers experience a degree of exploitation, it is generally considered to be less than that encountered overseas. However, Jordan states that "it is virtually impossible to work as a prostitute and stay within the law."[61] Invisibility among sex-workers exists for historic reasons, and because legal sanctions are still enforced. For example, in 1992, police in Christchurch arrested and charged several sex-workers with soliciting.[62]

Despite the invisibility of sex-workers, community involvement was fostered once the NZPC was formed in 1987. The NZPC is funded by government and its outreach programmes focus on support and advocacy services, as well as HIV prevention. A high level of knowledge about HIV/AIDS is thought to have contributed to the lack of infection among local sex-workers.[63]

### *8.73 The Sex-Worker as AIDS Icon*

Gilman maintains that prostitutes were depicted as being AIDS carriers once HIV was known to be heterosexually transmitted. For Gilman

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[61] Jordan, *Op. cit.*

[62] Maurice Williamson, *Op. cit.*: p. 5

[63] *Ibid.*: p. 3 According to the Hon. Maurice Williamson, "anecdotal evidence suggests that, because of our relatively late entrance to the AIDS experience, the sex industry in this country is virtually free of HIV" (Parliamentary address: 27/8/92). The prostitutes most susceptible to HIV infection (or already HIV+ when they arrive in New Zealand) are Thai women illegally brought to work in massage parlours in large cities such as Auckland (J. Chetwynd, public lecture: 24/8/94).

> this shift - from male victim to female source of pollution - clearly repeats the history of the iconography of syphilis. A new group has now been labeled as the source of disease: women, but not all women, only those considered to be outside the limits of social respectability. Even while acknowledging heterosexual transmission, the attempt is made to maintain clear and definite boundaries so as to limit the public's anxiety about their own potential risk.[64]

Like Gilman, Treichler refers to the 'discursive legacy' whereby prostitutes are "seen as so contaminated that their bodies are virtual laboratories for viral replication".[65] Brandt points to the stigma experienced by sex-workers, and also notes how red light districts in the USA were compared to malaria-producing swamps during the syphilis epidemic.[66] The writers agree that prostitutes became AIDS icons, despite evidence to suggest that rates of HIV infection among sex-workers were no greater than in the wider population.[67] Brandt challenges the notion of 'disease-bearing prostitute' by revealing how anti-prostitution controls imposed during World War One in the USA "had no impact

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[64] Gilman, "AIDS and Syphilis: The Iconography of Disease" in *Cultural Analysis, Cultural Activism,* 1988: p. 107

[65] Treichler, "AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification" in *Cultural Analysis, Cultural Activism,* 1988.: p. 45

[66] Brandt, "AIDS: From Social History to Social Policy" in *AIDS: The Burdens of History:* p. 151 See Treichler, footnote 14 in Chapter 6.

[67] Gilman *Op. cit.*: p. 105 and Treichler, *Op. cit.*: p. 49

Also: Dr W. Darrow, epidemiologist at the Centers for Disease Control, USA, stated that "so far we don't have any information to support the premise that prostitutes are passing the virus on to their clients. There are no confirmed cases of infection with the AIDS virus attributable to contact with prostitutes." (Cited in NZPC's submission to parliament: p. 6 [nd]).

on the rates of venereal disease, which increased dramatically during the war."[68]

As elsewhere, sex-workers in New Zealand were subject to legal sanctions following moves to control the syphilis epidemic in the nineteenth century. Laws to prohibit soliciting were formulated on the basis that women rather than men were the initiators of paid sex, and that society should be protected from female predators. The gender bias implicit in prosecutions for soliciting in New Zealand meant that "women coming most often to official notice in the nineteenth century were those labelled as prostitutes."[69] The laws enshrining such iconography still exist. The resultant inequities prompted MP Maurice Williamson (National Party) to seek reform because the laws "fail to take into account the clients and the employers. That seems like a law drafted by men, to protect men, and it's most definitely unfair to women."[70] His statement was made in the context of legislative reforms for prostitutes in the HIV/AIDS epidemic.

Most prostitutes practise safer sex in their professional lives.[71] Parliamentarians such as Maurice Williamson believe

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[68] Brandt, *Op. cit.*: p. 152

[69] Jordan, *Op. cit.*: p. 11

[70] Maurice Williamson, *Op. cit.*: p. 5

[71] Cindy Patton in *Sex and Germs: The Politics of AIDS* (1985) describes safer sex as 'modifying practices' for HIV prevention (p. 196). She writes that "the various AIDS groups rapidly developed what were at first called "safe sex" guidelines and later, "safer sex", "sensible sex" or simply "risk reduction guidelines"" (p. 134). The focus of these practices was risk-reduction strategies such as partner limitation, celibacy, investigation of sexual histories, HIV testing, condom use, and non-penetrative sexual intercourse. "Safe sex" became "safer sex" once it was realised that "safe sex" (particularly condom use) was not always 100% effective

that "we shouldn't dismiss the fact that sex workers have probably been one of the most effective groups of safer sex educators."[72] However, in New Zealand (as elsewhere) fears are commonly expressed about prostitutes spreading HIV/AIDS. In a letter to *The Christchurch Mail,* one correspondent stated that "brothels are like fire-works. They only need one cracker to set off a blaze of HIV infection".[73] In the following section, tensions experienced by sex-workers in the private and public realm are discussed according to the way society differentiates between 'respectable' and 'disreputable' women in the HIV/AIDS epidemic.

### *8.74 The Sex-Worker as Locus of Self-Control*

The dualistic notion of woman as locus of disease and morality has, as Gilman argues, resurfaced in the HIV/AIDS epidemic. The angel/whore dichotomy present in such a notion is evident in the statement "women have always been the ones to draw the line as to how far, man - animal - can go. Socially, sexually, you name it."[74] As measured by such standards, sex-workers could be deemed outside the self-control ("Just say no!") paradigm expected of other women. By insisting on safer sex practices, however, prostitutes in New Zealand have assumed the role of women who 'draw the line'. In so doing, they contravene the image of irresponsibility traditionally allotted to the whore.

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in preventing HIV transmission, primarily because of user error.

[72] Maurice Williamson, *Op. cit.*: p.3

[73] Lois Fechney, letter to the editor, *The Christchurch Mail* : 21/11/94: p. 11

[74] Dr Peter Tapsell as quoted in Rudman, *Sunday Star-Times,* 10/7/94.: C9

Of the prostitutes' newly-assumed role as health provider,[75] Maurice Williamson says

> [N]o fewer than seventeen [of twenty sex-workers] had been offered money for sex without condoms. That means that it has been the sex workers who've had to take the initiative in these cases, for the sake of themselves and their clients, to say "No! Sex without condoms isn't worth it!"[76]

The NZPC's "No Joe, no go" policy[77] is an example of assertive action-taking in the interests of self-protection. This policy was prompted, in part, by the need to persuade clients to use condoms. While the NZPC's policy is proof that prostitutes are capable of taking control in paid sexual encounters, its existence is mirrored by the well-documented inability by other women to do the same.[78] However, the sex-workers' work-place practices are not often sustained in their private lives.[79] This anomaly

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[75] Contrary to public perception, STD prevention concerned sex-workers long before the advent of HIV/AIDS. (Jordan, *Op. cit.*: p. 266)

[76] Maurice Williamson, *Op. cit.*: p. 3 Parenthesis has been added.

[77] Healy & Reed, "The Healthy Hooker" in *The New Internationalist*: p. 16 The 'Joe' is a euphemism for the condom.

[78] Various sources point to women's lack of success (or interest) in initiating safer-sex strategies with male partners. For example, Janet Holland, co-writer of "Desire, Risk and Control: The Body as a Site of Contestation" (in *AIDS: Setting a Feminist Agenda,* 1994: p. 62) states that young women she studied lacked the ability to control sexual encounters. Kippax, Crawford, Waldby *et al* (cited in Lupton, *Moral Threats and Dangerous Desires: AIDS in the News Media,* 1994: p. 3) state that women were shown to be largely powerless in the heterosexual encounter. There is also the perception that prostitutes, rather than respectable women, use condoms (Holland et al, *Op. cit.*: p. 77).

[79] Butcher in "Feminists, Prostitutes and HIV" (in *AIDS: Setting a Feminist Agenda,* 1994: p. 155) writes that "prostitute women often do not want to use condoms at home because it is reminiscent of work." Also: see next footnote.

occurs because, like all women, their intimate relationships are embedded in relations of power and trust as framed by the ideology of romantic love. The work/home division reflects the contradictions sex-workers face in their lives in terms of self-control. In her private life, the "No Joe, no go" heterosexual prostitute relaxes her standards because intimacy (trust, dependency, love) dictates barrier-free sex.[80] By so doing, she exposes the self-control paradigm as unworkable or undesirable in the private realm. She also exposes the contradictions of this gendered artifact because, in her private life, the sex-worker fits the model of the respectable woman unable (or unwilling) to deny sexual favours to men.

The idea that reputable women can, should, or wish to deny sex in intimate relationships persists despite the obvious difficulties it poses for many women. Likewise, the notion that the disreputable woman's power is solely located in her image as the dangerous, disease-bearing 'Eve' is sustained by either/or notions about women as constructed around the unproblematised sexuality of heterosexual men.[81] This public/private difference

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[80] *Ibid.*: p. 154. Butcher states that "it has been said elsewhere that in general the equations 'work = sex with a condom' and 'pleasure = sex without a condom' hold good (Kinnell, 1989). The condom is more than protection against disease, it is a physical barrier, a metaphor of exclusion for the woman at work, keeping the punter symbolically as far away as possible."

[81] Juhasz in "The Contained Threat: Women in Mainstream AIDS Documentary" in *Journal of Sex Research*, states that prostitutes are commonly portrayed as dangerous reservoirs of infection, needful of control, while white, respectable, married women are the 'innocent', acceptable, respected spokeswomen for female people living with AIDS (cited in Lupton, *Op. cit.*: p. 17) But see section in this chapter entitled "Sex Workers Survey".

can be turned around to 'explain' why ordinary, heterosexual women in committed relationships do not use condoms: since *their* sex is not a business transaction, protection is unnecessary, undesirable or even unthinkable. Casual sex, in falling between the two categories, justifies condom use. Thus, differentials in condom use are inextricably linked to the nature of intimacy, even though the trust inherent in such relationships may be misplaced in terms of being at risk of HIV infection.

The success of the NZPC's safer-sex policy is, to some extent, dependent on the nature of sex work as a business transaction - whereby the prostitute becomes the 'provider' of a desired 'product' (sex). This business paradigm, of course, is deemed unsuitable for women in their private lives. The transactional nature of sex work serves to provide leverage to women engaged in prostitution: the leverage also promotes survival techniques such as safer sex. Thus, safer sex serves two purposes: self-protection and 'product enhancement' (ie: 'clean' women for male clients).[82] The desire to protect both health and livelihood has been voiced by several members of the NZPC. In an Appendix to *Working Girls* titled "Off Our Backs and on to Our Political Feet!" the writers state that

> a few sex workers were invited to meet with the AIDS Task Force of the Department of Health. AIDS, of course, was something we had all heard about. Our wallets were beginning to register its effects, and certainly it was

[82] Given that most sex-workers have been offered extra money for unprotected sex, it could also be argued that, regardless of the risk of HIV, clients would prefer *not* to use condoms.

> becoming another reason for the wider community to stigmatise us further. We started to gather material on sex work organisations from around the world. In particular, description of the work carried out by PCV (Prostitutes' Collective of Victoria, Australia) provided us with cultural clues on how to proceed.[83]

The fact that 'whoredom' in New Zealand has obtained male compliance in the HIV/AIDS epidemic in the interests of self-protection and economic survival challenges the victim iconography articulated by Gilman.[84] Business transactions, client reluctance over condom use, enhancement of sexual services in the HIV/AIDS epidemic[85], and legislative and political endorsement have become organisational issues for sex-workers. While these issues have evolved from stigmatising iconography, sex-workers seek to utilise such images in the name of visibility, empowerment and self-esteem. The self-control paradigm adopted by sex-workers for physical survival in the HIV/AIDS epidemic is proving useful for political advocacy. It is also providing a challenge to the notion that self-control for women requires an atomised, asexual 'respectability' during a sexual epidemic.

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[83] in Jordan, *Op. cit.*: p. 271

[84] Gilman's model was specific to iconography of the USA and Europe.

[85] This is not to suggest that clients prefer sex-workers to women they meet in casual (non-commercial) encounters, merely that sex-workers sought a way to keep customers after their incomes had dropped in the wake of fear about HIV/AIDS.

## *8.75 Utilising Iconography: The NZPC's Role for 'Life'*

The NZPC's role is pro-active and includes safer-sex education for health providers and members of the public, as well as for co-workers. Typically, NZPC branches have a drop-in centre where safer-sex information and health and support services are provided. In Christchurch, the drop-in centre operates on week-days, from early afternoon to night.[86] Coffee and company are available, together with access to STD clinics, a needle exchange service, cheap condoms and lubricant, and an HIV/AIDS counsellor at specified times. The services are used by both female and male sex-workers and their clients.

Members of the NZPC collaborate with community and public health workers in the provision of health services; leaders also act as advocates and participate in inter-organisational and research activities. Pivotal to the NZPC's strategy for HIV prevention and self-empowerment is the production of a health-promotion discourse which, in its specificity, is akin to the bourgeois Life Project as explicated by Foucault. For sex-workers, this discourse is manifest in health-care ('Take care') information as produced in the NZPC's magazine *Siren*, in self-protection measures such as the "Ugly mugs" list,[87] and in such outlets and activities as advocacy, networks, drop-in centres

[86] Based on information supplied by organisers of the Christchurch branch of the NZPC.

[87] A list of abusive clients is kept by the NZPC and is supplied to sex-workers on request. Information includes descriptions of abusive clients (age, height, appearance, distinguishing features, ethnicity, occupation), his vehicle and other relevant details about weapons etc..

etc.. The discourse focuses on safety and risk, as is evident in exhortations to "Be Careful Out There. Practise Safe Sex. Look After One Another."[88]

The 'take care' discourse promulgated by the NZPC is framed by fear not only of HIV/AIDS, but of other risks associated with sex work. In writing for *New Internationalist*, NZPC members Catherine Healy and Anna Reed state that

> it's still the sex workers who are perceived by many to be a major reservoir of infection, the vectors of the transmission of HIV/AIDS into the general population. In the early days of AIDS it was inevitable that the sex industry would be scrutinized. The media in our own country - Aotearoa/New Zealand - ran stories that whipped up hysteria against prostitutes, with images of the 'vengeful AIDS victim. . . a crazed hooker on revenge trip against all punters'. We have yet to hear about the crazed punter hell-bent on infecting prostitutes.[89]

This lament is indicative of the NZPC's 'reverse' discourse in which risk is posited as external to the sex-worker in the form of clients, the police, sex industry personnel, and public stigma. It is inherent in statements about 'crazed punters' who "put holes in condoms for their own cheap thrills."[90] To offset such risks,

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[88] *Siren*, April 1994: p. 30

[89] Healy & Reed, *Op. cit.*: p. 17 Catherine Healy is National Coordinator of the NZPC and is also a WHO consultant on sex work to Pacific rim countries such as Vietnam and Thailand.

[90] "Former Sex Worker Disputes Safety of Legal Brothels" in *The Christchurch Mail*, 31/10/94: p. 1 Her statement is challenged by members of the NZPC who say that "stories about condoms busting on workers or clients putting holes in

members of the NZPC have formulated self-protection methods which use 'life' discourse as a central theme. As Foucault argues, the discourse is "beset by rules and recommendations."[91] His observation is borne out by the detailed advice NZPC organisers offer on a range of health, safety and civil rights issues. The advice includes warnings about police demands for photographs of sex-workers, and information about a) alarm systems for escorts, b) methods for dealing with predatory or abusive taxi drivers, clients and massage parlour operators c) the safe use of tampons and other devices, and d) STD prevention. An overarching sense of personal threat is apparent in the headings of articles which read "Danger: in the workplace", "Escorts Alarmed!","Surviving the Street" and "What gets on my goat!"[92]

NZPC organisers draw on the expertise of health workers, police, government officials and other experts in the field to support their health and safety efforts. An example of inter-agency collaboration is acknowledged in *Siren* and reads: "A representative of Land Transport met with the NZPC and gave us some hints on how to choose a taxi and what to do if something goes wrong."[93] The sense of risk, in this instance, led NZPC organisers (as informed citizens) to draw on governmental expertise. A sense of legitimacy is also engendered by the NZPC's role as providers of tax-funded public services. Linguistic clues

condoms are simply not true. . . we have our own supplies, so how would they [clients] even get hold of them?" (Espiner, "Sex Workers 'Just Ordinary People'" in *The Christchurch Mail*, 7/1//94: p. 5) Parenthesis has been added

91 Foucault, *Op. cit.* (1978): p. 37

92 All in *Siren*, April 1994 issue.

93 *Ibid.*: p. 20

from "This list is published by Land Transport"[94] and "Land Transport met with NZPC" give rise to the idea that the meeting between NZPC and Land Transport officials was conducted on a peer basis, and that members of the NZPC operated as equals rather than as stigmatised mendicants of government favours.

Legitimacy for sex-workers is enhanced through other risk-reduction activities such as the provision of multi-agency health services at drop-in centres. In the words of NZPC organisers Healy and Reed: "At one of our centres we've set up a medical clinic where we carry out anonymous HIV-testing for sex-workers. Can you imagine how empowering it is for prostitutes to interview doctors and nurses to ascertain their suitability for staffing our clinic?"[95] The language of empowerment infuses literature produced by the NZPC, and notions of threat and risk are countered with strategies designed to promote self-esteem. One strategy involved teaching sex-workers self-defence. As reported in a Christchurch newspaper, "The NZPC has produced a video instructing sex-workers on self defence and health issues hoping to empower people in a potentially dangerous situation."[96] Spokeswoman Anna Reed reiterated the 'legitimacy theme' in the article by saying

> I'm looking forward to the day that a woman can put on her CV that she has worked in the sex industry and has good communication skills, she's a good

[94] *Ibid.*

[95] Healy and Reed, *Op. cit.*: p. 17

[96] Espiner, *Op. cit.*

> listener, a good reader of body language and that these things be recognised as the skills they are.[97]

Sex-workers' generalised sense of risk is mirrored by society's fears about the moral and medical risks associated with prostitution. For members of the public who believe the 'disease-bearing prostitute' axiom, sex-workers calling themselves safer sex experts are engaging in risible double-speak. For sex-workers, the image of the 'Healthy Hooker' is far from oxymoronic.[98] Rather, it is a proud assertion and a repudiation of the disease-bearer image in the HIV/AIDS epidemic. True to the 'life' methods of the NZPC, this repudiation takes the form of self-advocacy, and a determination to reverse negative images associated with prostitution. In this vein, Healy and Reed maintain that

> there is now near-universal use of condoms by sex workers in industrialised countries. This is having a far greater impact on sexual culture than all the chats in doctors' clinics. We can't prove it, of course, but it is probable that prostitutes have been more successful in safer sex education than all the television advertisements put together. After all, the best way for someone to

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[97] *Ibid.* Anna's statement epitomises Foucault's 'reverse discourse' with respect to empowerment strategy: in referring to the non-sexual aspects of sex work, she aligns 'sex work' with other tertiary sector jobs such as banking, hotel and sales work which depend on interpersonal skills. This strategy fulfills Sullivan's requirement for "accounts of prostitution which assert the will and agency of prostitutes. . . which refuse the notion that women sell themselves in prostitution, and which reconfigure prostitution transactions." (*Op. cit.*: p. 197) An apt example of 'reverse' discourse is evident in the NZPC poster which states "The Best Sex is Paid Sex" (seen in NZPC's national office in Wellington).

[98] See title, footnote 77: this chapter

> learn something is to do it. So it follows, the best way for a man to start to feel OK about condoms is to have someone put one on him, and then proceed to give him a pleasurable experience.[99]

Such rhetoric may be considered more than self-aggrandisement by members of the NZPC. It serves to re-present a perspective by those on whom an unpalatable (often inaccurate) truth has been foisted. In the case of power-brokers such as Maurice Williamson, the rhetoric has succeeded to the extent that he presented the NZPC's perspective to officials and other members of parliament and government officials in an effort to secure law reform.[100]

### *8.76 Sex-Workers Survey*

Surveys about or relating to sex work have been a feature of the HIV/AIDS epidemic in New Zealand since 1991.[101] Most have been initiated by academics, with significant input by sex-workers. Prior to the HIV/AIDS epidemic, the activities of sex-workers in

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[99] Healy and Reed, *Op. cit*: p. 16

[100] On page 3 of his speech, Maurice Williamson said: "In fact the Prostitutes' Collective believes that it has done at least as much as all the advertising campaigns to popularise condoms amongst heterosexuals."

[101] The results of two surveys commissioned by sex-workers appeared in 1991. Both related to organisational issues rather than to sex work itself. ("Report on SIREN readership survey - 1991: a report to the New Zealand Prostitutes' Collective" - a report to the NZPC, 1991; and "The New Zealand Prostitutes' Collective - a process evaluation of its formation and operation" - a report to the NZPC, 1991: in Glaisyer et al, *Social Research on HIV/AIDS in New Zealand - A Bibliography 1984-1993:* p. 30). Professor Jane Chetwynd and Dr Libby Plumridge (Christchurch School of Medicine), Jan Jordan (Victoria University) and Karen Woods (Auckland University) are some academics involved in studying aspects of sex work in New Zealand.

New Zealand were little studied, except in relation to anti-prostitution legislation or to the history of immigration in the nineteenth century.[102] Once the NZPC was formed in 1987, however, a dialogue emerged between sex-workers and government officials, health workers and socio-behavioural researchers through collaborative efforts to prevent HIV. The visibility afforded the NZPC through this process gave organisers access to such tools of research as surveys, reports and evaluations, while providing academics with new areas of study. The meaning behind this development for image-making (the reshaping of Gilman's iconography about 'the syphilitic prostitute') and empowerment of sex-workers in New Zealand is analysed in the section that now follows. Foucault's theories about 'life' discourse are used to examine the strategies behind the NZPC's focus on survey research.

One of the NZPC's first tasks in establishing a viable Life Project was "to alert other people in the sex industry to our existence."[103] Out of this commitment the NZPC magazine *Siren:* (Sex Industry Rights and Education Network) was born. An evaluation of *Siren* was commissioned by the NZPC in 1991[104], at

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[102] Kehoe in her Ph.D titled "Medicine, Sexuality, and Imperialism. British Medical Discourses Surrounding Venereal Disease in New Zealand and Japan: A Socio-historical and Comparative Study", 1992: pp. 65-66 writes that such studies "are mainly concerned with the campaign surrounding the passage of the Contagious Diseases Act (1869) and an analysis of prostitution in the context of trends in the history of European immigration."

[103] Jordan, *Op. cit.*: p. 272

[104] Professor Jane Chetwynd of the Christchurch School of Medicine was employed by the NZPC for this purpose (Interview with Professor Chetwynd: 2/4/92).

about which time organisers arranged for a report on the agency's history and mode of operation.[105] These events signalled a move away from traditional research endeavours on marginalised groups in New Zealand. In 1993, social researchers from the Christchurch School of Medicine collaborated with members of the NZPC to produce a pilot study of the male clients of female sex-workers.[106] The synopsis of an Auckland research project also carried out during this period reads: "The aim of this study is to provide information on women parlour workers that will be useful to the New Zealand Prostitutes' Collective and others working to prevent HIV/AIDS and STD infection within the New Zealand sex industry."[107]

For Foucault, knowledge can be used to produce a 'discourse of resistance' against hegemonic ideas and practices.[108] For sex-workers in New Zealand, research knowledge has the potential to undermine hegemonic discourses only if stigmatising beliefs about disease-bearing prostitutes in the HIV/AIDS epidemic can

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[105] Chetwynd, "'The New Zealand Prostitutes' Collective - A Process Evaluation of its Formation and Operation': A Report to the New Zealand Prostitutes' Collective, 1991" (in Glaisyer et al, *Op. cit.*: p. 30) Evaluation of the NZPC followed the organisers' desire to ascertain the efficacy of outreach activities relating to HIV prevention.

[106] Chetwynd, J. & Plumridge, E. "Knowledge, Attitudes and Activities of Male Clients of Female Sex Workers: Risk factors for HIV", *New Zealand Medical Journal*, 107, 14/9/94: pp 351-3

[107] Woods, K.'"You Have Sex With a Condom. You're Making Love Without": Condom Use by Parlour Workers In and Out of Work', unpublished paper, component of Ph.D, University of Auckland, 1993 (cited in Glaisyer et al, *Op.. cit.*: p. 32)

[108] Foucault, *Op. cit.*(1978): p. 99 While there is an active and intense debate on whether Foucault's understanding of power, discourse and subjectivity *does* provide for the possibility of agency and resistance, his concept of a 'reverse' discourse is adopted in this study to explore the political strategies of the NZPC.

be scientifically challenged or disproved. Research such as the pilot study on the "Knowledge, Attitudes and Activities of Male Clients of Female Sex Workers: Risk factors for HIV" was recently undertaken on this basis, and the results published in such media as *The New Zealand Medical Journal* and *The Press.*[109] The project was undertaken by members of the NZPC and academics who opted to approach the topic of sex work in ways that challenged traditional perceptions framing prostitutes "as though they were acting on their own."[110] Thus, the research emphasis was not on sex-workers as individual actors, but rather as co-participants in New Zealand's sex industry.

The focus of the pilot study jointly undertaken by the NZPC and academic researchers was on risk behaviour rather than the activities of sex-workers *per se.* Since the sexual activities of prostitutes were deemed by the researchers to be unproblematic because of their insistence on safer sex, the spotlight fell on male clients whose 'pivotal existence in the world of sex work' had thus far been ignored.[111] Hegemonic assumptions that framed prostitutes as blameworthy were reversed, and male clients became vectors of disease (with sex-workers their victims). Iconographic reversals have appeared in statements such as a) "the woman worker may be at greater risk of contracting an infection than the other way around"[112] b) "The findings of the

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[109] *The New Zealand Medical Journal* ( *Op. cit.*) and *The Press,* 21/9/94: p. 3

[110] Morgan-Thomas (1991) in Butcher, *Op. cit.*: p. 151

[111] The Press, (*Op. cit.*)

[112] *Ibid.* Estimates place a woman's risk at acquiring HIV compared to heterosexual men's at about 3 to 1 (see discussion, Chapter 4)

study suggest that this view [that prostitutes are disease-bearers] may be naive and misguided"[113], and c) "the study points to the need to reorient our thinking about the roles played by workers and clients in the transmission of HIV."[114]

Male subjects of the study were negatively portrayed in various ways. They were said to ignore the risk of HIV even though many "used commercial sex services on their travels in countries where HIV infection rates were higher and condom use much lower than in New Zealand."[115] Clients were also described as being passive, as lacking in accurate knowledge about transmission of HIV, and as careless in their primary relationships with wives or partners. Although almost half were listed as white collar workers, most were reported as lacking the desire or ability to communicate with sexual partners.[116] It was also reported that "the initiative in [condom] use appeared to be with the sex workers: the sex worker both supplied the condom and put it on in most cases."[117] The researchers concluded that the findings of the pilot survey (from a sample of thirty men) were disturbing because "clients of sex workers were a key element linking the world of commercial sex with the broader community. This pivotal position meant they had considerable potential to spread HIV."[118]

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[113] *Ibid.* Parenthesis has been added.

[114] Chetwynd and Plumridge, *Op. cit.*: p. 353

[115] *Ibid.*

[116] *Ibid.* Given that 13 of the 30 men in the pilot study had regular(non-prostitute) sexual partners, their inability to communicate in sexual relationships has broader implications with respect to gender relations in the HIV/AIDS epidemic.

[117] *Ibid.*: p. 352 Parenthesis has been added

In New Zealand, as elsewhere, the sexual behaviour of the adult heterosexual man in the HIV/AIDS epidemic has usually been ignored. This bias continues despite an upsurge in socio-behavioural research.[119] While the pilot study on the behaviour of male clients signals a break from traditional research into prostitution, a focus on the prostitute/client nexus means that marginal behaviour remains the subject of academic enquiry. Nevertheless, this broader approach to the paid sexual encounter contributes to a de-emphasis of the stand-alone image of the prostitute, affording sex-workers an opportunity to be seen in context as co-participants (rather than sole constituents) of the pleasure industry. The publication of details about clients' sexual behaviour also serves to "redistribute what is said about it [sexual discourse]"[120], if only because the findings have been promulgated through scientific channels rather than by activist polemic.[121]

Writers such as Gilman, Treichler, Watney and Crimp maintain that HIV/AIDS is largely an epidemic of blame.[122] The

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[118] The Press (*Op. cit.*)

[119] In the bibliography *Social Research on HIV/AIDS in New Zealand,* there were no studies specifically related to adult heterosexual men's sexual behaviour, whereas separate sections were devoted to adolescents, the sex industry, injecting drug users and gay men.

[120] Foucault, *Op. cit.* (1978): p. 34 Parenthesis has been added.

[121] Lupton, *Op. cit.*: p. 3, in citing van Dijk (*Racism and and the Press),* writes that "the opinions of minority groups are rarely reported, and if they do receive attention they are often presented as partisan, whereas elite news actors or groups are presented as 'neutral'.

[122] Gilman, Treichler and Watney are all contributors to D. Crimp's book: *AIDS:*

research on AIDS commonly focuses on 'risk behaviour' as a means of identifying 'modes of HIV transmission'. The New Zealand pilot study is no different in this respect. Here, the clients' sexual behaviour has been investigated and found wanting with regard to their knowledge and practice of safer sex. Male clients are also deemed to risk their own, the sex-workers', and other women's health through resisting condom use. With the locus of blame transferred from sex-worker to client, the prostitute has been interpolated as safer sex expert, earning credit for her pro-active stance in reducing the risk of HIV. In terms of the 'epidemic of blame' paradigm, it is the client (rather than the sex-worker) who becomes the "dangerous element in the sexual exchange."[123] Like the bisexual man engaging in anonymous, man-to-man sex, it can be inferred that the male client places *all* women at risk through his refusal to wear condoms except when confronted by the responsible sex-worker.[124] Sex-workers can be seen to provide a public service to the broader community by protecting themselves and clients from disease, and by providing safer sex education for men who lack knowledge about HIV/AIDS. In addition, 'bad' women can be seen to protect 'good' women from the ravages of disease, since heterosexual men have been exposed as potential vectors of HIV. The relationship of sex-workers to 'good women' is thus reversed from that of the syphilitic prostitute who was deemed to

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*Cultural Analysis, Cultural Activism.*

[123] Chetwynd and Plumridge, *Op. cit.*: p. 352

[124] A sex industry worker in "Sex Workers 'Just Ordinary People'" (*The Christchurch Mail*: *Op. cit.*) claimed that "Up to 90% of our clients are in relationships".

undermine the health and progeniture of the 'race' (as discussed in Chapter 3).

In New Zealand's more egalitarian model, 'bad' and 'good' women are differentiated less by class than by sexual praxis in the HIV/AIDS epidemic, and the gap between both is being strategically narrowed by the sex-workers' campaign to be seen as protectors of public health. Their emphasis on the sexuality of *heterosexual* men in the HIV/AIDS epidemic is similar to Sullivan's feminist project, which would

> change the often destructive discourses which prostitute women are presently forced to embody. It would also change the experience of being a male client, challenging men to embody new forms of sexuality. This sort of discursive strategy would also contribute to a broader feminist project which is addressed to the reconfiguration of 'normal' ways of talking about women, sexual difference and sexuality.[125]

The researchers conclude the New Zealand pilot study by stating that further research should be done into "what stopped these men using condoms."[126] This recommendation contributes

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[125] Sullivan, *Op. cit.*: p. 197 One challenge to heterosexual men's sexuality in the HIV/AIDS epidemic is a poster published by Mainland Women and HIV Network (Christchurch) that states:
"If you're male and have more than one sexual partner and don't use condoms, we suggest you attach this to the front of your pants:

> Warning: sex with individuals like myself will be the leading cause of premature death due to AIDS for over four million women by the year 2000."

At least one member of the Mainland Women and HIV Network is a sex-worker.

[126] *The Press (Op. cit.)* Also: Chetwynd & Plumridge (*Op. cit.*: p. 353)

to a de-emphasis on the prostitute's role as vector in the HIV/AIDS epidemic. It also helps reframe notions about sex work by drawing attention to heterosexual men's sexual attitudes and praxis. The move exemplifies Foucault's discourse of resistance as produced by, or through, challenges to hegemonic ideology.[127] In the case of the pilot survey, the sex industry became the conduit through which subversive knowledge could be extrapolated, shaped according to scientific norms, then broadly articulated through the medical and popular media. This process is representative of what Foucault calls "local power relations at work."[128]

### *8.77 Conclusion: The Sex-Workers*

Emergence of the sex-workers' 'voice' in the HIV/AIDS epidemic is embryonic but unique. To place the arguments of this case study in perspective, sex-workers in New Zealand have yet to obtain the legal reforms obtained by gay men by way of the 1986 Homosexual Law Reform Act and 1993 Human Rights Amendment, and by injecting drug users in the 1987 Amendment to the Misuse of Drugs Act.[129] In part, this delay is due to the absence of organised political activism by sex-workers during the early years of New Zealand's HIV/AIDS epidemic, and, in part, to political changes in 1990 which halted the introduction of specific AIDS-related legislation (see Appendix II). Community organisers, such as gay men, who sought changes during the

[127] Foucault, *Op. cit.* (1978): pp. 95-6

[128] *Ibid.*: p. 97

[129] See Appendix II for the list of reforms sought by the NZPC.

'crisis' years of the HIV/AIDS epidemic were more successful in their efforts. For sex-workers, stigma still retards progress in the legislative arena, and its role in limiting organisational activities before 1987 should not be under-estimated. Lindberg claims that prostitutes in New Zealand are more stigmatised than gay men.[130]

The NZPC's political future is uncertain, and must be measured against the rising tide of moral extremism in the 1990s. In the USA, where many social trends first appear, political and institutional harassment of sex-workers has resurfaced as police take new steps to control prostitution.[131] In New Zealand, the advent of MMP is likely to result in a heightened focus on 'social problems' such as prostitution, as a plethora of political candidates in newly formed or re-formed political parties vie for popularity and power. Government funding allocations to the NZPC remain at a steady level, and tri-partite efforts with respect to HIV prevention continue. However, as noted in Chapter 5, the political and economic climate is less conducive to AIDS organising because of waning interest in HIV/AIDS and the fiscal constraints of health reform.

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[130] Speech by Warren Lindberg from the NZAF, Australian AIDS Conference, August 1988: reproduced as an appendix to NCA minutes No. 1

[131] News item, National Public Radio (NPR), USA: 17/2/95. It was reported that in some police jurisdictions, including Boston and Seattle, police were releasing details (photograph, date of birth, place of residence, crime) on Cable TV about convicted sex-workers and drug users in an attempt to 'clean up' prostitution and drug use by inflicting a sense of shame and fear on individuals named in the broadcasts. It was also mooted that details would be published on the basis of an arrest without a conviction.

## *8.78 Conclusion: The Theorists*

Gilman's portrayal of the female sex-worker as AIDS icon is supported by writers such as Treichler, Brandt, Kehoe, and Butcher, all of whom refer to "the historical spectre of the syphilitic prostitute"[132] in the HIV/AIDS epidemic. The image of the corrupt woman as explicated by Gilman accurately represents the history of the syphilis and HIV/AIDS epidemics in New Zealand. While his "shift from male victim to female source of pollution"[133] did not occur in New Zealand (syphilis was confined to Europe and the Americas during the middle ages), it has been a factor which has shaped government responses to HIV/AIDS. As Gilman suggests, the shift occurred through the "need for heterosexuals to retain the image of AIDS as a disease of socially marginalised groups" once "heterosexual transmission of HIV/AIDS [became] a media fact."[134] For sex-workers in New Zealand, this shift appeared in the mid 1980s and was expressed paradoxically through a) government sponsorship of the NZPC's HIV prevention activities, and b) increased negativity toward the activities of prostitutes.[135]

The explanatory value of Gilman's paradigm is limited to his

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[132] Kehoe, *Op. cit.* (1992): p. 3

[133] Gilman, *Op. cit.*: p. 107

[134] *Ibid.*: p. 105 Parenthesis has been added.

[135] In the study titled "Changes in Sexual Practices and Some HIV Related Attitudes in New Zealand: 1987-9", the 7% increase over two years in respondents' belief that prostitutes only had themselves to blame if they got infected with HIV was offset by a 20% decrease in blame directed at non-prostitutes becoming infected with HIV (J. Chetwynd, *New Zealand Medical Journal*, 1992: pp 237-239)

illustration of how sex-workers became AIDS icons rather than activists.[136] As noted, Gilman's perspective was developed from deconstructing pictorial images of syphilitics prior to the twentieth century. This static perspective is drawn from the social, political and economic realities of a harsher era. In contrast, Foucault's analysis of discursive power as a means through which social relations are created and contested, provides an insight into the way an ancient icon could be transformed into modern activist through interactive power relations between governments and their subjects. Analysis according to Foucault's perspective has led to an understanding of how the role of sex-workers could evolve from that of nineteenth century victim of moral, medical and legislative fiat to contributer to modern discourse in the HIV/AIDS epidemic. Foucault's exposition of discursive power in the modern era facilitates an understanding of the emergence of grassroots organisations such as the NZPC. This understanding is achieved through his analysis of the multiplying effects of discourse and its egalitarian impact on modern governance. Foucault's approach to power relations is constructed in terms of its indeterminate nature: power is all-pervasive, and hegemonic power is subject to challenge and transformation from a multiplicity of institutional, social or political 'sites'.

Foucault's work is not without its shortcomings in respect

[136] Gilman's chapter on AIDS iconography was developed from a chapter titled "Seeing the AIDS Patient" in his book *Disease and Representation: Images of Illness from Madness to AIDS* (1988). The book focuses on the construction of madness in the modern era, rather than on activism or the empowerment of AIDS icons.

of the present analysis. Despite a focus on sexuality in *The History of Sexuality: An Introduction*, he neglected to comment on the activities of prostitutes except obliquely through such phrases as "the extortion of truth, appearing historically and in specific places (around the child's body, apropos of women's sex)."[137] Here, Foucault meant that women's bodies were the focus of medical and regulatory attention in the exercise in hegemonic power, but his example was given only to demonstrate how power (as a force) was located in terms of a purpose (eugenics). The use of Foucault's broad-stroke theory in which power is framed as global, all-pervasive and impartial was not helpful for a detailed exploration of the NZPC. In this theory, resistance to hegemonic dominance is posited as being central and strategic, but its scope is so wide that one is left to ponder just how challenge becomes "mobile and transitory. . . producing cleavages in a society that shift about, fracturing unities and effecting regroupings".[138] As noted, a more useful source for the present analysis was Foucault's genealogy of sexual discourse. Here, insights into the role of discourse facilitated an understanding of how the NZPC's medico-scientific liaison could help produce 'new' knowledge, reframe ideology about the 'syphilitic prostitute', and redirect efforts away from "the extortion of truth. . . apropos of women's sex".[139]

Foucault and Gilman's theories in this case study provided an historical overview of an era of epidemic disease. While

[137] Foucault, *Op. cit.* (1978)

[138] *Ibid.*: p. 96

[139] *Ibid.*

Gilman's study is an illustration of how ancient ideology frames modern disease icons, Foucault's is a demonstration, in part, of how the effects of syphilis on the European bourgeoisie gave rise to modern rules for 'life'. Gilman's AIDS icon was reconceptualised as the paradigm on which Foucault's 'activist' model revolved. In part, this reconceptualisation was necessitated by the disparate (if related) nature of their work. Gilman's perspective, as utilised in this thesis, is contained in a single chapter. His emphasis is on the HIV/AIDS epidemic and to the victimisation of 'risk groups' by the media. In this perspective, power is obliquely phrased in terms of 'boundaries, limits and ideologies'. Foucault did not refer directly to the HIV/AIDS epidemic[140], and his contribution to victimology was to illustrate how certain individuals (women, children, prisoners, mental patients) were located in discourse. His work dealt with the generic exercise of power rather than its victimising outcomes. The synthesis presented in this case study highlights other differences such as the disjuncture between Gilman's 'nuts and bolts' perspective and Foucault's philosophical approach to power. This disjuncture is reflected in the tensions of New Zealand's HIV/AIDS epidemic. For members of the NZPC, Gilman's actuarial approach to AIDS image-making underscores the fragility of sex-workers' everyday political, economic and social existence, even if the intricacies of their political journey is best left to Foucault's grand 'genealogy of power'.

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[140] Foucault died of AIDS in 1984. His book titled *History of Sexuality (Vol. One)* was to appear in six volumes but was uncompleted at the time of his death (as noted in *The Concise Oxford Dictionary of Sociology*: pp. 186-187).

# CHAPTER 9

## SUMMARY AND CONCLUDING STATEMENT

*It is commonplace to say that the function of an ideology is to compensate a class for what it does not have, or to portray what is in the interest of one social class as being in the interest of society in general.*

*Francois Delaporte*[1]

## 9.1 HIV/AIDS: Disease and Praxis

HIV/AIDS is a disease replete with social meaning. Its initial appearance among gay men made HIV an epidemic for which moral, social and political judgements could be made in terms of pre-existing concepts about 'otherness' and sexuality. The framing of AIDS as a socio-sexual disease prompted writer Douglas Crimp to state that AIDS is known only through the actions that conceptualise, represent and respond to it.[2] In presenting his view, Crimp drew on the work of French writer, Francois Delaporte, who prefaced his book about the 1832 cholera epidemic with a challenge to medical epistemology. He wrote "I assert, to begin with, that 'disease' does not exist. It is therefore illusory to think that one can 'develop beliefs' about it or 'respond' to it. What does exist is not disease but practices."[3] I, too, believe

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[1] Delaporte, F. *Disease and Civilization: The Cholera in Paris 1832* (1986): p. 8.

[2] Crimp, D. "AIDS: Cultural Analysis/Cultural Activism" in *AIDS: Cultural Analysis/Cultural Activism*, 1988.: p. 3

[3] *Ibid.*: p. 6. Crimp argues that "[Delaporte's] assertion does not contest the existence of viruses, antibodies infections or transmission routes. Least of all does it contest the reality of illness, suffering and death. What it *does* contest is the notion that there is an underlying reality of AIDS, upon which are constructed the

that disease exists only within social and cultural parameters.

In confirming the 'disease as praxis' hypothesis, AIDS activists and writers such as Patton, Weeks, Treichler, Alice, and Mann state that the 'new' epidemic has exposed social schisms according to gender, race and class. All of these writers agree: HIV is a partisan disease. Their hypothesis was explored within this thesis in terms of AIDS discourse and iconography in New Zealand and overseas. New Zealand's responses to HIV/AIDS provided the basis for understanding how AIDS is managed within the 'disease as praxis' paradigm according to a particular social, political and cultural context.

## 9.2 Epidemic Precursors to HIV/AIDS: (1) Leprosy, Bubonic Plague, Cholera, Influenza and Poliomyelitis

A central argument of this thesis is that responses to HIV/AIDS were located in the history of other epidemics. In Chapter 2, I presented an overview of the leprosy, bubonic plague, cholera, poliomyelitis and influenza epidemics according to common themes and outcomes, most of which have, in turn, affected the way HIV/AIDS is conceptualised and managed. Like HIV/AIDS, the earlier epidemics were deemed catastrophic. In each, social factors had helped determine who became ill, survived or died. In this chapter, I argued that correlations between prejudice, social

representations, or the culture, or the politics of AIDS. If we recognize that AIDS exists only in and through these constructions, then hopefully we can also recognize the imperative to know them, analyse them, and wrest control of them." Parenthesis has been added.

inequality, ostracism and disease status are evident throughout epidemic history. During the leprosy epidemic, lepers were cast out to die according to the dictates of a social (biblical) decree. In the bubonic plague, Jews were vilified on the basis of pre-existing social prejudices, and many lost their lives through a policy of enforced ghettoisation in plague-ridden districts. This scenario was repeated, to a lesser degree, in the USA's cholera epidemic with respect to Irish immigrants and the poor. In each of these epidemics, social and ethnic outcasts bore the brunt of blame for disease, and responses were predicated upon measures which reified their social position. In the HIV/AIDS epidemic, social outcasts are again the victims of disease and blame. While public health measures have sometimes been equitable, other responses (the media, religious, political) have often vilified those deemed responsible for spreading HIV. The connection between blame, ostracism and the incidence of epidemic disease gave rise to Crimp and Delaporte's belief in disease as 'praxis', or a 'set of social practices' which determine the locus of disease.

Responses to disease took a different turn in twentieth century epidemics such as poliomyelitis and influenza. Higher standards of living (or rural isolation) resulted in a lack of immunity which saw young and healthy individuals dying from the catastrophic effects of 'normal' disease. Nevertheless, ethnicity emerged as a factor in morbidity and mortality rates for, say, Maori and Native American Indians who either lacked immunity or who suffered the effects of poverty and cultural dislocation. In the HIV/AIDS epidemic, ethnicity was again deemed a risk factor,

especially in the USA where AIDS is a leading cause of death among young African-Americans and Haitians. However, the issue of 'race' emerged most powerfully in the iconography surrounding the HIV+ African, so that this disease icon is framed as a 'dangerous, exotic 'other'' even in such isolated places as New Zealand.

Responses to influenza in New Zealand indicated the persistence of Western colonialist discourse framing Maori as inferior. Maori were castigated during the influenza epidemic, both for their lifestyle and for their susceptibility to disease. The result of this discrimination was a public health policy heavily weighted in favour of Europeans. Overseas discourse about influenza centred on the war metaphor, which was used to help garner funds and support in 1918. This metaphor remained in medical parlance after the influenza epidemic to shape discourse about HIV/AIDS in terms of the 'alien invader', 'viral enemy' or 'battle with AIDS'.[4]

The poliomyelitis epidemic saw a decline in blame meted out to victims because the disease mainly affected middle-class 'innocents' (children). Public health responses in New Zealand and overseas moved from physical (quarantine, isolation) to suggestive methods (health education) of disease control during this epidemic. I argue that the discourse arising from the poliomyelitis and other twentieth century epidemics centred on the rhetoric of cleanliness, an outcome of the germ theory.

[4] Dreuilhe, E. *Mortal Embrace*, 1989 The author used the war metaphor throughout the book to describe his 'battle' with AIDS.

Concerns about cleanliness in the poliomyelitis epidemic declined once the Salk and Sabin vaccinations were introduced, and have had little currency with respect to HIV/AIDS.

## 9.3 Epidemic Precursors to HIV/AIDS: (2) Syphilis

In Chapter 3, I wrote about how social understandings of sexuality in the syphilis epidemic had led to the creation of disease pariahs (prostitutes) who were forcibly isolated, treated, incarcerated, or killed. During epidemics such as the bubonic plague and cholera, many victims of disease had existed as social outcasts, but in the leprosy and syphilis epidemics, outcasts were also constructed in the name of disease. The difference resulted from the nature of the epidemics: leprosy and syphilis became chronic diseases, affecting individuals from all social classes. In the HIV/AIDS epidemic, 'disease pariahs' are individuals from marginalised groups. However, as in the leprosy and syphilis epidemics, HIV rapidly became a chronic disease associated only with 'dirty sex', so that anyone with HIV is at risk of becoming a pariah. Image-making in the HIV/AIDS epidemic is also shaped by the nature of AIDS: as in the leprosy and syphilis epidemics HIV infection is associated with sexuality and, in its final stages, is characterised by visible disfigurement.

I drew thematic links between the syphilis and HIV/AIDS epidemics. In Chapter 3, male syphilitics were often portrayed as feminised men (fops), who, like the biblical Eve, were deemed corrupters of men. Sander Gilman claims that powerful images

about promiscuous '(ef)femininity' carried over to the HIV/AIDS epidemic, where they alighted on homosexuals and prostitutes in terms of labelling and blame. I argued that AIDS imagery about gay men and prostitutes was created from disease stereotypes pre-dating syphilis and leprosy, such images had expanded during the syphilis epidemic by way of popular discourse, and that replication of these images during the HIV/AIDS epidemic is redolent of biblical imagery about 'Eve'. This imagery is an outcome of the moral condemnation that followed victims of 'sexual disease' throughout history.

Chapter 3 also outlined the way prescriptive codes for sexual and social behaviour that had emerged during the eighteenth century were prompted, in part, by fears about the effects of syphilis on the health and reproductive capacities of the European upper classes. At a time of Western colonialism, notions about racial superiority merged with ideas about moral and sexual propriety to become a potent ideology of disease. This ideology was mass-marketed during the nineteenth century as health education for all. Health education ('health promotion') promulgated the 'woman as sexual temptress' theme by way of mass media campaigns during the latter years of the syphilis epidemic.

Syphilis had been brought to New Zealand by the European traders and explorers, and continued in epidemic form well into the twentieth century. Despite its putative origin, Maori women were often blamed for 'spreading' syphilis into the general

population. Public health responses emulated those of Britain, and resulted in legislation framing women as vectors. Such laws remain, despite the agitation for reform by sex-workers during the HIV/AIDS epidemic (see Chapters 6 and 8). Discourse surrounding male sexuality during the syphilis epidemic centred on men's fitness for war. The activism of sexual health campaigner Ettie Rout resulted in condoms being supplied to soldiers in World War I. Male (hetero) sexuality had been problematised only in the context of fitness for war, and waned as a social concern during peacetime. Research on male sexuality in the HIV/AIDS epidemic has largely centred on gay men, with little concern, investigation or health promotion discourse directed at the sexual practices of heterosexual men.

## 9.4 Explicating the Links: Leprosy to HIV/AIDS

This thesis focused on the implications of prior and present image-making with respect to organisational responses to HIV/AIDS. I identified major themes by grouping sets of images according to each of the diseases discussed in Chapters 2 and 3. In the first group ('sexual diseases') leprosy, syphilis and HIV/AIDS are linked through the discourse about sexuality and STDs, and through their chronicity. These diseases are disfiguring in their end-stage symptoms: AIDS, syphilis and leprosy are each characterised by distinctive growths on face and limbs. In biblical times it was believed that disfigurement was the result of sin, and this idea became entrenched in Western thought. Leprosy and syphilis were conflated according to notions

about their symptoms, period of incubation, and degree of contagion. Leprosy and syphilis were known as 'dirty' sexual diseases and myriad images about the mad, bad or dirty lepers/syphilitics were produced in pictures and texts. Discourses about lepers and syphilitics that had proliferated in terms of biblical imagery became a rationale for promoting racial superiority during the eighteenth and nineteenth century. These were the discursive precursors to HIV/AIDS that converged, expanded, then alighted on the PWA.

The second group of diseases are those deemed catastrophic. Diseases such as bubonic plague, cholera, and yellow fever which were sudden, widespread and had high mortality rates, typify this group of epidemics. Twentieth century epidemics like influenza and poliomyelitis were not included in this category because influenza was the extension of an 'ordinary' disease, and mortality from poliomyelitis was low. In each of the pre-twentieth century epidemics, the theme of 'foreign invader' emerged. Disease icons were invariably foreign (Jews, Chinese, Italians, Africans, or Irish) or social outcasts (alcoholics, prostitutes, illegal drug users). The diseases (often called plagues) were long thought to be inflicted by God. Theories emerged to suggest causes such as miasma (poisonous humours), germs (contagion), and racial inferiority. The images that emerged from germ theory often constructed victims as dirty, degraded, or inferior. The discourses surrounding these epidemics were uniformly consistent: disease bearers were 'others' who could be vilified and blamed for disease. Such

images remained powerful in public consciousness despite the relative absence of catastrophic disease during the twentieth century. I argued that this imagery resulted from hegemonic ideas about risk behaviour and sexual 'typologies', and from other understandings such as those about the prevalence of epidemic disease among colonised or impoverished groups. Chapter 4 outlined how images from these groups converged during the HIV/AIDS epidemic to produce two distinct typologies, ie: the 'sexual' PWA (gay men, prostitutes), and the 'outcast' (injecting drug users, Haitians). It also noted the conflation of images such as that typified by the 'HIV+ African prostitute', or the 'African-American HIV+ drug user' in the USA.

## 9.5 New Zealand's Responses to HIV/AIDS

Responses to HIV/AIDS are not ahistorical but are embedded within discourse and public health praxis. Traditionally, public health responses in New Zealand have been modelled on those of Britain, whose authors 'were heir to a long and persistent tradition of thought in terms of ecclesiastic and medico-moral discourse'.[5] In this model, women and foreigners were consistently blamed for disease. Blame often translated into public health policy. For example, women syphilitics in Britain and New Zealand were incarcerated, and some Maori were barred from public hospitals during the influenza epidemic.

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[5] Kehoe, "Medicine, Sexuality and Imperialism. British Medical Discourses Surrounding Venereal Disease in New Zealand and Japan: A Socio-historical and Comparative Study", Ph.D, 1992: p. 284

Chapter 5 outlined the organisational responses to HIV/AIDS in New Zealand that were relevant to the main theme of this thesis. Injecting drug users, Maori and Pacific Islanders, youth, gay men and sex-workers were targeted for HIV prevention. This focus was sometimes erroneous in New Zealand's AIDS context: most sex-workers, for example, were disease free before the advent of AIDS. Nevertheless, the iconography served an ideological purpose: it replicated prior discursive paradigms about sexuality, 'otherness' and disease, and served to convince the New Zealand public a) that those at risk of HIV were the social outcasts of old, and b) of the government's role as protector of public (heterosexual) health.

In the face of government neglect, the gay community initiated and funded HIV prevention programmes for gay men between 1981-1984. Large-scale government HIV prevention campaigns began in 1985. The contraction of state responses after 1990 was due to such factors as a change of government, complacency about the epidemic, changes in WHO policy, and health reform. HIV disease is still mostly confined to the gay community, although the numbers of infected women have increased. HIV/AIDS in New Zealand remains a 'gay man's disease': gay men are still most at risk of HIV infection, and they and other marginalised individuals (sex-workers, IDU groups, Maori) continued to be funded for HIV prevention once the large-scale (heterosexual) media campaigns ceased. AIDS programmes are now being incorporated with STD prevention. Discursive links to chronic, sexually transmitted diseases such as syphilis have become more apparent within this organisational reconfiguration.

## 9.6 Theoretical Frameworks

My exploration of HIV/AIDS as a disease shaped by prior discourse and public health praxis was facilitated by the perspectives of two writers: Michel Foucault and Sander Gilman. Both writers approached their topics by explicating the discursive paradigms that frame the history of epidemics. Gilman provided a conceptual framework for understanding the nature of image-making in the HIV/AIDS epidemic. His particular focus was on the way AIDS icons had been created from pre-existing stereotypes about syphilitics. He also focused on the way AIDS icons had been created out of pre-existing racial and social stereotypes about injecting drug users and Africans. His insights thus provided a conceptual basis for reviewing the iconography of pre-twentieth century epidemics such as bubonic plague and cholera, and for examining the racial implications of the Peter Mwai case in Chapter 6.

Gilman's perspective was used to explore gender stereotypes in AIDS iconography. Based on Gilman's argument that women were portrayed as 'corrupters' in the syphilis epidemic, I traced the stereotype of the syphilitic woman to biblical images about Eve. This stereotype was explored in relation to sex-workers in the HIV/AIDS epidemic, particularly those deemed 'African prostitutes'. Issues concerning race and gender were found to be inextricably linked in Gilman's iconography, and in the HIV/AIDS epidemic in New Zealand and

overseas. I extended Gilman's focus on gender by concluding that a) bisexual women were not AIDS icons because they were subsumed under 'female' as a risk category (even though their STD rates in New Zealand suggested a higher risk with respect to HIV infection) and b) that lesbians escaped the angel/whore dichotomy because of their non-status in terms of HIV risk, or as sexual partners to heterosexual men. Bisexual men, on the other hand, had become AIDS icons because of their association with gay men. By extending Gilman's perspective on AIDS iconography according to these gender and sexual stereotypes, I demonstrated how the notion of Eve had infused AIDS discourse, and how this disease imagery was constructed only for its usefulness in signaling 'risk' to heterosexual men.

Foucault's analysis was used to broaden Gilman's perspective, and to explore the power issues inherent in creating, maintaining, or recreating images about gay men and others in the HIV/AIDS epidemic. In his book, *The History of Sexuality: An Introduction,* Foucault had theorised about the nature of discursive power and its impact on social behaviour. I argued that the gay community had first used discursive power in the 1970s to forge an identity in terms of a celebrated, rather than castigated, sexuality. It was this activism that paved the way for community organising in the HIV/AIDS epidemic.

The utility of discourse as a social methodology for shaping behaviour provided the basis for investigating responses to syphilis and HIV/AIDS in Part II. I explored the implications of

a secular health code (deemed The Life Project) for AIDS iconography by concluding that it had re-presented notions about 'Eve' along with generic ideas about individual responsibility. The Life Project was devised by the European bourgeoisie during the eighteenth century. This code enhanced the reproductive health and productivity of the upper classes in an era when diseases such as syphilis were endemic. Within this discursive paradigm, prostitutes and gay men continued to be icons of disease, blamed because they engaged in risky, non-reproductive sex. I inferred that the health code had expanded during the nineteenth century to become the twentieth century model for public health responses, and that this model provided the basis for grassroots and public health responses to HIV/AIDS. The Life Project thus emerged in the HIV/AIDS epidemic as a broad-based education programme labelled 'health promotion'. Although this programme targeted all individuals, AIDS icons such as drug users, gay men and prostitutes were treated differently with respect to funding, health promotion literature, and campaign objectives. Imagery about Eve framed the discourse of health promotion within a secular, generalised ideology for HIV prevention.

In Chapter 7, Foucault's argument about the utility of discursive power demonstrated how AIDS iconography could be used to both victimise and empower individuals in the HIV/AIDS epidemic. I identified the ways in which the iconography framing homosexuality, illegal drug use and prostitution operated as a catalyst for grassroots transformations. Foucault's theory

facilitated an understanding of how iconography had not only shaped public understandings about AIDS, but had been utilised by grassroots activists and others to a) influence governments in terms of funding and resources, b) help persuade authorities that measures used in prior epidemics such as quarantine, isolation or exile should be abandoned in favour of suggestive (and arguably kinder) methods such as health promotion, and c) change legislation which had criminalised 'homosexual acts' in New Zealand.

Foucault's theory of discursive power complemented Gilman's iconography in the case studies, both to enhance analysis of the material and to compensate for theoretical shortcomings. Gilman's focus on the process and outcomes of image-making had omitted a specific analysis of power, while Foucault's theory had constructed power as a totality that subsumed both the individual and notions of stigma. By combining the theories, the individual AIDS icon, activist or moralist was placed on centre stage in responses to HIV/AIDS. This exercise demonstrated how The Life Project, which once excluded (and was rejected by) non-hegemonic groups, had been urgently adopted by gay activists to meet the exigencies of HIV/AIDS. The iconographic discourse worked both ways: it categorised individuals unfairly, but also created political opportunities in an epidemiologic era.

My synthesis of Gilman and Foucault's theories facilitated a critical exploration of the transformations wrought by AIDS activists in New Zealand. The synthesis was pursued with New

Zealand's AIDS epidemic in mind: the case study material in Part I provided an historical perspective to the analysis.

## 9.7 Discourse and Iconography in New Zealand's HIV/AIDS Epidemic

Case study material in Part II demonstrated how New Zealand's HIV/AIDS epidemic has been shaped by, and is productive of, multiple discourses. AIDS discourses are most evident in media, parliamentary and community responses to HIV/AIDS. The image of the syphilitic 'Eve', reworked in the HIV/AIDS epidemic, has been particularly powerful in the New Zealand context. This image starkly contrasts with 'innocent' Eve (van Grafhorst), an HIV+ child who died in New Zealand in 1993. As outlined in case study material, Eve van Grafhorst was publicly celebrated and ultimately deified. She epitomised the respectable face of AIDS in New Zealand: her image elicited funds, donations and an abundance of Kiwi goodwill. Her 'white', Angel image was offset by the 'darker' image of Peter Mwai, an HIV+ African man who was jailed for offences relating to 'knowingly infecting' (white) New Zealand women.[6] The case study illustrated the production of multiple discourses about AIDS, and the persistence of a) prior imagery about corrupt women (biblical images of 'Eve') and 'innocent' children, and b) colonialist discourse which framed Africans as 'degenerate and inferior'.

The 'woman as disease-bearer' imagery that still clings to

[6] Worth, "AIDS and the Other: Race, Gender and Social Policy in the Peter Mwai Affair", *Social Policy Journal of New Zealand*, July 1995: p.24

the sex-worker has declared her blameworthy in New Zealand's HIV/AIDS epidemic. Comparisons between Eve van Grafhorst and the sex-worker with respect to AIDS iconography revealed how each utilised their public roles. Eve van Grafhorst rode high on public sympathy. Her celebrity image was constructed within the paradigm of 'the innocent child infected by a dirty disease'. The sex-worker, on the other hand, secured funding for HIV prevention on the basis of her disease-bearing image. As well as gaining a measure of power as community organisers and AIDS educators, the sex-worker dualistically positioned herself as both victim of men and protector of public health by insisting on condom use and by undertaking research on 'recalcitrant' male clients. Eve van Grafhorst also positioned herself as victim/protector, in terms of her public image as suffering HIV+ child and AIDS educator for the New Zealand public.

The image of 'innocent' Eve was also promoted over New Zealand's principal AIDS icon, the gay man. Early in the epidemic, media and medical discourses shaped the gay male PWA to a generic image of the hyper-sexual, effeminate disease-bearer, redolent of the syphilitic 'fop'. In New Zealand, this icon has been variously portrayed in the media as effeminate footballer (Lew Pryme), sexual browser (James Allen), or queen (Vincent: case study, Chapter 6). While individually invisible, the gay man was also iconised as an organisational entity in parliament and the popular media. In this role, he was an organiser, lobbyist and fundraiser who obtained government money, legal status and political clout. Whereas the public and government agencies

donated funds to Eve van Grafhorst (organisations such as Kiwi Kids for AIDS and the Angel Eve Trust) as a *result* of her disease status, the gay man was impelled to pursue government funding for HIV prevention on the *basis* of his role as AIDS icon. If the result of publicity for Eve van Grafhorst was public deification, the outcome for gay men as AIDS icons was ambivalence: funding and status were obtained only by reiterating his role as disease-bearer in the HIV/AIDS epidemic.

The case study for Chapter 7 demonstrated how parliamentary debate in New Zealand has been a rich source of AIDS iconography. Images about gay men as disease-bearers were particularly evident in the speeches relating to Homosexual Law Reform (1986) and The Human Rights Amendment (1993). AIDS iconography relating to gay men dominated speeches made by the opponents of reform. Unlike media reports about HIV/AIDS, the debates were often historically and philosophically focused. Frequent references were made to the Old Testament: allusions were also made to the New Testament, to the teachings of Greek philosophers, and to the Laws of Nature. Few references were made to the stigmatising outcomes of prior responses to epidemic disease, or to the history of public health in New Zealand. Lessons from the past were posed in terms of biblical morality, rather than its stigmatising effects. Historically-focused debate was used by parliamentarians on both sides of the House for political advantage, just as gay men were framed as sexual outcasts by both reformers and opponents of reform. However, while reformers argued that disease was an *outcome*

of stigmatised behaviour (to demonstrate the need for law reform) opponents argued that the *effect* of legalised homosexuality would be the spread of HIV.

## 9.8 Concluding Statement

This thesis focused on image-making and responses to HIV/AIDS in New Zealand. It demonstrated the links between epidemic history, public health praxis and community activism by locating New Zealand's response to HIV/AIDS in prior discourse about sexuality and disease, and by framing local responses with those from the USA, Canada, Britain and Australia. In each country, as in each epidemic, I demonstrated how people's understandings about disease were shaped by discourse and their own cultural and socio-political contexts.

This thesis analysed the origins and effects of discourses about AIDS, and extended Gilman's and Foucault's insights into the way images about epidemic disease and disease-bearers have been transmitted in terms of stigma or empowerment. The 'disease as praxis' axiom has held constant: its power and utility in New Zealand's HIV/AIDS epidemic has been demonstrated in various ways through legislative reform and media representation. In the event of another 'sexual' epidemic, a similar pattern can be predicted. Victims will again be stigmatised, the poor and feminised will be blamed: icons will be constructed around epidemic precursors, and the social, cultural and political concerns of the day.

I used Foucault's multi-faceted perspective on power to argue that AIDS discourse arose from the exercise of, and challenge to, hegemonic ideas and practices. What AIDS is, therefore, is defined by discourse: it is produced from a medley of biblical, historical, social and cultural discourses which have emerged as Gilman's 'iconography of AIDS'. AIDS discourse in New Zealand is expressed in common, activist and official terminology as 'the gay man's disease'. This terminology has its roots in the iconography of Eve.

This thesis demonstrated how hegemonic ideas which preceded AIDS helped construct PWAs according to 'typologies' of prior epidemics. These stereotypes have been deemed 'icons' by Gilman, and were excluded from the bourgeois Life Project as explicated by Foucault. The thesis outlined the way such exclusions provoked a discursive shift in the USA and other western nations during the civil rights movement of the 1960s, from which 'a politics of inclusion' was forcefully pursued during the HIV/AIDS epidemic. The dialectical process by which 'excluded' groups pursued the politics of 'inclusion' illustrated how AIDS icons such as gay men and sex-workers in New Zealand reframed The Life Project for funding, status and for physical and occupational survival.

I conclude this thesis with two summary points. First, its significance lies in the explication of how prior and current discourses shape responses to epidemic disease. Second, 'Eve'

was shown, in its many variants, to be a powerful organising theme in New Zealand. In constructing women and feminised men as vectors of STD, this iconography demonstrates the continuity of blame paradigms involving 'feminisation', and the tenacity of Judeo-Christian myths in shaping responses to twentieth-century disease.

# POSTSCRIPT

September 1995

The HIV/AIDS epidemic has been characterised by rapid changes to its epidemiology, iconography and politics. The fluid iconography of AIDS is an outcome of competing ideologies, advances in medical knowledge about HIV/AIDS, and of the epidemic's diffusion into broader population categories. In the first instance, AIDS image-making was restricted to the construction of gay men as disease icons; in the second, it was affixed to pre-existing sexual and racial stereotypes. This thesis was researched and written in the period of these two AIDS associations.

Today, the epidemic is increasingly associated with 'third' and 'fourth world' cultures as the epidemic spreads globally, or becomes endemic to poverty-stricken areas. If the crisis for white, middle-class heterosexuals appears to be over, the crisis for 'ethnicity' might have just begun. The outcome in terms of political sympathy and AIDS organising is significant: less money is devoted to its prevention. The reason for this decline in sympathy is unclear. Could it be that 'ethnicity' is less evocative of sympathy? That it is too diffuse or disempowered to organise along the lines of the gay 'project'? Or is it that disease can be placed at a greater distance when appended to 'race' in impoverished areas or in continents such as Asia or Africa?

New Zealand's AIDS context is also affected by change. Political changes, inherent, say, in the National Government's

commitment to health reform and 'smaller government' ideology have emerged. Since this thesis was written, staffing changes in the AIDS sector have resulted in several community and health sector realignments. For example, CIVDURG was temporarily managed by Ettie Rout (AIDS Foundation) after a staffing crisis, and now operates as The Roger Wright Centre with a new Board of Trustees. A vision-turned-reality has seen the Christchurch branch of the NZPC offer multi-sectoral expertise from a city site, but the Ettie Rout Clinic has been forced to relocate because of funding cuts. In the government sector, the PHC has been disestablished, and health funding and projects have been absorbed into the Ministry of Health and the Northern Regional Health Authority. Although such changes (large or small) might be inevitable, they symbolise the volatile nature of AIDS organising in New Zealand and overseas. This transformation prompts a cautionary note: future responses to HIV/AIDS might substantially differ from those investigated in this thesis. Nevertheless, as it has been argued in the preceding pages, the iconography underpinning responses to HIV/AIDS will remain.

# APPENDICES I AND II:

# ORGANISATIONAL RESPONSES TO HIV/AIDS

# INTRODUCTION TO APPENDICES I AND II

These two appendices examine organisational responses to HIV/AIDS in the USA, Canada, Britain, Australia and New Zealand. Appendix I provides a background to HIV prevention measures. It outlines responses from countries that are culturally or historically similar to New Zealand (Britain, Canada and Australia). The USA's response is also outlined because gay activists and health professionals in that country set the scene for managing a 'new' epidemic. In Appendix II, New Zealand's response to AIDS is comprehensively described according to how individuals and organisations operated during an impending and actual health crisis. Extensive field research was required before Chapter Five of the thesis could be written; the material in Appendix II therefore represents original research about organisational responses to HIV/AIDS in New Zealand. These two appendices provide the descriptive foundation for the thesis argument around AIDS discourse, iconography and power in New Zealand's responses to HIV/AIDS.

# APPENDIX I

## ORGANISATIONAL RESPONSES TO HIV/AIDS IN THE USA, BRITAIN, CANADA AND AUSTRALIA

## Overview

Much of the literature devoted to HIV/AIDS focuses on responses to the epidemic by media, government, and community organisations. Organisational involvement was not as evident for other twentieth century epidemics such as influenza and polio.[1] In fact, AIDS may be considered as much an 'organisational epidemic' as it is a health crisis, because of a proliferation of community (and some government) agencies dealing with the HIV/AIDS epidemic. This phenomenon is reflective of a bureaucratic age in which numerous health related organisations and agencies have been created to deal with the complexities of disease treatment, prevention and control.

Organisational responses to HIV/AIDS began in the USA, primarily because of the epidemic's putative origin. HIV prevention methods were developed by gay activists the USA, and were soon adopted by health workers around the globe. Nevertheless, responses to AIDS in these other countries were shaped by local factors with respect to health praxis, demography or politics. Each country, then, presents a unique picture, both in terms of AIDS epidemiology and responses to AIDS.

This overview of organisational responses to AIDS in western countries such as the USA, Britain, Canada and Australia

[1] Panem, *The AIDS Bureaucracy*, 1988: Introduction. Panem writes that AIDS required an 'extraordinary response'.

provides an understanding of the issues involved in managing a new epidemic. The responses of commonwealth countries (Britain, Canada and Australia) have been chosen for discussion because of their cultural, political and organisational relevance to New Zealand. The international AIDS context is important for several reasons. First, New Zealand responses to AIDS were influenced by WHO (The World Health Organisation), GMHC (the USA's Gay Men's Health Crisis) and AFAO (Australian Federation of AIDS Organizations). Second, the nature of New Zealand's organisational responses can be better understood within a cross-cultural comparison.

For the purpose of this appendix, the phrase 'community organisations' refers to grassroots agencies involved in HIV/AIDS prevention and care. Most organisations (also called AIDS Service Organisations (ASOs), Community-Based Organisations (CBOs), Non-Governmental Organisations (NGOs), Private Voluntary Organisations (PVOs) and Groups Outside Government (GOGs))[2] were formed by volunteers or activists who initially obtained funding from public or private charities rather than from government. Although these groups are referred to as voluntary organisations, most have received government funding since the mid 1980s. These organisations are subsumed under the most general term and acronym, as 'ASOs'.

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[2] Altman, *Power and Community: Organizational and Cultural Responses to AIDS*, 1994: p. 27

## The USA

This overview of the USA's HIV/AIDS epidemic focuses on early gay activism and the government's role during the 1980s, primarily because of the relevance to AIDS organising in New Zealand. Later responses to the epidemic, and organisational initiatives by other individuals (eg: women, African-Americans, Haitians and injecting drug users) are not discussed here.

Most USA literature about AIDS organising focuses on gay activism rather than on other initiatives. Indeed, it could be argued that while (white) gay men and women have been the *initiators* of HIV prevention programmes, others such as heterosexual women and African-Americans have been the *subjects* of government AIDS policy and programmes.[3] Little has been written about AIDS organising in the 1990s because a) HIV is no longer a new disease, b) its 'spread' among heterosexuals is lower than expected, and c) most strategies to deal with HIV/AIDS were implemented in the 1980s.

Early responses to AIDS in the USA were characterised by

[3] For example, researchers and project organisers at the Institute for Social Science Research at The University of Alabama have undertaken a community health project for African-Americans to prevent teen pregnancy, drug use, HIV and STDs. The project is funded by the National Institute of Health, a major USA funding agency. An HIV/STD prevention programme is also underway for women who use STD services in Birmingham, Alabama. The programme, funded by the NIH, encourages women to use 'female condoms' during intercourse.

disbelief and inaction, even among gay men. Shilts cites the example of the AIDS activist who was vilified in 1981 when he tried to raise AIDS awareness among gays. The activist was told that "he was hysterical, or participating in a heterosexual plot to undermine the gay community."[4] Once the impact of the epidemic was better known, however, AIDS activists formed self-help groups for HIV prevention and care.

Formal agencies were slower to respond. The USA government was roundly criticised by AIDS activists and others for its neglect during the mid 1980s. In one critique, the writer of a New York Times editorial made the point that "the [USA] Administration's response to AIDS has from the start been torpid, fitful, fragmented and riven with prejudice against those infected with the virus."[5] This writer, also an AIDS activist, charged that the government's responses to HIV were criminally inadequate, and that homophobia marked the response at all levels. Other writers agreed, but cited additional factors. Shilts, and Perrow and Guillen referred to organisational failure to deal with the epidemic. They specified in-fighting, status seeking, as well as 'homophobic' apathy among agencies and powerful individuals (eg: New York's Mayor Koch) as major impediments to dealing with the epidemic.[6] Kramer, an outspoken critic, stated

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[4] Shilts, *And The Band Played On*, 1987: p. 91

[5] Kramer, *Reports from the Holocaust - The Making of an AIDS Activist*, 1989: p. 267 Quoted from a New York Times editorial dated June 5, 1988. Parenthesis has beenadded.

[6] Shilts, *Op. cit.* and Perrow and Guillen, *The AIDS Disaster: The Failure of*

that:

> in this city [New York], our enemies include our mayor and our Department of Health. In this country, our enemies include our President, our Department of Health and Human Services, the Hitlerian Centres for Disease Control, the U.S. Food and Drug Administration, the Public Health Service, and the self-satisfied, iron-fisted, controlling, scientific frankensteinian monsters who are in charge of research at the National Institutes of Health.[7]

The trenchant criticism of formal responses to HIV/AIDS meant that opposing views such as those expressed by Thier were rarely heard. Thier maintained that "individual units of the [USA] government, particularly the Centers for Disease Control, the National Institutes of Health, and the Food and Drug Administration, have performed superbly notwithstanding the atmosphere of uncertainty, fear and pressure created by a new and terrifying disease." But even Thier admitted that "we have failed to develop a coordinated response against AIDS."[8] Panem, while rejecting the 'homophobia' thesis, also cited a piecemeal and tardy response to what she described as a 'novel' epidemic. However, she argued that governmental inadequacy was due to systemic errors stemming from 'inflexibility' (red tape), the fragmentation of decentralised county, state and federal

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*Organizations in New York and the Nation*, 1990: pp 168-9

[7] Kramer, *Op. cit.:* p. 103 Parenthesis has been added

[8] Thier in Panem, *Op. cit.:* Foreword

government systems, and budgetary constraints.[9]

Large-scale USA federal funding was allocated only in 1985, after the epidemic threatened the health of heterosexuals.[10] Even after 1985, AIDS activists deemed the funding paltry, and accused the government of rampant homophobia within its ranks.[11] The gay community's vigorous response to AIDS was thus enacted in the face of government apathy.[12] Gays continued to rely on their own resources and expertise, although these were supplemented by more generous government allocations after 1985.

Other factors, such as health sector practices, conservative party politics and a cumbersome bureaucracy had also served to delay the government's response to AIDS. Government neglect could not just be attributed to homophobia; it was also the product of party politics, institutional praxis and even cultural beliefs about the role of organisations in individuals' lives. To illustrate the latter, concepts about government and the role of private and public organisations in the USA are constructed around notions of individualism and private philanthropy. These notions can be compared to an erstwhile centralised, non-individualistic 'social welfare' tradition in New Zealand. The

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[9] Panem, *Ibid.*: p. 136

[10] *Ibid.*: p. 83-4

[11] Altman, *Op. cit.*: p. 113

[12] *Ibid.*

historical notion of self-reliance in solving social problems in the USA is juxtaposed with a distrust of government control, and is reinforced by the relative absence of large-scale government interventions.[13] Given this cultural paradigm, it is not surprising that self-help initiatives have been central to community responses to AIDS in the USA.

The 'self-help' model adopted by the gay community in the USA has resulted in extensive programming for HIV prevention and care. The success of gay activism has been such that in places like San Francisco the existence of numerous state-funded AIDS programmes is often due to gay political influence rather than to state or federal directives. This outcome prompted Mervyn Silverman, Director of San Francisco Public Health to say in 1985 that "If I lived west of the Mississippi and were diagnosed with AIDS, I would crawl to San Francisco."[14] The gay community's activism reflects the energy and success of its members, and greater numbers of HIV+ gay men in cities such as San Francisco. It is also indicative of a widening disparity in health care for HIV infected individuals across the nation, and the fragmentation of government responses. As well as the ability of pressure groups to influence government-funded health care on a

[13] That health campaigns were mounted by the USA government for the poliomyelitis and anticipated 'swine fever' epidemics suggests a) that large-scale government programmes *can* be mounted during health crises in the USA, and b) that homophobia might indeed have been a factor in the government's tardiness during the HIV/AIDS epidemic.

[14] Panem, *Op. cit.*: p. 79

community basis.

As in most democracies, USA politicians who shape HIV policy must heed their constituents' concerns. This fact allows powerful groups such as the NRA (National Rifle Association) or Moral Majority (a right-wing Christian group) to influence policy on emotive issues such as gun reform or abortion. The Moral Majority sought to shape government responses to what they considered an 'immoral' epidemic. Weeks reports that the Moral Majority was able to influence health policy during president Ronald Reagan's electoral campaign in the 1980s. He writes that "the Moral Majority became an important adjunct to the new conservative alliances that brought Reagan [the USA president who 'failed to respond to AIDS'] to power".[15] Moralists were also instrumental in promoting "Just Say No" sex education programmes for children in the USA.[16] Panem states that adults,

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[15] Weeks, *Sexuality,* 1986: p. 106 Parenthesis has been added

[16] Legat, "How The Young Love" in *Metro*, May 1994: p. 94, writes "Moral Right campaigners would probably prefer that the Family Planning Association, schools and sexual health clinics forgot about handing out condoms and just told young people to say 'no', something the FPA finds risible: all respectable overseas research shows that 'say no' campaigns simply do not work." For example, in one study in which USA 'abstinence' programmes were evaluated, "the only significant effect of the programme was to increase the mean sexual interaction level of the participants in comparison to controls. The results revealed that both male and female participants reported increases for several sexual behaviours." (*Owens, Achieving Effectiveness in Intervention*, 1992: p. 45) In another, the result was the same, so that the programme "had the end result of increasing the likelihood of condom use and decreasing the likelihood of abstinence." (Hernandez and Smith (1990), "Abstinence, Protection and Decision-Making: Experimental Trials on Prototypic AIDS Programs" in *Health Education Research,* 5 (3), pp 309-320).

too, were held captive to the moralists' concerns because "the public health imperative to disseminate sexually explicit information became confused with issues of morality, puritanism, pornography and First Amendment rights."[17] Organisational responses to AIDS in the USA are invariably shaped by moralists.[18] For instance, the problems in setting up syringe and needle exchange schemes for drug users in USA are largely the outcome of moral concerns about illicit drug use.

The fragmented nature of the USA's response to AIDS can be attributed to a simple geo-political fact: the size of the population (261 million) over a large geographical area. The health infrastructure has devolved into a cumbersome county, state and federal system that criss-crosses operational and geographical boundaries. Health agencies are often discrete and provide uneven, sometimes overlapping, services. They are specifically charged with being unresponsive to localised medical emergencies such as AIDS. Panem writes that:

> diverse state and local health responsibilities are served by a wide array of institutions. And each of the fifty states and seven territories, which provide

[17] Panem, *Op. cit.,*: p. 143 Also, according to Professor Patricia Stout (recently employed as Visiting Professor in Research at the Centers for Disease Control, Atlanta), the USA's first national 'condom campaign' did not get under way until 1994, primarily because of opposition by moralists. ("Issues to Consider When Designing AIDS Prevention Messages": Lecture given at the University of Canterbury, 17/8/94).

[18] Moralists do not necessarily belong to groups such as The Moral Majority. Such individuals (acting alone, rather than as members of organised groups) might serve on district councils, or be prominent in their local communities.

> guidance to localities for health care services, has a distinctive system. If a trend develops to bypass state agencies and develop direct ties between the federal agencies which fund health and the local dispenser, the pattern can become even more complicated. This pluralism contributes to the confusion involved in dealing with a health emergency.[19]

Panem argues that this pluralist, decentralised system mitigates against an effective and co-ordinated AIDS strategy. The USA's response to AIDS is thus a product of its fragmented health system and of party politics, and can be unfavourably compared to New Zealand's centralised, cooperative approach to HIV prevention.[20]

To summarise, organisational responses to HIV/AIDS in the USA are the outcome of uncertainty in dealing with a new epidemic, and of historical factors with respect to government structure, party politics and health praxis. HIV prevention measures vary in degree and quality as they are channelled through the fragmented system of local, state and federal government agencies responsible for health care delivery and programmes. Funding remained paltry until 1985 when large-scale allocations were approved by Congress. The size and heterogeneity of the USA's population are salient factors in the government's response, particularly since AIDS programmes must

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[19] Panem, *Op. cit.:* p. 47

[20] Peggy Koopman-Boyden, Chairperson of the National Council on AIDS, remarked that New Zealand's response to HIV/AIDS had been 'contained' (interview: 9/3/92).

be tailored to diverse needs. Gay activism was pivotal to AIDS organising during the early to mid 1980s. Other grassroots organisations in the USA have not been as pro-active as the gay community. Moral conservatives in the USA have had more impact on HIV/AIDS prevention and programmes than in other western countries. Cultural factors, such as the emphasis on self-help initiatives, a reliance on private philanthropy,[21] and a distrust of large-scale government interventions have also shaped the way AIDS is managed in the USA.

## Canada

Canada's HIV/AIDS epidemic began in 1981 among the gay and Haitian communities. In 1983, the number of PWAs stood at 100.[22] Gay organisers began HIV prevention and support programmes in the face of "the relative neglect of state health agencies in the early years of the epidemic".[23] Rayside and Lindquist believe that this neglect "placed burdens on local gay networks that could easily have overwhelmed them."[24]

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[21] While philanthropists in the USA donate large amounts of money for humanitarian purposes, their benevolence has rarely extended to PWAs. Panem (1988) notes that 'according to the Council on Foundations, only five of the national's leading philanthropies financed AIDS related programs'. The largest grant - the Robert Wood Johnson Foundation's $17.2 million effort to support community-based and home care - was not made until 1987." Panem, *Op. Cit.:* p. 70

[22] Rayside and Lindquist, AIDS Activism and the State in Canada. *Studies in Political Economy* (1992): p. 37

[23] *Ibid.*

According to the writers, the gay community self-funded their AIDS efforts until 1985, a phenomenon also characteristic of the USA.

The moralism of some state politicians in charge of health portfolios meant that attention paid to HIV/AIDS issues in Canada was, at first, limited to bio-medical concerns. Even as late as 1989, federal health minister Jake Epp was reported to be "consistently reluctant to say 'AIDS' out loud."[25] This reluctance, however, did not prevent needle exchange schemes from being set up in Canada's three major cities.[26] The government also increased funding for condom distribution in the face of strident opposition from right-wing conservatives.[27] Given these outcomes, it is apparent that Canadian moralists lacked the political influence of like-minded individuals in the USA.

Responses to AIDS in Canada were also threaded through a cumbersome local, provincial and federal government system. For historical reasons, government agencies dealing with health delivery in Canada are often accountable to the pharmaceutical industry and the medical profession. Thus, large sums of money

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[24] *Ibid.*

[25] *Ibid.:* p. 41 Jake Epp was federal health minister in Canada at a time when AIDS notifications were 'climbing into the thousands'. By 1988, there had been over 3,000 notifications in Canada (p.37).

[26] *Ibid.:* p. 42

[27] *Ibid.*

were allocated for public health, bio-medical or drug research rather than for HIV/AIDS service delivery.[28] Nevertheless, dependence on medical professionals and the pharmaceutical industry has meant that USA-style variations from one political jurisdiction to another are relatively limited.[29] Control over Medicare (a medical insurance scheme) also gave the Canadian government some influence over its network of health institutions.

Canadian ASOs, often operated by gay men and women, bear a close resemblance to agencies in New Zealand. They include:

a) Multi-purpose organisations such as the AIDS Committee of Toronto and AIDS Vancouver. These agencies run on similar lines to the New Zealand AIDS Foundation. They have been accused of being highly dependent on state funding and of becoming excessively bureaucratic.

b) Groups run by PWAs, whose New Zealand equivalent is the NPLWAU (National People Living With AIDS Union). These groups often have an activist agenda, and are less oriented toward mainstream ideas and goals.

c) Activist groups, similar to the USA's ACTUP (AIDS Coalition to Unleash Power). ACTUP is strictly activist. It

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[28] *Ibid.:* p. 44

[29] *Ibid.:* p. 45

has no real New Zealand equivalent.

d) In 1985, an umbrella organisation named CAS, or Canadian AIDS Society was formed. This organisation, which successfully brought together diverse groups under a single umbrella, has no equivalent in either Britain or the USA.[30] However, an umbrella organisation in New Zealand called CASONZ (Committee for AIDS Service Organisations in New Zealand) operated from 1989 to 1992. Australia has (or had) a similar committee.

Like New Zealand, Canadian ASOs were set up by gay activists. This concurrence relates, in part, to similarities between HIV infected populations in both countries. Most PWAs in Canada are gay men, with injecting drug users composing about four percent of the total.[31] This AIDS profile differs significantly from the USA, where the proportion of injecting drug users is about 31 percent.[32] While this disparity might reflect differences in HIV incidence between 'first' and 'second wave' countries, it is also evidence of the way injecting drug users in the USA have been denied access to needle exchanges, unlike IDUs in Britain, Canada, Australia and New Zealand.

The Canadian government's decision to fund ASOs after

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[30] *Ibid.*: p. 61

[31] *Ibid.*: p. 39 and *AIDS New Zealand,* Issue 20, February, 1994.

[32] See Chapter 4, footnote no. 21.

1985 was made "to avoid confronting AIDS issues on a government level."[33] Rayside and Lindquist write that the funding has created agency dependency, and has contributed to a reduction in community outreach and targeted services.[34] A trend also exists to co-opt AIDS-related tasks into established health structures, suggesting that the Canadian government is no longer averse to dealing with AIDS issues.[35] Perhaps, as Rayside and Lindquist argue, the pressure to 'normalise' AIDS policy by incorporating it into pre-established administrative agencies and routines is an effort to disempower community groups, and to de-activate radical energies.[36] The phenomenon has occurred in other western countries, and suggests an international and institutional trend in AIDS organising. It is arguable, however, whether community disempowerment is the unintended outcome of government policy, or its explicit intention.

To summarise, Canada's response to HIV/AIDS is contingent on provincial and federal factors, similar to the USA. Thus, local responses differ over a broad geographical area. Provincial and federal directives are more cohesive than in the USA. This phenomenon is due, in part, to the unifying influence of a national health insurance scheme. Cohesive health care policy and programming is also fostered by government reliance on two

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[33] Rayside and Lindquist, *Op cit.*: p. 41

[34] *Ibid.*: p. 48

[35] This trend is apparent in New Zealand, and is discussed in Chapter 5.

[36] Rayside and Lindquist, *Op. cit.*: p. 71

powerful institutions: the medical profession and the pharmaceutical industry. This cohesion comes at a cost, since government policy is shaped by the concerns of doctors and drug companies.

Political conservatives in Canada have influenced responses to HIV/AIDS, particularly during the early years of the epidemic. Unlike their counterparts in the USA, however, conservatives have failed to prevent initiatives like needle exchange, state funding for condom distribution, and safer-sex education. Canadian ASOs are served by an umbrella organisation which provides a forum for communication and strategy-making. Homogeneity of the HIV+ population, and the predominance of gay-run agencies replicates New Zealand's AIDS context. ASOs in Canada are now threatened by state co-option. This development suggests a consolidation or reduction of AIDS initiatives and services as state officials and policy-makers look to the long term management of HIV within the formal health sector.

## Britain

Britain's HIV/AIDS epidemic began in 1982 with the notification of three HIV infections.[37] Health authorities had reported 1000 cases by the end of 1987.[38] Despite this increase, it was clear

[37] Shannon, Pyle & Bashshur, *The Geography of AIDS: Origins and Course of an Epidemic,* 1991: p. 94

[38] Connor & Kingman, *The Search for a Virus - The Scientific Discovery of AIDS and the Quest for a Cure,* 1988: p. 20

that "the problem of AIDS in the USA still dwarfed that in Britain."[39] Notifications stood at 8.5 per 100,000 population in 1992, much lower than for the USA, and slightly less than in New Zealand.[40] The incidence of HIV/AIDS was also less in Britain than in West Germany and France.

Britain's response to AIDS was presided over by Margaret Thatcher, the conservative leader first elected to parliamentary leadership in 1979. According to Weeks, moral regeneration in the form of a return to 'Victorian values' was central to Mrs Thatcher's political platform.[41] Government responses to AIDS in Britain, therefore, were shaped by a long-serving conservative leader whose political agenda included fiscal restraint. Her attitude towards AIDS was reportedly one of 'personal antipathy'.[42] Not surprisingly, inertia initially characterised government responses to AIDS.[43] Like their counterparts in Canada and the USA, gay activists in Britain were the first to offer HIV/AIDS prevention and support services. For example, by

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[39] *Ibid.*

[40] As reported in *AIDS - New Zealand* (Issue 12, February 1992) some international figures are:

| | | | |
|---|---|---|---|
| USA: | 79.7 per 100,000 | Canada: | 20.1 per 100,000 |
| Britain | 8.5 | Australia | 18.7 |
| New Zealand | 9.1 | | |

As reported in *AIDS New Zealand* (Issue 25, May 1995), the cumulative total for AIDS in New Zealand is now 14.5 per 100,000 total population (see Chapter 5).

[41] Weeks, *Sex, Politics and Society,* 1989: p. 293

[42] *Ibid.*: p. 302

[43] *Ibid.:* p. 293

1982, the gay-run Terrence Higgins Trust (a London-based community organisation) offered a number of services to PWAs.

Most PWAs in Britain live in large urban centres such as London, with its gay community, or in Edinburgh, with its population of injecting drug users.[44] Because no discrete federal or state government system exists, AIDS policy and HIV-related services are managed by local health authorities and the Department of Health.[45] This phenomenon allows leaders like Mrs Thatcher to have considerable political influence over policy implementation in Britain.

The British government's early response to HIV/AIDS was affected by structural problems. Strong writes that "there was a general weakness underlying the government's response to AIDS: the lack of central coordination."[46] In an attempt to overcome the problem, the Ministerial Cabinet Committee on AIDS was formed.[47] However, this committee and other formal AIDS

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[44] Berridge and Strong, "AIDS Policies in the United Kingdom", *AIDS: The Making of a Chronic Disease*, 1992: p. 309 Needle exchange or similar programmes were established throughout Britain on a local, ad-hoc basis some time after 1986. In Edinburgh, injecting drug users were offered oral doses of illegal drugs rather than needle exchange facilities ("Can Clean Needles Slow the AIDS epidemic?" in *Consumer Reports*, July 1994: p. 467).

[45] Street, "A Fall in Interest? British AIDS Policy, 1986-1990", *AIDS and Contemporary History*, 1993: p. 226

[46] *Ibid.*: p. 227

[47] Berridge and Strong, *Op. cit.*: p. 308 There is no such committee in New Zealand. However, an interdepartmental advisory and information-sharing

agencies were disbanded in 1989 once the AIDS crisis was thought to be over.[48]

Britain's response to the HIV/AIDS epidemic is unique in one important respect: AIDS policy has been strongly linked to single-person politics. As prime minister, Margaret Thatcher was able to exert greater influence on AIDS policy than either USA or Canadian leaders, not because of a strong interventionist style, but because of "her apparent *lack* of interest in AIDS". [49] However, once heterosexuals seemed to be at threat of HIV infection, Mrs Thatcher delegated the job of AIDS policy to her deputy, Willie Whitelaw, who created a "period of wartime emergency" in 1986.[50] 'Emergency directives' were issued by officials, and implemented by way of a government structure traditionally responsive to crisis demands. This phenomenon suggests that it has been 'individuals' rather than 'bureaucracy' who shaped HIV policies and initiatives in Britain. It also suggests that there is little operational autonomy for British organisations. Nonetheless, government responses to AIDS have been shaped by political ideologues in Britain as well as in the

committee (the Interdepartmental coordinating committee on HIV/AIDS or IDCCHA) was set up in New Zealand, as was the NCA (National Council on AIDS). The latter, before it was disbanded in 1993, was a multi-sectoral committee which advised government on HIV/AIDS policy issues.

[48] *Ibid.:* p. 313

[49] Street, *Op. cit.:* 234 Italics by the author. Street observes that "when she wanted to impose her will, [Mrs Thatcher] chaired the relevant Cabinet Committee." Parenthesis has been added.

[50] Berridge and Strong, *Op. cit.:* p. 308 Willie Whitelaw headed the powerful ministerial committee on AIDS during Margaret Thatcher's prime ministership.

USA. The difference, it seems, is that the British ideologues who implement AIDS policy are mainly politicians who have a hands-on approach to HIV or public health measures[51] *and* who are relatively unencumbered by USA-style politics and red tape.

Three stages in Britain's organisational response to HIV/AIDS have been identified. Weeks calls these stages a) 'dawning awareness' (1981-1985), b) 'crisis management' (1986-1987) and c) 'normalisation of AIDS' (1988 onwards).[52] During the first phase, gay organisations attempted to meet the needs of PWAs on a voluntary basis. In the second, parliament underwrote Britain's response to HIV/AIDS by empowering certain individuals to direct policy or to allocate large sums of money to community agencies and existing health authorities. National AIDS awareness programmes were implemented during this phase. In the third stage, "political control of AIDS policy has largely reverted to the various agencies responsible for its implementation."[53] This 'clawing back' of state organisational power occurred as AIDS was normalised into a non-epidemic, chronic disease in terms of health management.[54]

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[51] In the first instance, Willie Whitelaw had 'absolute' control over AIDS policy and implementation. In the second, Mrs Thatcher's interventionist style was sometimes keenly felt (see footnote 57, this chapter).

[52] Weeks, *Op. cit.:* p. 301 and Berridge and Strong, *Op. cit.:* p. 312

[53] Street, *Op. cit.:* p. 233

[54] Berridge and Strong, *Op cit.:* p. 312

Britain's three-phase response is similar to that of other countries, notably Canada and New Zealand, and to some degree, it reflects the political and organisational structures of these countries. It also reflects the course of HIV/AIDS in first world countries where PWAs are mainly gay men rather than injecting drug users or 'others'.[55] Britain, with its focus on containment policies, and with its favourable political structure, appears to have fared better than the USA with its plethora of competing, heterogeneous organisations over which no one individual or 'voice' has effective control. The fact that Britain's HIV+ population has largely been confined to gay men indicates that Britain's response, whether governmental, community, or both, might have been well-directed and timely. Harm reduction programmes for injecting drug users, for example, have been instrumental in HIV prevention.[56]

In summary, Britain's response to AIDS has been predicated on conservative politics and an ideology of fiscal restraint. However, the ideology failed to impede British measures during

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[55] In 1990, there were 4098 PWAs in Britain. Only about 700 individuals were listed as 'other' (than homosexual). (Street, *Op. cit.:* p. 229) The significance of this fact is that HIV prevention is easier to chart and contain among a single group than in a heterogeneous population.

[56] In "Luvdup and De-elited" (in *AIDS: Facing the Second Decade,* 1993), Sheila Henderson writes about the "inspired [British] policies to limit supply [of illegal drugs] and reduce demand. In this area at least the UK is one of the few countries worldwide where 'harm reduction' - a concept and approach to intervention which pre-existed HIV in various guises within the drugs field - has been given, albeit quiet, official sanction in recent years." (p. 123). Parenthesis has been added. As noted in footnote 44 (this chapter), 'harm reduction' included the 'legal' supply of illegal drugs.

the 'crisis' years, except when Prime Minister Thatcher intervened. [57] As this outcome suggests, responses have been shaped by politicians whose approach has been authoritatively 'top down' despite a degree of interaction between government and community groups with respect to HIV/AIDS policy-making.[58] Thus, Britain's formal response was implemented on a coherent basis by powerful politicians rather than a plethora of competing organisations and interests. Per capita spending on AIDS-related projects has been higher than in Canada.[59] AIDS awareness, drug substitution, needle exchange, and, to a more limited extent, condom distribution have been central to Britain's response. Gay organisers initiated HIV prevention programmes, for which they received state funding after the mid 1980s. Most ASOs are now being stripped of some of their functions through state co-option.[60] This outcome represents a contraction in

[57] Street, *Op. cit.:* p. 229 describes how Margaret Thatcher effectively blocked a national survey on sexual behaviour, apparently because of her "instinctive distaste for invasion of heterosexual privacy." Street says that Mrs Thatcher "also caused health education campaigns to be cautiously inexplicit." (p. 234)

[58] Aggleton, Weeks & Taylor-Laybourn, "Voluntary Sector Responses to HIV and AIDS: A Framework for Analysis" in *AIDS: Facing The Second Decade,* 1993: pp 131-140. The authors write: "in a period of great policy fluidity, amounting at this stage to a policy vacuum at the level of statutory intervention, these early voluntary organisations were drawn into the processes of policy formation and helped shape the policy community that was emerging by the mid 1980s." Altman (1989) refers to this process as 'legitimation by disaster'. However, this period was relatively shortlived, and by 1986/7 "the statutory sector, in particular the National Health Service in Britain, and the older voluntary sector were able to reassert themselves." (p. 133)

[59] Rayside and Lindquist, *Op. cit.:* p. 40

[60] *Ibid.:* pp 70-71. In particular, AIDS hotlines are now administered by state

government responses to AIDS as Britain moves from 'crisis management' to 'normalisation'. The impact of health reforms, although not explored here, might also be a factor in this contraction, perhaps because the concept of 'managed care' demands fiscal constraint from the public health system.

## Australia

Australia's AIDS epidemic began with a single notification of HIV infection in April 1983.[61] By 1984, the epidemic had claimed lives among the gay community in large cities such as Sydney. Writers Nick Crofts *et al* claim that "back-projection modelling indicates rapid spread of HIV among gay men in Australia in the early 1980s, with 3000-3500 infections annually in 1984 and 1985, followed by a rapid decline to about 500-600 infections annually thereafter."[62] AIDS demographics in Australia are described as being 'remarkably similar' to those in New Zealand because most PWAs live in large, urban centres, and most are gay men.[63]

Australia's government is divided into a state and federal

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rather than community agencies.

[61] Lupton, *Op. cit.:* p. 44

[62] Crofts, Ballard, Chetwynd, Dickson, Lindberg & Watson, "Involving the Communities: AIDS in Australia and New Zealand" in *AIDS in Asia and the Pacific,* 1994: p. 1

[63] *AIDS - New Zealand,* Issue 16, February 1991. In 1991, gay men composed 90 percent of New Zealand's PWAs and 91 percent of Australian PWAs.

system. This structure serves a relatively small, urban-based population spread over a large geographical area. According to one writer and AIDS organiser, Australia's federal government has been pro-active in making and implementing AIDS policy. The writer describes the relationship between ASOs and government agencies as "a partnership which involves the community sector in all aspects of HIV/AIDS."[64] This response has been 'precedent-setting' and 'goes beyond normal Australian practice'.[65]

Australia's response to AIDS appears to have been coordinated at the highest level of government. For example, federal government was instrumental in establishing the Australian Federation of AIDS Organisations (AFAO), for which it allocated an operating grant of $600,000 in 1985.[66] Australia had developed a national HIV/AIDS strategy by 1989, and departments were bound to operate within its terms. Similarly, programme coordination was facilitated by a dedicated unit within the department of health. Altman writes that "Australia has been very generous in its funding of community-based organisations."[67] Government open-handedness has meant that "compared to some North American groups, or even the UK's

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64 Altman, "Expertise, Legitimacy and the Centrality of Community", *AIDS: Facing the Second Decade,* 1993: p. 7

65 *Ibid.*

66 *Ibid.* The AFAO links community and government AIDS organisations at a federal, state and local level.

67 *Ibid.*

Terrence Higgens Trust, Australian [community] AIDS organisations have been fairly uninvolved in fund raising."[68]

Australia's federal, state and community AIDS partnership, pro-active AIDS policy, funding generosity, and its well planned, vigorous and coordinated approach to HIV/AIDS is vastly different from the USA's response, despite the similarities in government structure. This difference suggests that Australia's responses to the epidemic have been influenced by cultural, political and economic factors as much as by organisational structure or health praxis. Some factors are identifiable. For example, Australia's formal approach to HIV prevention was little influenced by moral conservatives, and so, was considerably more robust than that of the USA. Australia's egalitarian spirit encourages political participation more than in non-egalitarian countries such as Britain or the USA. Thus, 'bottom-up' initiatives with respect to AIDS politics or organising are more likely to be successful in the political arena. The size of Australia's population (about 18 million) ensures that federal, state and local government structures are less unwieldy or fragmented than in the USA - a critical factor if adequate responses to a health crisis are to be formulated. Australia is also resource-rich, and in per capita terms, a wealthy country. As noted by Mann, a country's wealth is an important factor in funding an epidemic. In all these respects, Australia is indeed a 'lucky country'.[69]

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[68] *Ibid.:* p. 8 Parenthesis has been added.

Altman argues that Australia's funding nirvana has its downside. He writes

> what has been created in Australia is a very sophisticated and incestuous world of AIDS leaders, who are often paid employees of AIDS councils, if not in very close relationship with them. This group - of which I am a member - sits on proliferating government and non-government committees, which fly us around the country at an expanding rate, while rarely demanding that we account in any real way to the people for whom we allegedly speak.[70]

Despite Altman's disparagement of Australia's AIDS 'industry', the proliferation of programmes might have served the purpose for which they were intended (AIDS notifications fell sharply after 1988).[71] Altman also warns against the co-option of agencies and individuals into government structures. He argues that this process ensures that community organisers are

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[69] Horne, *The Lucky Country: Australia in the 1960s,*(1964) and *Death of the Lucky Country?,* (1976). Australia has long been known as 'the lucky country' by its citizens, mainly because of the abundance of natural resources. Some 'lucky' facts: Australia is the world's foremost diamond producer (*Time,* 31, August 1994: p.50), and the largest producer of bauxite, copper, lead, zinc and silver and other gems such as opal. Oil, gold and natural gas are also found in abundance. Queensland has been called 'an enormous food larder' (*Pacific Way,* 74, July 1994: p. 71)

[70] Altman, *Op. cit.* (1993): p. 9

[71] The WHO's *AIDS Surveillance Report,* 1993: p. 7.
AIDS notifications in Australia are as follows:

| | | | | |
|---|---|---|---|---|
| 1988 | 1731 | 1989 | 1626 | |
| 1990 | 1412 | 1991 | 1413 | |
| 1992 | 1293 | 1993 | 574 | (to May 1993) |

consumed by "the logic of government".[72] Although he feels that co-opted individuals can produce change within institutions, he says they are mainly "quasi-agents of the state" whose radical energies are killed off by "the long, slow march through endless grant applications."[73] Altman fears that PWAs will be less well served by the co-opted agencies, and that 'harder to reach' populations will be ignored, thus resulting in new infections.[74] This fear has been realised in the USA, where AIDS organisers are reported to be so preoccupied with bureaucratic 'housekeeping' that they are unable (or unwilling) to address the need of risk populations, who are often poor or non-white.[75]

To summarise, Australia's response to AIDS has been

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[72] Altman, *Op. cit.* (1993): p. 8

[73] *Ibid.:* pp 8-9 Concern about the consequences of funding dependency for the clients of AIDS organisations, and of the creation of an AIDS 'industry' itself, has been echoed by AIDS workers in New Zealand. In "The AIDS Industry", *Taking Liberties,* 1989: pp 113-125, writer Cindy Patton states that the AIDS industry (described as going 'from grassroots to business suits') is dominated by white, middle-class individuals who not only control funds, but who determine whom is allowed to speak about AIDS. (p. 116)

[74] Altman's concern might be justified. It was noted in 'Morning Report' (National Radio New Zealand, 11/8/95) that AIDS notifications in Australia increased sharply during 1995.

[75] Kramer( *Op. cit.:* p 102) in a letter to The Gay Men's Health Crisis (GMHC) in New York, writes: "I cannot for the life of me understand how the organization I helped to form has become such a bastion of conservatism and such a bureaucratic mess. The bigger you get, the more cowardly you become; the more money you receive, the more self-satisfied you are." (p. 102). Expressing similar views, Patton, *Op. cit.:* p. 123 writes: "Today, a growing number of white AIDS activists, and the communities of colour in general, view the major [USA] AIDS organizations as indistinguishable from government agencies, or agencies directed toward less controversial diseases." Parenthesis has been added

supported by federal, state and local governments. Gay activists, AIDS organisers and health officials have formed a successful partnership for HIV prevention in Australia. This partnership has been facilitated, in part, by Australia's spirit of egalitarianism. A degree of co-option might have occurred as the result of funding dependency. Australia's formal response provided a model for the New Zealand government, resulting in a number of similarly oriented committees and initiatives such as the national strategy for HIV/AIDS, a national coordinating committee for AIDS policy (the NCA), and a dedicated AIDS unit within the former Department of Health. Like New Zealand, Australia's epidemic mainly affects gay men. Australia's political system is similar to that of the USA and Canada, with a separate local, state and federal system. Like Canada, Australia's system serves a relatively small, urban-based population, and its government structure is relatively cohesive. Australia's response to HIV/AIDS has not been influenced by moral conservatives, or by lack of funding. Central to the response has been generous funding allocations for ASOs and coordinating committees, AIDS awareness programmes, the distribution of condoms, needle exchange schemes, and homosexual law reform.[76] Australia's pro-active approach to

[76] Tasmania is an exception to the Australian rule. The gay community in Tasmania has responded by 'turning themselves in' to police in an effort to bring attention to sodomy laws in that state. The federal government was reported to be considering legal moves against the Tasmanian government after the United Nations ruled that "Sections 122 and 123 of the Tasmanian Criminal Code were in breach of Australia's obligations under international human rights conventions." (*Sunday Star-Times,*

HIV prevention might have been a factor in the decline of new infections since 1988.[77]

## Conclusion

Examination of organisational responses to HIV/AIDS in the USA, Canada, Britain and Australia in this appendix reveals some of the factors involved in dealing with a health crisis; not only with respect to their obvious effects on PWAs, but in the way organisations or politicians have enacted (or blocked) policy initiatives. Patterns of AIDS organising have been explored in this appendix as a means of providing a framework for New Zealand's organisational responses to HIV/AIDS as outlined in appendix II. A summary of responses to HIV/AIDS in the USA, Canada, Britain and Australia is set out in table form overleaf as a visual aid to understanding the political, cultural and institutional influences on AIDS organising in these countries.

The USA provided a model for managing the HIV/AIDS epidemic, both in terms of strategies to adopt and mistakes to avoid. Thus, health organisations in countries such as Britain, Canada and Australia have benefitted from the USA's first-off AIDS experience. Nevertheless, local factors also shaped

C6, June 19, 1994) On 23/8/94, the Australian Federal Government passed a law standardising pro-gay legislation throughout Australia. This move effectively overturned Tasmania's state law outlawing homosexual acts. (Morning Report, National Radio New Zealand, 23/8/94).

[77] But see footnote 74, this chapter.

responses to HIV/AIDS in each of the countries listed. For instance, USA politics and the country's fragmented, cumbersome bureaucracy have mitigated against a coordinated response, while in Britain, a focused, 'top-down' political structure served to facilitate crisis measures.

Similar patterns in responses to HIV/AIDS were experienced in the USA, Canada, Britain and Australia. These patterns were marked by a) blame for individuals in 'risk groups', b) gay-initiated HIV/AIDS programmes in the early 1980s, c) an absence of government involvement in AIDS organising until the mid 1980s, d) public health funding and consultation (to a greater or lesser degree) between ASOs and government health agencies after 1985, e) a decline in the rate of new HIV infections during the 1990s, followed by, f) a decline in government funding for HIV/AIDS programmes during the 1990s.

Organisational responses to HIV/AIDS have been most alike in Britain, Canada and Australia. The demography of AIDS is also similar in these countries, where most infected individuals are gay men rather than injecting drug users or poverty-stricken individuals from minority groups. The rate of new HIV infections among gay men has declined in each country, but has risen among women and minorities, especially in the USA. It could be argued that the decline in new HIV infections among gay men is due to a variety of factors such as the efficacy and nature of organisation

TABLE 1: FACTORS AFFECTING ORGANISATIONAL RESPONSES TO HIV/AIDS IN THE USA, BRITAIN, CANADA AND AUSTRALIA

| FACTOR | USA | CANADA | BRITAIN | AUSTRALIA |
|---|---|---|---|---|
| Initial 'onset' country = A | A | | | |
| Second wave countries = B | B | B | B | B |
| Co-ordinated govt response | * | * * | * * | *** |
| Co-ordinated ASOs | * | *** | * | *** |
| Decrease in rate of AIDS | * | * * | * * | * * |
| Gay-initiated response | * * * | * * | * * | * * |
| Govt co-option of ASOs | * | * * | * * | * |
| Govt funding for ASOs | * | * * | * * | *** |
| Govt/ASO partnership | * | ** | * * | * * * |
| Homogenous HIV+ population | | * * | * * * | * * * |
| Govt. homophobia | * * * | * | * * | |
| Self-help ethos | * * * | * | * | * |
| Strong govt. leader | | | *** | |
| Strong moral lobby | * * * | * | * | |

Key: *No entry* = Nil * = Weak ** = Moderate *** = Strong

-al responses, and the reduced numbers of 'at risk' individuals. However, other explanations, such as the natural waxing and waning of epidemics, or of an epidemiologic plateau among 'risk groups' might also be relevant.

The main task of this appendix has been to provide a background to AIDS organising in New Zealand. As the appendix demonstrates, multiple factors have shaped responses to HIV/AIDS in the USA, Britain, Canada and Australia. These factors have influenced health officials and their organisations, which also operate according to their own ethos with respect to institutional praxis, efficacy, funding priorities and goodwill.

Appendix II next places New Zealand's response to HIV/AIDS in its cultural, historical and political context. This appendix also offers a background perspective for the main thesis theme, in which responses to HIV/AIDS by parliament, the media, and by community organisations such as the New Zealand Prostitutes' Collective and the AIDS Foundation were analysed to provide theoretical insights into the issues of iconography, discourse and power.

# APPENDIX II

## ORGANISATIONAL RESPONSES TO HIV/AIDS IN NEW ZEALAND

## Introduction

Appendix II describes organisational responses to HIV/AIDS in New Zealand; it serves as background material for the body of the thesis. The appendix is divided into two main sections. In the first, community responses to HIV/AIDS in New Zealand are outlined according to grassroots activism, and the formation of ASOs. In the second, formal sector responses are described, incorporating diagrams to demonstrate the role of organisations, the direction of policy and praxis, and the interface of AIDS organisational activities. Government measures are summarised within the historical and political context. The purpose of including diagrammatic material in this appendix is to illustrate the discrete but interconnected roles of community, medical and government sectors in AIDS organising in New Zealand.

## HIV/AIDS in New Zealand

Most PWAs in New Zealand live in the major cities such as Auckland and Wellington, with the majority residing in the populous northern regions. The HIV/AIDS epidemic in New Zealand is known by many as 'the Auckland disease'.[1] Resources and community programmes have therefore been concentrated in this city.[2] Like other 'Pattern I'[3] countries such as the USA,

[1] Allen, "At The AIDS Foundation, Fighting 'The Auckland Disease"; *Metro,* May 1986: pp 104-111.

[2] Heeringa in "The Ailing Foundation" (*Metro,* October 1994: p. 85), reports that there are ten competing specialist AIDS organisations in Auckland: The New

Canada, Britain and Australia, HIV/AIDS in New Zealand is an urban phenomenon that mainly affects gay men. A breakdown of AIDS notifications into the four regional health areas (RHAs), based on data collected to 30/6/94, is incorporated in Table 1 overleaf.

Although most PWAs are gay men, the number of HIV infections in this sector of the population is significantly lower.[4] Statistics for 1994 indicate that 95.5% of AIDS notifications were listed for gay men, compared with 57.3% of HIV infections (another 11.2% of infected men were marked 'unknown' in terms of risk category). Table 2 lists the numbers of PWAs and HIV positive individuals according to 'risk category' and gender. The HIV+ total (with about 16% 'unknowns') includes

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Zealand AIDS Foundation (NZAF), the New Zealand Prostitutes Collective (NZPC), Sexual Health Services, Family Planning (FPA), Community AIDS Resource Team (CART), Positive Women, Auckland Community AIDS Services (ACAS), Body Positive, Auckland Drug Information and Outreach (ADIO) and the National Union for People Living With AIDS (NPLWAU). Other main cities have some, but not all of these services.

[3] New Zealand is listed by WHO as being a 'Pattern I Country' with respect to HIV/AIDS, along with the USA, Western Europe, Australia and parts of Latin America. In Pattern I countries, most PWAs are gay men or injecting drug users. In Pattern II countries (the Caribbean and sub-Saharan Africa), the epidemic is deemed 'heterosexual'. In Pattern III countries (Eastern Europe, North Africa, the Middle East and parts of Asia), the epidemic lags behind that of Pattern I and II countries (Sills, *The AIDS Pandemic*, 1994 ). Some writers suggest a fourth category for countries such as Brazil and Honduras in which male bisexuality is deemed a risk factor (Shannon et al, *The Geography of AIDS: Origins and Course of an Epidemic*, 1991: p. 157).

[4] Figures for new HIV notifications should be viewed with caution because, unlike AIDS, HIV has not been declared a notifiable disease in New Zealand.

injecting drug users, women and gay men.[5] Women comprise 15.7% of new HIV notifications, while identified injecting drug users are listed as 5.6% of the total. Despite the variability of infections among different sectors of the population, the HIV/AIDS epidemic was, and and still is, said to be a 'gay man's disease.'

TABLE 1 AIDS NOTIFICATIONS IN NEW ZEALAND BY REGION[6]

| Region | Total | % Total | per 100,000 popn |
|---|---|---|---|
| Northern (includes Auckland, Whangarei and Northland) | 252 | 56 | 24.8 |
| Midland (includes Hamilton, Bay of Plenty, and New Plymouth) | 45 | 10 | 6.3 |
| Central (includes Wellington, Nelson) | 117 | 26 | 13.2 |
| Southern (includes Christchurch, Dunedin, Invercargill) | 37 | 8 | 4.9 |

[5] These opinions were offered by: a) Manager, Christchurch Intravenous Drug Users Resource Group (CIVDURG): interview, 8/12/93, and b) Ettie Rout Clinic counsellor, personal communication: 2/9/94)

[6] Based on Dickson, AIDS Epidemiology Group, personal communication: 28/9/94

## Table 2 Category of Risk Behaviour by Date of Notification of People with AIDS, and Those Identified as HIV+

| | AIDS | | | | HIV antibody positive* | | | |
|---|---|---|---|---|---|---|---|---|
| | 12 months to 31.12.94 | | Total to 31.12.94 | | 12 months to 31.12.94 | | total to 31.12.94 | |
| | No. | % | No. | % | No. | % | No. | % |
| Homosexual or bisexual+ | 42 | 95.5 | 399 | 84.4 | 51 | 57.3 | 571 | 57.3 |
| Homosexual & IDU+ | 0 | 0 | 9 | 1.9 | 0 | 0 | 10 | 1.0 |
| Injecting Drug User (IDU) | | | | | | | | |
| Male | 1 | 2.3 | 8 | 1.7 | 3 | 3.4 | 24 | 2.4 |
| Female | 0 | 0 | 3 | 0.6 | 2 | 2.2 | 7 | 0.7 |
| Blood Product Recipient+ | 0 | 0 | 6 | 1.3 | 0 | 0 | 28 | 2.8 |
| Transfusion related | | | | | | | | |
| Male | 0 | 0 | 1 | 0.2 | 0 | 0 | 2 | 0.2 |
| Female | 0 | 0 | 1 | 0.2 | 0 | 0 | 5 | 0.5 |
| Unknown | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 0.5 |
| Heterosexual | | | | | | | | |
| Male | 1 | 2.3 | 15 | 3.2 | 9 | 10.1. | 25 | 2.5 |
| Female | 0 | 0 | 14 | 3.0 | 9 | 10.1 | 46 | 4.6 |
| Perinatal | | | | | | | | |
| Male | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0.1 |
| Female | 0 | 0 | 1 | 0.2 | 0 | 0 | 1 | 0.1 |
| Not stated or unknown | | | | | | | | |
| Male | 0 | 0 | 16 | 3.4 | 10 | 11.2 | 243 | 24.4 |
| Female | 0 | 0 | 0 | 0 | 3 | 3.4 | 16 | 1.6 |
| Unknown | 0 | 0 | 0 | 0 | 1 | 1.1 | 12 | 1.2 |
| Other | 0 | 0 | 0 | 0 | 1 | 1.1 | 1 | 1.1 |
| TOTAL | 44 | 100.0 | 473 | 100.0 | 89 | 100.0 | 997 | 100.0 |

+ All male *includes people who have developed AIDS

SOURCE: AIDS - New Zealand, Issue 21, May 1995

## The New Zealand AIDS Foundation

The AIDS Foundation was established in 1984. As noted in Chapter 5, its purpose is to provide HIV/AIDS support, counselling and prevention services. The AIDS Foundation is the largest ASO in New Zealand, and receives the most government funding. For this and other reasons, the AIDS Foundation is considered 'the major player' in the field.[7] Figure 1 outlines the structure of the organisation and its sphere of influence. Gay men were, and still are, key personnel. They actively resist attempts to 'de-gay' the organisation even as their numbers decline in the HIV statistics, as funding levels are cut, and as service-delivery of the AIDS Foundation itself is the subject of criticism.

As Figure 1 indicates, the AIDS Foundation's three main functions are support and counselling for PWAs and other clients, HIV prevention for gay men, and human rights advocacy. The head office, located in Auckland, became the locus of operations after extensive organisational changes resulted in centralised funding and operations.[8] Head Office is involved in funding, formulating support and HIV prevention strategies, human rights advocacy, research, liaison, and publicity. It also supports a library for research purposes. While branch offices are part-funded through the central body, this process is set to change due to health-sector restructuring. Some branch offices (Auckland, Wellington

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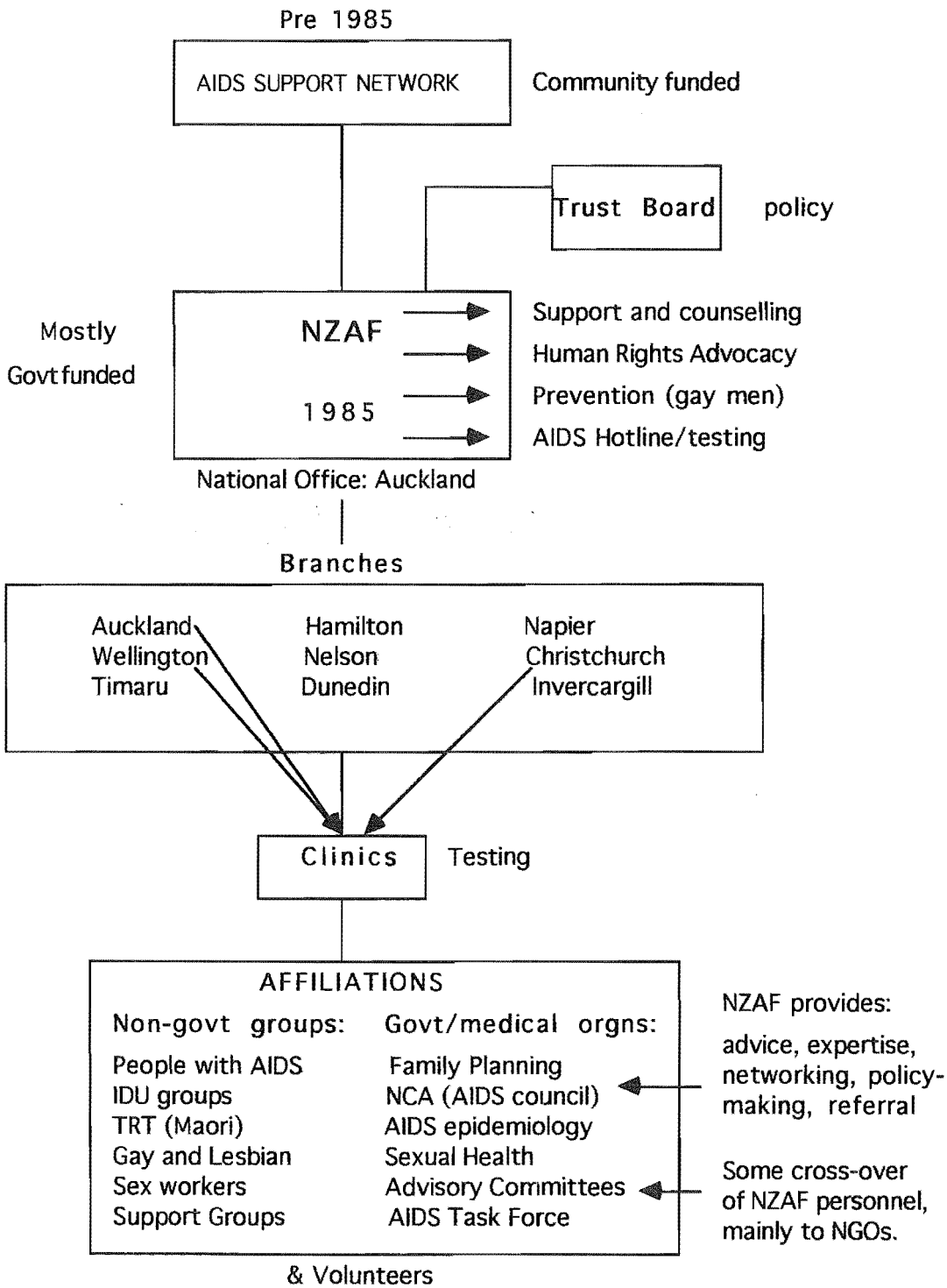
[7] Bruce, "The New Zealand Strategy on HIV/AIDS 1990: National Council on AIDS", Sociology Honours essay, 1994: p.2.

[8] NZAF informant, interview: 15/11/93

FIGURE 1 STRUCTURE OF THE NEW ZEALAND AIDS FOUNDATION



and Christchurch) offer testing facilities, as well as counselling, support and education. Branch managers liaise with personnel at head office, and with other branch and health-sector workers. Their clientele is diverse. One agency reports that heterosexuals compose fifty percent of the total, with an even higher ratio at other agencies.[9] The AIDS Foundation incorporated a large number of volunteers at the height of the epidemic. The depletion of the volunteer workforce has been attributed to several factors including passage of the Homosexual Law Reform Act, AIDS Foundation restructuring, and compassion fatigue.[10]

Despite the high numbers of heterosexual clients, critics maintain that the AIDS Foundation is interested only in providing services to gay men.[11] Detractors also hold that the AIDS Foundation provides inadequate services to women.[12] Further dissatisfaction has been expressed about service delivery in Auckland. A no-confidence vote against the AIDS Foundation was passed in 1990 because the organisation was "totally focussed on

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[9] *Ibid.*

[10] *Ibid.* The informant stated that, in 1989, "there were more than seventy volunteers working for the Ettie Rout Clinic. Now there are hardly any." Homosexual law reform, and the resulting visibility for gays, has meant less political involvement in 'gay' organisations such as branches of the AIDS Foundation.

[11] The AIDS Foundation's brief is also to provide HIV prevention programmes for gay men. This activity has suffered set-backs in recent years due to government funding cuts.

[12] An informant stated that "women are not very important to the NZAF". To offset such criticism, the AIDS Foundation put out a working paper entitled "HIV, NZAF and New Zealand Women" (1992). The response to this paper by one health researcher was that "it reads better than what's really offered - it overstates what's been done."

the Health Department - its funding source."[13] This focus highlights Altman's claim that "community-based organisations may come to do the bidding of the state, may reflect the bureaucratic structures of the state, and may offer leadership which ceases to represent the communities for which it claims to speak."[14] Heeringa writes that the AIDS Foundation's focus on the Health Department had transformed "the foundation from a community-based structure to a bureaucratic hierarchy."[15] ASOs such as 'Body Positive' and the 'Auckland Community AIDS Services' were created to fill the 'grassroots' gap after 1990.[16]

The AIDS Foundation has been a pivotal organiser of information, expertise, and in some cases, personnel, for other ASOs around the country. Gay men have also been incorporated into medical and governmental health infrastructures as advisors and consultants. They have been represented on high-level government AIDS committees (most notably the National Council on AIDS) and act as 'experts' and consultants for medical/governmental AIDS organisations.[17] While such involvement demonstrates the degree to which formal and

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[13] Heeringa, *Op. cit.*: p. 82 *Out!* magazine outlined the dissension between the NZAF and its Auckland branch in its 15/9/90 issue (p.4). A no-confidence vote was passed by members of the branch, together with individuals from HIV+ groups and volunteers.

[14] Altman, *Expertise, Legitimacy and the Centrality of Community,* 1993: p. 8.

[15] Heeringa, *Op. cit.*: p. 82

[16] Heeringa, *Ibid.*

[17] For example, members of the AIDS Foundation are consultants for the AIDS Epidemiology Group (Dunedin) and consulting members of the Christchurch Crown Health Enterprise's (CHE) AIDS Coordinating Committee.

informal organisations have collaborated to deal with a health crisis, it also indicates how the gay community has played a pivotal role in shaping New Zealand responses to HIV/AIDS. Acknowledging the primacy of this 'gay' factor is essential to understanding issues of power, iconography and legitimation in New Zealand's AIDS context.

## Law Reform

The 1986 Homosexual Law Reform Act was the first of several legislative reforms to serve as 'health measures' during New Zealand's HIV/AIDS epidemic. In 1987, an amendment was made to the Misuse of Drugs Act that paved the way for needle exchange.[18] In 1993, an amendment to the Human Rights Act outlawed discrimination on the grounds of sexual orientation.[19] The influence of gay lobbyists was apparent in the political lead-up to both the 1987 and 1993 amendments. For the 1987 amendment, members of the AIDS Advisory Committee (AAC) advocated needle and syringe exchange, and IV user education.[20] At least three members of the AAC had personal links with the gay community and the New Zealand AIDS Foundation.[21]

[18] New Zealand needle exchange schemes permit used syringes and needles to be swapped for new ones. Clients pay a small price for the 'fits' (packs of needles and syringes), which are provided by agencies such as the Christchurch Intravenous Drug Users Group (CIVDURG) or specified pharmacies.

[19] Luke, "Sweeping Gay Law Completes Reform Agenda" in *The Christchurch Press*, 29/7/93: p6

[20] Lindberg, *New Zealand National Strategy*, 1988: p. 40

[21] *Ibid.*: p. 37 Lindberg writes "the only member not a doctor was Kate Leslie, a

Advocacy by the AAC and others for legalised needle exchange schemes was so successful that "New Zealand became the first country to put a needle exchange scheme in place before drug users got infected with HIV."[22] For the 1993 amendment, a willing government, favourable political climate, and effective lobbying by the gay community and bodies such the National Council on AIDS (whose members included a number of gay activists) were key factors in achieving change. The AIDS Foundation's 'political arm' had also actively pursued a human rights agenda. Their activity was underwritten by the government by virtue of its funding to the AIDS Foundation.

Changes to New Zealand legislation that were aligned to HIV prevention are as follows:

*1986 Homosexual Law Reform Act.*

*1987 Amendment to Misuse of Drugs Act* - permits needle and syringe exchange.

*1990 Amendment to the Contraception, Sterilisation and Abortion Act* - permits sex education for children under 16.

*1993 Amendment to the Human Rights Act* - makes

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medical social worker, who was the chairperson of AIDS Foundation. Two of the doctors were gay, but the request for representation of a gay political lobby were declined. However, the committee invited discussion with AIDS Foundation and the gay community on most issues that seemed to require the community's collaboration."

[22] CIVDURG Manager, *Op. cit.* Not quite, according to Warren Lindberg, who notes that "on 1 April 1987 the NZAF announced the first IV drug transmitted HIV and the minister [of health] announced a change in the law [permitting needle exchanges]." *Ibid.:* p. 40

discrimination illegal on the basis of disability or sexual orientation.

*1993 Health and Disability Services Act* - emphasis on health promotion and health reform.

## From 'Crisis' to 'Community'

The creation of ASOs in New Zealand are the outcome of community activism, and of government initiatives that took effect after 1985.[23] The New Zealand Prostitutes' Collective (NZPC), modelled on the Australian prototype, was formed in 1987 after consultations between sex-workers and health department officials.[24] Other government-funded ASOs were established between 1987-1991. Figure 2 depicts the creation of key government-funded ASOs by name, date of establishment, and mode of operation.

To facilitate community HIV/AIDS awareness programmes, a special unit of the Department of Health (the AIDS Taskforce) was formed to provide community organisers with funding advice and expertise.[25] For groups like the Christchurch Intravenous Drug Users Group (CIVDURG) the unit proved invaluable, because "the [AIDS] taskforce steered us through the minefield of politics.

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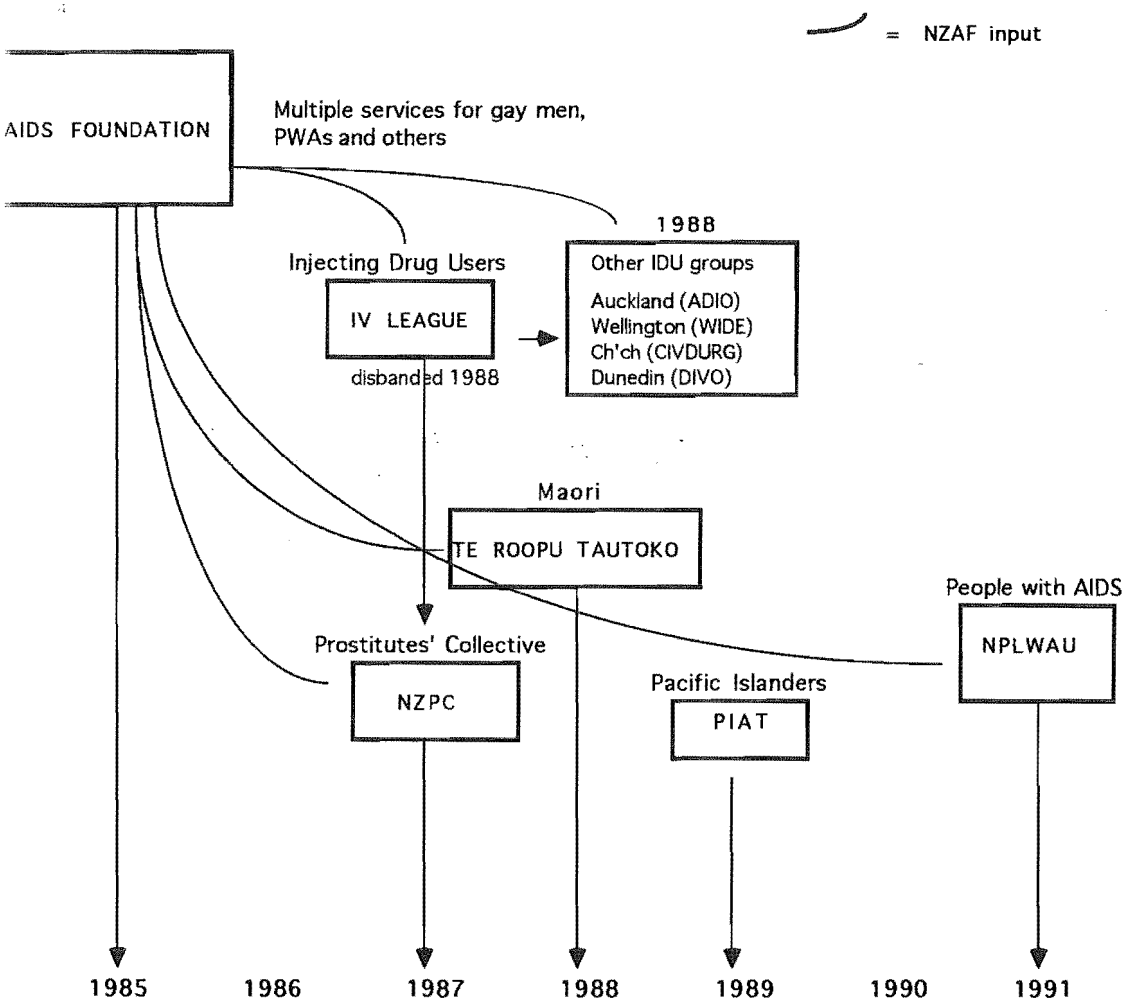
[23] This global phenomenon had occurred after HIV/AIDS was thought to be a threat to heterosexuals (see Appendix 1).

[24] Jordan, *Working Girls,* 1991: p. 272

[25] NCA minutes no. 13, appendix I: p. 7 The unit was disbanded in 1991 after government restructuring.

FIGURE 2 FORMATION OF SOME GOVERNMENT FUNDED COMMUNITY AIDS ORGANISATIONS IN NEW ZEALAND 1985-1991



It would be much harder now to set up without the Taskforce." [26] The government was not the only actor helping grassroots organisations set up HIV prevention programmes. The gay community and AIDS Foundation provided organisational impetus, as well as seeding funds and personnel. For example, the now-defunct IV League was formed by two gay HIV+ men who were AIDS Foundation affiliates as well as injecting drug users.[27] The AIDS Foundation also contributed to the establishment of Te Roopu Tautoko (TRT), the Maori HIV prevention group[28], and support by AIDS Foundation personnel is acknowledged by sex-workers who represent the New Zealand Prostitutes' Collective.[29]

Prior to the HIV/AIDS epidemic, there was a lack of political organising among either sex-workers or injecting drug users (IDUs). The key to understanding this political inactivity is the long-term stigma experienced by sex-workers and IDUs in New Zealand. Although the gay community had politicised during the 1970s, there was little follow-on for sex workers and IDUs. Individuals from these groups still operate outside the law in New Zealand. This status quo persists despite determined efforts

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[26] CIVDURG Manager, *Op. cit.* Parenthesis has been added

[27] *Ibid.* Organisers from the Christchurch Intravenous Drug Users Group (CIVDURG) have also liaised with the AIDS Foundation. An AIDS Foundation staff member was a member of CIVDURG's trust board.

[28] Lindberg, *Op. cit:* p. 46. While working for the AIDS Foundation, Rex Perenara set up a Maori HIV/AIDS support group within the NZAF that evolved into Te Roopu Tautoko (TRT). Rex left the AIDS Foundation to become director of TRT once government funding was obtained.

[29] Jordan, *Op. cit.:* p. 272

by the NZPC to have soliciting made legal[30], and regardless of lawful needle exchange.

According to Lindberg, "drug users and prostitutes in New Zealand are more socially disapproved of than homosexuals."[31] The continued illegality of 'soliciting' and IV drug use demonstrates a marked governmental ambivalence about the activities of IDUs and sex-workers. This ambivalence results in hands-off funding allocations for HIV prevention programmes[32], while the prosecution of illegal drug users continues as before, and on occasion condom-carrying sex-workers provide police with 'proof' of their crimes.[33] In this context, the amendment to allow needle exchange schemes contradicts other New Zealand's

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30 The NZPC has produced submissions advocating changes to

a) Sections 18, 19 and 30 of the Massage Parlours Act 1978 that prohibit sex work in massage parlours.

b) Sections 107-109, 148 and 149 of the Crimes Act 1961 that regulate brothel keeping, pimping and procuring.

c) Section 26 of the Summary Offences Act 1981 that governs soliciting.

d) The Telecommunications Amendment Act 1988 that prohibits commercialised telephone sex.

According to New Zealand laws which govern 'soliciting', men can offer payment for sex but women cannot offer sex for payment (the Hon. Maurice Williamson, [ex] Associate Minister of Health: speech on decriminalisation of soliciting: 27/8/92). This law was described by the minister as being outmoded and unfair.

31 Lindberg, *Op. cit.*

32 A CIVDURG trustee maintained that government-funded IDU HIV prevention groups are 'left alone' to operate as they see fit, a fact he ascribes to government's ambivalence about the activities of illegal drug users. (personal communication, 7/10/94).

33 No author listed, *Christchurch Press*, 'Prostitutes say law changes are urgent", 6/1/94: p.6. This news item outlines NZPC concerns about how police have used the presence of condoms as evidence to support a brothel-keeping charge.

legislation that deems many non-prescription drugs illegal.

The stigma experienced by sex-workers and injecting drug users has resulted in their suspicion of organised activities. It is argued that client invisibility significantly hindered early attempts to organise grassroots HIV prevention programmes among them. Nevertheless, a desire to "empower themselves within the wider social context" led sex-workers, for instance, to "meet in pubs, private homes, massage parlours, on the street and, typically New Zealand, on beaches to discuss in a semi-serious way the forming of an organisation specific to the needs of sex-industry workers."[34] For sex-workers, the late 1980s was a time of 'coming out'.[35] IDUs also felt a need to organise, although this desire was more directly linked to HIV prevention rather than community empowerment. Once established, the NZPC and IDU groups provided a number of educative services to clients. They also promoted safer sex information, often from the premises of drop-in centres, by outreach, or in the form of community magazines.[36]

Despite the legal barriers, efforts by Department of Health officials to incorporate community groups in HIV prevention work provided fledging organisations with a degree of legitimation as well as funding and expertise. Community leaders from the

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[34] Jordan, *Op. cit.:* p. 271

[35] Statement attributed to 'Catherine', founding member of the NZPC: *Ibid.:* p.272

[36] Magazines published by HIV prevention groups include: "Siren" (NZPC), "Nexus" (CIVDURG) and "Collective Thinking" (NPLWAU). The AIDS Foundation publishes "Network" and "Scene".

various ASOs are now consulted by public health authorities, and have been members of high-level committees such as the National Council on AIDS (NCA) - hailed by its chairwoman as a 'community' rather than 'medical' initiative.[37] Through membership of the NCA, community leaders gained a forum for information-sharing and contributed to official policies.

Legitimation has also resulted from the partnership between community groups and health researchers. Members of the NZPC, for example, have co-partnered surveys with health researchers, have attended local, national and international conferences on HIV/AIDS, and have gained visibility in their role as 'consultants' for AIDS research.[38] Representatives from the NZPC, the IDU and AIDS support groups act as safer sex educators for clients and other members of the New Zealand public, a move rarely seen in other countries.[39]

For community organisers, the visibility gained from HIV prevention activities has resulted in political confidence,

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[37] NCA Chair, interview: 9/3/92

[38] Members of the NZPC (Christchurch) have contributed to a number of projects undertaken by Dr Chetwynd the Professor of Public Health and General Practice, Christchurch School of Medicine. (Chetwynd: public lecture, "HIV/AIDS Research: ten years on": 24/8/94)

[39] Various sources, including "Local Aids Educator Honoured for Work", *The Christchurch Star*, 1/12/93: p. 6. Sex-workers and representatives from IDU groups and the NPLWAU have been involved in educating a number of individuals and groups about safer sex and other issues relating to HIV/AIDS. For example, talks about safer sex are given to school children, tertiary students, nurses and other health professionals, psychologists, Jaycees, business groups and the police.

particularly for the NZPC. Nevertheless, old attitudes equating prostitution with sin continue to undermine sex-workers' efforts to legalise their work activities. For example, New Zealand's National government, reported to be "scared that decriminalisation will lose them votes", has shelved recommendations to legalise soliciting.[40]

No efforts have been made by the IDU groups to seek reforms of New Zealand's 'hard drug' laws (perhaps because their efforts would be doomed to failure), or to raise their political profile. Their political inactivity is historical, and probably stems from fear of police action if drug-related activities are made known. Organising by IDUs appears to exist only with respect to needle exchange and HIV/AIDS awareness programmes which have been sanctioned by government.[41] The failure of injecting drug users and sex-workers to make political gains contrasts sharply with the changes wrought by, or in favour of, the gay community.

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[40] According to a key informant who has requested anonymity, the National Government intended to decriminalise soliciting, but the issue was dropped after it became a 'hot potato' in the run-up to the 1993 election.

[41] One of the most prominent activists for needle exchange schemes was a Christchurch pharmacist, David Pollard, who set up his own scheme in 1986. He was prosecuted just before legislation was passed in 1987, but by then many Christchurch IDUs were exchanging needles through his pharmacy. (Lichtenstein, 'An Initial Investigation into the New Zealand Response to AIDS', 1992: p. 37)

*Maori Organising*

The history of Maori organising in New Zealand's HIV/AIDS epidemic is characterised by tensions between competing groups. The AIDS Foundation provided a support group for Maori clients once it became obvious that "while many Maori gay men are integrated into the gay community, there are many more whose identity as Maori is stronger than their identity as gay."[42] However, Maori organisers state that their efforts to get funding for HIV/AIDS awareness programmes among Maori preceded the AIDS Foundation initiatives. To one such organiser, the AIDS Foundation's 'fierce territoriality' helped ensure that the director of the Maori HIV/AIDS awareness group, Te Roopu Tautoko (TRT), was an AIDS Foundation appointee.[43] Perceptions of TRT being a 'gay organisation' dealing with a 'gay disease' have resulted in difficulties for Maori HIV/AIDS workers. For example, a prevention worker was confronted with opposition from some *kaumatua* who "didn't want faggots on *marae.*"[44]

Unlike countries such as the USA, the incidence of HIV/AIDS in New Zealand does not differ by ethnic group. As stated in Chapter 5, Maori represent about 10% of New Zealand's PWAs, almost equal to their overall proportions in the population.[45]

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[42] Lindberg, *Op. cit.*: p. 45

[43] Educator, Te Roopu Tautoko Ki Te Wai Pounamau (Christchurch), interview: 8/10/93.

[44] *Ibid. Kaumatua* = 'Maori elders' in English. *Marae* = traditional meeting place

[45] NCA Chair, *Op. cit:* 9/3/92 and *AIDS - New Zealand,* issue 9: May 1991.

The TRT's brief is primarily to undertake HIV prevention work among Maori, although support is also provided on a voluntary basis. Prevention work is carried out by educators who approach Maori on *marae* or through employment training schemes, and who work with other agencies such as Plunket, sexual health centres, the Family Planning Association and prisons. Nine regional offices of the TRT exist throughout New Zealand. Most TRT offices are located in the North Island where larger numbers of Maori live.

Prevention work is often carried out by volunteers. The workers who undertake fundraising as well as HIV/AIDS prevention and support are reported to suffer 'burn out' as a result of their work.[46] Funding difficulties have contributed to ongoing tensions between the TRT and the AIDS Foundation.[47] TRT continues to liaise with the NZAF, but resents attempts by the AIDS Foundation to "walk on our money" with respect to HIV/AIDS funding for Maori.[48] Likewise, TRT is accused of

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However, according to the coordinator of TRT Ki Te Wai Pounamau, young Maori men are said to be the 'fastest growing group with HIV/AIDS.' (see footnote 8, Chapter 5). The information was obtained from the last meeting of the National Council on AIDS, held in October 1993. (Informant, personal communication: 30/8/94)

[46] Both the TRT and AIDS Foundation report staff burnout. An AIDS Foundation informant stated that "People are sick of HIV. One guy said he wouldn't come to a meeting if AIDS was going to be discussed again." One TRT branch office was mostly unstaffed during 1994 (Informant, personal communication, 5/7/95).

[47] TRT educator, *Op. cit.*

[48] *Ibid.* For example, there is now a joint NZAF-TRT programme for young, gay, Maori PWAs in Auckland. Funding has been obtained from Lottery Youth and the Community Organisation Grants Scheme (COGS). (Informant, personal communication, 30/8/94).

'apathy' and 'inefficiency' by other community organisers.[49] Competition between the groups has been exacerbated by under-funding to local branches of the TRT, and by cut-backs in government allocations to the AIDS Foundation's HIV prevention programmes.[50]

*Community Funding*

ASOs have competed for government funding on a yearly basis since 1990. Although community responses have been characterised by a high degree of networking and cooperation, inter-agency competition is now a feature of the funding process. The government remains the largest funding provider, but charitable agencies such as the Community Organisations Grant Scheme (COGS) and the Lottery Board also fund community groups (see 'Health Reforms'). As mentioned, the AIDS Foundation receives most of the government's allocation for community AIDS funding. Table 3 outlines POBOC (Payment On Behalf Of Crown) allocations for each of the ASOs during the 1992/3 financial year. The percentages included in this Table reveal that the AIDS Foundation received 63% of the total funding allocation. By 1993, this percentage had decreased, marking a downward trend in government provision to the AIDS Foundation.[51] The 1992

[49] Informants, personal communication: 24/7/93 & 11/9/94

[50] Ministry of Health, memorandum dated 8/7/92: AIDS POBOC funding. Both groups requested increased funding for 1992/93, and both were declined. Other groups such as some IDU agencies, NPLWAU, NZPC and PIAT received increases for 1992/3. The AIDS Foundation received cut-backs to its HIV prevention programme in 1993 (Heeringa, *Op. cit.:* p. 85).

funding share for IDU groups equalled 11.2%, with 11.3% allocated to Maori. Apart from the NZPC's percentage (6.7%), other groups (NPLWAU, Haemophilia Society and PIAT) were given a much smaller share of the budget.

A demonstration of the quality of HIV/AIDS prevention and support programmes has been critical to funding success in recent years. As Altman points out (see Appendix I), the process involves a long slow march through endless grant applications. Community organisers state that funding applications take time away from outreach activities. Time devoted to funding submissions has increased since the implementation of health reforms in July 1993. While applications for POBOC funding are made on an annual basis, most agencies also apply for supplementary funding from charitable organisations.

Most funding for HIV/AIDS programmes is allocated to services in Auckland, which is the largest population centre, and where most PWAs live. Government funding for HIV/AIDS is usually sent to a group's central office, which divides the money on a regional or needs basis.[52] This funding practice has meant that some ASOs compete on an intra- as well as inter-agency basis. The AIDS Foundation, for example, has restructured to

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[51] Heeringa, *Op. cit.:* p. 82. Heeringa writes that POBOC funding to the NZAF was $1.9 million in 1992, and $1.5 million in 1993.

[52] This funding structure has altered since the 1993 health reforms. Changes are discussed under 'Health Reforms' in this Appendix.

Table 3 POBOC* FUNDING TO COMMUNITY AIDS ORGANISATIONS FOR 1992/3

| Agencies | Funding $ | % |
|---|---|---|
| New Zealand AIDS Foundation (NZAF) | 1,705,625 | 63 |
| Te Roopu Tautoko (TRT) | 308,000 | 11.3 |
| New Zealand Prostitutes' Collective (NZPC) | 180,554 | 6.7 |
| Pacific Islands AIDS Trust (PIAT) | 106,000 | 3.9 |
| Wellington Information Drug Education (WIDE) | 77, 810 | 2.9 |
| Auckland Drug Information Outreach (ADIO) | 72,000 | 2.7 |
| People Living With AIDS Union (NPLWAU) | 64,554 | 2.4 |
| Christchurch IV Drug Users Resource Group (CIVDURG) | 62,257 | 2.3 |
| IV Union | 46,200 | 1.7 |
| Dunedin Intravenous Organisation (DIVO) | 45,000 | 1.6 |
| New Zealand Haemophilia Society | 40,000 | 1.5 |
| Total: | 2,708,000 | 100 |

* Payment on behalf of the Crown (govt. funding)

Total payout for drug-related groups = $257,067

Total percentage for needle-exchanges = 11.2%

Source: POBOC, undated Department of Health memorandum

ensure that its Auckland office and Auckland-based programmes have a larger share of the funding dollar. For smaller branches of the AIDS Foundation, such as the Ettie Rout Clinic in Christchurch, restructuring has meant that HIV prevention programmes have withered through lack of funding.[53] Organisers from TRT Ki Te Wai Pounamau (Christchurch) report severe funding constraints imposed by their national body.[54]

*Agency Structure*

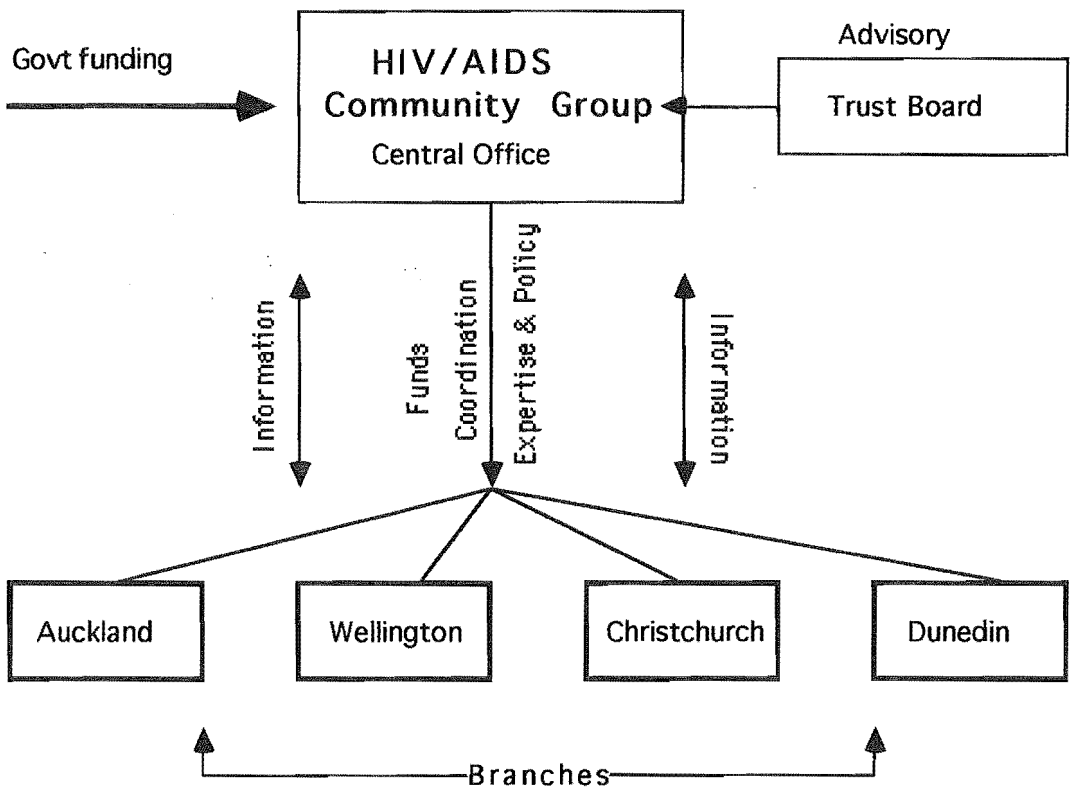
A diagram of a 'typical' ASO and its funding structure is presented in Figure 3. As the diagram suggests, most groups (with the exception of the needle exchanges) consist of a central body and a number of local or regional branches. The central body coordinates branch activities, liaises with other groups or individuals, arranges publicity, and writes reports or submissions to government. The central body is responsible for implementing policy decisions, and for the allocation of 'general' funds to branch agencies. Some agencies can also apply for separate funding from charitable organisations such as the Lottery Board or COGS.[55] For the most part, local branches focus on HIV

[53] Ettie Rout Clinic Manager: interview 15/11/93. The informant argues that the small percentage of PWAs in Christchurch can be attributed to the success of local HIV prevention programmes. Also: Gilling, in "Funding Crisis Puts AIDS Centre at Risk" in *The Press*, 12/12/94: p. 4 writes that "Christchurch's Ettie Rout Centre, which provides support and counselling to people with HIV and AIDS, is in danger of closing." The Ettie Rout Clinic moved to a less expensive location in 1995 (Informant, personal communication, 5/7/95).

[54] TRT Educator, *Op. cit.*

[55] Some funding arrangements have changed since the health reforms (see 'Health

FIGURE 3 STRUCTURE OF A 'TYPICAL' COMMUNITY HIV PREVENTION GROUP




(Branches can apply for additional funds from other sources)

prevention, support and allied services. Trust boards have been established to provide advice and to ensure accountability. Members of trust boards can be members of other organisations, or have expertise or interests relating to the group's activities.

*Community Responses: Summary*

Community responses to HIV/AIDS in New Zealand were initiated by members of the gay community in 1981. Other agencies staffed by sex-workers, Maori, IDUs, and PWA support groups were later formed with the help of government funding and expertise. Despite some tensions over funding and operational boundaries, community responses are characterised by a high degree of networking and cooperation. As a result of community involvement in HIV prevention programmes, individuals from 'risk groups' have gained a degree of legitimacy and visibility. Politically, the most successful agency is the AIDS Foundation, which is also the best funded. Funding allocations have also been received by the NZPC, IDU groups, and Maori and Pacific Island Trusts for HIV prevention work. The AIDS Foundation and gay community lobbied successfully for the now-legislated changes to homosexual law reform, needle exchange, and human rights legislation. To date, efforts by other groups such as the NZPC for legislative change to soliciting, massage parlour and brothel-keeping laws have not been successful. AIDS organising has become increasingly competitive as a result of government health

Reforms').

reforms. During the 1990s, there have been signs of a contraction in community responses to HIV/AIDS in New Zealand.

## Government Responses

Government responses to HIV/AIDS, although tentative at first, expanded in scope as the epidemic progressed. The next section of this appendix is dedicated to exploring the nature and scope of the New Zealand government's response to HIV/AIDS. Overseas influences, and government interaction with the community and medical sectors in New Zealand, are described and analysed. Diagrams are included to illustrate the links between overseas agencies such as the World Health Organisation (WHO) and government initiatives, and the various sectors involved in AIDS organising in New Zealand.

### *WHO's Influence: Policy*

Influential overseas agencies such as the World Health Organisation helped shape New Zealand's response to HIV/AIDS.[56] In 1986, the WHO held an International Conference on Health Promotion in Canada from which the 'The Ottawa Charter', a policy document for inter-sectoral responses to HIV/AIDS, was drawn.[57] The 'health equity/health promotion' recommendations

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[56] Sewell, "AIDS Research: Policy and the State", a paper presented at the 'Coping with AIDS - lifestyles and the Social Order' symposium, 1988: p. 43.

[57] Ottawa Charter for health promotion, 1986: p. 1 A copy of the charter was provided by Healthlink South.

made in the Ottawa Charter were adopted by the New Zealand's Department of Health, and provided a philosophical basis for service agencies dealing with HIV/AIDS.[58]

In 1989, an interim policy document on AIDS was produced by members of the National Council on AIDS (NCA), New Zealand's high-level, inter-sectoral AIDS committee. The NCA was committed to principles of the Ottawa Charter. As stated in the document:

> The philosophy of health promotion has also been adopted by most leading AIDS service providers and is affirmed by the Council [NCA] as the logical underpinning of a successful national strategy against HIV/AIDS in New Zealand.[59]

The NCA was disbanded in 1993 as a result of health restructuring. However, WHO's philosophy of health promotion had become the linchpin of health-sector praxis, and was ratified by the New Zealand government in The Health and Disability Services Act, 1993.

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[58] New Zealand's vigorous adoption of WHO recommendations for HIV prevention is linked to the fact that New Zealanders had been instrumental in writing the Ottawa Charter. Australians did not adopt the Charter with the same enthusiasm. (Informant, personal communication: 14/7/95)

[59] *The HIV/AIDS Epidemic: Towards a New Zealand Strategy,* 1989 and *The New Zealand Strategy on HIV/AIDS,* 1990: p. 1 Parenthesis has been added

*Early Measures*

By 1983, the New Zealand government had taken steps to investigate the incidence of AIDS. In that year, AIDS was made a notifiable disease ahead of a similar statutory requirement in Australia.[60] An AIDS Taskforce, modelled on the Australian counterpart, was formed in the same year. The taskforce, comprising "STD specialists and representatives from the Department of Health and the gay community, was set up to advise government on measures to control the epidemic."[61] At this stage, government funding to community groups was paltry; $8,600 had been allocated to AIDS activists for HIV prevention and support services by May 1985.[62] This phase of the New Zealand government's response to HIV/AIDS has parallels to Britain's period of 'dawning awareness' as described by Weeks (see Appendix 1).[63] Government measures during the early years of the epidemic in New Zealand involved information-gathering and investigation, rather than HIV prevention for its own sake. Plumridge and Chetwynd (forthcoming), believe that the government's attitude was marked by 'indifference'.[64]

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[60] Crofts et al, Involving the Communities: AIDS in Australia and New Zealand, *AIDS in Asia and the Pacific,* 1994: p. 45

[61] *Ibid.*: p. 50

[62] Parkinson & Hughes, "The Gay Community and the Response to AIDS in New Zealand. *New Zealand Medical Journal,* 1987: p. 78

[63] a) Weeks, *Sex Politics and Society,* 1989: 301 b) Berridge and Strong, "AIDS Policies in the United Kingdom", *AIDS: The Making of a Chronic Disease,* 1993: p.312

[64] Plumridge & Chetwynd, "The Rise and Fall of HIV/AIDS as a Public Health Issue: A Case Study", *Health Care Analysis* (in press), 1994: abstract.

By 1989, four million dollars was given annually to HIV/AIDS programmes in New Zealand. A total of 1.4 million dollars was allocated to the AIDS Foundation,[65] with lesser amounts distributed to other community groups. To complement this 'proactive' funding approach to HIV prevention, laws inhibiting 'risk group' participation in AIDS organising were changed. Community programmes could now be incorporated into the HIV prevention process as recommended by the WHO and members of the AIDS Taskforce.[66]

Large-scale media campaigns remained the prerogative of government. Annual HIV/AIDS awareness campaigns ran from 1985 to 1989, and health promotions in the form of pamphlets and posters about HIV prevention began to appear in medical surgeries and other health-sector outlets.[67] Discourse framing the gay man as 'victim' also began to emerge in New Zealand. Its existence is testimony to gay activism, the lack of moral conservatism, to a broadly sympathetic media, and to an egalitarian health tradition.

*Crisis Measures*

The government's role in the HIV/AIDS epidemic became one of crisis management once "its advisory Task Force recognized that effective control of the epidemic would depend on community cooperation and involvement."[68] In 1985, the government's

[65] *Ibid.:* p.79 AIDS Foundation records show that a sum of $1,581,224 had been allocated to the organisation for 1990.

[66] However, gay men were the main beneficiaries of the reforms. The legal status of sex-workers and injecting drug users remains ambiguous in New Zealand.

[67] Crofts et al, *Op. cit.:* p. 50

response began with broad-based funding allocations aimed at protecting the heterosexual population from HIV/AIDS,[69] and the gay community's requests for *targeted* funding were largely ignored.

Crofts *et al* outline the government's 'crisis' measures, stating that "the government's first AIDS budget in 1985 allocated funds for the screening of blood, free HIV antibody testing, the establishment of a new AIDS Advisory Committee, and a mass media campaign."[70] The response did not please the gay activists who had lobbied for community-based, targeted HIV/AIDS funding. Parkinson writes that:

> When the package was announced by the minister of health, most of it was for ELISA kits to test the blood supply. Less than half a million dollars was allocated to education and prevention work. The minister was careful, at that point, to avoid any public expression of support for the so-called risk groups. This was to change when he became fully aware of the solid contribution the gay community was making.[71]

### *The 'Crisis' Partnership*

A partnership between the government and the medical and community health sectors evolved after Labour came to power in

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[68] *Ibid.*

[69] Sewell, *Op. cit.*

[70] Crofts et al, *Op. cit.*

[71] Parkinson & Hughes, *Op. cit.*: p. 78

1984. While an informal partnership had operated between government, the medical profession and some members of the gay community during the early years of the epidemic, it developed into a three-way response between government, the medical profession and ASOs after 1985.[72] WHO provided the framework for an AIDS partnership, which was to be based on social rather than medical interventions.[73] Du Chateau writes that

> the New Zealand Health Department had been drawn into the global AIDS strategy controlled by WHO, and had put together the AIDS Taskforce based in Wellington. This metamorphasised into first the AIDS Advisory Committee and then into the present National Council on AIDS - moving all the time from a medical/scientific to a sociological (sic) stance.[74]

Most members of the AIDS Advisory Committee (AAC) had been drawn from the medical profession. The AAC's replacement with a much larger and occupationally diverse committee in 1988 (the National Council on AIDS) illustrates how WHO recommendations for equity and community participation shaped New Zealand's AIDS partnership.[75] Figure 4 depicts the establishment,

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[72] *Ibid.*

[73] According to the NCA's chair, "WHO tried to impose ideas on New Zealand about the way to approach HIV/AIDS organisationally because it has a global view." (Interview: 26/11/93)

[74] Du Chateau, *Op. cit.*: p. 78

[75] The NCA's twenty-three member committee included a sociologist (the chair), representatives from pharmacy, education, law, medicine, the Anglican church, nursing, the media, the Department of Health, psychology, the Maori and Pacific Island communities, and individuals from the 'risk groups' such as sex-workers, gay men, injecting drug users and PWAs.

structure and purpose of government AIDS committees.

*A 'Crisis' Committee: The Rise and Fall of the NCA*

Committees established by government during the crisis period were inter-sectoral, multi-disciplinary and collaborative. They facilitated a flow of information and expertise between members of disparate groups, and between the committees and other government bodies. Committee members acted as advisors to health-sector agencies or government, which in turn, implemented HIV/AIDS policy on a local, regional or national basis.

The National Council on AIDS (NCA) was established in 1988 to advise the Minister of Health on matters relating to HIV and AIDS.[76] With twenty-three members from a cross-section of New Zealand's society, it was reputedly "one of the biggest AIDS committees in the world."[77] The committee was chaired by a sociologist, ostensibly to ensure political independence from the government and medical sectors, and from pressure groups.[78] According to the NCA's chairwoman, the committee's size and diversity made it "difficult to forge a path between opposing groups."[79]

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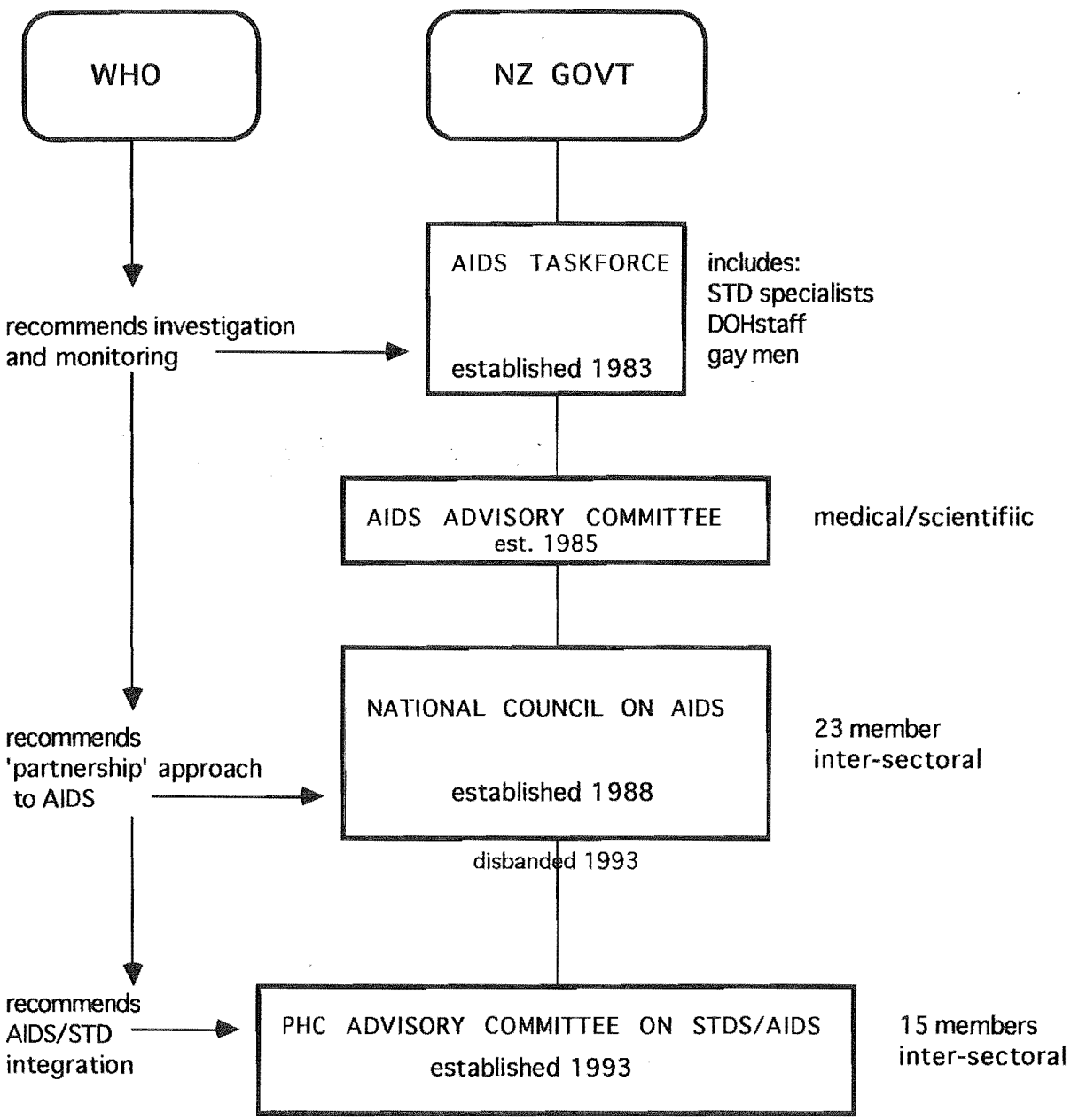
[76] NCA, *Op. cit.:* (1989): 1.

[77] NCA Chair, interview: 9/3/92

[78] *Ibid.*

[79] *Ibid.*

FIGURE 4 WHO POLICY AND THE CREATION OF ADVISORY COMMITTEES ON HIV/AIDS IN NEW ZEALAND



In 1990, the NCA produced a comprehensive three to five year national strategy titled 'The New Zealand Strategy on HIV/AIDS'.[80] While the document was not ratified by the incoming National government, its protocols were adopted by some health-sector agencies and employers. The NCA's role included acting as media watchdog and as advocate for AIDS-related law reform.[81]

The NCA was disbanded in 1993. According to one member "there was the feeling that the NCA had been given too hard a job to do in order to be successful."[82] Its role as autonomous critic, watch-dog and advisor on HIV/AIDS policy was terminated by government officials, some of whom believed that the NCA had become 'unwieldy' and 'a law unto itself.'[83] For visionaries such as AAC's chairman, Dr Richard Meech, the committee had been a means of securing community participation in HIV prevention programmes. For gay activists, the committee had been government's strategy for containing protest.[84] The demise of the NCA has been attributed variously to its nature, size, success, and redundancy in an era of health restructuring. NCA's chair

[80] *Ibid.*

[81] NCA minutes, 1988-1993

[82] *Ibid.*

[83] Public Health Commission (PHC) informant, personal communication: 29/11/93 Ironically, the PHC was also considered 'a law unto itself'. As a result, many PHC functions were absorbed into the Ministry of Health from 1/7/95 (Informants, personal communication: 30/6/95 & 5/7/95).

[84] NCA member, *Op. cit.* The informant believes that community participation in the NCA was government's way of 'shutting us up'. However, some government officials saw the committee as a forum for protest, and moved to disband it.

suggested that the committee's disbanding was just 'part of the national to regional shift that came with the health reforms'.[85]

*The Partnership at Work*

The 'partnership' plan, capped by the formation of the multi-sectoral NCA, was fully implemented within a four year time period. The NCA's former Chair commented that "one reason that political processes can be very quick is because New Zealand is a small country - officials all know one another, and/or can be easily accessed."[86] Despite the plan's apparent speed and efficacy, Crofts *et al* noted that the "partnership has been pragmatic and ad hoc rather than the outcome of a national strategy."[87] Their statement is supported by government's failure to formally accept or ratify the NCA's national strategy on HIV/AIDS.[88]

Figure 5 depicts the HIV/AIDS partnership, illustrating the links between government, community HIV/AIDS agencies, medical organisations and overseas agencies such as WHO and the Australian Intergovernmental Committee on AIDS (IGCA) during the crisis period.[89] Links with Australia have provided both

[85] NCA Chair, interview 26/11/93.

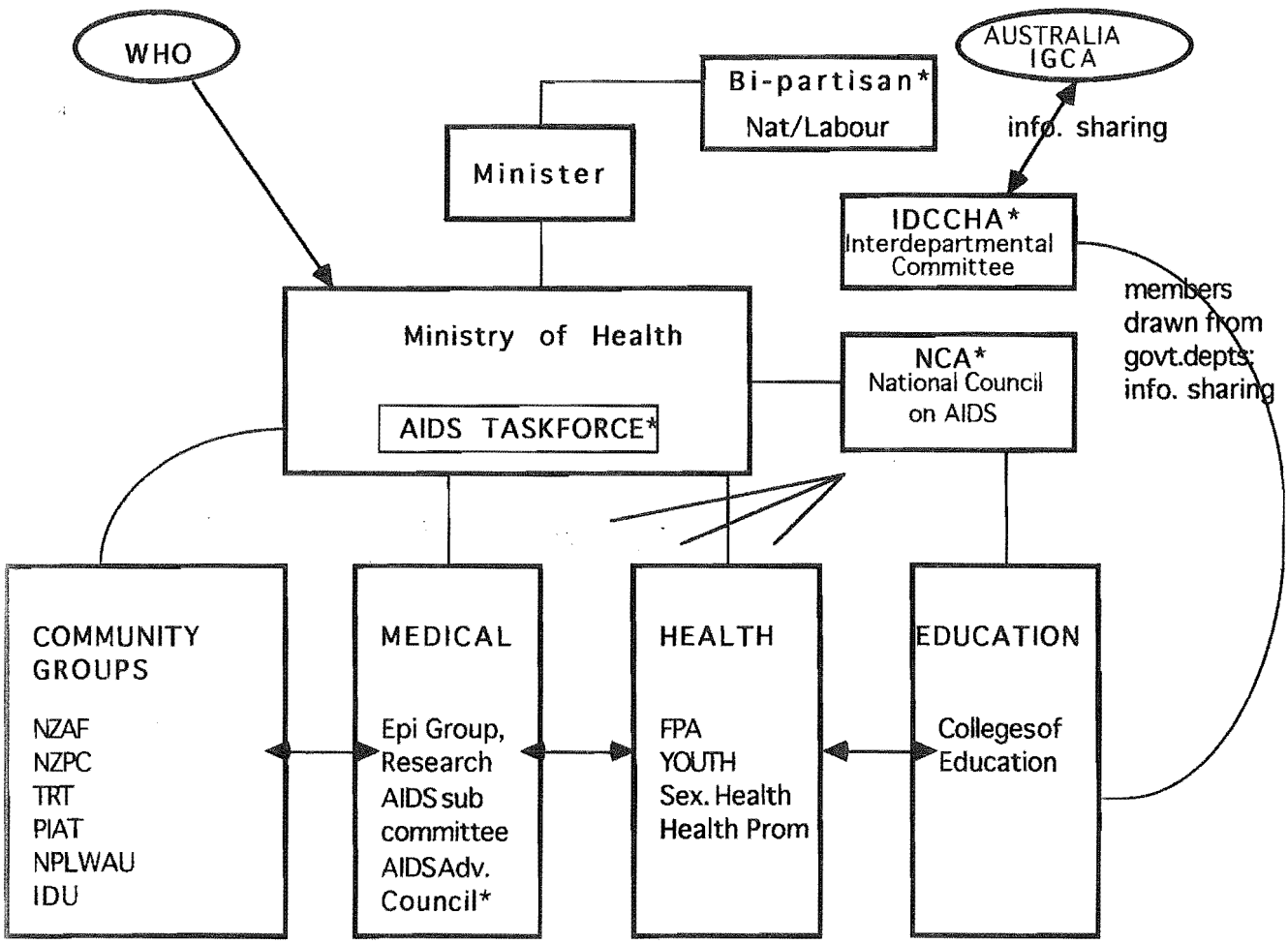
[86] NCA Chair, *Ibid.*

[87] Crofts et al, *Op. cit.*: p. 51

[88] *Ibid.*

[89] Australia provided a model for organisational responses to HIV/AIDS through the Intergovernmental Committee on AIDS (IGCA). New Zealand was an affiliate member

FIGURE 5 NEW ZEALAND'S HIV/AIDS PARTNERSHIP 1985-89




* disbanded or inactivated since 1990

n inclusive approach to HIV/AIDS organising in New Zealand during the crisis period

formal sector and community agencies with a practical framework for AIDS organising. The partnership survives in contracted form. Bi-partisan and inter-departmental committees, the NCA, and the AIDS Taskforce have been either inactivated or disbanded.

*The Partnership in Decline*

Crisis plans began to falter in 1990. Evidence of this change is that advisory committee recommendations to government increasingly fell on deaf ears. To some, it seemed that government officials were more concerned about reform than the HIV/AIDS epidemic. Staff changes in the government health sector resulted in frustration for AIDS activists and policy-makers alike. According to one member of the NCA, "the Department of Health was changing all around us - three or four generations of new people had to be educated about HIV/AIDS."[90] By 1991, questions were being raised about government's role in HIV prevention, and about the continued existence of ASOs in view of a WHO recommendation for HIV/STD integration.[91] The AIDS Taskforce, disbanded in the following year, "was the beginning of the end."[92] Committees such as the NCA, the bi-partisan committee and the IDCCHA were either disbanded or inactivated.

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of the IGCA. ("Summary of the Current HIV/AIDS Strategy in New Zealand as of August 1992" AIDS Epidemiology Group).

[90] NCA member, interview: 17/11/93

[91] NCA minutes, 25/6/91: p. 9

[92] NCA member, *Op. cit.*

Reasons given for their dis-establishment include government complacency about the HIV/AIDS epidemic,[93] and a belief that 'fat' should be trimmed in the health sector.[94] Devolution of health-related activities to regional centres is cited as a contributing factor.[95]

*Government Responses: Summary*

A summary of the government's role in the HIV/AIDS epidemic in New Zealand is provided in Table 4 overleaf. Initiatives are framed in three stages which are titled: a) 'investigation' (1981-1984), b) 'crisis intervention' (1985-1989), and c) 'contraction' (1990-1994). Stages one and two are discussed in this sub-section. Stage three is included for purposes of display, but is analysed under 'Health Reforms'.

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[93] Crofts et al, *Op. cit.*

[94] NCA chair, interview: 26/11/93

[95] *Ibid.*

TABLE 4 GOVERNMENT RESPONSES TO HIV/AIDS IN NEW ZEALAND[96]

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Stage one: 1981-1984 'Investigation'

| Year | Initiative | Community Response |
|---|---|---|
| 1983 | AIDS Task force established: advisory<br>AIDS made a notifiable disease | lobbying by<br>gay community |
| 1984* | $8,600 HIV/AIDS funding allocation to gay community. | |

Stage two: 1985-1989 'Crisis Intervention'

| | | |
|---|---|---|
| 1985 | $100,000 grant to establish the NZ AIDS Foundation<br>First public media campaign on HIV/AIDS<br>Elisa HIV/AIDS blood test kits purchased<br>AIDS Advisory Committee (AAC) established<br>Interdepartmental HIV/AIDS Coord. Committee (IDCCHA) formed<br>Free HIV testing<br>Blood supply screened<br>Bi-partisan AIDS committee formed (approx. date only) | |
| 1986 | Second public media campaign on HIV/AIDS<br>Homosexual Law Reform bill passed | |
| 1987 | Third public media campaign on HIV/AIDS<br>Funding for Prostitutes' Collective<br>Needle exchange amendment passed<br>First national conference on HIV/AIDS | |
| 1988 | Fourth public media campaign on HIV/AIDS | Community responses |

[96] This list is compiled from information available at time of writing and is not be exhaustive. Also: see 'Methodological Appendix' for a discussion of the difficulties in obtaining information about community, medical and government health sector responses to HIV/AIDS for this Appendix.

| | | |
|---|---|---|
| | Funding for TRT (Maori) | expand |
| | National Council on AIDS (NCA) formed: advisory | |
| | Second national conference on HIV/AIDS | |
| 1989 | Fifth public media campaign on HIV/AIDS | |
| | AIDS Epidemiology Group established: surveillance and monitoring | |
| | Funding for Pacific Island AIDS Trust (PIAT) | |
| | Funding for Christchurch Intravenous Drug Users Resource Group (CIVDURG) and other IDU groups in Auckland, Wellington & Dunedin | |
| | Third national conference on HIV/AIDS | |
| | DOH conducts youth survey | |
| | Increased funding to STD clinics | |

Stage three 1990-1994 'Contraction'

| | | |
|---|---|---|
| 1990** | Amendment permitting sex education for children <16 passed | |
| | Fourth and last national conference on HIV/AIDS | |
| | NCA's national HIV/AIDS strategy produced but not formally adopted | |
| | AIDS budget put 'on hold' | |
| | Interdepartmental Committee on AIDS (IDCCHA) in recess | |
| | Media campaigns lapse | |
| | Bi-partisan committee on AIDS inactivated | |
| 1991 | Condom promotion campaign abandoned | Community responses |
| | NCA limited to bi-annual meetings | stagnate |
| | AIDS Taskforce disbanded | |
| | IDCCHA reconvenes (renamed?) | |
| | Funding for 'youth initiative' to FPA and Colleges of Education | |
| | Funding to people living with AIDS union (NPLWAU) | |
| 1992 | Legislation on soliciting and brothel-keeping placed on back-burner | |
| | NCA's medium-term plan produced but not formally adopted | |
| | IDCCHA disbanded | |
| | NZAF prevention funds cut | |

| | |
|---|---|
| 1993 *** | NCA disbanded<br>Human Rights bill passed |
| 1994 | PHC's advisory committee on STDs and HIV/AIDS (SHAC) established<br>Ettie Rout Clinic faces closure<br>Management crisis at CIVDURG: renamed Roger Wright Centre<br>Funding emphasis changes: PHC funds national projects and 'health promotion' activities; RHAs fund medical/hospital/support services<br>Disestablishment of PHC announced (Dec.)<br>No PHC funding allocated to women's HIV+ groups for 1995 |

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* Labour government elected July 1984
** National government elected November 1990.
*** National's health reforms effective from 1/7/93

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Stage one of New Zealand's response to HIV/AIDS was characterised by active but relatively unsuccessful lobbying for targeted funding by members of the gay community, and by tentative government measures to identify the extent of the epidemic. Stage two was marked by multiple, government-funded interventions which arose from panic about an imminent 'heterosexual' epidemic. Stage three suggests complacency about the likelihood of a 'heterosexual' epidemic, a contraction in government initiatives, and a change in focus as HIV prevention is integrated with sexual health services.

New Zealand's three-stage response to AIDS is similar to

that of Britain as described in Appendix I, but was not presided over by a single-minded leader. Instead, the approach has been underwritten by successive National and Labour governments whose philosophies differ on a number of issues such as health, welfare and the role of government. Traditionally, the Labour party's social-welfare approach is offset by National's focus on small government and 'fiscal responsibility.' Distinctions between the two philosophies blurred during the 1980s as both Labour and National governments brought in sweeping political reforms to the public and private sectors. Nevertheless, their disparate ideologies helped to 'stage' the response during the HIV/AIDS epidemic. As Table 4 suggests, responses to AIDS by the National government during stages I and III have been marked by fiscal constraint and a more pragmatic approach to disease control, while those enacted during Labour's term of office in stage II were accompanied by increased funding, agency building, and anti-discrimination legislation.

Despite the differences in party politics, HIV/AIDS initiatives in New Zealand have been coherent compared to countries such as the USA. Responses to AIDS in New Zealand have been facilitated by historical factors such as community activism, political tolerance, and organisational informality. Moral extremism, such as that experienced in the USA, has been relatively absent. New Zealand's moral protagonists traditionally lack the political influence of their overseas counterparts, and

have failed to undermine local efforts to deal with HIV/AIDS.[97] Legislative reform during the HIV/AIDS epidemic has been facilitated by the simplicity of New Zealand's single-house parliamentary system. The broader response to HIV/AIDS is said to have been engendered by "collective action between groups [which] is a feature of social life in New Zealand."[98] Far-reaching reforms to the health structure "have created considerable uncertainty about the future of HIV/AIDS programmes and partnerships."[99]

## The Health Reforms

The National Government, determined to rewrite the social contract in favour of 'self-help', 'privatisation' and 'fiscal responsibility' after it came to power in 1990, began to review the previous government's AIDS programmes. A few weeks after the November 1990 election, the NCA was advised that "there was a strong possibility that it [the AIDS budget] will be cut back" and that "such cuts will be right across the AIDS budget and may affect contracts."[100]

The budgetary cutbacks that followed proved more attritional than catastrophic. While large-scale media campaigns

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[97] Moral extremists do exist in New Zealand. Some are politicians and journalists, who have "bristled at the sight of tax-funded posters of naked [gay] musclemen." (Heeringa, *Op. cit.:* p. 83). Parenthesis has been added

[98] NCA Chair, interview: 20/8/92 Parenthesis has been added.

[99] Crofts et al, *Op. cit.*

[100] NCA minutes, 15/11/90: p. 4 Parenthesis has been added

ceased after 1989 and the crisis infrastructure contracted, funding allocations for targeted (community) programmes remained, with some variability, at pre-election levels.[101] However, the bifurcated response of the crisis period was not entirely eroded: formal sector programmes for 'youth' were funded after 1990.[102] The axing of large-scale HIV/AIDS programmes was partly the outcome of National's drive for fiscal constraint.

Structural changes to New Zealand's health system began in July 1993 when the health system devolved to four regional health authorities (RHAs) whose role is to 'purchase' services from hospitals and other 'providers' in their locality.[103] Prior to this national-regional devolution, the Department of Health allocated funds to Area Health Boards in a top down, government-to-service provision.[104] The changeover to a multi-layered, competitive system not only overturned a centralised, non-

[101] Some funding losses and gains were experienced during this time. While cuts were made to the AIDS Foundation's HIV prevention budget, some of the IDU groups such as CIVDURG and WIDE, and the NZPC received increased funding (POBOC, undated). For the time being, the new government's funding strategy is one of redistribution rather than cost reduction.

[102] Funding allocations to formal agencies such as the Family Planning Association and Colleges of Education for HIV/AIDS prevention among youth were increased from fiscal years 1991/2 and 1992/3 (POBOC, undated), signalling a shift away from community to formal-sector prevention programmes.

[103] Fougere, 'The State and Health-Care Reform' in *A Leap into the Dark: The Changing Role of the State in New Zealand since 1984*, 1994: p. 112

[104] The new system, like the old, is 'topdown'. In some ways, it is even more centralised, with the budget for primary health care now capped together with the hospital services budget etc. (Geoff Fougere: personal communication, 14/8/95).

competitive health sector, but suspended, dismantled or reworked familiar HIV/AIDS procedures, units and protocols.[105]

Government's rationale for the business-oriented reforms is to create quasi-markets in which regional service providers compete against one another for funds. This process was intended to force providers to be more efficient, or to go out of business.[106] So far, the main effect of the reforms among service agencies is a jostling for funding 'contracts' from a variety of agencies (PHC, RHAs, and charitable organisations), and for specified services. One community organiser reports that he was obliged to compete with ten other agencies for RHA contracts, even though the staff of some ASOs were inaccessible to their clients.[107]

The Public Health Commission (PHC), the 'big projects' purchasing and advisory body established during the health reforms, allocated money to ASOs.[108] In effect, the PHC operated as the New Zealand government's national funding body for only two years after July 1993.[109] During 1994, this agency created a

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[105] Critics say that the new system is hardly market driven, but does have - at the edges - room for competitive supply of services. Note: There may be a large gap between the designers' (multiple) *intentions* for the new system, and its actual *outcomes* (*Ibid.*).

[106] Fougere, *Op.cit.*: p. 113 Not everyone agrees with this philosophy. Critics believe that costs and waiting lists will increase, and that the poor will be ill-served by a market-driven system.

[107] Interview with AIDS Foundation informant, 15/11/93.

[108] In this system, the RHAs act as regional purchasing agents for the national purchaser (PHC).

[109] The PHC was disestablished 30/6/95 (PHC Informant, 6/7/95)

special 'general population' HIV/AIDS fund at the expense of the 'targeted funding' (community group) allocation.[110] The move demonstrated the government's commitment to AIDS/STD integration according to WHO policy recommendations, or to its own prerogatives for better cost-benefit ratios.

Prior to reform, the Department of Health provided a locus for advice, administration, and implementation of health policy. Crofts *et al* state that the 1993 reforms resulted in "the decentralization of health service purchasing without a nationally coordinated strategy, and with only short-term funding."[111] A cut in hospital services in some rural areas has occurred. In some cases, health hazards have resulted from procedural confusion. One needle-exchange worker reports that "used needles and syringes are kept on the premises because under the new system there's no disposal policy. Important issues are being overlooked in favour of the reform minutiae." [112]

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[110] Heeringa, *Op. cit.:* p. 85 The government's action signals a further funding redistribution, away from 'specialist groups' such as the AIDS Foundation, to formal-sector groups such as Sexual Health and the FPA. Government funding for the AIDS Foundation's prevention programmes has been reduced from $750,000 in 1992 to $250,000 for 1995. Gay activists are reported to be "furious with the Public Health Commission's suggestion that money specifically aimed at men who have sex with men be slashed by more than 50% of last year's figure." (Wharemate-Sadler, "Funding Attack Planned" in *Man to Man,* 18/8/94: pp. 1&4)

[111] Crofts et al, *Op. cit.* However, the PHC funded national 'big projects'. Whether national funding will continue given the PHC's dis-establishment is unclear.

[112] CIVDURG Manager, Interview: 8/12/93

## Medical Responses

Medical responses to HIV/AIDS in New Zealand focus on medical-sector strategies that intersect with those of government. Socio-behavioural research and epidemiologic enquiry are linchpins of the medical profession's approach to HIV/AIDS.

Medical responses to HIV/AIDS in New Zealand have centred on advisory committee participation, monitoring, research and treatment. In the early years of the epidemic, health professionals helped form a partnership with government to investigate the incidence of HIV/AIDS. During the 'crisis' period, the relationship expanded to include other professionals and members of HIV/AIDS prevention groups as joint advisors on HIV/AIDS. Research activities during the crisis period centred on socio-behavioural investigation into sexual attitudes and practices of the local populace.

Bio-medical research on HIV/AIDS has not been actively pursued in New Zealand because "research budgets for AIDS are very limited compared to those of countries like the USA and France where most of the bio-medical and pharmaceutical research on AIDS is carried out."[113] The pragmatic decision to fund socio-behavioural research on HIV/AIDS was made in the knowledge that, for the time being, social-behavioural interventions are the sole means of HIV prevention.[114]

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[113] Chair, HRC Sub-Committee on AIDS Research, interview: 2/4/92

The medical/government partnership that evolved early in the epidemic was facilitated by "accessibility and informality which are the benchmarks of the political process in New Zealand."[115] Dr Richard Meech, Chair of the AIDS Advisory Committee (AAC) "was able to persuade the government that the committee's medical/scientific orientation was too narrow for a social-behavioural epidemic."[116] His influence, together with WHO policy recommendations, resulted in the AAC being disbanded in favour of the NCA. When the socially-diverse NCA was disbanded in 1993, its medically-oriented sub-committee on AIDS was retained.[117]

The Health Research Council (HRC), an umbrella organisation for the medical research community, formed a sub-committee on AIDS research in 1987. The committee's membership is made up of social scientists, medical professionals, health researchers and practitioners.[118] Committee recommendations resulted in the establishment of an AIDS Epidemiology Group in 1989. The Group's brief was to provide accurate, up-to-date information about HIV/AIDS in New Zealand.[119] The step to establish a

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[114] Lichtenstein, *Op. cit.*: p. 63

[115] *Ibid.*: p. 64

[116] NCA Chair, interview: 28/9/92

[117] PHC informant, telephone interview: 21/9/94

[118] Committee creation is typical of organisational activities in New Zealand, and reflects a 'public service' ethos.

[119] The AIDS Epidemiology Group was established at the suggestion of Dr Richard Meech, convenor of the Aids Advisory Committee.

discrete HIV/AIDS surveillance unit was taken to counter the sometimes unreliable and piecemeal AIDS data produced by government agencies.[120]

The AIDS Epidemiology Group's primary function is HIV and AIDS surveillance and monitoring as modelled on the CDC (Centers for Disease Control, USA) prototype. The Dunedin unit produces quarterly HIV/AIDS statistics, and an AIDS information update compiled from data supplied by doctors, ASOs, overseas agencies and researchers, and laboratories. Although the new unit "needed to be independent of government, and clearly seen to be so, to avoid identification with one of the major reference laboratories or with any particular clinical service"[121], it is jointly funded by HRC and government.[122]

The AIDS Epidemiology group has survived the health reforms. It was retained by the PHC on the basis of its 'usefulness'.[123] Its creator, the HRC Committee on AIDS, has also been retained by the Health Research Council.[124] The retention of medically-orientated committees and units by government and health-sector bodies during a period of contracted responses to HIV/AIDS is indicative of the trend toward integration.

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[120] Member of the Committee on AIDS Research, personal communication: 22/9/94

[121] "AIDS Epidemiology Group: Background", Appendix A, AIDS Epidemiology Group, undated: p. 1

[122] AIDS Epidemiologist, interview: 20/5/93

[123] PHC informant, personal communication: 29/11/93

[124] Committee on AIDS Research Chair, personal communication: 28/9/94

Venereologists have been involved in New Zealand's HIV/AIDS epidemic as 'service providers' for prevention and treatment of STD and HIV. However, the role of venereology in New Zealand's HIV/AIDS has long been disputed by AIDS activists (see Chapter 5). Members of the gay community in New Zealand continue to actively resist attempts by medical professionals to incorporate HIV/AIDS programmes into the public health sector. Parkinson, in focusing on the dynamics of power in the AIDS service sector, writes that "the sources make it clear that the STD service's current push for integration of AIDS and STD services is a further attempt to establish a control which was deliberately denied to venereologists, for reasons which are as valid today as they were five years ago."[125] The reasons alluded to by Parkinson include the venereologists' preference for a 'medical' rather than a 'holistic' approach to HIV/AIDS clinical and prevention services, and their poor relations with gay men.[126] Friction between gay men and some venereologists over control of HIV/AIDS programmes has, to some extent, undermined New Zealand's collaborative response to HIV/AIDS. At one time, this friction was prompted by Dr Janet Say's publicly-stated views about homosexuality in publications such as *Challenge Weekly*.[127] Such inter-sectoral dissension highlights a case of 'moralists' versus 'gay activists' in New Zealand's organisational

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[125] Parkinson, 'Unclean Hands at the Coalface: The Venereology Society, The Integration of STDS and HIV/AIDS, and Conflict over Resources': unpublished paper, 1991: p. 1

[126] *Ibid.*: p. 8.

[127] *Challenge Weekly* is self described as "New Zealand's National Christian Newspaper".

response to HIV/AIDS. Perhaps as a result of gay critique and of the venereologists' desire for integration, funding and status,[128] sexual health services are now more client-oriented and 'holistic' in their approach to HIV/AIDS service delivery.[129]

*Medical Responses: Summary*

Medical responses to HIV/AIDS have been characterised by involvement at a committee, research, monitoring and treatment level. Medical professionals have ratified the 'partnership' approach to HIV/AIDS by working with non-traditional groups on advisory committees and in collaborative research. Research emphasis has been on socio-behavioural rather than bio-medical investigation. The two main HIV/AIDS research centres are in Christchurch and Dunedin, while the major treatment centres are in Auckland and Wellington. Early efforts by medical researchers to gauge HIV/AIDS 'risk' focused on knowledge, attitudes and sexual practices in relation to HIV/AIDS, while later efforts have assumed a 'predictive' role. In the treatment sector, the HIV prevention role is increasingly sought and gained by

[128] Lack of status has been a 'huge issue' for STD workers who "are often as stigmatised as their clients." (Sexual Health Centre informant, interview: 13/10/93)

[129] The Christchurch Sexual Health Centre now aims to be 'non-threatening' and 'holistic' in line with Ottawa Charter recommendations (interview with Sexual Health Centre informant: 13/10/93) Ironically, the AIDS Foundation's Ettie Rout Clinic in Christchurch has moved into premises occupied by Sexual Health. The reason given for this move is 'lack of funds' rather than 'integration'. However, a new director has been appointed at the Centre who is highly regarded among community groups, and better relations may be the result.

venereologists whose challenge to community-based services is indicative of the integration of HIV/AIDS programmes in New Zealand.

## Conclusion

HIV prevention strategies in New Zealand have been formulated at a community, medical and government level. Community activists were first to stage a response to the epidemic by way of political activism, HIV prevention and AIDS support services. Government measures in New Zealand correspond to Britain's three-phase response to HIV/AIDS. The period from 1981 to 1984 is marked by official indifference to the plight of gay men. Crisis intervention began in 1985, mainly due to fears about the spread of HIV into the heterosexual population. During this period, the New Zealand government funded a number of community HIV prevention groups, created the support infrastructure to facilitate and monitor HIV prevention programmes, and coordinated the response at a national level. In 1993, a contracted response ensued under the rubric of health reform. The policy of crisis intervention which had been facilitated by an 'expansionist' Labour government has withered under National's desire for 'smaller government'. The shift from a proactive to reactive government response was underscored by a belief that HIV/AIDS in New Zealand had become a manageable epidemic.[130]

[130] NCA Chair, *Op. cit.* , and Ettie Rout Clinic manager, interview: 29/11/93. AIDS notifications in New Zealand have levelled off from a high of 78 in 1991 to 44 in 1994. (*AIDS - New Zealand:* Issue 24, February, 1994).

During 1993, moves were under way to integrate HIV/AIDS with STD programmes and services, in line with the World Health Organisation's global strategy on HIV/AIDS.

The decline in AIDS notifications in New Zealand may be attributable to a variety of medical and non-medical factors. These factors include vigorous responses to HIV/AIDS by the gay community, government measures to protect the blood supply, establishment of legal needle exchange schemes on a national basis, safer sex practices among New Zealand's sex-workers, the instigation of broad-based public health campaigns for heterosexuals, and improvements in medical treatment of AIDS-related conditions. Organisational responses to HIV/AIDS in New Zealand mirror those of Australia and Britain where the epidemic affects mainly gay men, and where its later onset allowed government and informal-sector agencies time to formulate timely HIV prevention strategies.

New Zealand's organisational responses to HIV/AIDS have mostly been characterised by inter-sectoral collaboration. Cooperative efforts have been facilitated by political informality, egalitarian principles, and by the relative absence of political and moral extremism. Cultural homogeneity, and New Zealand's small population and geographical area have contributed to the coherence of HIV prevention measures. This response, modelled on an AIDS 'partnership' between the government, medical and community sectors has resulted in legitimation for

members of stigmatised groups, access to new avenues for socio-behavioural research, and comprehensive HIV/AIDS prevention strategies and programmes during the crisis period and beyond.

New Zealand's history of social progressivism is evident in the reform of HIV-related laws. Syringe and needle exchange, legalised 'homosexuality', and the allocation of government funding to members of stigmatised groups are outcomes of recent amendments. No laws have been passed for the quarantine of PWAs, or for the testing of individuals suspected of being HIV+. Legislation which prohibits government funding of needle exchanges, such as that in the USA, is also absent. However, laws controlling women's sexuality have yet to be repealed. This legislation, which makes 'brothel keeping' and 'soliciting' illegal in New Zealand, is the heritage of government responses to the earlier syphilis epidemic. The absence of proscriptive legislation and health measures in the AIDS epidemic in New Zealand is indicative of a continued shift from the 'coercive methodology' of former epidemics (syphilis and polio) to a continuance of 'suggestive techniques' for HIV/AIDS prevention that had begun during the poliomyelitis epidemics.

Influential actors in the community, medical and government sectors have initiated HIV prevention programmes in the gay community, created avenues for socio-behavioural and epidemiologic research in the medical sector, and influenced

government policy during periods of crisis intervention and integration with STD services. Responses have also been influenced by overseas trends, panic levels, political changes and by pre-existing institutional praxis. Early in the epidemic, members of the gay community adopted the HIV prevention and support strategies of AIDS-affected communities in the USA. Government initiatives have been shaped by Australian and British policies, which in turn have been shaped by WHO recommendations. This overseas advice helped stage New Zealand's approach to HIV prevention along the lines of 'investigation' (1981-4), 'crisis intervention' (1985-89) and 'contraction'/integration with STD services (1990-). Britain and Australia have provided New Zealand's health sector with organisational models for crisis intervention.

A summary of factors affecting New Zealand's organisational responses to HIV/AIDS is included in Table 5. The information it contains can be compared to Table 1 in Appendix I, which outlines factors affecting organisational responses to HIV/AIDS in the USA, Canada, Britain and Australia.

The future of HIV/AIDS organising in New Zealand is uncertain. The absolute effect of the 1993 health reforms on HIV/AIDS programmes and strategies is unknown. The status quo is likely to remain, but with an increasing emphasis on integrating programmes into the pre-existing health sector, and with the attrition of some community programmes. Despite the

far-reaching effects of government cost-cutting and health reforms, responses to HIV/AIDS might be sustained at viable levels, if only because the infrastructure exists, and because of broad agreement in New Zealand between government, consumer groups, and health-sector organisations about the desirability of disease prevention.

Table 5 FACTORS AFFECTING ORGANISATIONAL RESPONSES TO HIV/AIDS IN NEW ZEALAND

| FACTOR | OUTCOME |
|---|---|
| Later onset of HIV/AIDS epidemic | community and govt agencies had time to prepare responses based on overseas models |
| Gay men first PWAs | gay-initiated response, re-emergence of gay politics |
| WHO policy/local politics | three-staged response |
| Government funding for HIV/AIDS | support for community responses broad-based education campaigns. |
| Partnership approach | coherent, multi-sectoral response |
| Social progressivism | legislative change |
| Cultural homogeneity, small population & geographical size | easier delivery of HIV/AIDS programmes |
| Relative absence of moralists | fewer impediments to implementation of HIV/AIDS programmes |
| Decrease in AIDS notifications | contraction of government responses, complacency |
| Health reforms | reorientation of government responses toward health promotion, introduction of 'competitive' ethos to health-sector funding, reduction of centralised health infrastructure |

# FRAMEWORKS AND FRUSTRATIONS:

# A METHODOLOGICAL APPENDIX

## Introduction

I used a multi-faceted approach to this study in order to compile, synthesise and analyse diverse materials and data. Each section of the thesis reflects a different methodology. Part I and Appendix I were derived from existing literature: they involved synthesis of material from a variety of sources. In Part II, I used theoretical frameworks to explore discursive outcomes of media, parliamentary and grassroots responses to HIV/AIDS in New Zealand. Appendix II used qualitative research methods, synthesis of published material, documentary analysis and diagrammatic reconstruction of organisational material. In the following paragraphs, I discuss each of the methods used, and explore problems, issues and influences that arose in the course of the research.

## Search and Synthesis: Part I

I synthesised material from books, theses, and papers about plagues and epidemics for Chapters 2 and 3. I obtained most of the material from the libraries of the Universities of Canterbury (New Zealand) and Alabama (USA). The books had mixed value: texts ranged from modern accounts of the syphilis epidemic by Brandt and Fleming, to dated studies of the influenza outbreaks by Stokes and Vaughan. The problems I encountered in developing an historical overview arose from the dearth of books either written about the epidemics or listed in library data sources. The task

was also complicated by the fact that most writers confined their studies to one country (the USA), or to medical rather than sociological aspects of the epidemics. For instance, Brandt, Rogers, and Vaughan wrote about the USA epidemics. Ross and Vaughan also focused on public health, medical and epidemiologic aspects of poliomyelitis and influenza.

Disparities in style and content and textual inconsistencies hampered my efforts to organise a coherent account of epidemic history. For example, Crosby's contention that influenza affected everyone equally was contradicted by the selected effects presented by Rice and Vaughan. Similarly, Ross's unproblematised account of New Zealand's response to the 1916 poliomyelitis epidemic contrasted with the highly differentiated USA critique by Risse. I found consistency to be better achieved in some edited chapters of *AIDS: The Burdens of History* (eg: chapters by Fee, Fox, Musto, Brandt, Risse, Karp, Porter & Porter, Rosenberg) and where possible I used this material. I also used the chronological format in Risse and Musto's chapters as a guide for presenting material in Chapter 2.

Non-medical texts about New Zealand's epidemics were also scarce. I could locate only two published books: Rice's *Black November: the 1918 Influenza Epidemic in New Zealand* and Butterworth and Ross's *Mind Over Muscle: Surviving Polio in New Zealand.* The latter's utility was limited for use in this thesis because of its focus on personal histories. Unpublished theses by Fleming , Kehoe, and Ross provided me with information about

responses to some local epidemics.

A broader range of published and unpublished material on HIV/AIDS (Chapter 4) was available. Books, edited chapters, journal articles, conference papers, theses, reports, newsletters and newspaper items about HIV/AIDS overseas were in plentiful supply from libraries and other sources. I also had access to local data such as *AIDS - New Zealand* (the AIDS Epidemiology Group's newsletter), and to information about the gay community's response from sources such as LAGANZ (Lesbian and Gay Archives of New Zealand). Telephone or written requests for material from some other sources such as the AIDS Foundation (Auckland) or TRT (Dunedin) were wholly unsuccessful.

Theorising the Data: Part II

The task in Part II was to link thematically the material about prior epidemics (Part I) with data about New Zealand's organisational responses to HIV/AIDS (Appendix II). I obtained a theoretical overview by utilising the theories of Gilman and Foucault, both of whom offered an historical perspective in their analysis of an epidemiologic era. I wrote Chapters 6, 7 and 8 as an exploration of Gilman's and Foucault's theories. Case studies for these chapters provided a means of integrating theory and data in the local context. I selected discourse analysis as the most appropriate methodology, primarily because rhetoric, discourse and ideology were common features of the material.

Material from Appendix II (HIV/AIDS in New Zealand) was

included in Chapter 5. Iconographic constructs from Part I provided a framework for interpreting the role of discourse, activism and iconography in AIDS organising in New Zealand. This analysis was broadened in Chapter 6, with a general discussion about iconography in the HIV/AIDS epidemic.

I based the case study in Chapter 6 on media items I had collected over three years from 1992-1994. Most items came from Christchurch newspapers *(The Christchurch Mail, The Press, Christchurch Star)*, or from general interest magazines such as *Metro, Listener, North & South, Woman's Day, New Idea,* and *The New Zealand Woman's Weekly.* An analysis and quantification of these items are presented in graph form in Chapter 5. I wove Gilman's perspective on AIDS iconography into the material, and used his deconstructive approach to provide methodological consistency. My decision to present a case study about the local media's response to HIV/AIDS stemmed from the compelling nature of the Eve van Grafhorst story, and from the realisation that this material was thematically consistent with the material of other chapters. I did not attempt to undertake a more general 'content analysis' of items about HIV/AIDS in New Zealand's popular media, primarily because of my preference for Gilman's icon-focused methodology.

I collected parliamentary material for the case study in Chapter 7 as part of my investigation into New Zealand's organisational responses to HIV/AIDS. As the project evolved, it was apparent that debates surrounding the 1986 and 1993 reforms provided a wealth of discursive material to which the

theoretical insights of both Gilman and Foucault could be applied. I identified the themes that had emerged in speeches about HIV/AIDS by highlighting words or phrases (rights, freedom, plague, sin, conspiracy, moral, Old Testament, sodomy, decency, family, unchristian, etc.) which suggested ideological bias. A list of parliamentary strategies was also compiled. The list included such 'persuasive' tactics as the conservatives' use of survey results to support their opposition to law reform, and their efforts to lace speeches with statistics, quotes, and other discursive markers to legitimate their cause.

The appearance of a news item in *The Press* about research on the clients of sex-workers prompted me to include a case study about the NZPC in Chapter 8. Execution of the study entailed a synthesis of relevant material gathered for the thesis. Gilman's image-making, as analysed in Chapters 3, 4 and 6, set the scene for explicating the NZPC's strategies for self-empowerment. I analysed the prostitute's role as progenitor of 'reverse discourse' by synthesising material gathered about the NZPC with insights from Foucault's *History of Sexuality; An Introduction* . The ideas framing the Life Project and 'discourse production' were particularly useful for this analysis.

Investigation: Appendix II

Little had been written about HIV/AIDS in New Zealand before I began this project, and even less about local AIDS organising (see Introduction). Thus, while information about AIDS organising in the USA, Canada, Britain and Australia could be compiled from

available texts for Appendix I, information for New Zealand's response to HIV/AIDS in Appendix II called for an approach involving original research. The following discussion is about the methodology involved in obtaining material for this appendix, and the subsequent issues that arose from conducting original research in New Zealand. The data and its descriptive presentation in Appendix II served as the broad frame of reference for Part II of the thesis.

*a) Method*

Formal and informal methods of data collection were utilised for Appendix II. I began the research by consulting library sources for information about AIDS organising in New Zealand, and by requesting epidemiologic data from the AIDS Epidemiology Group. Naming relevant organisations was a task facilitated by academics familiar with AIDS organising in New Zealand (Jane Chetwynd, Geoff Fougere and Peggy Koopman-Boyden). These academics also supplied the names of individuals in AIDS organising, some of whom could be approached for interview.

Reports, journal and media articles, committee minutes and epidemiology data provided me with an introduction to AIDS organising (see 'References' for details). *Metro* articles, for example, yielded information about the funding, structure, goals and problems of the New Zealand AIDS Foundation, some of which was presented as a critique ('The Perplexed Person's Guide to CHARITY', 'The Ailing Foundation')[1]. Items from the *New*

*Zealand Medical Journal* listed medical interventions, HIV/AIDS statistics, survey results and HIV prevention strategies in New Zealand. Committee minutes offered details about the National Council on AIDS (NCA) and the Christchurch AIDS Coordinating Committee. Newspaper items relating to organisational responses were scarce, perhaps reflecting a lack of public interest. My purpose in obtaining data from documentary sources for this chapter was twofold - to gather information on New Zealand's HIV/AIDS epidemic (disease context) and to obtain material on HIV prevention (organisational context).

Scholarly publications on AIDS organising were also scarce. Two papers which might have offered corroborative, contradictory, or useful information about New Zealand's response ("AIDS Policy response in New Zealand: Consensus in Crisis" and "The Rise and Fall of HIV/AIDS as a Public Health Issue: A Case Study") were withheld for copyright reasons.[2] Another, Kevin Hague's unpublished paper titled "Some Responses to the HIV/AIDS Epidemic in New Zealand" was unlisted in the main libraries.[3] Problems in obtaining access to scholarly

[1] a) Corbett, J. 'The Perplexed Person's Guide to Charity' *Metro:* September 1993

b) Heeringa, "The Ailing Foundation", *Metro,* 1994

[2] Both items were listed in *Social Research on HIV/AIDS in New Zealand: A Bibliography 1984 - 1993,* p.55. The first ("AIDS Policy Response in New Zealand: Consensus in Crisis") was *in press* as at October 1994, and the second ("The Rise and Fall of HIV/AIDS as a Public Health Issue") had been submitted for publication. Neither paper was available from library sources at time of writing, and the authors declined to release them until after publication.

[3] Hague, K. "Some Responses to the HIV/AIDS Epidemic in New Zealand", unpublished paper, 1989. Listed in *Social Research on HIV/AIDS in New Zealand - A Bibliography 1984 -1993,* p. 54

articles resulted partly from the lack of material, and partly from my initial unfamiliarity with AIDS information networks. Judith McMorland's paper titled "Issues in the Development of an Organisation: A Case Study of the New Zealand AIDS Foundation 1985-90" was obtained, but proved to be a theoretical outline of action research for the purposes of evaluating the AIDS Foundation.[4]

I conducted confidential interviews to supplement my knowledge of AIDS organising in New Zealand. My decision to conduct interviews rather than a formal survey was made in the hope that personal contact would facilitate the data-gathering process, my understanding of HIV/AIDS organising, and the researcher/subject relationship. I also hoped that agency visits would provide some useful contextual information relating to staff, services and clientele. I selected informants from relevant government, medical and community agencies, and conducted semi-formal interviews to elicit both structured and unstructured responses. The interviewees (by title, agency and date of interview) are:

| *Title:* | *Agency:* | *Date:* |
|---|---|---|
| Director | AIDS Epidemiology Group | 5/93 |
| Senior Research Fellow | AIDS Epidemiology Group | 5/93 |
| Health Researchers (3) | Christchurch Health Services Research Unit | 7/93 |

[4] McMorland, J. "Issues in the Development of an Organisation: A Case Study of the New Zealand AIDS Foundation 1985-1990", Queensland, Conference: Second World Congress on Action Learning, Queensland University, 1992

| | | |
|---|---|---|
| Emergency Nurse | Christchurch Hospital | 8/93 |
| Member | Christchurch Hospital Bio-ethics Committee | 11/93 |
| Manager | Christchurch Intravenous Drug Users Group | 12/93 |
| Coordinator | Christchurch Prostitutes' Collective | 9/93<br>11/93 |
| Member | Christchurch Prostitutes' Collective | 11/93 |
| Charge Nurse | Christchurch Sexual Health Centre | 10/93 |
| Health Advisors (2) | Christchurch Sexual Health Centre | 10/93 |
| Venereologist | Christchurch Sexual Health Centre | 10/93 |
| Manager | Ettie Rout Clinic | 11/93 |
| Office Manager | Ettie Rout Clinic | 4/92<br>8/93 |
| Educator | Health Promotions | 8/93 |
| Manager | Health Promotions | 8/93 |
| Chair | HRC Sub-Committee on AIDS Research | 4/92 |
| Curator | Lesbian and Gay Archives of NZ | 11/93 |
| Chair | National Council on AIDS | 3/92<br>5/92<br>11/93 |
| Member | National Council on AIDS | 11/93 |
| Educator | New Zealand AIDS Foundation | 4/92 |
| Volunteer | New Zealand AIDS Foundation | 9/94 |

| | | |
|---|---|---|
| Youth Coordinator | New Zealand AIDS Foundation | 7/94 |
| Researcher | New Zealand AIDS Foundation | 7/95 |
| South Island Manager | New Zealand Family Planning Association | 9/93 |
| Educator | Te Roopu Tautoko | 10/93 |
| Education Coordinator | West Alabama AIDS Outreach | 5/94 |

My decision to list informants by agency and title rather than by name relates to political sensitivity. Changes to AIDS organising in New Zealand, and the uncertainty caused by health reform and the political nature of AIDS organising meant that anonymity was sometimes preferred.

I conducted twenty-seven on-site and eight telephone interviews, most over a two year period from March 1992 to May 1994. The informants were chosen on the basis of their status (managers, policy-makers) or because they were involved in HIV prevention, research or AIDS organising. One informant (the NCA Chair) was interviewed three times because of her pivotal role in AIDS organising. I conducted several other interviews on a group basis (Sexual Health, NZPC, HSRU, Health Promotions) because of the diversity of staff involved in AIDS work in those agencies, or because the principals operated as a collective. I focused on interviewing service providers rather than medical professionals because of my intention to investigate HIV prevention strategies rather than the treatment of HIV/AIDS. Most interviews took place in Christchurch where problems with respect to costs and

access could be minimised. One interview was conducted in Alabama, one each in Dunedin and Auckland, and two in Wellington.

Because of difficulties of access, telephone interviews were conducted with a policy analyst from the Ministry of Health, a health researcher, the Public Health Commission's (PHC) senior professional advisor (three times), educators from Sexual Health and the New Zealand AIDS Foundation, and the director of the New Zealand AIDS Foundation. Most informants were located in Auckland or Wellington.

I asked questions to ascertain agency size, structure, funding, function, affiliations and goals. Apart from the structured replies, most interviews yielded other resource material in the form of pamphlets, newsletters, organisational charts, magazines, media releases, working papers, submissions, samples and posters. Issues of concern such as health restructuring, funding and integration were also discussed in interviews, or during follow-up telephone conversations. Where possible, the information I obtained from the interviews was supplemented by informal networking. Contacts were also made when I attended a symposium, conference and committee meeting,[5] a World AIDS Day fair and the NZPC drop-in centre at Christchurch.

The interviews were not taped, but were written in

[5] a) Symposium: Hepatitis C, Christchurch: August 1992
b) HRC Conference on Bio-Ethics: Dunedin, November 1993
c) Christchurch AIDS Coordinating Committee, August 1993

longhand and transcribed later, usually after interview. This strategy enabled me to note which material was 'off the record', and to add notes of my own. Where negotiated, copies of the transcriptions were sent to informants for comment. My decision not to tape the interviews was made in the hope that informants would speak more openly about their work, insights and feelings. Confidentiality was assured by transcribing interviews myself, by non-disclosure of interview details to other informants, and by omitting names from the thesis.

Analysis of interview and other material followed. I compiled flow charts to illustrate the nature or existence of relationships between the various government, medical and community agencies. These charts provided much of the diagrammatic material. Dates and details of how each organisation was created, restructured or disbanded were included on the charts: their local, national and international affiliations were also noted. I supplemented these details with information about New Zealand's new health and political infrastructure, which I charted in diagrammatic form. Chapters on New Zealand's welfare and health reforms by health researcher Geoff Fougere provided the conceptual overview for this exercise.[6] I matched legislation

[6] The following chapters were provided by Geoff Fougere:

a) "Undoing the Welfare State: The Case of Hospital Care", in *Politics in New Zealand,* 1978

b) "The State and Health Care Reform" *(Op. cit.* :1994).

c) "Struggling for Control: The State and the Medical Profession in New Zealand", in *The Changing Medical Profession,: An International Perspective,* 1993

d) "From Market to Welfare State? State Interventions and Medical Care Delivery in New Zealand", in *In the Public Interest: Health, Work and Housing in New Zealand,* 1984

which had marked the change from ideology to policy or praxis with data on the flow charts to provide an initial overview of AIDS organising in New Zealand. A synopsis of this material is presented in Table 4 of the text ('Government Responses to HIV/AIDS in New Zealand'). I separately recorded and presented the activities of government, community and medical agencies to reflect differences in their style and approach to HIV prevention.

*b) Rationale*

I began the thesis with a focus on AIDS organising in New Zealand. For this reason, and because of its potential utility for health workers and researchers, Appendix II is a substantial part of the thesis. My strategy for this appendix was not to explore the gaps, inconsistencies and epistemological problems in New Zealand's AIDS story (although they surely exist), but to present a comprehensive account of AIDS organising. From this description, an analysis or critique of organisational responses could begin. It was my belief that digression from this focus would marginalise my primary goal of identifying and analysing iconography, power and discourse in organisational responses to HIV/AIDS in New Zealand.

*c) Issues: Stake-holders, Gatekeepers, and AIDS 'Ownership'*

Most problems I encountered in undertaking the research related to access. I found access to informants to be unproblematic if

they worked in local, grassroots organisations (CIVDURG, NZPC, TRT, Ettie Rout) or in local service organisations (Sexual Health, Family Planning Association). Local informality and the highly cooperative nature of AIDS organising in Christchurch facilitated this outcome. Members of the local branch of the NZPC were particularly welcoming, and their openness to the research seemed remarkable given their traditional invisibility.

Access to national or high-level informants proved more difficult. Interviews of high-level personnel yielded a wealth of unquotable 'off the record' material, or evasive replies. In addition, some local writers who were protective of their subject-matter were reluctant to share material. My requests for material or access to informants at a major AIDS service organisation were mostly ignored, and permission to attend workshop, committee or annual general meetings of several important organisations (NCA, NZAF, HRC Sub-Committee on AIDS) was denied.[7] These factors might have compromised the picture of AIDS organising as presented in Appendix II. To side-step the problem, I resorted to obtaining all NCA minutes via 'The Freedom of Information Act, 1982'. The minutes were a useful means of familiarising myself with issues concerning some agencies and individuals.[8] However, my success in obtaining the minutes prompted a PHC official to remark that "people were

[7] a) Reasons given ranged from 'inappropriate' to 'the meetings are confidential'. The committees are publicly funded.

b) All except two requests to the major AIDS service organisation were ignored.

[8] The minutes contained valuable information about policy initiatives, government committees, personalities involved in, and issues affecting HIV/AIDS in New Zealand. However, committee discussions (which would have been more revealing) were omitted. I received copies of all except the final minutes.

very surprised." He also hinted that access would have been denied had I applied under the now-defunct PHC regime.

Informants' concerns about information were variously manifested. One individual twice requested the transcript of her interview, others declined to comment on sensitive issues, or referred me to someone else. Participants often preferred to speak about the politics or problems of other agencies, or to speak about the roles or actions of other people. In this event, I cross-referenced the information to my file of the agency or individual concerned. In many cases, unsolicited comments provided colour, contradiction or corroboration to existing material, although the informant's subject position had to be taken into account.

Some interview questions elicited more information than others. Enquiries about funding were the least successful, those about service provision most readily answered. High-level informants tended to tailor their replies. Questions about the nature of NCA minutes or AIDS politics, for instance, yielded "The minutes are just a public face" and "Politics? It's all just a game - that's what makes it fun." Skill was needed to piece together anecdotal and substantive information. Several informants also offered a 'party line'[9], rather than their own insights. This phenomenon is indicative of the highly politicised nature of AIDS organising in New Zealand, and stems from a desire to shape understandings about HIV/AIDS which relate to AIDS funding.

[9] Some of the informants' statements hardly varied from the 'official' line contained in the agency's newsletters, papers, reports etc.. Reasons for this outcome may relate to: a) the amount of 'distance' (socio-sexual, political) between the researcher and informant, or b) the type of agency.

*d) Access and Travel: A Personal Note*

Problems of access were exacerbated by the fact that I visited the USA during the latter part of the project. While most of the time overseas was spent writing, some interviews I wished to conduct after the initial fieldwork in 1993 had to be postponed until my return. Logistical problems in transporting the material became another issue. To protect against loss, I made several copies of all material, which I both mailed separately and carried in hand luggage to and from New Zealand. The problems inherent in combining travel and thesis were offset by access to plentiful, on-site information about AIDS in the USA. My understanding of AIDS organising in both countries was not only greatly facilitated, but led me to appreciate the quality of New Zealand's response to HIV/AIDS.

## A Methodological Reflection

The methodology I used in this thesis was shaped by the nature of the research, and my preference for hands-on investigation. Survey and statistical analyses could have yielded information about organisational function, but might not have elicited contextual insights, or the personal ideologies, anecdotes, complaints and uncertainties which so informed this study. It was also apparent that the largely non-bureaucratic, interactive nature of AIDS organising in New Zealand fits with a flexible, investigative approach. Research methods for this thesis were also dictated by personal style and preference, as well as by the demands of the research itself. The research led me to conclude

that multiple, eclectic methodologies were not only desirable, but were crucial in the production of this thesis.

Other models of organisational analysis were considered. These models included Kirp and Bayer's cross-national comparative analysis which recommended identification of a) public health and policy-making traditions, b) the status of marginalised groups, and c) the existence of sex education; and Perrow and Guillen's AIDS impact model.[10] Each model had some useful aspects, but neither would have suited my objectives. Kirp and Bayer's model was created for the purpose of cross-cultural comparison, while Perrow and Guillen's model was devised to analyse the USA's complex, fragmented and bureaucratic public health system.

Major problems and issues in the production of this thesis related to access to data and informants. Access to local material proved difficult because of changes within New Zealand library data systems, non-existence of certain information, and retrieval problems. The number of stakeholders and gatekeepers involved in AIDS organising was particularly important in the execution of this project. It meant that access to informants was a trial-and-error process involving negotiation, serendipity and occasionally, second-best strategies. This thesis is not only about AIDS politics, it was also shaped by those politics: its methods, insights and investigations represented a political process in themselves.

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[10] a) Kirp, M. & Bayer R. (eds) *AIDS in the Industrialized Democracies: Passions, Politics, and Policy*, 1992

b) Perrow, C. & Guillen, M. *The AIDS Disaster: The Failure of Organizations in New York and the Nation*, 1990

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Resource Material:

Pamphlets, newsletters, magazines, AIDS updates, organisational charts, personnel lists, media releases, discussion papers, posters,

samples and other resource materials were obtained from:

AIDS Epidemiology Group, Dunedin

Christchurch Hospital

Christchurch School of Medicine

Christchurch Intravenous Drug Users Group (CIVDURG)

Health Services Research Unit

Lesbian and Gay Archives of New Zealand (LAGANZ)

New Zealand AIDS Foundation (NZAF)

New Zealand Family Planning Association (NZFPA)

New Zealand Prostitutes' Collective (NZPC)

New Zealand Venereology Society (NZVS)

Sexual Health Centre

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Te Roopu Tautoko (TRT)

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