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Forget Burial

Illness, Narrative, and the Reclamation of Disease

by

Marty (Melissa) Fink

A dissertation submitted to the Graduate Faculty in English in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York
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dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

Forget Burial: Illness, Narrative, and the Reclamation of Disease

by

Marty Fink

Advisor: Robert Reid-Pharr

Through a theoretical and archival analysis of HIV/AIDS literature, this dissertation argues that the AIDS crisis is not an isolated incident that is now “over,” but a striking culmination of a long history of understanding illness through narratives of queer sexual decline and national outsiderhood. Literary representations of HIV/AIDS can be read as a means of resistance to the stigmatization of people of color, women, immigrants, and queers, debunking the narratives that vilify these subjects as threats to national security and health. In drawing connections between illness, history, and the African diaspora, my work adopts a queer theoretical approach to illuminate how boundaries around sexual and gender identities are often intertwined with representations of nationality and race. Through a feminist analysis of novels by Sarah Schulman, Rebecca Brown, Jamaica Kincaid, Patricia Powell and Octavia Butler, this project demonstrates how discourses of HIV/AIDS have been metaphorically and linguistically connected to symbols ranging from national borders to capitalist commodities, and even gothic vampires. In conjunction with these fictional texts, I concurrently undertake an archival study of writing by community leaders from the first decade of the pandemic whose work successfully countered and reinscribed harmful narratives of HIV/AIDS. By integrating transnational literature with archival materials by New York City-based writers including Iris De La Cruz, Katrina Haslip, and Bradley Ball, my work communicates the urgency of transcending national borders and narrative genres to effectively confront the HIV/AIDS pandemic on a global scale.

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Introduction

HIV/AIDS, Illness History, and Narratives of Resistance

Narratives of HIV/AIDS reveal that the AIDS crisis is not an isolated incident that is now “over,” but a striking culmination of a long history of perceiving illness as always infiltrating from without. Rather than viewing HIV/AIDS as an unprecedented scientific phenomenon, it should instead be positioned as a contemporary moment within an ongoing history of disease. An investigation into this history of illness uncovers that when racial and sexual boundaries are narratively sedimented as sites of contagion, the citizenship status and medical needs of those perceived as national outsiders become subject to violent neglect. A feminist analysis of fictional works by Sarah Schulman, Rebecca Brown, Patricia Powell, Jamaica Kincaid, and Octavia Butler demonstrates how narratives of HIV/AIDS discursively position gendered and racialized subjects as threats to national security and public health. In calling attention to the cultural linking of queerness and illness as well as the social construction of disease itself, these texts illuminate how illness writings can also serve as cultural interventions, allowing our present significations of HIV/AIDS to be revised and reclaimed. Integrating literary and theoretical approaches with archival works by HIV-positive community leaders including Katrina Haslip, David Wojnarowicz, and Iris De La Cruz demonstrates the urgency of revisioning illness histories and disease narratives to effectively confront the HIV/AIDS pandemic on a global scale.

Situating HIV/AIDS Narratives within a History of Disease

As many cultural theorists have demonstrated, HIV/AIDS is not merely a biological or scientific entity, but an event constructed by the social and political narratives we assign to

disease. In *Altered Conditions*, Julia Epstein charts these rhetorical underpinnings of illness, observing how from physicians' case studies to epidemiologists' reports, illness narratives imbue disease with cultural meaning. Such narratives, moreover, overdetermine individuals' physical experiences of suffering and related stigma. From Susan Sontag to Paula Treichler, theorists have insightfully exposed the metaphors and significations underlying the medical reality of HIV infection. This work demonstrates how our understandings of HIV/AIDS cannot be separated from the anti-queer and racialized discourses through which AIDS narratives emerged. As Douglas Crimp argues in *Melancholia and Moralism*, "AIDS does not exist apart from the practices that conceptualize it, represent it, and respond to it. We know AIDS only in and through those practices" (28). Similarly, *AIDS: The Artists' Response*, housed at the New York Public Library archives and originally released by Gran Fury in 1989, suggests that HIV/AIDS ought to be regarded as the product of the cultural context within which it appeared:

Enter AIDS. Here is—minimally—a medical condition identified and defined by committee, an edifice of words and other signs: an epidemiologic surveillance definition fitted to a stupefying variety of human conditions (diseases as symptoms). And as rapidly as AIDS became recognized and addressed by politicians, community organizers, landlords, employers, PWAs (people with AIDS), writers, and artists, it accreted the meanings by which we have come to understand it.

Scholars including Thomas Long, Alexandra Juhasz, Ross Chambers, and Simon Watney have correlatively examined how media representations of the pandemic since the early 1980s have continuously framed HIV/AIDS as inextricably linked to narratives of sexual deviance and sin, constructing the pandemic as "a divine punishment for unnatural acts or a sign of individual moral collapse" (Epstein171).

In *Policing Desire*, Watney addresses the ramifications of such representations, arguing that in locating HIV/AIDS as an illness endemic to queers, drug users, and people of African descent, the devastation wrought by HIV/AIDS is construed “not as accidental but as a symbolic extension of some imagined inner essence of being, manifesting itself as a disease” (8). By locating HIV/AIDS as the product of sexual and racial otherness, the media propounded the notion that this illness is the natural outcome of immorality and deviance rather than a consequence of the preexisting social stratification experienced by populations denied access to resources on the basis of race, gender, immigration status, and sexual orientation. As Epstein reveals, “epidemiologic patterns of HIV infection correlate with the inequitable economics of health care, and the relations between poverty, unemployment, educational ghettoization, urban despair, and family dispersement” (169). As Cathy Cohen documents in *The Boundaries of Blackness*:

The lack of action, from the general public on down to the president, was and is directly tied to the conception of AIDS as a disease of white gay men, black and Latino/a drug users, and other marginal people engaged in ‘immoral behavior.’ The image of the disease, propelled by homophobia, racism, and drug phobia, allowed and even promoted indifference toward the deaths of people with AIDS. (20)

By positioning HIV/AIDS as the physical consequence of such groups’ very existence instead of as the by-product of systematic discrimination, these populations were further stigmatized as contagious carriers of infection. As a result, human suffering became narrated as an intrinsic outcome of a particular essence, rather than as an impetus to improve public access to social services, prevention programs, and adequate care.

Positioned as deserving of illness by the media, the government, and by misinformed public health officials, affected populations fought back on every level, challenging those narratives that reduced them to “AIDS victims,” “junkies,” and “perverted dykes and fags” (Cohen 21). As Crimp observes:

Every public agency whose job it is to combat the epidemic has been slow to act, failed entirely, or been deliberately counterproductive. We have therefore had to [. . .] fund and conduct our own treatment research. We have had to rebuild our devastated community and culture, reconstruct our sexual relationships, reinvent our sexual pleasure. Despite great achievements in so short a time and under such adversity, the dominant media still pictures us only as wasting deathbed victims; we have therefore had to wage a war of representation too. (146)

Narratives of HIV/AIDS thus recall a rich history of grassroots activism and cultural resistance. HIV/AIDS, Crimp implores, “is not a fixed thing, a natural phenomenon that necessarily engenders one response or another [. . .] AIDS work interacts in complex ways with historically changing systems of medical knowledge and government power” (19).

Exploring and commemorating this history of intervention and insurgence is foundational to a comprehensive understanding of our present and future reactions to HIV/AIDS.

From within this contemporary analysis, however, we must also acknowledge the pandemic’s relationship to long history of illness predating the context within which HIV/AIDS emerged. As Allan Brandt attests, it is “only when we recognize that diseases have a history—that they are more than discrete biological entities—and that their causes are complex and varied, will we be able to address them effectively and humanely” (vii). It is, therefore,

essential to locate HIV/AIDS within a larger framework of narrating disease. Investigating HIV/AIDS in conjunction with illnesses ranging from smallpox and influenza to cholera and malaria uncovers that, with its accompanying narratives stigmatizing national outsiders, sexual deviants, and racial Others, HIV/AIDS is neither unprecedented nor is it unique. As Epstein observes:

AIDS is by no means the first disease to elicit a rhetoric of blame, pollution, and stigma, or the first epidemic that has infringed on human and civil rights. Jews were accused of spreading bubonic plague in Rome in 1656, just as African-Americans were held responsible for syphilis in the United States in the 1930s [. . .] We could find the same doling out of blame to the disenfranchised in other outbreaks of these and other diseases—leprosy, yellow fever, typhoid, cholera, tuberculosis. (169)

HIV/AIDS, illustrates Epstein, fits comfortably into a longstanding tradition of constructing illness through narratives of fear and blame. As Paul Farmer concurs, “from typhoid to tuberculosis and AIDS, blaming the victim is a recurrent theme in the history of epidemic disease” (87).

In her reading of illness narratives from the Victorian period, Athena Vrettos similarly exposes the obsession of “Victorian culture” (3) with “the otherness of disease” (3). Vrettos calls attention to the linguistic function of illness discourse as an attempt to “explain the meaning of racial difference and restore a sense of social and material order [. . .] controlling potentially disturbing cultural issues by relocating them in questions of physiology” (3). Just as disease is positioned as a forum for moderating socio-political instabilities, such uncertainties, when they arise, are themselves cited frequently as the logical outcome of illness. In *History of AIDS*, Mirko Gremler traces this phenomenon back to the seventeenth century wherein European

doctors, unsure of the scientific cause of certain diseases, explained their origins as stemming from “the intrinsic variability of diseases, conjunctions of the stars, increase in population, contact with foreigners, and degeneracy of the human species in general and of the white race in particular” (105). Addressing the emergence of HIV/AIDS as a contemporary phenomenon that was repeatedly characterized as being scientifically “new,” Gremk emphasizes that both in terms of its biology and of its cultural dimensions there exists little novelty in HIV/AIDS. Gremk exposes that “retroviruses capable of causing AIDS have certainly existed for at least several decades, quite probably for several centuries and perhaps for millennia [. . .] To resolve this problem of the origin of the current pandemic, we must consider a complex of factors in which the biological and the social are inextricably intertwined” (141). Rather than constituting a new disease, HIV/AIDS, in the context of illness history, is revealed to exist not as an isolated moment that will conclude with the advent of a vaccine or cure, but as a culturally mediated event within an ongoing history of illness. “The history of each disease” (156), writes Gremk, “contributes to the history of all the others” (156). Not only do these histories predetermine the origination of HIV/AIDS in a biological sense, but in tracing the social and political contexts predating the pandemic, we can also predict the emergence of HIV/AIDS as a cultural moment as well.

Regarding HIV/AIDS as a cultural event points to the further convergences between an ongoing history of stigmatizing disease narratives and the contemporary setting within which the pandemic emerged. Watney, for instance, traces these connections between illness narratives and the political climate of the 1980s. He writes that “whilst Reagan and Thatcher wage real wars on imaginary external aggressors (Nicaragua, the Malvinas islands, Grenada, Outer Space), another ideological spearhead is being launched against an enemy within. Not a virus which can

and must be conquered but rather those who suffer from it” (16). The targeting of HIV-positive people is not, Watney uncovers, merely the product of HIV infection, but rather an extension of the prevailing political profiling (along national, sexual, and racial lines) characteristic of the time. It is thus no coincidence, Watney reveals, that “what had initially been stigmatized as a ‘Gay Plague’ suddenly became ‘Black Death’ with racist images of hypersexual black men fueling white anxieties” (184). Speaking to this construction of HIV/AIDS as a disease only affecting those already categorized as deviant, Epstein also exposes how narratives of the pandemic position national otherness as well as homosexuality itself as “illness or immorality” (11). A historically-situated examination of HIV/AIDS narratives, accordingly, uncovers how such discourses of racialization and of the inevitable decline of the homosexual are historically rooted and should thus be viewed as predicting, if not largely catalyzing, the crisis of HIV/AIDS.

Homophobia, Narrative, and the Construction of a Pandemic:

Anti-queer sentiments of homosexuality as a disease whose inevitable outcome is death predate the pandemic by at least a century, as such narratives of decline date back to the construction of “homosexuality” itself. In *Homographesis*, Lee Edelman traces this history of identifying “homosexuality with illness and contagion” (80). Edelman illustrates that “the complex issue of ‘AIDS’ is massively overdetermined by the fact that the homophobic response to the demands for gay social and political equality, long *before* the phenomenon of ‘AIDS,’ was hinged on the historic equation of homosexuality with the unnatural, the irrational, and the diseased” (86). In *The Epistemology of the Closet*, Eve Kosofsky Sedgwick observes that as homosexuality itself was “crystallized” (184) into a construct there emerged an accompanying “endemic and ineradicable state of [. . .] male homosexual panic” (185). Sedgwick demonstrates that the pathologization of queerness served not only to enforce legally heterosexual behavior but

to proscribe a gamut of preexisting homosocial relations between men as fearful, contagious, and deviant. The conceptualization of this deviance is written into our knowledge systems themselves, as Sharon Marcus reflects how “it is not surprising that those who devised the Library of Congress headings in the late nineteenth century defined homosexuality as a sexual deviation to be sandwiched between bestiality and incest, on one side, and prostitution, sadism, fetishism, masturbation, and emasculation, on the other” (192). In “Picturing Deviancy,” Stuart Marshall cites Foucault, who identifies that “the psychological, psychiatric, medical category of homosexuality was constituted from the moment it was characterized” (22). Marshall traces the connections between this pathologizing of homosexuality as illness and its visual documentation—made possible through the advent of photography—noting that “some of the earliest official representations of characters we could now describe as male homosexuals are to be found in a period of medical history which predates by forty years the construction of the medical and social homosexual identity described by Foucault” (22). Like Foucault’s rendering of the “strange pleasures” (54) of sexuality and sexual perversion as that which “would eventually result in nothing short of death” (54), Marshall emphasizes that in creating a medical classification and representation of the homosexual man, “these images were already intimately connected to descriptions of disease” (22).

In “All the Sad Young Men,” Jeff Nunokawa analogously traces the historical roots of regarding queer men as “a population doomed to extinction, anyway” (312). Responding to Crimp, Nunokawa observes how “despite all the achievements of [queer] activism, ‘the dominant media still pictures us only as wasting deathbed victims.’ This may be in part because the dominant media has *always* pictured gay people as ‘deathbed victims’” (312). In dialogue with Nunokawa, Crimp illuminates this “legacy of literary portrayals of gay men as always already

doomed, the logical outcome of our having been pathologized from the moment homosexuality was invented as a category of nineteenth-century sexology” (200). Foucault similarly traces the historiography of sexually transmitted infections as forming a discourse which “claimed to ensure the physical vigor and the moral cleanliness of the social body” (54) and which “always promised to eliminate defective individuals, degenerate and bastardized populations” (54) including intersexed persons, racial Others and homosexuals. Crimp extends this observation to cinematic representations of queerness, remarking that “Vito Russo saw the same pattern in the history of Hollywood’s portrayals of gay men and lesbians. At the end of *The Celluloid Closet*, he appended a necrology, in which he cataloged the causes of premature death of hundreds of gay and lesbian film characters” (200-201).

This same trend can be observed in classic queer literature, as tales of inevitable death and decline are endemic to gender and sexual transgressors from Radclyffe Hall’s Stephen Gordon to James Baldwin’s Giovanni. Like Nunokawa and Crimp, Thomas Long similarly traces the historical pervasiveness of such narratives that position homosexuality as resulting in devastation and death. Long, for instance, calls our attention to 1970s evangelical American Christian, David Wilkerson who “was not the first religious writer to equate homosexuality with epidemic disease, nor was he the last. One widely published and popular evangelical fundamentalist, Tim LaHaye, wrote in 1978 that ‘America is experiencing a homosexual epidemic’” (6). Long uncovers that these discourses situating homosexuality itself as an epidemic in need of a cure also served as the foundation for 1970s anti-queer campaigns like those of Anita Bryant. Long recalls how “America was typologically configured as both Sodom and ancient Greece, and homosexuality or even only tolerance of homosexuality leads it along the ‘road to ruin,’ thus simultaneously constructing a crisis and demonizing homosexuals [. . .] as

‘anti-God, anti-Christ, anti-Bible, anti-life, anti-constitutional and anti-American’ (8). Long demonstrates the “resilience” (8) of this discourse that posits homosexuality both as immoral and as deadly sin, that is, the natural cause of irreversible decline. This narrative’s application to HIV/AIDS a decade later, accordingly, should be viewed not as an unprecedented reaction to a novel illness but as a predictable extension of a firmly entrenched yoking of homosexuality and disease.

Such narratives, moreover, directly affect cultural reactions to HIV/AIDS itself. In *Acts of Intervention*, David Román also traces how responses to HIV/AIDS reflect preexisting mythologies that equate homosexuality with illness and death. Román observes that:

Since the earliest days of the epidemic, gay men have been identified nearly irreversibly with AIDS, a construct that has both perpetuated the decimation of gay men throughout the 1980s and paradoxically facilitated the spread of AIDS into non-gay communities in these years. The encapsulation of AIDS as ‘homosexual,’ despite the knowledge that HIV and AIDS surfaced simultaneously in other populations not contained within the category of ‘homosexual’ [. . .] locked the linkage between homosexuals and AIDS as a foundational logic in the cultural understanding of AIDS. (xxii)

This definitive fusing of homosexuality and HIV/AIDS stems out of the larger cultural narratives that position queerness itself as a disease. As Nunokawa demonstrates, “our culture’s inclination to regard gay men as *marked* men continues to play an important role in the current health crisis, helping to determine popular opinion, government policy, medical research agendas, and officially endorsed therapeutic strategies” (312). In *Facing It*, Chambers similarly cites such historical narratives of homosexuality as the impetus behind the phobic and discriminatory

treatment of people living with HIV/AIDS. Chambers elucidates that “the irrationality of treating an AIDS patient as contagious had its most likely source in [. . .] the homophobic myth that views homosexuality itself as contagious: not just a disease, like AIDS, that can be transmitted but one you can ‘catch’ from simple social contact with gay people” (25). “There is nothing particularly new about this representation” (22), writes Marshall; “it can be located in an historical context and traced through the discourses of medicine, psychiatry and criminal anthropology from the middle of the nineteenth century. To a great extent it simply reworks, repeats and refines a lexicon of pathological images which was already in place” (22). As Epstein concurs, “less than a decade after homosexuality was demedicalized in the psychiatric literature, the new disease of AIDS that became associated with male homosexual practice functioned in effect to remedicalize homosexuality itself, both as a behavior and as an essence” (“AIDS, Stigma” 297). Chambers likewise points to the consequential rendering of queers themselves as human manifestations of disease: “by virtue of the homosexuality of which AIDS is itself held to be an indexical sign, they are understood to be *socially contaminating agents*” (25). Thus, longstanding narratives of homosexuality as illness, in tandem with the new rhetoric of HIV/AIDS, combined to position the pandemic as the logical outcome of sexual deviance, blaming queers for the spread of disease as well as for their own demise.

This narrative of queer social contamination attains central prominence in the rhetoric of President Reagan. As Nicola Nixon observes, in November of 1987, Reagan “had yet to acknowledge the existence of AIDS publically” (118). At this time, “after at least 26,000 Americans had already died of AIDS, Reagan did, however, finally make a statement: ‘I have asked the Department of Health and Human Services to determine as soon as possible the extent to which the AIDS virus has penetrated our society’” (Nixon 128). Quoting Crimp, Nixon calls

attention to Reagan's use of the word "penetrating" to differentiate between queers with AIDS and the rest of "our society." This notion that an epidemic need not concern the American president if it only affects already marginalized citizens is also addressed by Cindy Patton in *Globalizing AIDS*. Drawing connections between illness and class, Patton argues that "health" as a general concept has an inbuilt function of positioning disease as a suitable outcome not only of queerness, but of poverty as well. Patton demonstrates that "epidemiology could hide the crimes of a class-tiered health care delivery by naturalizing the background definition of health used to mark an epidemic: *Health* was the natural state of the middle class [. . .] Thus, epidemics would be noticed largely if and when they threatened the middle class" (42). In locating homosexuals, drug users, and racialized groups as existing apart from the general population, anti-queer, anti-poor, and racist discourses could provide justification for a lack of government concern toward those infected. Rather than viewing the pandemic as an opportunity for creating targeted prevention materials and increasing social funding, these narratives produced the concept of the "risk group" to separate and stigmatize further those socially categorized as being somehow already ill.

Addressing this construction of "risk groups" as existing in opposition to the "general population," Jan Zita Grover calls attention to the normalizing of heterosexuality as fundamental to discourses of disease. Drawing attention to the elemental neologisms of HIV/AIDS, Grover facetiously remarks that:

Heterosexual is not a polite word. It is commonly used only in gay circles or in those liberal settings where there are a large number of professed *nonheterosexuals* present, in which case it functions as a self-conscious preface: "Well, I'm heterosexual but..." [. . .] Even then, it smacks of distaste. To employ it around other heterosexuals suggests that

heterosexuality is not a given, but something to be accounted for, a cultural rather than a natural construction. Because such troubling associations accompany the word, how much more diplomatic to employ a term that doesn't raise the specter of sexual practices or identities at all. Hence, *general population*. (23)

In uncovering how linguistic constructs serve to normalize sexual classifications and hence to marginalize the crisis HIV/AIDS, Grover outlines the necessarily political connotations of a queer identity. Grover illustrates that the "general population," "as a term [. . .] bespeaks neither sex nor revolution. Its very amorphousness guarantees widespread identification. Who, after all, would not regard him- or herself as part of the general population? The answer, of course, is that no self-respecting queer can or should" (23). Grover reveals how entwined within this notion of the general population are the ideological tenants that position heterosexuality as healthy and by extension render queerness as illness. Treichler, similarly, outlines that "another appeal of thinking of AIDS as a gay disease is that it protects not only the sexual practices of heterosexuality but also heterosexuality's ideological superiority" (23). James Jones also uncovers how such narratives locate homosexuality as the "'real' illness" (240) behind HIV/AIDS. Citing Watney, Román likewise observes that "as in all contagion/seduction models, homosexuality must therefore be policed, disavowed, and/or contained to protect the assumed general population" (3-4). Watney identifies this process as "The Spectacle of AIDS," arguing that "calls for the quarantining of people infected with HIV, or the compulsory HIV testing of all gay men, immigrants, and other extra-familial categories, clearly derive from this prior, unconscious compulsion to censor and expel the signs of sexual diversity from the domestic field of vision" ("Spectacle" 77). The result of such a spectacle, Watney warns, is the misplacing of concern upon "risk groups" instead of on building awareness and strategies for prevention,

thereby increasing everyone's risk for contracting HIV. Crimp concurs that this function of "risk groups" is exemplified by the passing of the Helms amendment which ensures that no prevention funds can be provided for the two largest "risk groups," drug users and homosexuals. The Helms amendment thus "makes clear the social and political, as opposed to epidemiological, functions of the *risk group* concept: to isolate and condemn people rather than to contact and protect them" (Crimp 28).

Reclaiming and rejecting these epidemiological myths that position "risk groups" as infecting an "innocent" general population, activist filmmaker John Greyson's *Zero Patience* "pinpoints the potential such narratives have to distort" (Brophy 229n). Treichler identifies how Greyson's HIV/AIDS musical exemplifies the role of theory in an epidemic, urging us to consider "how knowledge is produced, about how we come to accept truths about AIDS, about the contingent status of what we know, and about the beneficiaries of competing accounts" (313). In exploiting the epidemiological narrative central to Randy Shilts's *And the Band Played On* that positions one gay man, "Patient Zero," as the vector of HIV/AIDS, *Zero Patience* reveals that "from the start, AIDS is not only an epidemic of medicine, but also an epidemic of blame. Haitians, gay men, prostitutes, drug users, Africans: these are just some of the so-called carriers constructed by hysterical headlines and hypocritical governments." Citing Crimp, Treichler identifies how "the real problem with Patient Zero" (312), is that "he already existed as a phobic fantasy in the minds of readers before Shilts ever wrote the story" (312-313). Nunokawa likewise exposes how the epidemiological narrative "recirculates and renders explicit the rumor that gay men are fated to die early" (312). In an interview with Matthew Hays, Greyson also identifies that "sexy sub-plot" (154) of Patient Zero "meant that readers didn't remember Reagan's criminal indifference, but rather, the contagious promiscuity of a single gay

man” (154). Inverting these narratives, the film uncovers how “unscrupulous scientists have asserted without evidence that the African green monkey is the source, that HIV is the cause, and that Patient Zero brought AIDS to North America. In fact, none of these so-called facts have been proven. [. . .] Zero should be lauded as the slut who inspired safer sex.” Refuting this mythology of blame, the film features AIDS activists who intervene in this history of situating illness as the product of national outsiders. The activists launch their protest at a museum exhibiting Patient Zero as the cornerstone of its illness collection, “The Hall of Contagion.” In a musical montage, the activists break into the museum, replacing a statue of “Typhoid Mary” with “Fanny Wright: 19th Century Feminist and Health Activist,” and a statue of “the Tuskegee victim” with a likeness of “George Washington Carver, 1864-1943: Herbalist, Botanist, Teacher.” Just as Greyson’s film locates Patient Zero within a long history of scapegoating outsiders as vectors of illness, it also demonstrates how these narratives can be intercepted and reframed.

Like Greyson, Patton reveals how these conceptions of illness as arriving always from elsewhere are rooted in cultural narratives predating HIV/AIDS. In *Globalizing AIDS*, Patton undertakes a reading of Dorothy Rabinowitz’s “The Secret Sharer: One Woman Confronts Her Homosexual Husband’s Death from AIDS,” as a contemporary rearticulation of a classic tale of sexual duplicitousness and scientific perversion, “the Dr. Jekyll and Mr. Hyde narrative” (70). Linking Rabinowitz’s story to Robert Louis-Stevenson’s narrative of duplicitous villains and sexual transgression, Patton observes how:

The now possibly infected wife says, ‘I married a very different person,’ and the writer takes pains to distinguish between the husband’s localized homosexual life (‘in the

bathhouses, Alex marched around exhibiting himself”) and his despatialized straight life (‘everywhere else, he was the quintessential straight, sometimes homophobic male’). In relation to the ‘general population,’ who live in the generalized ‘everywhere else,’ homosexuality—and with it, HIV—is proper to, even endemic in, the imagined place of gay community. (70)

In locating HIV/AIDS within these imagined queer spaces, the pandemic is framed as originating outside the so-called general population and invading it by way of the monstrous queer. Reading the *Jekyll and Hyde* narrative in the Victorian context of illness, Elaine Showalter identifies the links between Dr. Jekyll’s “profound duplicity of life” (“Syphilis” 101) and the “physical vocabulary of syphilitic deformity and regression” (“Syphilis” 101). As in Rabinowitz’s narrative of HIV/AIDS, Showalter illustrates how “in Stevenson’s fantasy of the diseased and divided self” (102), “desire becomes syphilitic frenzy” (“Syphilis” 102), and Mr. Hyde becomes a physical embodiment of “the full horror of [Jekyll’s] sexual sins” (“Syphilis” 102). In addition to reading Stevenson’s novel as a metaphor for sexual disease, Showalter also calls attention to the reemergence of such narratives in relation to HIV/AIDS. In *Sexual Anarchy*, Showalter argues that HIV/AIDS is an illness “typical of the *fin de siècle*” (4). Showalter situates the pandemic as a response to “threats of sexual anarchy” (4) and as the outcome of “panic and backlash against [the] sexual liberalism of the 1960s and 1970s” (4). Showalter further observes how “the AIDS epidemic has fueled homophobia and an emphasis on monogamy and celibacy rather than a commitment to sex education and information about safer sexual practices” (4). Such responses, Showalter argues, are the result of cultural instability at the end of an era. Showalter outlines how “in periods of cultural insecurity, where there are fears of regression and degeneration, the longing for strict border controls around the definition

of gender, as well as race, class, and nationality, becomes especially intense” (4). Showalter demonstrates that narratives of the pandemic point to its existence not as a novel moment in our cultural history, but as a cyclical manifestation of the anxiety that resurfaces alongside each century’s turn.

Willean Decline and Narratives of AIDS

Showalter also demonstrates how no narrative is so quintessentially linked to the trope of the doomed homosexual than that of Oscar Wilde’s *The Picture of Dorian Gray*. Nunokawa, similarly, regards Wilde’s novel as a classic entrenchment of contemporary narratives that emerged with HIV/AIDS. In his reading of *And the Band Played On*, Nunokawa observes that “this is an old story; the lethal prophecy that confronts Dugas’s partners and readers was predicted a century ago, in the doom that defines an inaugural image of gay identity, the image of homosexual desire inscribed in and on *The Picture of Dorian Gray*” (313). Not only does Wilde’s novel provide a prototype for the narrative of inevitable demise, but its existence is also linked to the construction of homosexuality as a fated personal identity. Nunokawa attests that “published in the last decade of the nineteenth century, just in time to participate in the construction of homosexual identity in England, *Dorian Gray* casts the homosexual intensities it pictures as signs of an essential attribute [. . .] in the deepest grounds of the self” (314). Nunokawa compares the decline of Dorian with Wilde’s parallel biographical narrative, revealing how the novel was actually used as evidence in Wilde’s own conviction: “saturated with metonymic markers of the love that dares not speak its name, the novel prompted nearly universal opprobrium when it was first published [. . .] and was adduced as evidence against its author during the trial of his homosexuality” (314).

Showalter, correlatively, illustrates that “the emergence and medicalization of the modern homosexual identity in the 1880s reached widespread public attention with Oscar Wilde’s trial and conviction in 1895” (3). Mirroring contemporary narratives of HIV/AIDS, Wilde’s own public decline, like that of his famous Dorian, was rendered the inevitable outcome of queerness and illness, his sentence a divine punishment for sexual transgression. Showalter writes that:

Indeed, many Englishmen regarded the homosexual scandals of the 1880s and 1890s, up to Oscar Wilde’s trial, as certain signs of the immorality that had toppled Greece and Rome. ‘If England falls,’ one clergyman warned, ‘it will be this sin, and her unbelief in God, that will have been her ruin.’ A public furor over prostitution and the sexual epidemic of syphilis changed the discourse of sexuality, the body, and disease. (3-4)

In substituting the fall of Wilde for the fall of England, this narrative reveals the interconnectedness of nationality and sexual control. This tension between sexual deviance and national belonging is similarly articulated in E.M. Forster’s *Maurice*, wherein our hero cannot reconcile his position as a “decent” (59) “Englishman” (53) with his being “an unspeakable of the Oscar Wilde sort” (153). “Clasped” (52) together with his Cambridge schoolmate Durham with whom he is “lying breast to breast” (52), Maurice instinctively rejects his companion’s profession of love by exclaiming: “Durham, you’re an Englishman. I’m another [. . .] it’s the worst crime on the calendar” (53). Citing Wilde as the benchmark for sexual transgression, Maurice reveals how homosexual identification is antithetical to national belonging. In rendering Wilde’s own conviction and illness a national spectacle and moralistic example, this public scandal, Derek Duncan concurs, is not a “purely personal matter” (24) but a silencing of

all those whose sexual identities run counter to national projects that dare not imagine themselves “‘posing’ as a sodomite” (Fone 14).

Narratives of Syphilis: Precursors to HIV/AIDS:

In addressing this cultural legacy of Oscar Wilde, Showalter reads *The Picture of Dorian Grey* not only as an allegory for queerness, but as a tale of syphilis as well. She argues that “Wilde also uses the late-nineteenth-century obsession with visible vice to suggest that the degeneration of the painting is a sexual disease, the outward sign of Dorian’s sexuality in a repressive culture” (177). Showalter reads “the changes that take place in the portrait as the ‘leprosy of sin’” (177), observing that the vices that “eat it away are like the progressive pathologies of syphilis: ‘hideous face,’ ‘warped lips,’ ‘coarse bloated hands,’ a red stain that has ‘crept like a horrible disease over the wrinkled fingers’ [. . .] and a general air of the bestial, sodden, and unclean” (177). In linking such narratives of syphilis to those of the “AIDS victim,” Watney identifies that in the dominant media, “we witness the ‘AIDS victim,’ usually hospitalized and physically debilitated, ‘withered, wrinkled, and loathsome of visage’—the authentic cadaver of Dorian Gray” (“Spectacle” 78). Recognizing the likeness between the syphilitic imagery of *Dorian* and the contemporary media representations of AIDS, Showalter points to the congruencies between the two diseases. Showalter observes that “as we live through our own age of venereal peril, the parallels between syphilis and AIDS seem particularly striking” (189). Showalter argues that “both diseases have provided the occasion for sexual and social purity campaigns and for a retreat from the liberalization of sexual attitudes” (188). In “Syphilis, Sexuality, and the Fiction of the Fin de Siècle,” Showalter observes that “whereas in the Renaissance syphilis functioned as a religious symbol of the disease in the spirit, and during

the Restoration became a political metaphor for the disease in the state, fin de siècle English culture treats it as a symbol of the disease in the family” (“Syphilis” 89). “A symbolic illness” (189) akin to HIV/AIDS, “syphilis became an obsessive public crisis at the precise moment when arguments over the future of marriage, discussions of the New Women, and decadent homosexual culture were at their peak” (Showalter 188).

In further likeness to our current pandemic, discourses of “sin and retribution” (Showalter 188) dominated syphilis narratives as well. Showalter reveals how HIV/AIDS was not the first illness to serve as “a metaphor for racial evil” (189) or to be rendered the inevitable outcome of sexual perversion. In “Is the Rectum a Grave,” Leo Bersani similarly links the two diseases, remarking how “the realities of syphilis in the nineteenth century and of AIDS today ‘legitimate’ a fantasy of female sexuality as intrinsically diseased; and promiscuity in this fantasy, far from merely increasing the risk of infection, is the *sign of infection*” (211). This obsession with the visible signs of queerness, immorality and sexual transgression—the heartbeat of Wilde’s novel—is also tantamount within cultural reactions to both syphilis and HIV/AIDS. Not only are both diseases repeatedly represented through their visual symptoms but both yield a fascination with the visibility and hence invisibility of those like Dorian whose transgressions remain undetected. As Showalter relays, “in a notorious parallel to the Victorian calls for the branding of syphilitics, William F. Buckley recommended that ‘everyone detected with AIDS should be tattooed in the upper fore-arm, to protect common needle-users, and on the buttocks, to prevent the victimization of other homosexuals’” (191).

Speaking directly to this preoccupation with the physical symptoms of sexualized infections, Sander Gilman undertakes a comparative investigation of the signs and images used

to publically represent both syphilis and HIV/AIDS. At the outset of “AIDS and Syphilis: The Iconography of Disease,” Gilman calls attention to the fact that “we must stress that AIDS is thought to be caused by a retrovirus, now labeled HIV, spread by direct contact with infected body fluids, including blood and semen. Sexual contact is not necessary to contract the virus. But AIDS was characterized not as a viral disease, such as Hepatitis B, but as a sexually transmitted disease, such as syphilis” (90). Gilman demonstrates that because HIV/AIDS serves a parallel cultural function to prior sexual infections, its representation shares much in common with the “five-hundred-year-old iconography of syphilis” (91). As with cultural markers of HIV/AIDS, this iconography does not present an ahistorical means of depicting syphilis but rather portrays this new illness in conjunction with a longer tradition of understanding disease. Gilman observes how those with syphilis were illustrated in “the long-established iconographic tradition of the leper, who bears the signs of his disease to the world” (95). Gilman explains that although “by the sixteenth century, leprosy was no longer endemic in Western Europe, its iconography remained as part of the popular storehouse of images of disease and pollution and was immediately attached to the new disease of syphilis” (95). As in the case of HIV/AIDS, drawing on a history of previous illnesses provided a means through which to narrate and conceptually contain a seemingly novel disease. Gilman uncovers how “the conflation of such images of earlier, known ‘diseases’—for which there was a perceived cure—with the new disease of syphilis provided a vocabulary through which to understand and, thus, to limit the disease” (95). Current depictions of HIV/AIDS, accordingly, cannot be fully understood without looking backwards to the root of these earlier representations. As Gilman argues, “the appropriation of the iconography of syphilis for the representation of people with AIDS is not random; it is, rather, a result of the perception that the sexual orientation of people with AIDS

was determinant, and that these people suffered from a sexually transmitted disease” (98). Thus in order to solidify the sexual connotations of HIV/AIDS and with it the inevitable physical deterioration of its carriers, this longstanding iconography was again employed.

Responding to this historical iconography, activists and artists began to produce work addressing these representational connections between prior illnesses and HIV/AIDS. For instance, photographer Linda Troeller’s work from 1987 draws connections between HIV/AIDS and yet another sexualized disease, tuberculosis. In Gran Fury’s *AIDS: The Artists’ Response*, Troeller’s exhibit is featured for calling “attention to the social meanings of illness by coupling contemporary images about AIDS with historical images of her mother’s bout with tuberculosis—another modern disease with a set of clearly constructed socio-sexual meanings” (Atkins). Troeller juxtaposes photographs and diary excerpts from her mother’s stay in a tuberculosis sanatorium in the 1930s with the documents and images of Barbara Cleaver, “founder of a Mothers of AIDS Patients group, whose son died of AIDS in the 1980s.” Of the correspondences between these two figures and their experiences, Troeller reflects that “the parallels are dramatic.” In a review of Troeller’s work from the same publication, Robert Atkins commends the artist for revealing that “every death is a personal tragedy, but the politicization that invariably affects sex-related diseases makes each AIDS death also partake of a constellation of social meanings transcending the individual.” In calling attention to the stigma foundational to tuberculosis as it intersects and recurs in relation to HIV/AIDS (Troeller, for example, notes the incidence of TB co-infection among those already living with HIV), Troeller advocates that our present pandemic cannot be separated from an earlier history of illness, nor should this history be obscured or forgotten.

In *No Magic Bullet*, Allan Brandt analogously identifies the “resurgent ‘syphilophobia’” (182) that accompanies contemporary representations of HIV/AIDS. Recalling the history of syphilis, Brandt explains that a fear of syphilis was propounded by conservatives with the intention of discouraging premarital sex, especially after the advent of birth control. Sexual infections, he illustrates “were employed to argue for a more restricted sexuality” (5). Like HIV/AIDS, syphilis was construed as “an affliction of those who willfully violated the moral code, a punishment for sexual irresponsibility” (5). Brandt also traces the magic bullet philosophy that emerged with the advent of penicillin in 1928. Brandt points to the reality that while drug treatments can be “effective against certain microorganisms, the magic bullets cannot combat the social and cultural determinants of these infections” (161). Brandt illustrates that so long as diseases and their narratives are used to control sexual behavior these morally grounded ideologies will not aid prevention but will rather impede therapeutic approaches to care.

Like Brandt, Gilman also traces this pattern of assigning blame to those who suffer from syphilis to contextualize our current perceptions of HIV/AIDS. Gilman indicates that this trend toward vilifying those who are infected is additionally compounded by gender. Gilman notes that “only during the Enlightenment does the image of the syphilitic shift from male to female, and with this shift comes another: from victim to source of disease” (95). Gilman observes this same shift in HIV/AIDS discourse, noting that the move “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” (107). In addition to locating the role of gender and sexual deviance in discourses of both syphilis and now HIV/AIDS, Gilman reveals that HIV/AIDS is certainly not the first disease that has been blamed on wayward women, national outsiders and

racialized Others. Gilman observes that illness discourse seeks assurance “that we are not at fault, that we have been invaded from without, polluted by some external agent. In the late fifteenth century, syphilis was first understood as linked to another major event of the 1490s, Columbus’s voyages of discovery to the Americas” (100). Just as national and racial transgression was believed the root of syphilis in the fifteenth century, sentiments linking race to the incidence of syphilis (and later HIV/AIDS) can be clearly observed in the twentieth century as well.

Race, Narrative, and Histories of Disease

In *The Boundaries of Blackness*, Cohen compels us to consider: “how do we explain a 1990 *New York Times* survey in which nearly one-third of black New Yorkers contacted (29 percent) believed that it was true or might be true that the ‘virus which causes AIDS was deliberately created in a laboratory in order to infect black people?’” (26) In addressing this question, Cohen emphasizes the urgency of revisiting a long history of illness predating the pandemic to better understand the social context underlying this contemporary disease. Cohen states that “without knowledge of the historical circumstances of black Americans, it would be difficult to understand the mistrust of public health officials exhibited by many African Americans, whose relationship to the medical industry has been informed and defined by a history of blame and manipulation” (26). In recalling this history, Cohen draws our attention to “the most infamous and public example” (26) of such medical neglect, “that of the Tuskegee Syphilis Study where black subjects were denied treatment for syphilis so government health officials could study the progression of this disease” (26). In her analysis of the Tuskegee study, Susan Smith explains that the participants “joined under false pretenses because the health workers never informed the men that they had syphilis or that they would not receive treatment.

Instead, the men were told they would be treated for ‘bad blood,’ a vague term that referred to a range of ailments, including general malaise” (113). Once enlisted, Smith recalls, these participants, all of whom were black, “were not told they could spread the disease to their sexual partners or that they were part of an experiment predicated on nontreatment of syphilis until death” (113).

In exposing the inbuilt racism emblemized by the Tuskegee study, Smith further observes how this experiment was contingent upon historically rooted “white assumptions about the health and sexuality of African Americans” (109) and the related “expectation that syphilis was endemic to black populations because of sexual promiscuity” (109). In *Bad Blood*, James Jones concurs that the study resulted directly from racialized understandings of syphilis as a sexual condition intended to punish its hosts. Jones reveals how this ideology is reflected in the official statements of physicians as recorded at the turn of the century. In this medical literature, African Americans were regarded “as having earned their illnesses as just recompense for wicked life-styles. This preoccupation with personal responsibility for disease assured syphilis a prominent place in the medical discussion of black health. What better example of just retribution could be offered than the philanderer who contracted syphilis” (Jones 22). Cohen analogously points to “the role that sexuality—in particular what is called deviant or non-normative sexuality—has played in justifying [. . .] the implementation of marginalizing systems ranging from slavery to, most recently, workfare” (35). Cohen uncovers how an understanding of the medical system and of studies like Tuskegee cannot be viewed apart from these larger narratives positioning black sexuality as inherently deviant and thus manifesting itself as disease.

Like Cohen, Jones also identifies the racial narratives underlying medical studies like Tuskegee. Jones attributes the Tuskegee study to medical beliefs that “differences in natural

immunity, degree of susceptibility, and relative severity of reaction to various diseases often separated the races” (18). Jones argues that in order to prove that African Americans have different susceptibility to illness than whites, “physicians extrapolated from individual cases to the entire race because they wished to defend slavery” (18). While African Americans were viewed as a source of syphilis, other diseases were similarly racialized to frame African American health as justification for enslavement. Diane Herndl, for instance, exposes how medicine was used to claim that “physical labor and difficult working conditions that would be harmful to whites were in fact beneficial for blacks, and that slavery was the ideal condition for maintaining the African-American’s health” (555). Smith concurs that “some physicians argued that African Americans were more resistant than white people to certain diseases, such as yellow fever and malaria, and therefore were better to field labor” (5). The reverse narrative was also employed, positing that “if black people became sick it was because of an inherently weaker constitution rather than a result of unhealthy living and working conditions” (5). Brandt likewise explains that “by arguing that [black Americans. . .] suffered milder attacks, physicians created a medical sanction for sending blacks into the rice fields and canebreaks [. . .] [and that] such unhealthy work was more humane than employing white laborers” (18). Consequently, the Tuskegee Syphilis Study is not an anomalous aberrance on the part of the medical profession but an outcome of historically entrenched views that position African Americans as somehow more deserving than white people to die of advanced and untreated disease.

As these theorists attest, revisiting these racialized discourses of illness can illuminate how these historical narratives remain prominent in relation to HIV/AIDS today. In his discussion of Tuskegee, Gilman observes that:

A similar story can be told about AIDS in the 1980s. In the United States, AIDS has been labeled an ‘African’ or ‘Haitian’ disease. 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 [. . .] It was also assumed that American blacks had a greater immunity to syphilis because of the ‘African’ origin of the disease, leading to the horrors of the Tuskegee syphilis experiment. (100)

Patton further observes how in representing the high rates of HIV infection among African Americans and black immigrants, the media’s portrayal of “the demographics of AIDS” (xiii) failed to call attention either to strategies for treatment and prevention, or to the structural inequalities facing these populations to begin with. The racializing of HIV/AIDS itself, Patton shows, “did not prompt a sharp analysis of the systemic and localized racism and poverty in some of the world’s wealthiest nations; rather, in the case of the U.S. media, the image of an African continent of seething sex and rampant death was simply relocated to describe America’s black communities, now said to be ‘like’ villages in Africa” (xiii). Tracing these narratives of both domestic and global AIDS, Priscilla Wald identifies how “journalistic portraits of AIDS in Africa, [. . .] resemble Joseph Conrad’s *Heart of Darkness*” (235). Citing Watney, Wald observes that it is “as if HIV were a disease of ‘African-ness,’ [. . .] ‘the viral embodiment of a long legacy of colonial imagery which naturalizes the devastating economic and social effects of European colonialism’” (235). In *Serious Adverse Effects*, Celia Farber similarly links narratives of colonialism to the discourses of HIV/AIDS. Farber quotes South African AIDS activist Anthony Brink, who contests that “in this country, we’ve just come through a racist, fascist dictatorship involving white supremacism and *untermenschen*, and

AIDS ideology invites a whole new framework for those ancient racist ideas to bubble back up” (181).

Returning to Cohen’s interrogation into the perception that HIV/AIDS was created intentionally to infect those of African descent foregrounds this link between historically based narratives and such conspiratorial beliefs. The HIV/AIDS crisis is indeed an extension of histories spanning from the atrocities of medical experiments like Tuskegee to the uses of smallpox as an instrument of genocide against indigenous communities. As Jeanette Farrell documents, “some settlers found ways to infect native people with the disease, such as trading them blankets contaminated with smallpox scabs” (30). Considering the legacy of racism embedded within American narratives of illness and health, Cohen outlines that “repeatedly, when hearing or reading of the CDC’s early failures in research on marginal communities, members of African-American communities raise the possibility that the CDC was engaged in some type of conspiracy against people of color” (148). Cohen aptly observes that:

Although it is understandable that community members might see the problems at the CDC as part of a more general pattern of neglect, exclusion, and genocide on the part of dominant institutions, I suggest something a bit more systematic, dangerous, and long term is happening. Institutional marginalization produces effects that far outlive the sinister actions of individuals. So to those concerned with conspiracy theories at the CDC, I suggest that sometimes the effects of institutional practices of exclusion and ideological narratives of deviance result in a cumulative marginalization more daunting than any conspiracy a few white men in a room could concoct. (148)

This sentiment of institutional mistrust is echoed by Joseph Beam in a 1986 archival issue of *Black/Out* addressing government negligence in response to HIV/AIDS. Beam exposes that “the State (a euphemism for white people) has never been concerned with the welfare of Black people [. . .] It is not a matter of whether their racism is intentional or unintentional. We die ‘by accident’ daily and the State is a witness who documents that demise.” Beam quotes poet Essex Hemphill as a call to arms for black communities to take health issues into their own hands. Beam relays that “Hemphill writes in ‘For My Own Protection:’ We should be able to save each other / I don’t want to wait for the Heritage Foundation to release a study saying / Black people are almost extinct...” In inciting black communities to rally for their own health, Beam’s mandate is certainly not unprecedented as the legacy of medical injustice of black communities is accompanied by a dynamic history of resistance as well.

In *Sick and Tired of Being Sick and Tired*, Smith documents this history of resistance to counter dominant depictions that figure African Americans “only as recipients of aid or victims of neglect” (3). Smith charts how “black health activists attempted to create public health programs and influence public policy at every opportunity [. . .] to reach underserved Americans over the last century” (3). For instance, black leaders like Booker T. Washington employed the discourses of emerging scientific movements like germ theory to make arguments against racial segregation and health care apartheid. (Smith 40) Smith recalls how “black leaders [. . .] pointed out that because germs did not respect segregation, white people were at risk for contracting diseases from black people [. . .] they argued that it was in the interests of white people to safeguard black health” (40). Pointing to the potency of narrative as a means of intervention within health care policies, Smith revisits the tales of illness transmission orated by Washington to politicize health as a means of social reform.

Smith, however, also outlines that in Washington's narratives of germs crossing the color line, "the focus of these stories" (42) of contact and contagion recurrently "targeted black women" (41) for "spreading disease to whites" (40). Smith, however, documents that rather than passively accepting this recurrent trope of racialized women as vectors, African American "laywomen" and non-professional service providers actively countered these mythologies in order to improve access to care. Smith documents a long history of African American women working on the frontlines of health care reform. Smith recalls that "focusing on health issues permitted black women an authoritative voice in the realm of political organizing. They exploited the identification of health needs with the domestic realm in order to take on very public roles and engage in a little-recognized form of civil rights work" (169). Smith, moreover, charts how this history of black women-led health care organizing is frequently unrecognized. Historians, Smith reveals, often erroneously credit the government and not community-based interventions *in response to* this government for advancements in black health. Smith counters this common misconception by illustrating that "the federal government and New Deal programs did not save black America—African Americans rescued themselves" (82). Smith, accordingly, points to a present conundrum in the historicizing of HIV/AIDS. Yet again, marginalized populations have been forced to secure their own health care rights in the face of government neglect, and these histories of resistance by people of color, women, and queers are again in danger of becoming obscured.

Writing Resistance: Recalling the Work of Iris De La Cruz

In light of this phenomenon of historical erasure, it becomes critical to document the legacy of ground-up resistance in response to HIV/AIDS. Archival writings by HIV-positive community members commemorate the movements and experiences of those resisting

HIV/AIDS. One such body of work that emblemizes the struggles and successes of grassroots HIV/AIDS activism is that of Iris De La Cruz. A health care worker dedicated to countering the stigmas attached to female sexuality, drug use, sex work, and HIV/AIDS, De La Cruz contributed to a variety of organizations including the People with AIDS Coalition, the Gay Men's Health Crisis, PONY (Prostitutes of New York), and ACT UP/New York. In an issue of *Outweek* magazine from 1990, De La Cruz writes that "I am an activist because, not only am I advocating for the rights of PWAs, but I am fighting for my *own* life" (36). Recognizing the link between personal survival and political work, De La Cruz reflects that "there are some that wanted to tie me up and force feed me condoms to shut me up. But fuck 'em. I had a good time getting this disease and I'm going to have a good time dealing with it." In her monthly column for the People with AIDS Coalition's *Newsline*, "Kool AIDS with Ice," De La Cruz depicts resistance as a means of survival. She writes: "Let's get this straight. I HATE this virus, and it's this hatred and rage that keeps me going. Wimps get buried." De La Cruz's contributions to the fight against HIV/AIDS are innumerable. In "Sex, Drugs, Rock n' Roll, and AIDS," De La Cruz charts some of her own achievements, recalling that:

I started a group for bi- and heterosexuals dealing with HIV. I do AIDS outreach and education. I teach safer sex and show addicts how to clean their works [. . .] the rage that burned is now a hot anger. I've been to too many funerals with this disease. I'm tired of the newly diagnosed being made to feel dirty. I'm tired of my people being neglected and left dying on the streets. My child is now 19 and we're very close. The legacy I want to leave her is for her to remember her mama was a survivor. She survived drugs and she survived her own worst enemy, which was herself. And she taught others survival. She may or may not have survived AIDS, but she kicked ass while she was here. (134)

Of her role as an AIDS activist, De La Cruz explains that "I'm on a campaign to disprove the old myth of what a PWA looks like. And acts like. My feeling is to laugh and have a good time, even with this virus. Also, I want a chance to show off my hot little summer clothes." Calling attention to the importance of maintaining humor even in the face of a deadly disease, De La Cruz dedicates her column to "the true miracles who can laugh at [. . .] themselves. We will survive on our snickering."

Revisiting De La Cruz's contributions to HIV/AIDS literature provides an effective means of understanding the various struggles involving stigma, treatment, and prevention issues during the early years of the pandemic. De La Cruz, for instance, uncovers the medical "hysteria" around CD4 cells, which doctors posited as an indication of one's health in relation to HIV. In scrutinizing this system of biological obsession, De La Cruz appropriates the language of the medical profession to regain control of her own condition. Mocking the severity and absolutism of medical discourse, De La Cruz writes that "I had to send out birth announcements today! I just got my blood work back from my doctors and I noticed I gave birth to a fresh new T4 cell! How exciting! I didn't even know I was pregnant. I didn't even get laid!" Demonstrating how one can regain sovereignty over physical and emotional health even without the ability to influence one's own cell biology, De La Cruz laughs at the reality that her T-cells are disappearing. She jokes that "I tried to put an announcement in the obit column in the NY times, but they weren't hearing it [. . .] I was gonna put their little pictures on the back of milk containers ('Have you seen this CD4 cell?')" In a similar manner, De La Cruz calls attention to the parallels between addiction to illegal substances and dependency on the therapeutic drugs prescribed for HIV/AIDS. She muses that "isn't it weird that I've given up illicit drugs to do toxic drugs? My shit probably could light up a generator for twenty years!" De La Cruz also

integrates a politicized discussion of HIV/AIDS into her own personal life, sharing her struggles and successes with dating, flirting, love, and relationships. For instance, of her marriage to Paul, De La Cruz publically celebrates that "this is going to be the world's first HIV wedding. The guests can throw AZT instead of rice. And we're going to be passing out those cute little gold coin condoms as wedding favors (with little bows) because wedding favors are just so tacky and I love my friends enough to want them to stay safe."

In addition to sharing resistance strategies from her personal life, De La Cruz's writing, like the support groups she facilitates, also provide a venue for community building and social cohesion. In one of her monthly columns, De La Cruz proposes that "I'm going to kick off a new idea in the *Newsline*; it's going to be called the hot PWA of the month. So, if you have any photos of yourself or your buddies to send them in with a paragraph or two about yourself, we'll run it." Re-sexualizing and playfully eroticizing images of people living with HIV/AIDS, De La Cruz cautions to "please make sure you have at least minimal clothing on, (although I'd be more than happy to accept nudes for my own personal use) because the *Newsline* doesn't need an obscenity suit." De La Cruz also advertises the Coalition's upcoming events, including "our infamous HIV dance," "a chance to get dressed up and act slutty!" De La Cruz muses that:

I haven't been out dancing in so long... are they still doing the frug? So since I haven't gotten my hip-hop down pat, I guess I'll have to make up my own steps. The first one is that old standard, the I.V. pole waltz. This is done using an I.V. pole as a partner. If you still have a line hooked up, that's even better since it shows intimacy and a common bond between you and your partner. There is nothing as graceful as seeing this done in perfect unison and not like me who ran into people (usually nurses) and ended up caroming the

pole off the walls trying to navigate turns. Then we have the neuropathy jerk. This is done with the arms or legs held (or both) held stiff. These people have been known to do a great robot too. Real romantic is the tuberculosis tango. This is where both partners dance to a regular tango up to the minute where they dip and then they both break down into wild hacking fits of coughing. Preferably in one another's face. This shows commitment and longing. Especially for oxygen. If performed right, it will bring tears to the eyes.

Through the employment of humor, De La Cruz encourages people to move out of a position of isolation or pity, coming together as a community united through and beyond the virus itself. De La Cruz's humor mirrors that employed by filmmakers like the Los Angeles-based John Goss, whose 1989 production, *Stiff Sheets*, provides a "Fabulous Facist Fashion Show" to call attention to the government and health care atrocities made apparent by HIV/AIDS. Staged in front of a Los Angeles hospital as part of a larger demonstration by ACT UP, the show features drag queens sporting fashions like "Band Aids!" "the official solution to the AIDS epidemic," and "Night Sweats: more than a fashion, it's a condition, more than a style, it's a symptom." The campy announcer marvels that "these Sweats attract little or no attention at all. It took 8 years of federal inaction to perfect this outfit, and it will last a lifetime." Featuring a finale of "homophobes on parade," *Stiff Sheets*, like De La Cruz, utilizes humor to build community and to address the severity of the pandemic while exposing the culpability of those whose inaction allows it to thrive.

De La Cruz not only provides a nuanced and insightful approach to the work of surviving HIV/AIDS, but her writing also evidences how her personal experiences are tied to larger

manifestations of racism, sexism, and homophobia historically sedimented into the medical system. In an interview for the GMHC Oral History Project, De La Cruz discusses her experience as both an injection drug user and as an HIV-positive woman, reflecting that “I was in pretty good shape before the virus, even with the drug addiction. The only thing it's affected is attitudes of medical professionals. If I knew then what I knew now, I would never tell anyone that I had a drug addiction.” De La Cruz explains that “there's a whole thing with addict-aphobia: I was already drug free when I got this virus but it didn't matter; all of a sudden there was distrust.” De La Cruz describes her experiences of destigmatizing drug use within health care settings, of making HIV/AIDS visible in high schools, and of raising public awareness in order to combat the discrimination blocking access to adequate treatment and care. De La Cruz also addresses the necessity for practical strategies for prevention such as needle exchange programs. Speaking to the historically entrenched narratives of villification identified by theorists like Crimp, Watney, and Brandt, De La Cruz explores how narratives of moral judgment impede responses to HIV/AIDS as a virus and health issue, framing it instead as an indication of immorality or as punishment for sin. De La Cruz reflects that in her professional work, she constantly witnesses the dissemination of such moralistic narratives by health care providers. De La Cruz relays that she is constantly fighting to debunk the narratives that reinforce how drug users are “all criminals, they have absolutely no morals, no scruples, they're physically dirty, unclean” as well as the “racial stereotypes, sexual stereotypes and the stereotypes with addiction.”

De La Cruz, moreover, ties this stigma of HIV infection and drug use to larger systems of racism. She reflects how “A lot of it is racism. When I started drugging, it was with people of color; the war on drugs started when it started affecting whites, when it came into the

suburbs. The same thing with AIDS—if it was just a bunch of niggers and faggots, let them die—it’s that much less welfare, that much less dealing with people: these are expendable people.” Citing this commonly held attitude as that which justified the government’s atrocious inaction during the first decade of the pandemic, De La Cruz asserts how “the bottom line now is it’s not only addicts, their whole families are dying, so called ‘innocent’ people are dying.” As with historical narratives positioning illnesses like malaria and yellow fever as a natural outcome of race and racist notions of health, De La Cruz reveals how these myths have resurfaced to determine contemporary cultural reactions to HIV/AIDS. Reflecting on the personal devastation she experienced as a result of these narratives, De La Cruz fights to counter prejudices and to demand adequate treatment of those who have been and continue to be regarded as undeserving of health. In addition to participating in direct action work with groups like ACT UP, De La Cruz also initiated a series of counseling programs, support groups, and community events to promote survival and community building even in the face of this stigma. Of the virus, De La Cruz explains that “I know that it’s there, but I can live with it. This is what I try to teach the people that come to my groups. You can live with this. If you survive drugs and all the bullshit, all the discrimination, you can survive AIDS. Or at least while you’re alive you can live.”

In commemorating community leaders like De La Cruz, we can revive a body of literature that resists those historically entrenched illness narratives that sexualize and racialize HIV/AIDS. Just as literary and queer theory provide a means of deconstructing socially contrived categories of sexual, racial, and gender identity, so too can these practices intervene within narratives of disease. Literary theory, argues Edelman, reveals how all discourses of HIV/AIDS necessarily “cannot be disentangled from their implication in the linguistic or the rhetorical” (80). Edelman “locates ‘literary theory’ between the categories of ‘politics’ and

‘AIDS,’” (79) to indicate that “both of those categories produce, and are produced as, historical discourses susceptible to analysis by the critical methodologies associated with literary theory” (79). Crimp similarly identifies how “queer theory, like much recent postmodern theory, tells us that humanity is not a universal and natural condition of being but a contingent and cultural construction of historical, social, linguistic, and psychic forces” (148). Crimp explains that “knowing this, queer theory also knows the political urgency of understanding how and why we are denied our humanity through these very forces” (148). E. Patrick Johnson, accordingly, recognizes the value of not only providing necessary services to people living with HIV/AIDS, but of also undertaking a critical cultural intervention within AIDS narratives themselves. Johnson declares that:

Due to the growing number of African Americans infected with and contracting HIV, queer theorists must aid in the education and prevention of the spread of HIV as well as care for those who are suffering. This means more than engaging in volunteer work and participating in fund-raising. It also means using our training as academics to deconstruct the way HIV/AIDS is discussed in the academy and in the medical profession. We must continue to do the important work of physically helping our brothers and sisters who are living with HIV and AIDS through outreach services and fund-raising events, but we must also use our scholarly talents to combat the racist and homophobic discourse that circulates in white as well as black communities. (148)

Employing literary theory to “crucially unsettle this storytelling process” (Epstein 186), narratives of illness can be deconstructed, replaced, revised and reclaimed.

HIV/AIDS Writing and Reclamations of Disease

My first chapter, “Bottom-Up in the Archive,” will consider the work of Sarah Schulman alongside archival writings by other New York City based activists including David Wojnarowicz, Bradley Ball, and Iris De La Cruz. Positioning illness narratives as a source of queer community building and grassroots resistance, these works effectively document reactions to government negligence in the early years of the pandemic. These writings also provide a model for reclaiming narratives that render those infected as doomed homosexuals and drug addicts responsible for contagion and deserving of death. Such an analysis instead revives a rich history of creative interventions against the homophobia and racism endemic to the medical system, demonstrating how historical narratives of disease are amendable to revision. My next chapter will move to an investigation of gender, queerness, and caregiving in the fiction of Rebecca Brown. Through a comparative analysis of Brown’s HIV/AIDS narratives, “A Good Man,” and *The Gifts of the Body*, I will trace the erasure of women and of queer female sexuality more broadly by dominant discourses of HIV/AIDS such as those propounded by institutions like the CDC. Reading queerness within Brown’s work will uncover how narratives can resist and reclaim gendered sexualities and activism in the context of the pandemic.

Moving from these local works to a study of transnational HIV/AIDS narratives, my third chapter will undertake an analysis of national borders and queer sexual representation in Jamaica Kincaid’s *My Brother* and Patricia Powell’s *A Small Gathering of Bones*. Forging connections between the seemingly disparate spaces of borders and prisons, this chapter will explore how historically rooted conceptions of national outsiderhood, quarantine, racialization, and policing are foundational to our current understanding of HIV/AIDS as a global disease. Recalling archival histories of prisoner activists like Katrina Haslip points to the ways in which we can only begin to fight HIV/AIDS once sexual and gender transgression, poverty, race, and migration

are themselves decriminalized. Situating these questions of sexuality, identity, and race into an examination of the linguistic constructs of HIV/AIDS, my final chapter will undertake an analysis of Octavia Butler's vampire novel, *Fledgling*, as a site of resistance against harmful illness metaphors espoused by the pandemic. Reading Butler's vampires as a community of HIV-positive survivors allows for a reclamation and rearticulation of narratives of disease.

Each of these various works, moreover, speaks to a wide spectrum of issues regarding the gendering of disease. Exploring these texts in tandem not only reveals much about the complex experience of those who fall under the rubric of "women and AIDS," but also suggests how feminist analysis can challenge and deconstruct illness discourses as well. Feminist health, as Treichler reminds us, points to the ways in which gender, like disease, is founded upon "linguistic and material subjects who exist within language and history" (96). Treichler traces how "AIDS was assumed by most of the medical and scientific community to be a 'gay disease' and a 'male disease'—assumed, that is, to be different from other sexually transmitted diseases" (42). Identifying the material conditions that gender illness, invisibilizing women and producing additional stigma, Treichler recalls how women and queers joined together to "rewrite the AIDS plot" (Treichler 98), intervening in illness history itself. Steven Epstein locates these successes within a longer feminist health movement predating the pandemic, observing how "many lesbians (and heterosexual women) who would become active in the AIDS movement were schooled in the tenets of the feminist health movement of the 1970s, which likewise advocated skepticism toward medical claims and an insistence upon the patient's decision-making autonomy" (12). As Treichler observes, the HIV/AIDS crisis became a moment through which these politics were clearly articulated. She documents how:

The story of women and AIDS can be read as a dense narrative about women's health and American society; economic opportunity and political power; sexuality and safety; law and transgression; individual autonomy and reproductive freedom; the right to social services and health-care resources; the deformities of the American health-care system; alliances with others; and the significance of identity in everyday life. (277)

Employing feminist theory alongside a queer framework will provide a forum through which to recall these histories while simultaneously contesting essentialized notions of illness, sexuality, and gender itself.

HIV/AIDS activism, moreover, marks a crucial shift from a gender segregated gay and lesbian movement toward a cross-gender model of organizing envisioned inclusively as 'queer.' Though a significant impact of lesbian involvement in HIV/AIDS activism served to create visibility around the effects of HIV/AIDS upon women—as lesbians, as caregivers, and as a risk group repeatedly overlooked by the medical establishment—the overwhelming contributions of queer women within the AIDS activist movement further signifies the interconnectivity of male queers delineated as the so-called “victims of AIDS,” and the female queers who increasingly located themselves as the sexual and social allies of these targeted men. Thus responses to HIV/AIDS effectively renegotiated preexisting political divisions and gender differences, allowing men and women to organize together under the more gender-amorphous rubric of queer. As Jean Carlomusto reflects in an interview with the ACT UP Oral History Project, “what really galvanized me to this issue” (3) was the “horror of seeing homophobia manifested when people were sick” (3). Carlomusto reveals how the men and women of ACT UP formed complex affinities that were political, social, and even sexual in nature, and that these alliances

resulted in concrete outcomes beneficial to both the gay and lesbian communities from which these members originated prior to convening around issues of HIV/AIDS.

Since this moment of unification in the early 1980s, this construction of a queer political identity continues to gain increasing momentum, as queer issues today are no longer regarded as separately affecting men and women but are rather viewed as a political agenda extending across gender lines. As a crucial tenant of queer theory itself, these binaries of “male” and “female” are themselves being called into question not only as social groupings but as personal categories of identification. By reenvisioning queer politics as extending beyond a gay and lesbian framework to include the experiences of being transgender or gender-queer, this politics centers itself in its refusal to regard the specific needs of trans people, of women, of dykes, or of fags as existing apart from the larger queer movement itself. It is both because of and also in spite of its overwhelming effect on communities of gay and same gender loving men that HIV/AIDS remains an issue affecting queers of all genders and sero-statuses. The homophobia and social stratification underlying the medical responses to this disease makes HIV/AIDS a crucial concern for anyone identifying along this queer spectrum today. Writing as a young gender-transgressive queer, HIV/AIDS and its accompanying narratives—which in some respects exist outside of my own experience of gender identity, serostatus, and generation—remain an integral part of my cultural history and sexual identity. In tracing the legacy of HIV/AIDS writing and organizing by both HIV-positive and HIV-negative women, I do not attempt to contest the centrality of this medical crisis on the lives of men, but rather to suggest a critical framework through which to understand the gendered repercussions and queer narratives of disease. This project is thus intended to address the far-reaching impact of HIV/AIDS narratives upon the identities and experiences of queer and transgendered folks today.

What is AIDS?

This intervention into historical representations of disease and into current narratives of HIV/AIDS raises the crucial question articulated by Celia Farber of “what *is* AIDS?” (316). “To what extent is it viral” (316), asks Farber, and “to what extent associated with living conditions?” (316). Farber implores that “we have been vastly motivated to explore the viral aspects of AIDS—and all but thoroughly disinterested in exploring the sociological ones” (316). “The future of AIDS” (316), writes Farber in 2006, “is that it is no longer an equal opportunity sexually transmitted disease but a social catastrophe” (316). This understanding of HIV/AIDS as a social phenomenon is certainly a current reality but it is neither a novel way of regarding the pandemic nor is it a new development. As a historical analysis reveals, diseases as wide-ranging as hysteria and anthrax, swine flu and cancer, are all socially constructed as we cannot understand suffering apart from the narratives through which these illnesses exist. Like its historical predecessors, HIV/AIDS was never “an equal opportunity sexually transmitted disease,” but was always rooted in sexualized and racialized manifestations of moral judgment and structural inequalities. Though Farber posits this observation in the global context of unequal access to resources and health, such disparities have characterized the AIDS crisis from its inception. These links between the early years of the pandemic and its current state are evidenced within archival activist writings. For instance, in an annual report from *Bebashi: Blacks Educating Blacks About Sexual Health Issues* from 1986, the social dimensions of HIV/AIDS as an illness were already firmly explained. The report asserts how:

AIDS is a disease, not a lifestyle. And the methods through which it spreads are no longer a mystery or hard to explain. But the socio-political reality is that those who have traditionally had greater access to health care and educational opportunities are those who

today are learning how to protect themselves against this disease. And those who are traditionally forgotten are again being forgotten—with tragic, almost genocidal consequences. (2)

In another archival column by two queer black women, Lorraine Stevens and Vera Hill, it is similarly asserted that “I don’t want to just talk about AIDS as if it’s this isolated thing that doesn’t have anything to do with anything else. I don’t think there is any way that you can talk about AIDS unless you talk about the fact that *America* is in crisis and AIDS is just another of those many, many crises that are facing the American people” (1). The authors reject narratives that vilify people living with HIV/AIDS, identifying that “the real enemies of the family are poverty, unemployment, police brutality, indecent health care, Ed Koch, Ronald Reagan, and the growing mentality that is taking over” (1).

Such archival writings call attention to the immediate reality that in both domestic and international settings, HIV/AIDS continues to affect people unequally based on already existing systems of marginalization. These very inequalities, moreover, are cited repeatedly as both the cause of and the justification for medical apartheid and institutional neglect. As Paul Farmer observes:

Our society ensures that large numbers of people, in the United States and out of it, will be simultaneously put at risk for disease and denied access to care. In fact, the spectacular successes of biomedicine have in many instances further entrenched medical inequalities. This necessarily happens whenever new and effective therapies—from antituberculosis drugs to protease inhibitors—are not made readily available to those in need. (12)

Farmer argues that “in a very real way, inequality itself constitutes our modern plague” (12). What is required, Farmer implores, is structural intervention, rather than simplistic calls for individual behavior change. Farmer censures the current practice of implementing so-called “culturally sensitive” (86) education programs to “protect” (86) poor women from HIV/AIDS as an example of the erroneous viewpoint that “the way to diminish risk is to increase knowledge” (86). Farmer asserts that “through this cognitivist legerdemain, we have expediently moved the locus of the problem—and thus the focus of interventions—away from certain features of an inegalitarian society and toward the women deemed ‘at risk.’ The problem is with the women; thus the interventions should change the women” (86). Farmer illuminates that the eradication of HIV/AIDS cannot begin with the individual, because individual health is overdetermined by the social circumstances within which individuals live. These social institutions, literary analysis also uncovers, are themselves constructed in accordance with the cultural narratives through which health and disease have historically been understood. As Wald observes, it is through narrative interventions within these discourses of contagion that will either “exacerbate or begin to address the inequities” (270) foundational to the existence of HIV/AIDS.

Such narrative interventions, furthermore, point to the urgency of also demanding a concrete structural overhaul of the systems that perpetuate HIV/AIDS. In identifying the injustices made apparent by the pandemic, Anne-Christine D’Adesky calls for a “global scale-up effort” (230) wherein treatment is implemented on a “grassroots level” (230) with an increased focus on developing “women-controlled methods of prevention” (230) such as microbicides. D’Adesky calls for an ideological shift wherein it should no longer be “considered acceptable for political leaders to debate openly who will live and who will die; [. . .] to weigh these human lives on a scale of human productivity and lost human capital” (319) or in terms of “the potential

lost profits of the wealthiest multinational corporations in the most profitable industrial sector—pharmaceuticals” (319). Revealing that while drugs and corporations move freely across borders in the name of economic profit, people are discursively rendered expendable and denied access to generic medications and affordable treatments. D’Adesky contends that “the barrier to access is not poverty, or illiteracy, or the inability of Africans to take their drugs consistently, or any other indices of national development or capacity; it is a lack of political commitment pure and simple” (319). Echoing the activist voices of the 1980s and early 1990s, D’Adesky maintains that HIV/AIDS deaths remain the outcome not of a virus but of an international political system that allows expendable people to die. Revisiting these earlier historical movements thus clarifies that the real struggle against the pandemic is not simply about getting drugs into bodies but about changing those culturally situated beliefs that justify “suffering and death [. . .] as inevitable in one place and unthinkable in another” (Wald 270).

Because HIV/AIDS is not an isolated phenomenon but a contemporary moment in a long history of disease, it should not be regarded as a something which will somehow end with improved treatments or vaccinations, or with our present solution of unaffordable and unequally distributed regimens of toxic drugs. As a current manifestation of time-honored narratives of racial otherness, moral transgression, and queer decline, HIV/AIDS should be situated as an opportunity for intervention rather than as a biological entity in need of a “cure.” While working toward a medical solution for HIV/AIDS is certainly a priority, resolving the scientific aspect of the pandemic will only address this particular illness and none of its causes: poverty, homophobia, racism, gender violence, and access to care. Truly mediating the crisis of HIV/AIDS will require a novel approach that removes the onus of prevention from the individual and begins to recognize the social and historical factors predicating disease. As Román

observes, “if we are now to resist the banalization of AIDS, and if we are to continue the cultural work necessary so that we do not abandon hope, we will need to draw upon the historical legacy of AIDS performance and activism. When we do so, we both recover a record of our past and seek to secure the future of our communities” (284). By revisiting the legacies of those who contested the phobic narratives of HIV/AIDS, we can begin to implement a model for concretely reclaiming and rewriting disease.

Chapter 1

Bottom-Up in the Archives: Sarah Schulman, Activist Communities, and HIV/AIDS

The work of activist and writer Sarah Schulman demonstrates how HIV/AIDS literature can effectively intervene within stigmatizing narratives of disease. In fictionalizing and chronologizing early reactions to HIV/AIDS, Schulman's work should be read not in a literary vacuum but viewed in relationship to the activist and queer movements within which she belonged. In placing Schulman's writings in dialogue with a largely unpublished body of work by HIV-positive community leaders including Iris De La Cruz, David Wojnarowicz, Michael Callen, and Bradley Ball, a history of resistance emerges, transforming our understandings of illness narratives and HIV/AIDS. Addressing issues of government inaction, familial abandonment, institutionalized homophobia, and media representation, these writings document how cultural and medical evolution arise not from state-sanctioned interventions but from bottom-up political coalitions in the face of overwhelming systematic neglect. Archival materials documenting community responses from the first decade of the pandemic demonstrate how writers and activists challenged harmful narratives rendering HIV/AIDS as symptomatic of sexual, gender, and racial transgression. Excavating these works provides an important record of intervention within a history of narrating disease, demonstrating the transformative possibilities offered by grassroots organizing and by literary representation itself.

Writing from the forefront of the AIDS activist movement as a longstanding member of ACT UP/New York, Schulman connects sexuality and illness narratives to the cultural contexts within which they exist. Schulman's fiction not only identifies the social causes underlying the HIV/AIDS crisis but also depicts those radical communities and sexual practices misrepresented

by the mainstream media and by scientific accounts of the pandemic. Theorists including Alexandra Juhasz and Simon Watney identify how popular press reporting in television and print journalism converged with official medical reports and scientific publications to frame HIV/AIDS as a gay plague, whose “risk groups” of sexual and racial others were concurrently narrated as both hapless victims and dangerous threats. (See for instance, Juhasz, *AIDS TV*; and Watney, *Policing Desire*). Schulman’s work unveils a history of ground-up responses launched to intervene in this narrative phenomenon. Her writing traces how community-based productions such as alternative media and video, independent newspapers and magazines, and grassroots newsletters and scientific reports countered these narratives of victimization and spread. In establishing racism, gender discrimination, and homophobia as both outcomes and as precursors to the incidence of HIV/AIDS, blame is shifted away from those who are HIV-positive and onto institutions whose anti-queer and racist policies facilitated the emergence of HIV/AIDS as a medical crisis and cultural event.

Examining mainstream reactions to HIV/AIDS alongside the community and literary responses they produced permits an understanding of how activists like Schulman mediated these harmful illness narratives, altering the future course of the pandemic. In situating Schulman’s role within the AIDS activist movement as its point of departure, this analysis moves beyond a dichotomy which understands the experiences of gay men living with HIV/AIDS in opposition to the perspectives of lesbians working at the frontlines of these grassroots organizations. This account is necessarily queer in its replacement of a gay and lesbian model of gender-divisive organizing with one which seeks to commemorate the converging of these two communities in the fight against HIV/AIDS. Schulman’s investment in combating what was initially perceived as a gay male disease marks a moment of unification toward exposing the anti-queer sentiments

fueling the spread of HIV/AIDS while continuing to prioritize an investigation of how gender and sexuality compound to inform cultural reactions to illness. Furthermore, examining HIV/AIDS writings from the mid-1980s to mid-1990s captures a climactic moment of activist upheaval coinciding with some of the initial public responses of the government and the media to the crisis of AIDS. Writings from this period also document the function of homophobia and racism in fueling government inaction to the initial epidemic rates of infection, a history frequently erased by contemporary mainstream accounts of how the pandemic commenced. In focusing specifically on the context of New York City wherein Schulman's fiction and political organizing is predominately located, this study provides merely one instance of community intervention into the course of disease. While an investigation of other periods, locations, and national contexts is also critical, this analysis poses a starting point through which to view archival and community-based histories as interventions into dominant representations of illness.

Building upon her earlier examination of the links between homophobia and the spread of disease, Schulman's most recent novel, *The Child*, explores our changing relationship—both individually and culturally—to HIV/AIDS. *The Child* revisits themes introduced in Schulman's 1995 HIV/AIDS novel, *Rat Bohemia*, wherein the lesbian heroine Rita and her gay, HIV-positive co-narrator David trace the connections between familial abandonment and the progression of disease. These protagonists exemplify the queer bonding of a cross-gender friendship cemented by common experiences of sexual outsiderhood. The two concur that "there is nothing on earth that could kill us more efficiently than parental indifference" (63). David connects the emergence of his own AIDS symptoms to his family's refusal to accept "sissy-wissy me" (64) with "limp wrists and a will of steel" (64). His feelings of rejection mirror Rita's frustration that in trying to elicit love from her father, "[she] always get[s] destroyed" (189). The abandonment

of Rita by her biological family results in tangible symptoms like "feeling sick to my stomach, ugly, hateful, repulsive, disgusting [. . .] knowing that I am bad" (188). In *AIDS and American Apocalypticism*, Thomas Long similarly observes how "as many of those who developed AIDS discovered, their birth families were often as censorious about their dying as they were about their living: life-companions and friends excluded from medical and funeral arrangements or those too ill to take care of themselves remanded 'homo' or in some cases the dying simply abandoned by families of birth" (30). Like Schulman's fictional representation, Long's work illustrates how historically entrenched narratives rendering homosexuality as impetus for physical decline present concrete consequences for familial reactions to queer kin and to HIV/AIDS. Explicating upon his parents' detestation of homosexuality and their unwillingness to acknowledge his resilience in the face of a life-threatening disease, David compares his family to COINTELPRO, a government force designed to infiltrate revolutionary movements like the Black Panthers in order to divide and quell them. Through this analogy, David consolidates the link between familial rejection and the broader maintenance of citizen complacency; the family becomes a direct affiliate of larger social institutions that allow homophobia to discard and disempower queers.

In *The Child*, similarly, our lesbian heroine Eva Krasner renders familial abandonment as "her version of the Kennedy conspiracy" (110), a force much greater than any individual could singly conceive. Eva and Hockey—like their younger counterparts Rita and David—depict how familial rejection feels like being "hit on the head with a hammer every day" (107), "the one thing Eva could never outrun" (107). Extending upon the concerns raised by *Rat Bohemia*, *The Child* explores why Eva remains dislocated from her parents even as social institutions appear to adopt a more tolerant stance toward queers. She traces how:

Because of AIDS there was a social shift, and the kind of vulgar homophobia the Krasner family dutifully practiced went out of fashion. A new, slicker kind that they could never master came into vogue instead. So now the family brilliantly changed gears. Now they no longer cited the homosexuality as the justification for their cruelty. They now pointed to the consequences of their cruelty as its own justification. (111)

While this explanation can certainly be understood literally, illustrating how homophobia motivates the unjust misrepresentation of Eva's family drama, this paradigm can also be conceived more broadly as an indictment of the U.S. Government whose blatant anti-queer responses to HIV/AIDS in the early 1980s are now manifested in a "slicker" (111) manner that justifies the initial and continued mistreatment of people living with HIV/AIDS. By obscuring its own role in allowing the virus to spread, the government, in analogy to Eva's familial rejection, blames those who are seropositive for contracting HIV.

Set in New York City after the introduction of protease inhibitors in 1996, *The Child* also links familial and government neglect to issues concerning treatment and drugs. As drug therapies become the so-called solution to HIV/AIDS, they occupy an omnipresent position within the novel in their many doses and forms. Throughout the narrative, Schulman connects her characters' reliance on drug treatments to social forces extending beyond the biomedical model's limited scope. Illustrating how HIV/AIDS must be handled not as a solely scientific phenomenon but as a political crisis, Schulman observes in *Stagestruck* that "recent medical advances with protease inhibitors and combination therapies are beginning to cast an artificial cast of resolution over the surface of the AIDS crisis. But [. . .] if a glass of clean water was the cure for AIDS, most infected people in the world today would be unable to access it" (137).

Extending beyond issues of accessibility alone, *The Child* demonstrates how drugs, complete with their unknown long-term capacities and ghastly side effects, become an unsuitable substitution for the institutional reform that must take place not only on a global scale, but within American institutions as well. Such measures, *The Child* implores, must begin with the family. In *Rat Bohemia*, David exemplifies this discrepancy between drug treatments and familial reform by inquiring, "why didn't the newspapers announce [. . .] that parental kindness helps people with AIDS live longer? Because that's asking for more than people can do. Love our gay children? Impossible! We just want a pill, it's easier" (53). The notion that scientific advancement can cure HIV/AIDS fails to consider how stratification and stigma contribute to infection rates and to the inaccessibility of drug treatments along class, geographic, and racial lines. Corporate controlled chemical substances, therefore, prove an untenable alternative to the elimination of those socially compounded forces that jeopardize the right to health.

In *Moving Mountains: The Race to Treat Global AIDS*, Anne-Christine D'Adesky further investigates the insufficiency of drug treatments in the absence of wider institutional reform. D'Adesky argues that rather than citing a lack of infrastructure as a reason for withholding much needed medications worldwide, the HIV/AIDS pandemic should instead serve as an impetus to address precisely those forms of development and redistribution that could curb increasing rates of infection. While a lack of access to resources contributes to the global spread of HIV, such factors should not be used as justification to deny treatment and prevention campaigns. D'Adesky shows how "it's possible to manage HIV and concurrent disease in the poorest settings, in spite of limited infrastructure, and these efforts are intrinsically linked to prevention [. . .] By treating global AIDS, we will bring multiple resources to address poverty and other social and economic conditions that allow HIV to flourish" (225). D'Adesky demonstrates that

the lack of initiative on the part of politically conservative governments combined with the agendas of profit-driven drug companies create political barriers to abating the disease.

D'Adesky reminds us that "it is important to consider what could be achieved if true political will for treatment was forthcoming" (290). D'Adesky uncovers that in designating insufficient funds to treatment and prevention, "the US has made its lack of commitment to global AIDS perfectly clear" (291).

D'Adesky also reveals how it is not merely the amount of money allocated to HIV/AIDS, but how politicians, influenced by moralistic and corporate incentives, elect to spend it. She illustrates how:

Bush's new AIDS initiative also gives outside groups with specific religious agendas greater leverage to determine the social, economic and health agendas of developing countries. He did a similar thing in the US, creating new drug treatment and AIDS initiatives so that faith-based groups could qualify for federal funding. These groups, of course, oppose condoms and innovative safer sex programs aimed at sex workers and gay men. [. . .] They've also gone after AIDS groups, in San Francisco and elsewhere, who run explicit safer sex campaigns aimed at gay men, pulling federal funding from such programs. (305)

D'Adesky illuminates that governments' responses to the HIV/AIDS crisis are a direct reflection of how queer sexuality and sexual freedom is legally and institutionally addressed. She observes that "globally and domestically, this is not a benign agenda. [. . .] those [institutions] that Bush supports tend to have a very conservative 'family values' agenda. And conservatives take a dim view of homosexuality, and of outreach to such vulnerable communities" (305). Using her fiction to establish the multidirectional ways in which this systematic homophobia is naturalized

from the level of policy to the individual, Schulman links the dying lament of characters like David to the survivor's predicament faced by Rita, Eva, and Hockey who remain to bear witness to an obscured history of corporate greed and government neglect.

In calling attention to these links between political policy, homophobia, and HIV/AIDS, Schulman's work should be read alongside writings by other members of queer, feminist, and AIDS activist communities to which Schulman belongs. Supplementing the biological family as the only available system for support, a larger chosen familial unit emerges as we read Schulman's work in tandem with those with whom she was socially and politically engaged. An important body of non-fiction writing from the first decade of the pandemic can be juxtaposed with Schulman's novels, revealing not only thematic correspondences but the existence of an interpersonal network within which these narratives were produced. One such corpus of work which cogently connects the individual experience of illness to its political context is that of Iris De La Cruz, a fellow ACT UP organizer and community member alongside Schulman. (See for instance, the ACT UP Oral History Project's "Interview with Jean Carlomusto"). In her writing as well as her community work, De La Cruz addresses the social and institutional barriers to combating the disease. In "We're All Fighting for our Lives," an article published in the People with AIDS Coalition's *Newsline* in 1990, De La Cruz, like Schulman, connects the lack of services provided to people living with HIV/AIDS to "a government that feels we are *all* expendable and is very willing to let us die." In tracing the course of the pandemic's first decade, this article connects HIV/AIDS to other social crises that are similarly mediated by gender, racial, and class-based discrimination. De La Cruz observes that "now the virus has hit the heterosexual middle class and people are starting to take notice. It reminds me of the drug epidemic. Drugs were around in poor communities for years and years. Nobody bothered doing

anything about it and the attitude was 'let them all kill themselves.' The same thing is happening with AIDS." By revealing how government inaction is directly indicative of the pandemic's predominantly affecting queer people, drug users, and poor people of color, De La Cruz offers strategies for resistance rooted in community-based efforts to demand better services and to provide treatment for those already infected. Placing community building and peer support at the heart of her work, De La Cruz promotes organizing across difference as the most effective means for challenging authoritative neglect.

In similarity to Schulman, De La Cruz also emphasizes the importance of familial support in combating HIV/AIDS. Throughout her writing, De La Cruz demonstrates her mother's instrumental role in helping to navigate a health care system that treats people living with HIV/AIDS in a discriminatory and dehumanizing manner. De La Cruz reflects on her hospitalization for advanced tuberculosis, recalling how "the hospital staff tried doing things at their convenience. They were messing with the wrong one. I have seen my mother physically drag a nurse into my room to take care of me. Residents used to hide out in the medication room when they heard my mother was on the floor." De La Cruz commends her mother for not only supporting her through what was supposed to be a terminal stay in the hospital, but also for helping to reunite other people with living with HIV/AIDS with their own estranged parents. She declares with pride how "my mother has evolved into an AIDS militant in her old age." Providing patient advocacy and demanding adequate treatment, De La Cruz's mother represents the crucial role that parents and other primary caregivers can play in fighting for health care rights.

In her writing, moreover, De La Cruz uses humor not only to confront difficult issues of sickness and death, but also to show tangibly how this type of parental advocacy might be

achieved. She recalls, for instance, that while in the hospital, “food was the last thing on my mind. So my mother came up armed with corned beef and ice cream and sat there by my bed until I consented to take a bite.” Taking the dismal situation of feeling too ill to eat and turning it into a humorous moment, De La Cruz convincingly relays the importance of support networks in helping regain a position of wellness and self-esteem. De La Cruz also jokes that “Jewish mothers, by law, must take a course in ‘nudging.’ [. . .] my mother could be an instructor [. . . she] bugged me into walking, and, when I was released, into getting out of the house. Needless to say, I’m well enough now to the point where she feels she can bug me about house work.” Through uplifting narratives of survival, De La Cruz demonstrates a skillful ability to laugh at adversity and suffering. She charts her own recovery and continued resistance to both the virus and to its mediating stigmas, illustrating the essential nature of support from one’s family and friends.

Recognizing that familial support is not universally accessible, De La Cruz stresses the importance of building networks through which to cope not only with the virus but with issues of parental abandonment and related fears of disclosure. Moving away from a model that figures caregiving as emerging only from within nuclear family networks, De La Cruz recounts her experiences of attending and later leading support groups to show those estranged from their families of origin that “they were not alone and support was available to them.” In an article for *Newsline* entitled, “The Great Sero-Positive Sedar: Or, Pigging Out on Passover,” De La Cruz charts the success of community building efforts in breaking isolation and combating stigmas of HIV/AIDS. She explains how:

My mother has started a sort of tradition. She started making Passover Seders for people dealing with HIV. This started out a couple of years ago, after I was released from the

hospital with an AIDS diagnosis. It was only supposed to be a one-shot deal because I was supposed to die, but it was since evolved into an annual event. Since I spent all my time perfecting my Camille death bed scene, I had no time to make any new friends. (and my old friends, I didn't want to see my old friends.) So my mom put up a sign at GMHC for PWAs who wanted a home cooked meal.

De La Cruz's narrative reveals how she too would have remained isolated and housebound had it not been for her mother's initiative in creating a social forum for people living with HIV/AIDS. De La Cruz again uses humor to convey the importance of community bonding and to encourage those who share her experience by refusing to adopt a dismal tone. She depicts her own reluctance to participate in Passover by admitting that "I wasn't too overjoyed about that since I wasn't all that thrilled about eating at that point. And [. . .] having strangers in the house would also mean I would have to be civil, which was a drag. Your family *knows* just how bitchy you can be. I looked forward to this in much the same way as I'd look forward to dining on crushed glass."

In spite of her initial reluctance, De La Cruz admits that "our guests came, unknown and unwanted (by me), and wonder of wonders, I had a good time. What made it even better, was the fact that I was still pretty sick, so I got out of doing dishes. What ended up happening was we all became friends and an annual tradition was born. I guess nobody thought I would ever live this long. Certainly not me." Connecting survival and recovery to community support, De La Cruz charts her physical and emotional improvement to the network she builds by extending her family's traditions to others living with HIV/AIDS. Her writing, similarly, aims to connect her own health and longevity to others in her community. She surmises that "I guess if I stay

alive, we'll have to do this every year. So listen up, you guys, on our twentieth anniversary, we're gonna *really* kick it!! Thank mom.”

De La Cruz further charts her own transition from a position of isolation to one of community by connecting the sustained improvement of her health to the continued tradition of Passover. She documents how “this past Passover found me still alive. And healthy enough to do dishes [. . .] And then there was the question of who to invite. I had a lot more friends this year than I did when I was diagnosed [. . .] The guys that came before were also present this year, along with the assorted perverts that comprise my family and friends.” Through her story of Passover, De La Cruz addresses issues of identity politics, expressing fears that her guests’ differences might prevent them from getting along: “the group consisted of gay white men, blacks, Latinos and lesbians. And me and my family. I was waiting for war to be declared. I thought 'I'm gonna have to seat these people very carefully or I'm gonna be peeling them off the ceiling.” De La Cruz illustrates how such forums for HIV/AIDS-related community building can provide an opportunity for people to interact with others with whom they may not normally associate around the dinner table or within their own home. De La Cruz demonstrates how such events may facilitate the alliances and friendships essential to combating disease. As De La Cruz remarks, “wonder of wonders, [everyone] got along fine [. . .] We all had a great time and maybe people have learned to leave their prejudices at the door and deal with one another as people.” Just as De La Cruz calls for coalition building as a necessary form of resistance in “We’re All Fighting for Our Lives,” her Passover narrative reinforces the importance of establishing support-based communities in order to counter the stigmas of HIV/AIDS.

Like De La Cruz, Schulman also positions activist and community-based organizing as essential to fighting the pandemic. In *My American History*, Schulman documents "the ravages of Reaganism" (2) by providing a participant-observer account of grassroots responses to government inaction and to the anti-queer sentiments of HIV/AIDS. Schulman emphasizes the importance of understanding that "virtually all constructive responses to the AIDS crisis have originated at some point in the gay and lesbian community with no help or else outright obstruction from the government" (113). Lee Edelman similarly links government negligence to the birth of movements like ACT UP, citing the popular slogan "SILENCE=DEATH" as "a challenge to the murderously postponed and cynically inadequate official responses to 'AIDS' and as a rallying cry for those who have borne the burden of care-taking, suffering, and death" (81). Schulman extends this analysis of government neglect to draw "the obvious conclusion" (220) that "the government does not want to end the AIDS crisis" (220). In "AIDS Writing and the Creation of a Gay Culture," Michael Denny supports Schulman's position, arguing that writers depicting the HIV/AIDS crisis "registered the initial shock of AIDS as a historical event, that moment when [. . .] because of criminal neglect and indifference, this eminently preventable epidemic, which should have been treated as an emergency but was not, spread throughout the land and became a medical fact and an omnipresent threat" (42). Addressing a range of topics from media representation, to lesbian issues, to the closing of the baths, Schulman positions a lack of institutional support as the catalyst for bottom-up political action by those HIV/AIDS most severely affects. She declares that "even if it takes all of our energy, I still intend to do everything I can to at least keep these issues alive" (222).

Like the writings of Schulman and De La Cruz, the work of New York City-based artist and writer David Wojnarowicz was also elemental to the creation of the AIDS activist

community Schulman depicts. In his memoir, *Close to the Knives*, Wojnarowicz consolidates the links between institutionalized homophobia and his own infection with HIV. He explains that "my rage is really about the fact that when I was told that I'd contracted this virus it didn't take me very long to realize that I'd contracted a diseased society as well" (114). Wojnarowicz expresses Schulman's concerns that in order to combat HIV, we must recognize the political dimensions of the virus as well. Placing his personal experience of HIV/AIDS within a larger cultural context, Wojnarowicz asserts that "I know I'm not going to die because I got fucked in the ass without a condom or because I swallowed a stranger's semen. If I die it is because a handful of people in power, in organized religions and political institutions, believe that I am expendable" (230).

Like Schulman, Wojnarowicz does not merely point to an abstract system of homophobia, but provides explicit examples linking the institutionalized hatred of queers to the proliferation of HIV/AIDS. Wojnarowicz concretely illuminates that while some politicians have managed to cover up this negligence, "allocating just enough money so it looks good on paper" (107), others continue to demonstrate unabashed anti-queer sentiments as justification for medical neglect. Wojnarowicz writes that "I read the newspaper stories about the politician in Arizona saying on the radio, 'To solve the problem of AIDS just shoot the queers...' and his press secretary claimed the governor just didn't know the microphone was on and besides they didn't really think this would affect his chances for reelection" (106). Much critical writing supports Wojnarowicz's position, connecting the government's failure to respond to the AIDS crisis to the homophobia underlying its policies. As Jed Bryan observes in "Crying Wolf?: The Genesis of the AIDS Epidemic," the government's lack of intervention and resource allocation indicates a willingness to allow queer people to die. Bryan traces the logic that "if gays weren't

really human, then the health threat to nongays was inconsiderable” (69). He also extends that “if only gays were infected and dying, silence on the part of those in power could serve several purposes: (1) avoid responsibility and cost indefinitely; (2) avoid political repercussions among gay-haters; (3) get rid of some, if not all, of the members of a problematic subculture” (69).

Wojnarowicz’s narrative not only confirms Bryan’s observation that homophobia motivates increasing rates of infection, but his memoir also insightfully demonstrates how this reaction is not specific to HIV/AIDS. Wojnarowicz illustrates how this attitude of expendability has also been extended to other marginalized populations including drug users, African-Americans, immigrants, and sex workers. HIV/AIDS is revealed not as an isolated incidence of medical negligence, but a contemporary moment in a long history of governments responding to a disease on the basis of who is deemed at risk and whose interests are best served by its effects. Like De La Cruz and Schulman, Wojnarowicz’s analysis places HIV/AIDS within a preexisting context of institutionalized discrimination, revealing how political policy bears calamitous effects on the health of those populations most likely to be targeted by government neglect.

In addressing these issues, Wojnarowicz’s memoir attests to his refusal to be depoliticized or made invisible by the atrocities of HIV/AIDS. Wojnarowicz vows that “I don’t want to witness the silencing of my own body. I don’t want to be polite and crawl into the media grave of ‘AIDS’ and disappear quietly” (230). This message remains central within Wojnarowicz’s photography as well. In a series of self-portraits, Wojnarowicz portrays himself with his mouth sewn shut and with his body buried alive. In a photograph by Bill Dobbs, Wojnarowicz sports a denim jacket with a pink triangle on the back, relaying the message that “if I die of AIDS – forget burial – just drop my body on the steps of the F.D.A” (80). In his unpublished “AIDS Journals,” Stuart Edelson, another New York-based writer and artist,

similarly speaks to this unwillingness to “disappear quietly.” Edelson reveals how the visibility of people living with HIV/AIDS is actually exacerbated by a system which forces those who are ill to continue to participate in the workforce. As Edelson depicts:

I have a pretty good idea that the amount of money I would have to live on if I went on permanent disability, would be totally inadequate to cover my needs. I would be acquiring a new and worse disease called POVERTY! So I've decided to put that inevitability off for as long as I can. Let me embarrass or disgust them all into knowing how mean our system is.

Edelson illustrates how the debilitating symptoms of illness become embodied manifestations of institutional neglect. Edelson's never-published journals not only shed light on the dire effects of government policies, but such forgotten documents also attest to the struggles and resistance undertaken by those who died of HIV/AIDS.

Like Edelson, Wojnarowicz also maps the correlations between public policy, social position, and access to care. Wojnarowicz illustrates how reactions to HIV/AIDS would differ if the virus more visibly affected dominant groups. He argues that "if this were a disease that appeared to strike only politicians and religious leaders, would the president hesitate for more than twenty-four hours to allocate more funds for research and health care?" (159). In accordance with Wojnarowicz's observation, many others point to the discrepancy between reactions to HIV/AIDS and responses to the contemporaneous epidemic, Legionnaire's Disease. An epidemic slightly preceding HIV/AIDS in 1976, Legionnaire's Disease struck a group of American Legion members attending a convention in Philadelphia, causing an illness that was later discovered to have spread through the hotel's ventilation system. (Foege 616) As Maxine

Wolfe illustrates in “ACT UP: A Direct Model of Community Research for AIDS Prevention,” Legionnaire’s Disease, unlike HIV/AIDS, was treated as a matter deserving of unyielding resources and attention, provoking a “rapid and well-funded response to uncovering the cause of death of a small number of American Legion members” (227). Bryan similarly observes that:

Legionnaire’s disease and toxic shock syndrome had appeared in the recent past, and the concern for ‘innocent victims’ had caused a flurry of activity among government and medical personnel as well as special interest groups. Money had been immediately appropriated and the soothing social blanket of ‘We’re doing all we can—we’ll take care of you’ was thrown over the panicked country by a sympathetic media. Here was the opportunity for us to observe society’s commitment to its gay population. (69)

As Larry Kramer attests in *Reports from the Holocaust*, the government’s indifference, held in stark contrast to its reactions to other epidemics, serves the reverse effect of unveiling how little those in power value queer people’s lives. Kramer argues that “if KS were a new form of cancer attacking straight people, it would be receiving constant media attention, and [. . .] research would be proceeding with greater intensity. The very government agency—the Centers for Disease Control, in Atlanta—that is monitoring KS so slowly is the same CDC that vigorously investigated Legionnaire’s disease” (20). Such comparisons illustrate the magnitude with which homophobia, racism, and class-based discrimination serve to render populations unworthy of health advocacy and social intervention. As a poster by Gran Fury challenges us to ask: “When a government turns its back on its people, is it a civil war? The U.S. Government considers the 47, 524 dead from AIDS expendable. Aren’t the ‘right’ people dying? Is this medical apartheid?”

Such documents inspire an interrogation into the ways in which health care in this country is distributed not universally according to need but rather is stratified along the lines of sexuality, citizenship status, class, and race. In *Medical Apartheid: The Dark History of Medical Experimentation of Black Americans from Colonial Times to the Present*, Harriet A. Washington explores this bifurcation of the health care industry along racial lines. She documents the medical injustices faced by African Americans, unveiling a long history of exploitation and inadequate care. Addressing the consequences of a racially-bound health care system on HIV/AIDS, Washington raises a series of questions regarding the outcome of such inequalities: “had African Americans not been excluded from early AZT therapy on the basis of flawed HIV-treatment clinical trials (that largely excluded them), would the number of HIV-infected African Americans be lower today? Would the number of all domestic AIDS cases be lower, considering that black Americans today constitute half of all the HIV-infected?” (400). Connecting the experience of HIV-positive African Americans to a broader history of exclusion and abuse, Washington exposes how the “mounting evidence of the racial health divide confronts us everywhere we look” (3). Washington demonstrates how reactions to HIV/AIDS are directly tied to racist and class-based perceptions of the disease. She argues that “because AIDS strikes the marginalized, concern and sympathy have been largely replaced by stigmatization, moral judgment, and deadly indifference” (330). Washington’s analysis mirrors the message at the crux of both Schulman and Wojnarowicz’s writings. Like Washington, Wojnarowicz’s narrative and artistic work illustrates that allowing people to die because of their sexual desires, income, or skin color represents nothing less than “public and social murder” (107), and should thus be perceived and treated as such.

In conveying this message that "denying all people information that could protect them in an epidemic is nothing more than wholesale murder" (133), Wojnarowicz employs Holocaust analogies to reiterate the severity of HIV/AIDS upon his community and his own life. He observes that "to be losing one's friends at a relatively young age leaves one with what I imagine a concentration camp survivor might feel—to be the repository of so many voices and memories and gestures of those who haven't make it; *those who have died from the way this disease was handled by those in positions of power*" (229). As John Charles Goshert argues in "The Aporia of AIDS and/as Holocaust," such comparisons between the AIDS pandemic and the Nazi Holocaust are troubling because of notable differences between the two events, and because of the magnitude of indiscriminate misappropriations of the Holocaust to describe dissimilar situations. Goshert asserts that "the linkage of AIDS and/as Holocaust fails to form an adequate analogy through which current suffering could be rendered knowable" (67).

Goshert, however, also observes that when writers like Schulman and Kramer discuss AIDS in relation to the Holocaust, they do so not to indiscriminately assimilate the two events, but to reveal how the legacy of the Holocaust shapes the ways through which they understand their positions as witnesses to the decimation of their communities and friends. Goshert explains that for Jewish descendents of Holocaust survivors, connecting AIDS to their own histories "simultaneously inform[s] and irreparably complicate[s] the witnessing and testimony of the crisis of representation that has traveled alongside the emergence of AIDS" (68). In her fictional writing, Schulman places her characters in flux between living with the recent memory of the never-to-be repeated Nazi Holocaust and the role of witness-survivor to thousands of needless deaths from HIV/AIDS. As Michael Sherry observes in "The Language of War in AIDS discourse," Holocaust analogies including protest signs like, "Out of the Baths, Into the Ovens"

(42), as well as metaphors linking PWAs to the internment of Japanese-Americans during World War II, “highlighted human causation and the state’s agency—for human responsibility and state power are central to the experience of war—and it justified extreme action to challenge or shape state power” (44). Again these images are at once effective and problematic in their appropriations of outside cultural events to secure the desired effect of mobilizing governments.

In his reading of *People in Trouble* and *Rat Bohemia*, Goshert similarly posits that Schulman documents the Holocaust as the context from within which her characters experience HIV/AIDS in order to inspire urgent institutional reform. Goshert explains how Schulman actually differentiates the Holocaust from the HIV/AIDS crisis by positioning the family as “the locus of distinction between the two events” (62). Goshert shows how Kramer analogously draws attention to “this is a horrible singularity of the gay situation” (62), articulating the root of this difference between the two events in asking: “can Jews imagine being hated *by their parents* for their Jewishness?” (62). Like Wojnarowicz and Schulman, Kramer employs Holocaust analogies to connect homophobia to the historical pathologizing of queer sexuality itself. In *Reports from the Holocaust*, Kramer argues that “whatever else they were called, Jews were never thought of as ‘sick’ by the majority, nor Judaism an illness. Where did this notion of homosexuality as an ‘illness’ come from, and why has it persisted for so long?” (242). Linking the historical construction of a medically rooted homophobia to present day responses to a “homosexual disease,” Kramer admonishes New York City’s Mayor, Ed Koch, for refusing to provide adequate funding to combat HIV/AIDS. Kramer asserts that “with his silence on AIDS, the Mayor of New York is helping to kill us” (43). Like Wojnarowicz, Kramer points to the government as the source of the crisis, explaining that “AIDS didn’t just happen. It was allowed to happen [. . .] we definitely could have contained it” (258). Addressing Reagan, Kramer

decries that "there's only one word to describe his monumental disdain for the dead and dying: genocide" (158). Kramer's anger and outspokenness, however, is not intended merely to document history but as a call to action for governments, the gay community, and heterosexuals alike to alter their reactions to the crisis of AIDS.

Kramer's brash political intervention, however, was not met without criticism as many found fault with the polemics and rhetorics of his approach. Long, for instance, cites Edelman to critique Kramer's "equation of gay political passivity with murder" (101). Long recalls that "Kramer tended to present sexual identities in essentialist terms, addressing 'my people' as though there existed a monolithic gay community, and citing the usual list of history's hundred great homosexuals as though there were among them no nuances of self-understanding, not to mention complex multiple subjectivities constructed by vastly different historical contingencies" (101). Long reveals that even in Kramer's calls for government action in response to HIV/AIDS, the historical narrative that positions homosexuals as somehow lethal and fated for death remains infused in Kramer's speech. Long recounts that "Edelman further questioned what difference there was between Pat Buchanan's and Larry Kramer's assertions that gays were killing each other, supporting his contention that discourse on AIDS is always 'infected'" (101). Most problematic about Kramer's project, argues Long, is his inability to move his call for action out of the present context to understand how HIV/AIDS speaks to a wider historically based problem in health care provision and discrimination around access to care. Long writes that "HIV and health care have proven to be more complex and recalcitrant than any binary oversimplification can absorb. The tactical effectiveness of Kramer's discourse was thus far less effective at fostering continued action than it was at mobilizing it" (104). D'Adesky further points to the limitations of Kramer's Holocaust metaphors and rhetorical maneuvers, which though effective

in raising public awareness of HIV/AIDS as genocide, failed to consider the larger social and historical ramifications of the imagery he employed. In addressing the current state of the pandemic, D’Adesky returns to such formulations of “this weighty and difficult concept—genocide—with its historical gravitas and ability to make us wince, because I think it fits, for me, as the rare word I can find that matches the breadth and impact of the AIDS pandemic [. . .] [that] a lack of HIV treatment will cause for some 6 million of the now 46 million people who need drugs today” (322).

In a 1988 article from the PWAC *Newsline*, Michael Callen, another prominent and controversial AIDS activist and community leader, also portrays HIV/AIDS as genocide. In fact, it was Callen himself who initiated the *Newsline* as its original editor in 1985, to address the fallout of this government neglect. As Max Navarre reflects in “Fighting the Victim Label,” the *Newsline* effectively provided a forum for people to combat this institutionalized indifference, reclaiming agency in regards to their health. Navarre raises questions including:

What kind of information do those people normally get? What kind of care? Thanks to the miserliness and homophobia of our federal government, there are very few support systems available to the people who need them most: those living in rural areas, the impoverished, the incarcerated. The *Newsline* reaches some of these people (it is free to PWAs), and all of them have an opportunity to speak out, to let other PWAs know about their situations, simply by writing in. (146)

Through the vehicle of the *Newsline*, Callen employs community journalism as an outlet to publically draw these links between genocide and government negligence. Callen asserts that “AIDS is our Holocaust—and I do not use that analogy lightly” (72). Taking a far more

reductive approach than Schulman, and consequently achieving the accusatory effects and shock value cautioned by Goshert, Callen reasons that “if a government sees that its people are dying, and that government chooses *not* to do all it can do to end that suffering, then people are just as dead as those who were rounded up by the Nazi’s and gassed” (72). Unlike Schulman and Kramer who both experienced the Holocaust as decedents of survivors, Callen refuses to account for the differences in intentionality between the U.S. and Nazi governments. Callen focuses only on the fatal effects of ingrained homophobia and legislative inactivity on “dead who didn’t have to die” (72), and upon “our bravest and best [that] are falling all around us” (73). Drawing attention to the government’s lack of effective treatment options for people living with HIV/AIDS, Callen exposes the deadly outcomes of poorly structured clinical trials, underutilized prophylactic methods, and inadequate scientific research. Callen boldly claims that “there’s no other word for that besides genocide” (73). In similarity to Wojnarowicz, Kramer, and Schulman, Callen’s accusations against “the murderously slow business as usual federal bureaucracy” (73) become a meaningful call to action for queers to take matters into their own hands. This article, also delivered as a speech at New York’s gay pride rally in 1988, calls for community-based efforts around the continued establishment of drug trials, self-advocating for medications, and persistent political actions, forcing the government to begin to assume responsibility for the crisis of HIV/AIDS.

Callen, furthermore, connects government responses to HIV/AIDS to the criminalization of “gayness itself” (73). He argues that as “a tide of anti-gay violence washes over us, [the] stigma of AIDS joins with your garden variety of homophobia to light a fire of hatred and violence” (73). As Edelson concurs in his AIDS Journals, “in our present condition, it’s about as easy to feel good about being gay as it was for those entering gas chambers to celebrate their

Jewishness. [. . .] For me, the most painful aspects of AIDS is the return of the pathetic homosexual. It took so long to conquer that devil and here he is again” (4). Similarly, an article published anonymously in the *PWAC Newslines*, “Surviving the AIDS Genocide,” also takes up considerations of how institutionalized homophobia drastically alters the course of the disease. Identifying “a much wider problem than mere governmental callousness,” the author details the connections between harmful homophobic discourses and a process he terms, “covert genocide,” where “judgment is used as a basis for attempts to ‘help’ this group by forcing them to give up [their] negative characteristics.” Like Callen and Edelson, the author argues that AIDS deaths can be linked to the historically rooted “judgment” that “homosexuality is an unnatural and sterile life-style in which despair, misery and death are the natural and inevitable outcome.” Recalling the work of Vito Russo, the author links such beliefs to representations of queerness within popular media wherein gay relationships “almost invariably ended in suicide or murder for the homosexual characters or conversion to heterosexuality (perhaps a fate worse than death?).” The author ties such observations to the literary tradition as well, observing that “Christopher Isherwood [. . .] pointed out that stories about homosexual couples were acceptable and touching if one or both of them were dead (read *Death in Venice* for the clearest example).”

This mythology of the inevitable death of the homosexual is placed under scrutiny by a wide variety of activists and artists including Schulman, Callen, and Wojnarowicz. In his 1987 short film, “The ADS Epidemic,” Toronto-based activist filmmaker John Greyson challenges this paradigm by presenting viewers with the “Acquired Dread of Sex Syndrome.” Characters in outrageous apparel and stylized settings satirize Luchino Visconti’s film adaptation of *Death in Venice*, challenging the notion that queerness=death through a musical score whose subtitled lyrics read: “this is not a Death in Venice, / it’s a cheap unholy menace, / please ignore the moral

message.” Greyson’s parodic film also mimics newscasters’ reports of the modes of viral transmission, informing viewers that: “you can get ADS from watching TV [and] in sex ed classes, / you can get ADS from doctors and cops; / you can get ADS from high school jocks [. . .] you can get ADS from the Toronto Sun, / you can get ADS from Ronald Reagan.” Upon mentioning the U.S. President’s name, Greyson flashes a picture of Canadian Prime Minister, Brian Mulroney, connecting the notorious culpability of the U.S. government to the Canadian context. As Greyson humorously reveals, negative discourses linking homosexuality to unavoidable decline allow narratives to circulate which render AIDS deaths as inevitable, rather than the result of homophobia and government neglect.

This narrative yoking of queerness and inevitable decline is also explored by Jeff Nunokawa in “‘All the Sad Young Men’: AIDS and the Work of Mourning.” Like the anonymous author of “Surviving the AIDS Genocide,” Nunokawa explains that AIDS deaths are propelled by “more than a simple hatred of homosexuals” (311), because there exists “a kinder, gentler, and perhaps more pervasive homophobia [that] also counsels acquiescence to the catastrophic effects of AIDS, namely a deep cultural idea about the lethal character of male homosexuality” (311). Extending upon the observations of Schulman who warns readers of an increasingly slick and resilient homophobia that justifies the continued mistreatment of queers, Nunokawa argues that:

The reluctance of the Reagan administration, as well as most state and city governments, to furnish significant funding for research, treatment, or effective education [. . .] draws even the least suspicious observer to conclude that they didn’t and don’t care much about saving the kinds of people who were and are dying by the tens of thousands. (311)

Connecting historical discourses that equate homosexuality and death to those that allow the government to permit HIV's spread, Nunokawa acknowledges that in order to effect institutional change, such narratives of decline must first be unpacked and erased.

Callen also addresses the links between historical narratives of the doomed homosexual and the mythologies of HIV/AIDS. Throughout his work, Callen strives to dismantle the notion that one's sexual practices will result invariably in death. He instead argues for political resistance to statutes that equate homosexuality and promiscuity with inevitable destruction. In an Oral History interview with GMHC, Callen observes that "interestingly enough, all the long term survivors were politically involved in the struggle against AIDS. I was actually thinking of entitling my article, 'Politics: Are They the Cure for AIDS?' I kind of think they are, but that's another story." Presenting a direct correspondence between participation in social justice movements and personal health, Callen shows how long-term survivors "were involved outside themselves. They were self-concerned without being selfish [and were] very frisky, very opinionated, very educated about AIDS. A majority of them had thrown a doctor or health care provider out of their room for failing to explain a procedure or tell them what their options were." Refusing to relinquish self-determination to those in positions of authority, survivors, argues Callen, must continue to advocate for the right to their sexual desires and freedoms, as well as their medical needs. Callen reiterates these concerns in his book, *Surviving AIDS*, in which he debunks the myth that AIDS is a death sentence, providing readers with strategies for resistance. Like his edited volume *Surviving and Thriving with AIDS*, Callen recommends self-determination and political engagement as necessary prescriptions in the fight against the disease.

In contrast to De La Cruz and Schulman's recommendations to seek reconciliation with estranged parents and siblings, Callen also suggests "getting rid of relationships, sometimes even [. . .] family relationships that [are] not nurturing and not supportive and surrounding themselves with people who love them." Callen's advice recalls a crucial scene in *The Child*, wherein Eva dismisses the advice of "other gay people who [. . .] told her she should be relieved to be rid of [her family], just settle down with her friends and Mary and forget. They usually said this over a third martini, after five excuses, three lies, four missed deadlines, and every other sign that they themselves were [. . .] suffering from their own family's abandonment" (107). Schulman complicates Callen's advice, suggesting that although it may be necessary to cut ties to one's kin, the damage from the rejection of one's biological family produces irreparable ends. However limited in its ability to reverse this initial damage of familial loss, Callen's advice permits those who cannot reconcile with homophobic parents or siblings to rebuild a chosen network of support. Viewed in tandem, Callen's recommendations bolster Schulman's observations by offering a prescription for rebuilding chosen families through which to process these rejections themselves. Callen aptly calls attention to the importance of maintaining agency over situations like familial abandonment which may appear beyond personal control. It is this form of self-directed action, Callen shows, that allows people to survive in spite of infection. Callen ends his interview by asking: "was I controversial enough?" nodding to his own role as a heretical figure within the AIDS activist movement. By reinforcing his commitment to challenging even the most widely held beliefs, Callen turns accountability back to the government, the health care industry, the family, and even his queer community, forcing social institutions to claim responsibility for suffering in relation to HIV/AIDS.

While there exists a diverse selection of conventionally formatted articles exposing the homophobia underlying government neglect, HIV/AIDS archives also yield a wide variety of creatively designed, self-published materials to call the queer community to action in defense of their own lives. One such document from 1989 takes the format of a newspaper, *The New York Crimes*, “not to be confused with the *New York Times*,” with which it shares its layout and font. This “periodical” calls attention to the government atrocities ignored by the mainstream media. Featuring headlines like, “AIDS and Money: Healthcare or Wealthcare,” “Women and AIDS: Our Government’s Willful Neglect,” and “Koch Fucks Up Again,” this paper covers those stories conspicuously absent from *The Times*, holding authorities accountable for their untenable reaction to HIV/AIDS. Directly confronting the underrepresentation of AIDS in the media, *The Crimes* exposes the adverse effects of this institutional invisibilizing of women, people of color, the homeless, and prisoners. *The Crimes* illustrates “how inadequate and indeed morally reprehensible the City’s response to the AIDS crisis has been.” The *Crimes* urges readers to break this media silence, no longer allowing public information sources like *The Times* to conceal the lack of response by the City’s leadership.

Another creative publication from 1992 takes the form of a brightly colored newsletter titled, *Wake Up Queers or We’re All Through*. Published by a group of “Anonymous Queers,” this graphically alluring, full-size printout addresses concerns including the leadership role of lesbians within HIV/AIDS movements, questions of power and race, and the refusal to accept empty tokenistic measures such as the red ribbon campaign. One article features an illustration of a red ribbon in the shape of a noose, followed by the caption: “Watching AIDS ‘awareness’ mutate from a simple red memorial ribbon to a sequined fashion accessory makes me want to hang myself with one.” This author explains that “I’m sick of people who want to ‘symbolize’

their concern over the traumatic decimation of queers. Red ribbons remind me not of the dead, but of the rest of us, who live in a world where a mere nod to such unthinkable suffering is considered an appropriate response.” Rather than feel something has been accomplished through the symbolic donning of a ribbon, this article suggests that a more effective response to HIV/AIDS involves actively challenging institutions like “the corrupt and imbalanced healthcare system, which was devised and nurtured by profit-minded murderers and their million-dollar lobbyists.” Once again, accusations of government inefficiency are presented as an indictment that “now is the time to act. Not through empathy, or gestures of concern, or advocacy [. . .] but by kicking ass, for the lives of our future brothers and sisters. *And in the memory of those already gone.*” Drawing on this tradition of challenging mainstream symbols of HIV/AIDS, similar critiques of the red ribbon campaign appear in contemporary forums. For instance, in 2008, a self-portrait by HIV-positive photographer, Richard Sawdon Smith, features his naked body, blindfolded and bound by a giant red ribbon. Sawdon Smith’s portrait gestures not only to the remembrance of those who are dead, but also to how the ribbon “has been institutionalised and appropriated too as a potentially insincere shorthand for institutions and businesses to appear as caring, while at the same time questions the definition of a person solely by their illness” (1). *Wake Up Queers* draws attention to this very conundrum, revealing the limiting and problematic meanings underlying the ribbon as a cultural representation of HIV/AIDS.

In addition to complicating cultural symbols of HIV/AIDS, *Wake Up Queers* also warns readers that “the AIDS crisis is genocide, a handy extermination of the unwanted. But until we’re all dead, AIDS will operate an industry that makes a killing off our lives and our deaths.” Putting a nuanced spin on the connections between genocide and government responses to HIV/AIDS, this article shows how AIDS deaths are motivated not only by ideological forces like

homophobia, but by the material and economic tenants of a capitalist health provision industry. This article emphasizes how the treatment of those living with HIV/AIDS cannot be viewed without an investigation into the structures underlying the health care system itself. It shows how “the system has a lot invested in keeping the industry growing: it keeps critics at bay, it creates the illusion that they care, and it reaps huge profits for them.” Published in 1992, this statement still carries great weight today as we live in the midst of a global pandemic which generates a multi-billion dollar industry for drug companies whose profits would wane with the discovery of a vaccination or cure.

D’Adesky, accordingly, identifies the potential of global AIDS activism to subject the drug industry itself to radical reform. She mirrors the concerns of the Anonymous Queers as she writes that “looking beyond AIDS to the greater revolution in global health-care and policy, will the gains of the access movement extend to other arenas? Will medicine for life-threatening diseases be removed from the realm of commercial profits? Will the battle of AIDS drugs and patents lead to wider uses of generics globally?” (18). Similarly, in his introduction to *Global AIDS: Myths and Facts*, Paul Farmer also addresses HIV/AIDS not as an isolated event, but as indicative of wider medical concerns. He illustrates that:

We can accept a world of radical polarization [. . .] in which the calculus of cost-effectiveness determines that poor people must die of disease for which the affluent are successfully treated as a matter of course. Or we can work for a world of solidarity, in which people from different backgrounds cooperate to mobilize resources and build the foundations of a dignified life for all, prioritizing the needs of the most vulnerable. (xxiii)

It is this refusal to mobilize resources and to treat health care not as a commodity, but as a basic human right, that obstructs efforts toward both treatment and prevention, allowing for continued devastation by HIV/AIDS.

In one of the final entries from his hospital diaries, Vito Russo addresses precisely these connections between a profit-driven service industry and the health of people living with HIV/AIDS. Russo expresses the anger that results from watching one's own body deteriorate in the face of government apathy and negligence. He writes that "I no longer believe the extortion that if I'm patient and cooperative 'something will come along.' I have nothing to lose as long as greedy, money-grubbing, power hungry people are in charge I'm just a pawn in your marketing strategies." Russo fervently connects his own death to the inadequacy of the American health care system. He reprimands the apathy of those working within this system, extending that:

I blame all the doctors who are dullards, robots and placators- women and men more concerned with their public image in a profession twisted by greed than with their dying patients. Cowards who keep silent because an activist doctor is unacceptable to the sick, inhumane establishment to which they toady every day of their miserable lives which consist mostly of buying a country house and planting tulip bulbs for the spring.

Although Russo died in 1990, his diaries mirror Farmer's 2003 account that views the HIV/AIDS crisis not as the catastrophic outcome of a wayward virus, but as the result of a system based on unequal access to resources, treatment, and care.

Central to our understanding of the pandemic today, the appearance of such critiques can be traced back to early journalistic accounts of public responses to HIV/AIDS. For instance, in

their 1987 article, “Insuring Profits from AIDS: The Economics of an Epidemic,” Mark McGrath and Rob Sutcliffe document a discursive shift from the notion that “AIDS might not be too bad a thing if it reduced the world’s population of undesirables and deviants” (9), to the contemporary view that AIDS is a “serious” (9) problem that cannot be ignored. As Steven Kruger argues in *AIDS Narratives: Gender and Sexuality, Fiction and Science*, this shift was also marked by the growing fear that HIV/AIDS could also affect those within the “general population” (80), making the disease a subject for mass concern only once it could be contracted by those who did not identify themselves as drug users or queers. Like Russo, McGrath and Sutcliffe further link the devastation of HIV/AIDS to the existence of health services where “health is in many respects still a commodity provided for profit” (11). Such profitable conditions, though driving governments out of their “criminal inertia” (13), allows HIV to spread in a manner that disproportionately affects “economically disadvantaged sections of the population” (14), creating a two-tiered system of treatment where those who cannot afford access become the recipients of a “genocide of neglect” (24).

Wake Up Queers also voices similar fears that AIDS deaths will continue out of motives of profit. The Anonymous Queers caution that “our government was never set up to meet the needs of its people. Especially people who are expendable: queers, all people of color, all women and the poor.” The authors reason that because of the inequalities built into American social systems like the health care industry, a disease will not be motive enough to save the lives of those whose rights have been denied since this country’s inception. The authors also state that “no systems, laws, codes of behavior, policies or initiatives have been freely granted to protect us. And the system won’t give them over now just because we’re battling a fatal illness. We must fight for our rights and fight for our lives.” As the article continues, it takes an interesting

spin, connecting the activist goal to “fight for our lives” to the proliferation of positions and services that have sprouted up in the queer community and within the AIDS industry in general. The authors argue that although “we are the executive directors, policymakers, fundraisers, grant writers, lawyers and case workers [. . .] we are still supporting and supported by a system that wants us to die.” Ironically, in helping to abate the AIDS crisis by providing essential, concrete forms of advocacy, prevention, and care, service providers are actually shifting responsibility away from elected officials who continue to negate their leadership roles in fighting disease: “We work hard so men in power don’t look so evil as they pick us off one by one [. . .] Meanwhile, they are hiding behind our hard work.” As a result of this troubling observation, the authors conclude that “the primary goal of anyone working in AIDS who cares about PWA’s should be to lose their job.” Oddly enough, the paradoxical reality around HIV/AIDS service work is that workers must actually diminish the requirement for their work to continue. The article urges those in service positions to:

Eliminate the need for your job, your services, by fighting the system that perpetuates them. Copy demonstration flyers on your office Xerox machine. Organize your clients to demand more services from the government. Miss too many days of work for being at demonstrations. Criticize your boss openly. Get on TV, in the papers, on the radio, questioning your agency’s use of funds. Fight with doctors and bureaucrats. Pass on inside information to others who can use it against the system. Falsify official documents in favor of clients. Lie to superiors. Distribute AIDS medications without a license to clients without Medicaid. Exchange dirty needles for clean ones. Use the system against itself. All you’ve got to lose is your job. PWAs have their lives at stake.

HIV/AIDS activist work, the authors illustrate, cannot be legitimated nor can it be professionalized by existing within an institutional context. For activism to be effective, it must break the rules of state-sanctioned services and conventional employment, transgressing boundaries of acceptability in order combat the injustices that necessitate these very institutional structures themselves.

This conflict between activism and propriety, justice and law, is grappled with by Schulman in her premiere HIV/AIDS novel, *People in Trouble*. Just as *The Child* raises legal concerns about who is responsible for fifteen-year-old Stewart Mulcahey after he is exiled from his family for being queer, Schulman's earlier work poses important questions about how we as individuals can respond to those institutions that so greatly affect our personal lives. *People in Trouble* raises the dilemma of how to challenge unjust laws and corporations when it is these systems themselves that prevent people from standing up for what "is right" (47). The novel ends by announcing precisely this predicament that "we are a people in trouble. We do not act" (228). This statement is grammatically constructed so that causality disappears—it cannot be determined whether our trouble comes from our inability to act, or whether our inaction is a result of our previously occurring status as being in trouble. This paradigm is demonstrated earlier in the novel when Molly's dying friend Ronnie wishes to oppose double-blind clinical trials but feels silenced by these very structures that threaten his chance to survive: "he was afraid that if he made trouble they would give him sugar instead of medicine" (45). Unlike this "troubled" character, the novel's reader is privy to the historical wisdom that thanks to the help of groups like ACT UP, such double-blind placebo studies were discontinued in the case of AIDS, revealing the utility of direct action in opposing medical injustices.

The novel, likewise, introduces the fictional activist group, aptly named Justice, to demand that authorities begin to provide “prevention, care and cure” (118). Like the *Wake Up Queers* newsletter, Justice spokesperson James explains that “America will never be healthy as long as it exists in an advanced state of hypocrisy” (118). James, furthermore, refuses to wait for the system to right itself but instead takes action, inspiring his peers to stand up and “correct this wrong” (118). As the Anonymous Queers assert, when people are dying, it is morally reprehensible to sit back and do nothing, even if it means breaking the rules. *People in Trouble*, consequently, reserves special praise for those AIDS activists like the “band of veterans from the now defunct women’s liberation movement who [. . .] weren’t afraid of getting arrested” (159). Mirroring the Anonymous Queers’ recommendation to strive toward losing your job, Justice members reveal that even those working outside of the AIDS industry have a responsibility to exploit bureaucratic resources. In one motivational speech, an activist, Daisy, declares that “we don’t need offices. We are employed in offices. Steal Xerox, take White-Out, use postage machines, make phone calls. Your job is a prison of measured time. So make their time work for you” (157).

Schulman’s novel also traces the historical roots underlying AIDS activist groups like ACT UP. *People in Trouble* connects HIV/AIDS organizing to a historical lineage of queer political movements, using Justice’s diverse membership to illustrate the multi-faceted movements that predicated its formation. Schulman positions Justice as an exciting opportunity for “old-time radicals of various stripes who had rioted in the sixties at Stonewall” (158) to unite with “street Furies who had all been around the block a couple times,” (158) and even “distinguished homosexuals with white-boy jobs, who had forgotten that they were *queer* until AIDS came along” (158), because they “found out what a lifetime of anger could create” (158).

Schulman connects notions of “queerness” to activism, arguing that anyone can be a homosexual but that it requires an awareness of how gender and sexuality are politicized in order to gain a sense of oneself as “queer.” It is this transformation that bohemian artist Kate undergoes throughout the novel as she begins to understand how her sexuality can extend beyond physical desire into the transgressive realm of occupying a deviant lesbian subculture as well as a non-normative gender identity. It is this sense of difference that ties Kate to the AIDS activist movement and to a community of other radical queers. As she recognizes upon talking to a stranger on the bus, “it was our gayness that connected us [. . .] it is the danger that brings you together, makes you need each other and feel so close” (162). Schulman illustrates how movements like Justice are not merely driven by personal urgency and social responsibility but also by the communal need to validate queer identities, histories, and selves. Supplementing the failures of the biological family to provide acceptance, ancestry, and belonging, Schulman illustrates how queers can come together cross-generationally and across gender lines to rebuild familial networks of support.

In addition to sedimenting this connection between HIV/AIDS organizing and queer community building, *People in Trouble* also explores obstacles to constructing effective social justice movements. In response to Justice’s call to action, the omniscient narrator remarks that “no one can ever be as angry when it’s hopeless as they can be when there’s something to be done about it. People work for change when they think there’s a chance of getting it. Otherwise they say, ‘Why bother?’” (119). This question of how to believe in the ability to effect change is answered through the novel’s romance. Molly’s relentless determination to pursue a relationship with the married and closeted Kate mirrors the very philosophy that enables her to take political action against HIV/AIDS. Her attitude as an activist stems from her conviction as a lover who

firmly “belie[ves] in everyone’s potential for change, and [who] continued despite the odds. She was willful. She was desiring. She was very deliberate” (42). As Molly learns from her relationship, “fighting with someone is very, very intimate. Tolerating them is condescending but being angry at someone is the best way of keeping them in your life [. . .] when you are angry at someone, they are present. You have something to be mad at, you have them. Then they have to consider you” (42). Anger, Schulman reveals, become analogously productive as the force which motivates both the recognition that something is awry, as well as actual change itself. In similarity to *Rat Bohemia*’s depiction of “the war-weary ACT UPers seething in the pews” (82), *People in Trouble* fictionalizes anger as an overwhelming force in not only motivating Molly’s pursuit of Kate, but also in the narrative leading up to Molly’s participation in Justice. The narrator repeatedly reveals how in relation to HIV/AIDS, “all [Molly] knew was anger” (72). She is described as “very angry with an energy that had nowhere to go” (47). Like her friend Jeffrey who becomes “really furious” (73) at the end of his life, Molly represents a band of activists who are “tired of feeling helpless in hospital rooms” (94) and are looking for “something substantial to do in the face of all these funerals” (94). Molly demonstrates that people must “unite in anger” (158) to combat HIV/AIDS. As Molly recognizes both politically and in her personal desire for Kate, the most effective battle is waged by those who “have nothing to lose” (74), and who are angry enough to participate in a movement for actual change.

In his unpublished journals, Bradley Ball, a political organizer alongside Schulman who served as the first recording secretary of ACT UP, also investigates this motivating function of anger. Ball’s personal narratives mirror Schulman’s fictional project of tracing the connections between queerness, rage, loss, and organizing toward social reform. Ball’s diaries and letters

chart the emotional and political climate underlying the formation of ACT UP in 1987. Ball writes that:

Oh God, I'm tired and angry. I've been living with AIDS for so long. [. . .] On my way home I remembered what I heard John Rechy say in 1980. He said that gay people are the only minority group bound and determined to demonstrate how happy they are. Michael Savino and I were talking about the spontaneous candlelight vigil that was held right after Harvey Milk had been shot. The blacks could never understand why the gays weren't *angry*. Watching *Eyes on the Prize*, one notices that every succeeding funeral oration gets angrier and angrier.

Ball connects the gay rights movement to the struggle for civil rights, noting the failure of queers to express the productive rage demonstrated by African-Americans. It should, however, be noted that Ball makes this comparison through somewhat problematic terms, adopting a troubling outsider position from the communities he discusses. Ball's journals nevertheless chart how the AIDS crisis incited queers to reconfigure their movement from one of passivity to one powered by rage. Just as sentiments of "enormous anger" (47) are central to Schulman's fictional account, such feelings are also preserved in historical documents like those of Ball, historicizing the mounting fury in response to institutionalized homophobia and HIV/AIDS.

In his journals, Ball also links the HIV/AIDS crisis to the birth of the gay rights movement, expressing his frustrations with the increasingly commercialized nature of Gay Pride. He writes that:

Goddammit, I'm so fucking angry! Stonewall was supposed to bring us out of the closet and into the streets. In 1977 it was Anita Bryant. We were supposed to unite against her

hateful campaign. And now there's this awful disease which is knocking us over like dominoes and this is supposed to be bringing us together. And we're lighting candles and singing songs and planning for floats and balloons and celebration.

Rejecting the cheerful auspices of Pride, Ball finds in ACT UP an opportunity to react to the government's "pitiful five year plan for AIDS," and to publicize the anger that should be driving the movement. Ball regards the HIV/AIDS crisis as an incentive toward reclaiming and redefining public demonstrations of what it means to be queer. In a letter to Don Luxton from 1988, Ball connects the mobilization of the gay community to a wider landscape of government neglect. Ball describes how:

The political situation continues to deteriorate. Meanwhile we plan our presence in the lesbian and gay pride parade. Meanwhile we plan an offensive civil disobedience against the food and drug administration. The goal there is to set the stage for a political show trial. There are plans. The group gets bigger and bigger and angrier and angrier. The spectrum of issues to be addressed gets broader and broader.

Through his writing, Ball charts how activism emerges in response to government initiatives which he describes as "worse than a farce." As his entries progress, Ball's own experience of living with HIV, in tandem with his increasing political awareness around issues of social justice, allows him to reconceive the struggle for gay rights as a movement that intersects with a host of other histories of resistance. Developing a far more informed perspective than that of his earlier comparison between the Milk assassination and civil rights, Ball's writing begins to identify factors that differentiate as well as those which unify diverse movements for social reform.

For instance, in an entry from 1990, Ball takes up questions of how sexual oppression is tied to race and class, quoting bell hooks to better understand his own situation. Ball draws from hooks's observation that "as more middle class white women lose status and enter the ranks of the poor, they may find it necessary to criticize capitalism [. . .] Hard times have a remarkable way of opening your eyes." Ball traces his own shift in class position to his ability to critique not only the government's reaction to HIV/AIDS specifically, but also the larger systems within which HIV/AIDS exists. He reflects that "certainly my abrupt slide from white-collar administrator to unemployed, to unemployable, to suicidally depressed, to welfare recipient, to disability recipient intensified my radical orientation from liberal reformist to revolutionary anarchist." Ball's journal maps this ideological shift, tracing how his own politicization and anger relate to and extend beyond his experience of disease.

In charting this transformation, Ball's journals also trace his community's evolving reactions to illness and death. In an entry from 1987, Ball envisions his own death from AIDS. Like Schulman's characters, Ball ties thoughts of his mortality to the activist movement in which he takes part. As a result, he begins to imagine his own life and death as a political act. Ball writes that:

I thought about my funeral. If people are going to carry candles, I'd rather they lit torches. If people are going to sing pretty songs, I'd rather they sang a march. If people are going to be silent for half an hour, I'd rather they do like the Jews at Jericho and march around the city in absolute silence for six days. And if someone is going to play "Taps," I'd rather they do like the Jews at Jericho and blow trumpets on the seventh day and make a great noise and collapse the walls.

Ball's passionate vision of his own funeral reflects the urgency shared by fellow AIDS activists including New York City-based writer, David Feinberg, to publicize and politicize death. In *Queer and Loathing*, Feinberg discusses the impact of political funerals, stressing that "this is not a game. This is life and death. This is murder. This is the physical evidence. This is AIDS" (264). As an "advertisement" from *Wake Up Queers* similarly attests, "throughout the AIDS crisis, furious activists with advanced HIV disease have been saying they want their deaths to help further the fight against this country's neglect and incompetence in the face of AIDS." Pointing out that many deaths have gone unacknowledged and unvalued by the government, this "ad" reveals that unnecessary deaths and dead bodies themselves may actually be used for political ends: "For years, the desires of activists who want to make a final statement with their bodies have gotten lost in a flurry of bereavement, familial wishes and the plain American terror of death. We think it's time our premature deaths carry some of the same fury and focus that have marked our lives." Creating an "organization that can carry out the directives of fellow PWA's who want political funerals," this ad offers to help community members plan their own politicized deaths, "whether that means a procession down Fifth Avenue, delivery of the coffin to the White House, or whatever. We're taking this action out of love and rage. The times are only getting more desperate. If you're interested, we'd like to talk to you." Like Ball's speculations, this proposal allows those with terminal illnesses to gain control over something as finalistic and dismal as an unnecessary death.

Nunokawa, however, calls attention to the limitations underlying such acts of politicized mourning, evidencing how images of dead gay men are provoked by a homophobic culture that permits AIDS deaths to happen. He argues that "at the same time that a virulent or embarrassed distaste for homosexuals functions to silence the mourning of gay culture, a softer homophobia

helps to incite it” (319). Nunokawa argues that although brave acts of publicizing grief may initially appear as transgressive, “the variegated regime of heterosexism not only inhibits the work of acknowledging the loss of a gay man, it also exacts the incessant reproduction of this labor, by casting his death as his definition” (319). Nunokawa outlines how in publically parading the bodies of dead gay men, male homosexuality is problematically defined in relation to this historically rooted trope of inevitable queer decline. In *Melancholia and Moralism*, Douglas Crimp also identifies similar problems, characterizing political funerals as all too often appearing “indulgent, sentimental, defeatist—a perspective only reinforced, as Kramer implies, by media constructions of us as hapless victims” (132-3). Just as Crimp and Nunokawa point to the unsustainability of political mourning, Ball too becomes alienated by symbolic attempts to assert one’s politics posthumously. Even the ad in *Wake Up Queers* acknowledges how a lack of effective political mourning may be tied to our cultural practices in relation to death: “political funerals has remained just that—an idea. Political funerals aren’t part of the American activist tradition, as they are in Ireland, South Africa, and other countries.”

Acknowledging the problems inherent to U.S.-based, activist funerals, Ball critiques his own earlier vision, observing in a journal entry from November 1992, that:

A political funeral was held on Monday. Mark Fisher had his open casket delivered to the door of the Republican campaign headquarters in New York. From David Robinson tossing his lover’s ashes on the White House Lawn to David Wojnarowicz to this, political funerals are now, I’m afraid, less an action and more a vogue. I once wanted such a funeral and the truth is I wanted it so that people would see how absolutely I had committed my body and soul to the cause.

Forced to resign from his position in ACT UP because of political disagreements among the membership, Ball feels lost without the movement to provide him with an activist outlet and with community support. Dismissed by the organization to which he dedicated so much of his life, Ball views ACT UP with a sense of accomplishment as well as with resentment and regret. Ball's journals provide a complex narrative of political commitment and personal growth through which he documents his lived experience with HIV/AIDS. In detailing a complex range of emotions, Ball's journals not only provide a forum for self-awareness but also remain an important historical record of how cultural resistance transformed personal as well as public reactions to the pandemic itself.

In her recent work, Schulman calls attention to the problematic disappearance of voices like Ball's, as narratives like those preserved in his diaries are replaced with historically inaccurate representations of HIV/AIDS. In *Stagestruck*, Schulman points to the dearth of mainstream representations of how queer communities fought back against a government that wanted them dead and in doing so brought about social, medical, and political reform. Schulman argues that current discourses instead credit those very institutions whose callous indifference initially permitted the epidemic to spread. Critics including Celia Farber point to the scientific inaccuracy of lauding governments for taking credit for medical interventions like AZT, a drug Farber argues, which should be remembered instead for its "toxicities and flawed science" (181). As critics like Susan Smith demonstrate, illness history is consistently laden with similar narratives that figure governments as "saving" populations whose health care gains were initiated by affected communities to counter marginalization from these indifferent governments. Smith reveals how such a rhetorical move is not new, nor is it specific to HIV/AIDS. Smith recalls that from yellow fever to syphilis, African American communities have consistently provided

their own health care systems in response to government neglect, a form of political resistance often obscured and later credited to government programs and initiatives, many of which did more harm than good. (Smith 82) As Smith observes, “government interest in black health was not without its price. Ironically, federal attention to disease in black Americans could have a detrimental impact on the health of the black poor” (82).

A similar narrative trend can also be observed in relation to the history of malaria. In *Malaria: Poverty, Race, and Public Health in the United States*, Margaret Humphreys explodes the common notion that malaria was eradicated by “some combination of determined disease fighters and public health technology” (2). Humphreys revisits these mythologies of malaria, exposing that “this is not what happened, either in the nineteenth century or in the twentieth” (2). As in the case of AZT, a drug widely held as a scientific breakthrough intervention against HIV/AIDS, Humphreys uncovers how “most versions of malaria’s career in the United States attribute its demise to the U.S. Public Health Service’s DDT campaign of the 1940s” (2). Humphreys argues that while this is a “plausible explanation” (2) it at most “accounts for only a tiny percentage of malaria’s reduction, since malaria had largely disappeared before it could be eradicated by DDT” (2). Humphreys, furthermore, explains how as a result of such narratives of the successes of DDT, the Centers for Disease Control became a credible public institution. (133) Humphreys documents that “the public demand for DDT did much to solidify the image and reputation of the fledgling CDC. Yet this burst of activity occurred when malaria seemed to be disappearing” (134). Humphreys thus reveals how narratives commemorating the discursive success of perilous treatments like AZT and DDT bolster medical institutions by oversimplifying and reducing histories of illness to purely scientific rather than social interventions into disease.

In order to illustrate the disconnect between such dominant narratives of government intervention and the multifaceted struggles and successes of the AIDS activist movement, Schulman undertakes an investigation of Jonathan Larson's Broadway hit, *Rent*. Schulman compares *Rent* with its inspiration, her own *People in Trouble*, outlining the larger cultural repercussions of Larson's appropriation of her novel. Schulman observes that "while relying on my work for structure and content, he had transformed it into a dominant-culture piece by removing the lesbian authorial voice" (13). Schulman argues that the "positioning of heterosexuals front and center of the crisis [. . .] denies the actual AIDS experience, both individually and socially" (54). Schulman argues that in drawing on her imagery, characters, and themes, but using them toward the expression of a normalizing tolerance where "'we' are all the same, as long as 'we' are represented from a dominant cultural point of view" (81), *Rent* not only overlooks the lived experience of gender discrimination, poverty, and racialization but creates a falsely equalized account where "the suffering and the existence of millions of gay people over centuries is completely erased" (102). *Stagestruck* charts Schulman's attempt to engage the Larsen estate in a legal battle over the lack of formal recognition awarded for her artistic contributions to *Rent*. Schulman concludes that her inability to claim due monetary and authorial credit remains secondary to the cultural implications of having queer works depoliticized and normalized into the dominant culture.

Schulman also examines this phenomenon in relation to the popular Hollywood film, *Philadelphia*, arguing that such mainstream productions represent queer people as alienated from their own communities and as reliant on dominant institutions for advocacy and support. Schulman views such distortions as "not only absurd but grossly ahistorical, since the abandonment of people with AIDS by heterosexual society is the most historically significant

factor in the initial escalation of the crisis in the United States” (49). Schulman emphasizes that in response to such misrepresentations, we must continue to assert that queer people living with HIV/AIDS are not helpless victims but members of an active community who came together to build “a world of services, advocacy organizations, and personal relationships in response to the epidemic that later became the foundation of support” (49-50) for others living with HIV.

Crimp, for instance, explains how contrary to dominant narratives of sex education as imposed upon queers by authorities, safer sex was not recommended by the government but invented by queer people in order to protect themselves and their partners. Filmmaker and former ACT UP/New York member, Jean Carlomusto documents this history in her upcoming film *Sex in an Epidemic*, which traces events and debates leading up to the invention of safer sex while portraying a history of community-based resistance to HIV/AIDS.

As Cindy Patton likewise reinforces in “Resistance and the Erotic: Reclaiming History, Setting Strategy as we Face AIDS,” it is crucial that we do not forget the “grassroots, community effort” (69) around safer sex. Patton points to the Federal Government’s initial refusal to “fund direct research on the efficacy of condoms” (70). Emphasizing the importance of documents like *How to Have Sex in an Epidemic*, coauthored by Michael Callen and Richard Berkowitz, Patton argues that “it is essential that those concerned with the broader implications for AIDS understand the history of the gay community’s safe sex organizing” (69). In *Globalizing AIDS*, Patton traces this history of safer sex, observing how “in the late 1970s, before anyone had even imagined AIDS, some gay periodicals were already promoting condom use [. . .] These preliminary community changes, designed to halt hepatitis B, rest on a political argument drawn from the women’s health movement” (66). Connecting queer safer sex initiatives to the advancements in self-advocacy central to the feminist health movement, Patton explains that “the

historic lack of STD care and especially the denial of information about prevention for gay men were caused by a homophobic medical system. In this late 1970s analysis by gay-health activists, STDs were not a fact of promiscuity but a means through which the state controlled sexuality” (66). Schulman, accordingly, traces the history of safer sex organizing in opposition to the negligence of the state, countering misrepresentation that safer sex was imposed from without. In *My American History*, she observes how:

Safe sex was invented by gay men. Michael Callen and Dr. Joseph Sonnabend claim authorship. It was publicized by gay men through networks and service organizations and graphic design and street activism, all born in and supported by the lesbian and gay community [. . .] with no help or else outright obstruction from the government. (113)

Like Patton, Schulman reclaims this important achievement in queer history as an outcome motivated by the negligence rather than the assistance of the US government.

In *Surviving AIDS*, Callen recalls his own role in the invention of safe(r) sex, remarking that “although ‘avoiding the exchange of potentially infectious bodily fluids’ has now become the accepted standard of AIDS risk reduction, we were harshly criticized—especially by the Gay Men’s Health Crisis (GMHC)—when we first proposed it” (7). Daryl Wein’s 2008 documentary *Sex Positive*, also pays tribute to the struggles and achievements of Richard Berkowitz, one of the co-founders of the safer sex movement. In *Stayin’ Alive: The Invention of Safe Sex, A Personal History*, Berkowitz details his work with Callen and Sonnabend, documenting how governments not only failed to respond to the crisis and to provide safer sex materials, but how “they actively opposed those of us who produced these recommendations with our own resources” (175). As Carlomusto documents in her film, Callen and Berkowitz’s

recommendation that gay men alter their sexual behavior not only sparked awareness and sex education programs but also yielded great controversy and debate.

Such debates regarding the creation of safer sex are also documented in a GMHC Oral History interview with Larry Mass. The author of a critical body of the emerging literature on HIV/AIDS, Mass produced some of the earliest AIDS journalism published in the gay newspaper, *The New York Native*. A gay physician and AIDS activist, Mass worked to re-envision how a wide range of queer sex acts could be practiced without the transmission of HIV. Deeply concerned that fears of viral transmission would undermine the revolutionary work of gay men in the 1970s who advocated for non-monogamous, sex positive relationship configurations, Mass worked with other members of the gay community to protect what he views as “non negotiable” advances in queer life. Mass recollects that “I was not willing to retreat [. . .] from my belief in the greater values of the sexual revolution. And I fought very hard early on in the epidemic to maintain those values and withhold them.” As Mass demonstrates, it was activist work from within the gay community and not prescriptions from the government that allowed queers to reexamine sex as an activity that can be practiced while reducing risk or harm.

Responding to the erasure of these queer histories of resistance to HIV/AIDS, Schulman’s work attempts to re-center such narratives of community achievement. In *Queer and Loathing*, Feinberg similarly reveals that what compels him to write about HIV/AIDS is his desire “to reflect experiences of being HIV-positive and gay life so people can recognize their feelings and feel less isolated” (69). Schulman likewise views literature as a forum through which to represent collective experiences of homophobia, illness, and institutional marginalization. While such narratives are often overshadowed or replaced by commercially successful productions like *Rent*, Schulman’s creative enterprise remains invaluable in spite of

its limited marketing potential. As Feinberg attests, “books dealing with HIV/AIDS aren’t going to sell like Danielle Steel, but neither are books with primarily gay content” (69). Schulman’s writing, consequently, battles to break down this divide between what is deemed palatable for mass consumption and the underrepresented realities of her own experiences. Schulman strives to move representations of queerness out of the margins and into historical and artistic records of public life. As she writes in *My American History*, “my greatest wish for lesbian writing and for AIDS writing [is] to break out of the closed world of community, relationships, the privacy of coming out. The demand has not been made on the straight world, the male world. [. . .] I don’t want to only show straight people how we live. I also want to show them how they live” (251). In recognizing how the targeted marketing of her work toward queer readers prevents it from reaching a broader audience, Schulman remarks in *Stagestruck* that “I’ll never forget Michael Bronski’s comment at the Key West Writers’ Conference that the only reason something exists called ‘AIDS fiction’ is because of homophobia. Otherwise, it would be called American fiction” (23).

Schulman’s conviction to document these underrepresented histories of HIV/AIDS is reflected in the recurring discussions of witnessing and memory that emerge throughout her fictional work. In *Rat Bohemia*, Rita explains that “David is very concerned about being remembered [and] I’m concerned about remembering because, after all, I’m going to be left behind” (44). Rita observes how “Dave brings memory up all the time [. . .] he’s focused a lot of worry on being forgotten” (44). This obsession with memory is endemic not only to Schulman’s characters, but it remains a key thematic element within a range of HIV/AIDS fiction from this period. For instance, Bo Huston’s *Remember Me*, similarly features a narrator who works as a writer but fears that because he is young and unpublished, his legacy will be erased by

HIV/AIDS. Huston's narrator connects his frustrations around battling his way into the literary establishment to physically fighting HIV. The novel opens with the observation that while "death is merely a rumor" (9), "disappearance is the real dilemma" (9). Writing, as a result, becomes "my romance, my accomplishment, my fantasy, my chore" (123). Constantly "searching for safety and remembering" (123), Huston locates narrative not only as a strategy for the preservation of his health but as the key to maintaining his legacy as well.

In his non-fiction writing, Bradley Ball also expresses precisely this fear that if his diaries remain unpublished his contributions to the fight against HIV/AIDS will be overlooked by those who survive him. In an entry from 1992, Ball quotes Michael Callen, asking himself, "*what's your legacy, my mind demands to know. What difference have you made?*" Like the fictional characters of Schulman and Huston, Ball connects publication to the vital process of collective remembering, reflecting that "when I planned my suicide, *Outweek* had just folded so there would have been no space for an obituary. Now I'm out of the game and out of history." Ball raises questions central to *Rat Bohemia* and *Remember Me*, asking: "would anyone tell my story? What difference did I make? Someone is making a documentary about Bob. Michael Callen has a body of work and an astonishing record of achievement in the first decade of AIDS. I, too, want to be remembered, honored." Like Ball, Stuart Edelson similarly imagines how his memory will be treated once his is gone. He connects his impending death to the American literary tradition, reflecting that "there's also an image of Tom Sawyer's 'death' operating in me. I like to imagine the impact of my passing. It's fun to think I'll be favorably talked about." Mirroring Huston and Ball, Edelson worries that because he will die at a young age, his impact as a writer will soon be ignored. He writes that "I think, perhaps few will even notice I'm gone. So many gay men have dropped off the face of the earth over the past five years. Almost no one

mentions them. That's a part of our stigma. People are too embarrassed by the probable cause of their deaths. How many ways are we destroyed? Many!"

In *Rat Bohemia*, Schulman demonstrates that in order to counter these many forms of destruction, survivors must reclaim stigmatizing illness discourses while memorializing those lost to HIV/AIDS. As a young, gay, Jewish writer, Schulman's character David brings to mind literary figures like David Feinberg who share Schulman's position as queer historians of New York City life. In *Queer and Loathing*, however, Feinberg himself reveals the barriers that having AIDS places upon these crucial tasks. He writes that "I'm beginning to lose perspective. I need more distance. I cannot write about being ill when I am ill" (273). Recognizing this difficulty of documenting the pandemic from within its midst, Rita observes how David "is going by a very outdated definition of what history is. He was still pretending that history is the passing down of anecdotes from one set of friends to another. When they're all dead there is no more continuity of the generations. I'm the one who's going to be left and have to do all the remembering and frankly, I'm never going to tell those anecdotes to anyone" (50). While Rita expresses the fear of being unable to preserve the contributions of writers like David, Schulman's activist work strives to resist this erasure by building a historical record based on these very anecdotes themselves.

Using anecdotes and oral histories to build an archival record of the AIDS activist movement, Schulman, in partnership with filmmaker Jim Hubbard, created *The ACT UP Oral History Project*. A participant-observer record that documents the multiple realities of HIV/AIDS, the *Oral History Project* re-centralizes those experiences obscured by mainstream representations of the pandemic. Working in tandem with Hubbard, Schulman collects the testimonies of surviving members of the various cells of activity that comprised ACT UP/New

York. Through a growing collection of interviews, Schulman compiles narratives addressing subjects as wide ranging as media coverage, treatment advocacy, health insurance, racial representation, artist collectives (like Gran Fury), youth issues, women's struggles, queer activist histories, and global responses to HIV/AIDS. These retrospective accounts allow participants of ACT UP to reconstruct narratives of their experiences from a temporal distance in order to connect their losses and achievements to our contemporary understandings of HIV/AIDS.

The ACT UP Oral History Project, accordingly, collects a variety of narratives commemorating some of the late figures of the AIDS activist movement. Schulman's archive illustrates how this movement comprised a community wherein various members shared intimate and often familial connections resulting in an immeasurable sense of mourning loss as friends and lovers continued to fall ill and die. Schulman, for instance, documents Jim Eigo's tearful recollection of the impassioned struggles waged by his companions, "long term gay and AIDS activist[s]" (21) Vito Russo and Marty Robinson. Joy Episalla's interview also memorializes her friends through their involvement in her ACT UP affinity group, "The Mary's." She recollects some of The Mary's actions such as throwing confetti money that reads, "Blood on Your Hands" (11) at George Bush Sr., as well as chaining their members to the desks of live broadcasting news reporters to denounce the Gulf War, demanding the public recognize that "the War is at Home. The War is against AIDS" (14). The original work of The Mary's can be found in the archives where flyers and posters document the injustices enacted by the Bush administration. The Mary's, for instance, strategize to counter the "undermining," "underfunding" and "undercounting" of the pandemic by spearheading a campaign of sending AIDS obituaries to the White House.

Through her interview with Schulman, Episalla also recalls the narrative history of HIV/AIDS, detailing her and her friends' involvement in publishing works like *Wake Up Queers* or *We're All Through*. Recollections of these cultural and artistic interventions are entwined with depictions of the individuals who comprised the movement. Remembering her friend Tim Bailey in "his leopard skin printed silk scarf, and his sunglasses, [looking] his fabulous self" (53), Episalla continually points to his unyielding sense of political energy from battling inhumane doctors in the hospital to requesting his dead body be delivered to the White House Lawn. Connecting these memories of her friends to their fundamental roles within ACT UP, Episalla paints her friend as the activist that "Tim was and I was" (50), honoring their lives while also commemorating their political work.

The *ACT UP Oral History Project* not only documents the personal achievements of those who are gone, but also recounts the historical context within which these political interventions occurred. In her interview with Schulman, Ann Northrop recalls this social climate as one wherein "people in power, not caring about the lives of people who didn't have power, [were] willing to accept a system of attrition, where people would die" (9). Northrop also traces the emergence of ACT UP in relation to her earlier involvement in anti-war and feminist struggles. She recalls that "while certainly, it was about gay men, it was also about race and sex and class and [. . .] when I then found out [. . .] about ACT UP, and that there were people going out in the streets and demonstrating [. . .] I thought, wow, here's my home" (9). Recognizing the unique experience of gay men while also identifying her own role in combating a gendered and racialized disease, Northrop points to the opportunities for cross-gender unification between queers through HIV/AIDS activism. Ann Philbin similarly identifies the links between gay men living with HIV/AIDS and her participation in ACT UP, charting her own initiation from the art

world into the activist movement “because we were losing people in droves” (15). Philbin laments that the effects her friends’ deaths can never be known “because the losses, the people that died, were such huge forces, creative forces, and talents that by extension, the world changed by virtue of their loss [. . .] We don’t know what David Wojnarowicz would have gone on to write, but we know the last thing he left us with was a kind of an amazing thing [. . .] as a statement of rage it was a remarkable thing” (15). In response to Schulman’s question of how AIDS losses altered the artistic work produced by the living, Philbin calls attention to the immediacy that remains between survivors and those left behind. She remarks that an answer to such a query would require even greater distance and time: “it’s one of those questions, you know, maybe 20 years from now, 50 years from now, people will be able to answer it better than we can” (15). Pointing to the inability of those who directly witnessed AIDS deaths to quantify their losses, Philbin identifies the dilemma at the crux of HIV/AIDS literature—that one can record but cannot reflect—a disconnect that Schulman attempts to bridge, or at least to more effectively record, through the creation of the archive itself.

This difficulty of historicizing a contemporary pandemic is also addressed by Sawdon Smith in his photography series, *In the Archive*. Sawdon Smith’s witty and innovative portraits feature his own naked body in the archives, observing photographic slides of earlier works constructed by people living with HIV/AIDS. Exploring the paradoxical conjunction between the HIV-positive body and its archival representation, Sawdon Smith shows how the archivist can double as the HIV-positive subject as well. Acting out the presumed discrepancy between the lived and historicized experience of HIV/AIDS, Sawdon Smith demonstrates how such discourses can render the body as Other, as alien, and as diseased. Yet this body remains the self, a recognition enacted by Sawdon Smith through his portraits. Sawdon Smith’s work also

points to the fact that HIV/AIDS cannot be documented from a removed location, as the pandemic is currently being historicized by those who remain affected and infected by HIV. While contemporary writers now have some distance from the early years of HIV/AIDS, we must still recognize our proximity to this cultural event as it continues to unfold. As Schulman remarks in *My American History*, "to be writing about something of this enormity when it surrounds you leaves those of us who write about AIDS no possibility of objectivity. Nor can there be any conclusiveness since the crisis and our responses to it change radically and daily" (194).

In spite of such limitations on conclusiveness and narrative certainty, HIV/AIDS literature, like other instances of writing about crisis from within its midst, serves a critical political function. We can recall, for instance, that slave narratives and anti-lynching tracts by African-American authors including Harriet Jacobs and Ida B Wells strategically emphasized their topic's urgency to position literary representation as a catalyst for immediate reform. In *My American History*, Schulman accordingly attests that the purpose of HIV/AIDS writing should be to incite concrete political change. Such change, Schulman concludes, must be effected through direct action and grassroots organizing. Schulman explains that writers should be free to produce art however they want, but "when they're finished with their work, they need to be at demonstrations, licking envelopes and putting their bodies on the line with everybody else" (194). Schulman argues that while literature might serve as a catalyst to activism, it is not necessarily a means of producing tangible results. She writes that "the way we get justice is by confronting the structures that oppress us in a manner that is most threatening to those structures. That means in person as well as in print" (194). In response to this statement, however, Kruger asserts that Schulman's writing is in fact activism in its countering of harmful

narratives of HIV/AIDS. Kruger argues that works like *People in Trouble* not only motivate readers to take action, but also provide a “real reconception of how ‘we’ as a culture and society think about, represent, and treat AIDS and people with AIDS” (300). Kruger illustrates the under-recognized potential for literature to impact institutional practices, observing that while such narratives do not “stand in for other, more direct political work” (301), writings like Schulman’s are nonetheless essential for “responding to a health crisis still largely understood in (homophobic, racist, sexist) terms that continue to block an honest and open public discourse on sex and safer sex; a real commitment to the health not just of the uninfected but of those living now with HIV and AIDS” (301). HIV/AIDS literature, Kruger illustrates, works to demand “effective health care and education for all” (301) by reclaiming stigmatizing narratives of illness.

Through narratives of queer community building and grassroots interventions against HIV/AIDS, Schulman, like De La Cruz, Wojnarowicz, Callen, and Ball, presents her own experiences and observations to rewrite the mythologies of disease. In documenting the devastation and anger sparked by early reactions to the pandemic, this body of writing traces the emergence of an activist community countering government inaction, homophobia, and familial abandonment. These overlapping personal accounts raise questions central to our contemporary understanding of HIV/AIDS and its literary representation, revealing how storytelling is foundational to collective memory and to preserving the history of resistance accompanying the pandemic. Schulman also demonstrates how the narrative experience of queer sexuality, as explored further in the following chapter on Rebecca Brown, plays a key representational role in articulating the sexualizing and gendering of illness. In re-centering the realities and

achievements of queer HIV-positive communities, narratives like Schulman's not merely challenge stigmas of HIV/AIDS but provide a critical intervention into a long history of disease.

Chapter 2

The Gift of Dykes: Queer Caregiving and Sexual Erasure in Brown's *The Gifts of the Body*

Like the activist work of Sarah Schulman, Rebecca Brown's *The Gifts of the Body* candidly represents community-based responses to HIV/AIDS. While this critically acclaimed novel unapologetically confronts the barriers to caring for people with AIDS, the erasure of healthy bodies within the narrative reveals how the pandemic is often represented in opposition to female sexual practices. Though queer frameworks point to the utility of viewing sexuality apart from essentialist gender classifications, it remains necessary to consider the impact of gender and gender-based marginalization in relation to the pandemic. Unlike Brown's short story, "A Good Man," which depicts HIV/AIDS from the perspective of an unabashedly queer female narrator, *The Gifts of the Body* de-centers the narrator's personal life, establishing queer desire as that which only transpires between men. This phenomenon can be observed in HIV/AIDS narratives ranging from media representations to medical reports which position female sexuality, especially healthy and queer female sexuality, as removed from authoritative definitions of what constitutes a person with AIDS. This marginalization of women and of issues of gender in the context of HIV can be traced back to the original CDC definitions of AIDS as a disease primarily affecting men. Such definitions position women as vectors, victims, caregivers, and walking wombs rather than as subjects with tangible health needs. While it might initially appear that Brown's novel provides yet another example of an AIDS narrative that inscribes health workers and queer women as sexless victims or voyeurs of disease, a closer reading compellingly complicates such assumptions. Brown's public status as a queer writer, combined with her removed documentary-style prose, allows for a nuanced interpretation of how and why her narrator's sexuality, like her identity more broadly, remains unnamed. In tracing

the ways in which queerness surfaces and disappears throughout the text, Brown's writing, like that of Schulman, offers an opportunity to revisit archival works countering the invisibility of women living with HIV/AIDS. By reading Brown's novel alongside the work of groups like ACT UP and of community leaders like Iris De La Cruz, the hidden activist politics and queer histories underlying Brown's text become increasingly clear, challenging normative representations of women and HIV/AIDS.

In her 1993 short story, "A Good Man," Brown depicts illness and caregiving through a narrative of queer friendship and desire, politicizing female sexualities in relation to HIV/AIDS. "A Good Man" follows the budding friendship between our narrator and Jim, who begins to suffer from symptoms of AIDS. When the narrator first reveals that her friend is sick, she also discloses that she and Jim are both queer: "Jim shuffles and I almost expect him to make his standard crack about the two of us growing old together in the ancient homos home for the prematurely senile, pinching all the candy stripers' butts, but he doesn't" (94). Though the narrator acknowledges Jim's physical symptoms, like the sweat on his beard and his splotched face, it is the absence of Jim's "standard" sense of humor that alerts her to the severity of his condition. In addition to signifying his health and longevity, Jim's "homos home" joke is also 'queer' in its vision of the two friends retiring together in a place that houses neither gender exclusively. Like the queer bonds between Rita and David in Schulman's *Rat Bohemia*, the relationship between Jim and the narrator locates HIV/AIDS as a point of unification between lesbians and gay men, linking their experiences and identities under the rubric of queer. Regarding each other as a queer "family" (103), Jim proclaims to the narrator at a Gay Pride rally that "every single screaming fairy prancing down this boulevard and every last one of you pissed-off old Amazons is my family. My kith and my kin and my kind. My siblings. Your

siblings” (112). These connections between family and queer revolution are embodied by Jim’s late lover, Scott, whose memory is revisited by the narrative in photographs where he stands “holding up a Stonewall fist and grinning” (140).

This familial relationship carries over from the realm of “screaming” and “prancing” and Pride, into spaces of illness. The narrator, for example, labels herself as Jim’s sister to gain access to hospital privileges denied to “friends.” While Scott emblemizes queerness and resistance, his death leaves Jim without an immediate family, causing him to become closer with the narrator. As their friendship develops, Jim recurrently reinforces the importance of refusing to apologize for so-called sexual deviance. Warning his friend of the dangers of shame and its corollary of having to “crawl back into the nearest closet” (112), Jim encourages the narrator to hold up her “sweet gorgeous sexy face” (112) and march alongside him in the streets: “Jim pranced back to me and yanked me into a chorus line where everyone, all these brave, tough pansies, these heroic, tender dykes, had their arms around each others’ backs. Jim pulled me along. I felt the firmness of his chest against my shoulder” (113). Developing an intimacy that is in one sense, non-sexual, but in other aspects, sexually determined and physically expressed, their relationship becomes at once familial and queer, a bond that proves invaluable to the narrator’s later role of caring for Jim.

Jim’s illness, moreover, actually compels him to seek out romantic possibilities for his emotionally guarded and dateless friend. Brown paints queer desire as a complex and potentially vicarious process, as the two consummate their own relationship through persistent attempts to bestow one another with sexual partners. The narrator explains that “Jim still desired, despite what he’d been through with Scott, despite how his dear brotherhood was crumbling, that some of his sibling outlaws would find good love and live in that love openly” (102-3). As her

“sibling outlaw,” Jim is constantly cruising on the narrator’s behalf, employing various strategies from charming strangers at bars to placing personal ads under her name. At once humored and annoyed by her friend’s brazen gestures, our narrator justifies this behavior as that which allows Jim to “continue the family” in spite of his own sickness and his loss of Scott: “his talk, his ploys to find someone for me, were his attempts to make the story of a good romance come true” (102).

This collision of AIDS symptomology and queer female desire emerges yet again in the hospital, where Jim repeatedly points out the sexual tension between his friend and his doctor. He constantly teases the narrator with observations like, “don’t you think she’s cute? I think she’s cute. Almost as cute as you are when you blush” (104-5). This sexual dynamic stands in contrast to more prototypical early AIDS narratives characterized by waning sexuality and inevitable decline. As Steven Kruger argues in *AIDS Narratives: Gender and Sexuality, Fiction and Science*, such literary trajectories serve to reflect “the phobic, and particularly homophobic movement in which gay desire is equated with an impulse toward death” (Kruger 78). Brown’s narrative instead positions illness as an opportunity for flirtation. As Dr. Allen checks up on her patient, she also checks his “sister” out. These potentially dire hospital sequences are skillfully eroticized through Brown’s sexually inflected prose: “Dr. Allen feels Jim’s pulse, his forehead, listens to his chest. She asks him to open his mouth. She asks him how it’s going today [. . .] how nice it is that Jim has such nice visitors, then tells him she’ll see him later [. . .] I stare out the window as hard as I can” (104). Caregiving becomes the locus of sexual desire, as Jim describes his doctor for the narrator’s benefit as being “so good with her hands” (104). In the presence of Jim’s doctor, the narrator experiences flirtation alongside an increasing awareness of the severity of Jim’s condition: “I turn away and stare out the window again. Sure I’m blushing.

And sure, I'm thinking about Dr. Allen. But what I'm thinking is why, when she was looking at him, she didn't say 'you're looking good today, Jim.' Or [. . .] we're gonna have to let you out of here soon, Jim, you're getting too healthy for us" (105). Although Brown's narrative certainly presents illness as its central focus, it does not do so at the cost of queer desire or sexual health. By aligning the narrator's sexuality with Jim's illness, Brown creates a paradigm in which health and illness, women and queerness, can coexist within a narrative of AIDS.

In exploring her narrator's queer desires, Brown not only complicates the relationship between illness and sex, but in doing so, Brown also defies conventional representations of women and HIV/AIDS. Sexually motivated and emotionally complex, Brown's narrator challenges dominant cultural representations of HIV/AIDS which remove personal agency from the experience of disease. As Dacia Charlesworth demonstrates, women are often reductively figured "as caregivers" (2), "as transmitters of HIV" (2), or "as 'flowerpots or potential mothers'" (2) whose health needs are rendered secondary to their reproductive capacities. Through historically entrenched illness narratives and their accompanying gendering of disease, women have consistently been positioned as sexual infectors of others. For instance, syphilis narratives dating back to the fifteenth-century have always figured transmission as occurring unidirectionally from women to men. Just as women were legally rendered solely to blame for incidence of sexually transmitted infections in the Victorian period, women continue to be viewed in HIV/AIDS prevention literature as "the only population described as actively infecting others" (Charlesworth 7) and as the sole culprits responsible for "transmitting HIV to children" (Charlesworth 6). As Charlesworth observes, "heterosexual men (as fathers) are ignored and, most importantly, not represented as transmitters of HIV" (5). Just as prevention efforts only focused on women in the context of risk to unborn children, medical procedures also endorsed

practices like giving women toxic drugs like AZT while pregnant in order to slightly decrease the risk of viral transmission to the fetus (a risk we now know to be effectively eliminated with proper pre-natal care), conveying how “the value of [women’s] own lives is consistently placed below that of the unborn” (Charlesworth 9). In her reading of HIV/AIDS narratives, Charlesworth argues that “it is clear that women are expected to be primary caregivers for those infected with HIV/AIDS, are given more responsibilities because of this identity, and are not considered to be a population in need of care or even at-risk themselves” (6-7). Charlesworth explains how such roles by extension position women to be “pure, pious, domestic, and submissive [. . .] [a framework that] not only places more responsibility on women but also marginalizes other populations and marks them as unlikely and unworthy to provide care to others” (7).

While Brown’s narrative certainly figures her protagonist as a caregiver, the relationship that develops between the narrator and Jim challenges precisely those prototypical caregiving narratives that Charlesworth critiques. Caregiving becomes not a reductive oversimplification of (queer) female identity, but a means of building communities and forging interpersonal connections between queers. In *Women Take Care*, Katie Hogan similarly explores how AIDS caregivers are often problematically rendered as “the good woman” (3), devoid of sexuality and sexual preference. Hogan illustrates how, “in literary responses to AIDS, whether a fictional character is HIV positive or negative, her own health, sexuality, and personal history are rarely if ever, developed and explored in their own right” (3). Hogan shows how female characters are valued for qualities of “sacrifice and caretaking” (3) where women’s roles are confined to those of “mothers, caretakers, and wives” (3). Hogan claims that, as a result of such depictions, women’s own needs in regards to prevention, infection, sexuality, and risk are replaced with

“chaste images” (3) that appear in opposition to “queer sex, injection drug use, [and] urban cultures” (3). Such sterilizations marginalize women by oversimplifying and misunderstanding their actual relationship to the pandemic. Brown, accordingly, subverts this dynamic by instilling her protagonist with a complex queer identity wherein her role as a caregiver is just one facet of her lived experience of queer family, history, and self.

Like Brown’s narrative, Alexandra Juhasz’s “The Contained Threat: Women in Mainstream AIDS Documentary,” further complicates Hogan’s analysis of caregiving narratives by revealing how women are figured not only as chaste caregivers but also as dangerous vectors of illness. Juhasz explains how “women were depicted as *contained* threats: an oxymoronic representation that allowed them to register simultaneously as iconographic site of danger and as easily controlled subject” (27). Juhasz argues how in print and in popular media, women are portrayed in a manner that justifies exerting control over their bodies and sexual practices. She reveals that “the *threat* that women currently pose is not just viral transmission, but the very gains of the women’s liberation movement: economic, political, and sexual independence” (28). As both Juhasz and Charlesworth observe, harmful representations of women and AIDS are “used to legitimize social inequalities” (Charlesworth 1), promoting a return to pre-liberation values of “monogamy, marriage, children” (Juhasz 28). Juhasz, however, shows that while mainstream representations of HIV/AIDS serve these conservative, anti-feminist ends, alternative media can reclaim such harmful vehicles, placing such reactionary values under scrutiny. As one such counter-narrative, Brown’s short story provides a radical substitute for images like Hogan’s “good woman” (3), depicting caregivers instead as sexual, dynamic and queer. By intervening in HIV/AIDS narratives that figure women as infectious or as victims,

Brown's narrative provides of model of intervention within discourses fundamental to the historically rooted gendering of contagion and disease.

Endowing her narrator with political and sexual agency, Brown illuminates the central role of women within the AIDS crisis, not only as caregivers but as members of the queer communities affected by this disease. In *Wake Up Queers or We're All Through*, a self-published activist newsletter released by "Anonymous Queers" in 1992, an article entitled "Lesbians and AIDS" similarly attests that "without a doubt, lesbians are the backbone of political activism in America." The anonymous authors illustrate the profound commitment that queer women have demonstrated not only in relation to HIV/AIDS, but also "in every progressive movement you can name." The article asserts how: "we work in the AIDS activist movement—demanding the discourse include issues of race, class, and gender discrimination. We lead the movement for reproductive freedom—storming the Senate floor, disrupting the Supreme Court, and defending abortion clinics [...]" In pointing to the multifaceted role of queer women within grassroots movements extending to and beyond HIV/AIDS, this article raises the troubling paradox that "we're more visible now than we have been in years. We are also more silent. We thought if we forthrightly proclaimed our identities, a politics of that experience would follow. 'I am out, therefore I am.'" This article reveals that it is not enough simply to be visible, but that in order for activism truly to serve lesbian communities, it must first make "our lesbian-specific political needs clear to anyone, including ourselves." Undertaking this challenge, Brown's narrative moves beyond merely asserting the presence of a queer heroine, transcending identity politics in order to identify for readers what tangible health needs and political concerns affect queer women in the context of HIV/AIDS.

In addition to providing a queer female perspective on caregiving and the AIDS crisis, Brown reveals how queer caregiving can allow for reciprocity between care providers and recipients. Jim's illness, for instance, actually becomes the impetus for the narrator to begin dating again after a painful breakup with her girlfriend. Caring, we come to discover, is not a unidirectional process between the narrator and Jim, but an act that is repaid as Jim consoles the narrator and encourages her to move past this destructive relationship. Rather than rendering caregiving as a one-sided process where women must put their own emotions aside in order to support others, the relationship between the narrator and Jim instead allows for mutuality and vulnerability. While their relationship is not based exclusively around either HIV/AIDS or illness, Jim's wavering health certainly motivates his desire not only to see his best friend find a new lover but also to encourage her to take better care of herself. He urges her to "clean it up, girl. As a favor to the Ranger? As a favor to the ladies? Take care of that luscious body-thang of yours. Yes? Yes?" (109).

Shifting the boundaries of concern away from the person with AIDS and onto the caregiver, Brown complicates one-sided models of both caregiving and queer love. Not merely a patient, Jim sends the narrator chocolates at work to cheer her up after a painful run-in with her ex-girlfriend, making her "the talk, the envy of the office for a week" (111). As the narrator begins to provide emotional support for Jim after Scotty's death, Jim reciprocates with great panache: "Jim sweet-talked my apartment manager into letting him into my tiny little studio apartment so he could leave me six --- *six* --- vases of flowers around my room when I turned twenty-seven. He taught me how to iron shirts" (111). Like family, the two even spend the night together in order to provide support: "I slept on his couch, the mornings after we'd both had more than either of us could handle and didn't want to be in our apartments alone" (11).

Although Jim and the narrator do not constitute what could be classified as a “traditional” coupling, their cross-gender, queer love restructures models of support offered by more conventional dyads. In “Gay Men, Lesbians, and Sex,” Patrick Califia depicts “queers doing queer things together” (198), advocating the merits of building sexual and social relationships across gender lines. In this article from 1983, Califia promotes controversial models of “lesbian/gay solidarity” (198) that became increasingly valuable in combating the crisis of AIDS. Califia reflects how “gay male friends and lovers have taught me things that I would never have learned in the lesbian community. I can’t exaggerate my admiration for the well-developed technology, etiquette, attitudes, and institutions that gay men have developed to express their sexuality” (196). As Califia demonstrates, the sexual and emotional bonds that form across gender lines allow for a richer understanding of what it means to be queer. HIV/AIDS presents an opportunity to build a queer community that transcends gendered boundaries and spaces, creating solidarity and even sexual relationships between fags and dykes.

Brown’s caregiving narrative, accordingly, becomes a queer and gender transgressive site for politically responding to HIV/AIDS. While caregiving is typically regarded as antithetical to activism, a divide embodied by the split between service provider organizations like The Gay Men’s Health Crisis (GMHC) and activist groups like ACT UP, these two goals of providing care and demanding social change are certainly not mutually exclusive. In an *ACT UP Oral History Project* interview, Jean Carlomusto reveals that:

It was a contest for who was going to control the discourse around AIDS. Was it going to be in an increasingly professional model, like “We’re going to care for people. We’re going to set up this whole professional organization to manage the care and advocacy of people living with AIDS,” which was the GMHC model. Or was it going to be, “The

rules are fucked and nothing's going to change until we get out there and we change them, and we advocate." So really the two messages should have been complementary and not competitive, because there was a need to have an organization that was managing care for people with AIDS, because the changes did not happen automatically. And GMHC lessened the suffering, and continues to lessen the suffering of people with AIDS. But at the same time, without ACT UP there would be no changing of society. ACT UP changed the health care delivery system. It changed the way drugs are approved. It changed the very way people conceive of gays and lesbians in our society. (40)

As Jeannine DeLombard similarly observes in "Who Cares? Lesbians as Caregivers," caregiving can indeed be regarded as "a form of gay activism" (350). AIDS caregiving, DeLombard explains, not only provides clients with access to services like "shopping, cooking, cleaning, and legal and financial counseling" (351), but caregivers like those depicted by Brown challenge the notion that care should be provided exclusively by one individual, a burden oftentimes assigned to family members who are female and queer. DeLombard shows how "rather than receiving care from a single overworked primary caregiver, a significant number of people with AIDS appear to receive support and assistance from a team of friends, family, volunteers, and professionals" (351). DeLombard reveals how queer caregiving also challenges heteronormative familial models, moving away from the nuclear family as ideal unit and toward the creation of a queer, activist community. DeLombard argues that while "rejection by their families of origin has led many lesbians and gay men to create new families among themselves" (350), these "new" families provide a space through which to critique institutions extending beyond the family alone. Like Schulman's emphasis on family as essential to queer health,

Brown's narrative locates care provision as a point of entry into opposing broader institutional systems that allow Jim to fall ill with AIDS.

Through the development of this radical caregiving relationship, Brown's narrative also documents the AIDS hysteria characteristic of the period in which the story is set. "A Good Man" takes place in 1984, when the HIV/AIDS epidemic became a full scale crisis in New York City, inciting a surfeit of unwarranted panic and dread. Unlike in *The Gifts of the Body*, wherein the narrator repeatedly reflects upon her own prejudices and shortcomings, one of the few moments of self-criticism in "A Good Man" occurs when the hospital deems Jim a health risk, compelling the narrator to reflect upon her own fears of casual contact and transmission of HIV. First published in 1993, "A Good Man" provides a retrospective look at the mass hysteria and resulting cruelties that took place within hospitals and other institutional caregiving situations, causing hospital visitors to fear their sick family members and friends without any medical justification for doing so. Brown's fictional narrative mirrors autobiographical accounts documenting this sort of malpractice from within institutionalized settings. In her autobiographical essay, "Fighting for My Life," Melina Singleton reflects that "anytime I start talking about the hospital, I get very angry" (51). Singleton recalls her own experience as an HIV-positive woman who was treated as a pariah by those who were appointed to provide her with care: "I made my bed every day, but when I asked them to help wash me, they gave me a washrag in a bowl and said, 'Do it yourself.' I mean, they were disgusting. There is no excuse for the way they treated me, none whatsoever" (51). Singleton shows how this site of mistreatment was also "the first time I had ever been around any other women who had HIV like me" (51). Although a locus of stigma and cruelty, the hospital nonetheless holds the potential to become a space of education and community building for women whose infections and illness

remain invisible outside its walls, rendering such abuses by care providers all the more disturbing.

In addition to documenting institutional mistreatment on the part of the medical establishment, Brown's story also addresses the impact of the epidemic on gay and lesbian communities, exploring issues of fear, mourning and loss. Brown illustrates how mourning can become a barrier to intimacy for the narrator and for Jim. After Jim's death, the narrator observes that she must sleep alone because: "if I lie next to someone I will break apart" (137). Jim, likewise, experiences the loss of Scott as an initial barrier to his budding friendship with the narrator, as memories of Scott cause him to shut down, both emotionally and physically: "all of a sudden he clammed up, he just clammed right up and left. He wouldn't let me walk home with him. I tried calling him but he wouldn't answer" (100-101). This same "clamping up" later happens to the narrator as well. When Jim dies, the narrator observes, "I'm stiff. I'm like a statue. My body can't bend and I can't see" (143). Yet it is the narrator's friends who help her overcome this immobility, just as she helps Jim cope with the loss of Scott. Mourning becomes an opportunity for closeness and community support. The narrative, accordingly, raises concerns of the remembrance of those lost to HIV/AIDS. As writers like Schulman and Bo Huston demonstrate, the relaying of anecdotes and stories is crucial for those who are sick as well as for those who survive. Brown's narrator reveals her own worries around succeeding and remembering Jim, observing after his death that his friends begin to express sentiments like, "now it's like he was never here. What did he ever do that's gonna last? It's like his life was nothing" (136). Like Schulman and Huston's protagonists, Jim is also an artist whose illness impedes his ability to continue his cultural work, as he cannot paint in the hospital. At his friends' suggestions that they bring him his paints, Jim's sunny sense of humor disappears.

Although Jim is troubled by his inability to live on through his art, we later discover his already completed paintings of Scott. His friends find paintings "of a Scotty that we never saw; Jim's Scotty. Painted alive again by Jim" (140). Brown's narrative reveals how art, including literature, can serve as a memorial, "painting alive" communities and friends devastated by HIV/AIDS.

Just as mourning and community building call attention to forms of medical negligence in relation to HIV/AIDS, such issues cannot be examined without confronting gender discrimination as well. As represented in Brown's fiction, a large body of documentary writing from this period draws upon feminist models of health activism to expose instances in which women's medical needs are overlooked. In the late 1980s, as more and more women began to exhibit symptoms of AIDS, activists launched campaigns to alert authorities, service providers, and the wider public about women's issues in relation to the pandemic. One such campaign involved the Centers for Disease Control's failure to list symptoms experienced only by women such as pelvic inflammatory disease, pulmonary tuberculosis, and cervical cancer, in their definition of what constitutes AIDS. Gender, consequently, becomes a determining factor for who receives health care, disability benefits, education, treatment, research, clinical trials, and a host of other services frequently denied to women on the basis of this definition. Risa Denenberg, for instance, identifies the recurring situation wherein women would enter hospital settings suffering from opportunistic infections of AIDS such as pneumonia or influenzas that were not observed in HIV-positive men. (Denenberg "Unique Aspects" 32-33). In such situations, many women exhibiting these symptoms were not tested for HIV, and their conditions were allowed to worsen undetected and untreated because of the CDC's exclusion of these

symptoms in the clinical definition of what constitutes AIDS. (Denenberg “Unique Aspects” 32-33).

In framing HIV/AIDS as that which only affects gay men, drug users, hemophiliacs, and other racially targeted groups, all of which were predominately gendered by the media as male, (Juhasz “Contained Threat” 26) there subsequently emerged a series of scientifically unfounded reports informing women that they need not protect themselves sexually as they were “perceived to be virtually untouched by AIDS” (Juhasz “Contained Threat” 26). Women were also systematically excluded from clinical studies and experimental drug trials on the grounds that the risks associated with untested medications could affect their reproductive capacities. (Denenberg “Treatment” 74) Even in cases where women were terminally ill and consented to taking reproductive risks, participation inclusion was often denied on these grounds, conveying the recurring message that women’s “reproductive capacities are valued more than our lives” (Christensen 5). As a result, clinical studies massively underrepresented female participants, as Denenberg recalls that in 1988 only 5% of trial participants were women. (“Treatment” 74) Denenberg notes that this “lack of enrollment of women in drug trials may be due to lack of recruitment, deliberate exclusion, or failure to meet specific needs such as child care or transportation” (“Treatment” 74). Denenberg also points to the historical factors underlying women’s lack of access to the medical system, observing how “IVDU’s [Intravenous Drug Users] poor people in general, prisoners, and women of color in particular have experiences of abuses within the system—for example, sterilization abuses, sexual abuses, or drug experimentation—and be reasonably hesitant to seek health care” (“Treatment” 72) or to participate in clinical trials. The CDC definitions, moreover, are what guide physicians to provide patients with AIDS diagnoses, entitling them to disability and pension benefits, health

insurance, and access to care. Many women, Denenberg reveals, were dying from AIDS before ever receiving the diagnostic benefits and necessary services on account of these systemized forms of gender disparity. (Denenberg “Numbers” 3) Taking on the CDC at a national level, groups like ACT UP responded through protests, civil disobedience, lawsuits, and media campaigns to include women more directly in their definition of AIDS.

For instance, on June 19, 1991, ACT UP/New York placed an advertisement in the *New York Times*, demanding the CDC amend its definition of AIDS to include women. Countering stigma and invisibility propounded by the dominant media, this advertisement brought this issue to the attention of the wider public. The headline reads, "Women Don't Get AIDS: They Just Die from It." This ad forces readers to recognize the contradiction between the CDC's grossly inaccurate assessment of women and AIDS, and the grim reality that such invisibility plays in women's daily lives, causing women to die faster than men. The ad also explains how:

Undercounting AIDS cases kills. The CDC's failure to include these symptoms in their AIDS definition suppresses the true scope of the AIDS pandemic. It distorts epidemiology vital to providing health care, investigating treatments and determining funding levels. It leaves many individuals and physicians uninformed—tragically affecting education, prevention, diagnosis, and treatment, as well as access to public benefits and insurance disbursements.

Moving beyond the mere presentation of facts, this ad forces the *Times*' readership to bear witness to this injustice, rendering complacency and inaction an inadequate response to the pandemic and its accentuation of preexisting gender disparities. The ad's effectiveness lies in its ability to call readers to action through its presentation of current events. Its text implores that

"the CDC's persistent refusal to expand the AIDS case definition is nothing short of willful and deadly negligence. This is why AIDS is a crisis. *Every* American should be outraged." Like Brown's short story, this advertisement does not stop at conveying the tragedy behind AIDS deaths but connects institutionalized forms of inaction and inequality to the crisis of AIDS itself. As the article states, it is not enough simply to acknowledge the untenable treatment of women, but it is instead crucial to "*demand* the immediate revision of the case definition of AIDS to include *all* the symptoms identified by researchers and clinicians working with HIV-infected people. *Demand* that the CDC adjust its method of collecting statistics to reflect 'modes of transmission' instead of listing 'risk groups.'" This text points to the practice of stigmatizing groups who are affected by HIV/AIDS rather than enumerating the behaviors and social factors that place these groups at risk. This advertisement not only reveals the political barriers underlying women's access to health, but it also shows how women can actively combat damaging and moralistic responses to the disease.

ACT UP's resulting success in changing the CDC definition of AIDS is one of many gains secured by women confronting powerful institutions to meet their own medical needs. Such concessions were not handed to women by elected officials in power but were brought about through grassroots organizing by and for HIV-positive (and negative) women themselves. For instance, in 1988, the ACT UP Women's Caucus organized a similar campaign against *Cosmopolitan* Magazine. This action protested the publication of an article erroneously claiming that women "would not contract HIV even if they had unprotected vaginal intercourse with an HIV-infected man" (Wolfe 231). This article was not an anomalous instance of misinformation but a publication reflecting the greater trend of disseminating life-threatening misinformation within mainstream representations of HIV/AIDS. In an *ACT UP Oral History* interview, Jean

Carlomusto discusses her documentary film, *Doctors, Liars, and Women*, that captured this action. Carlomusto recalls how once "we brought this issue to the public eye" (19), the activists involved were then excluded from the participation in the ensuing debate on the television program, *People are Talking*. Carlomusto reflects that "the women who actually organized the action were not put on the panel" (19) to be included in the public forum. Illustrating the tenacity and creativity of her collective, Carlomusto recounts how ACT UP managed to "sneak into the audience" (19) and take over show: "Chris Norwood and Denise Ribble marched on stage and sort of just sat down there and said, 'Why don't you have any women on this panel? You're making us invisible'"(20). Carlomusto also recounts ACT UP's Shea Stadium action in 1988 as another instance of women taking control of the media to show that "straight men needed to be encouraged too to use condoms, that this was their responsibility. And I think truly it was something that people came along with from their feminist background [. . .] from the women's self-help movement" (25). Capturing these events on film, Carlomusto, like Brown, demonstrates how cultural and artistic production can become a means of securing agency over one's own health.

In "The Contained Threat," Alexandra Juhasz addresses this question of how women can regain control over disempowering images of sexual health. Juhasz asks: "how do women protect themselves from controlling images, controlling doctors, controlling legislation? One place, surely, is by taking control of representation" (43). Juhasz illustrates how community members working at a grassroots, activist level, can redefine how women are perceived in relation to HIV/AIDS. She observes that "women—PWAs and AIDS activists, health care workers and AIDS specialists, documentary makers and writers—can successfully muster our representational forces to attempt to contribute to the social construction of women and AIDS"

(43). As a figure who achieved great success in redefining representations of HIV-positive women, we can again recall the writings and achievements of Iris De La Cruz. An esteemed member of organizations including the People with AIDS Coalition, ACT UP, and GMHC, De La Cruz's writings provide a model for self-empowerment and community building, challenging dominant representations of women and HIV/AIDS.

Throughout her writing, De La Cruz revisits her feelings of isolation in the early 1990s, prior to discovering one of the only existing support groups for women with AIDS. She recalls that:

I felt like I was the only woman in the world with AIDS [. . .] All of a sudden I discovered other women with the virus. There were black women, white women, Latinas, rich women, and poor women. There were addicts and transfusion women. They were mothers and sisters and lovers and daughters and grandmothers. Some were militant lesbians and others were Republicans (imagine that! Even Republicans get AIDS). (134)

Without diminishing the utility of the resources and alliances of the gay male community, De La Cruz asserts the need for women living with HIV/AIDS to receive support that is gender-specific. In a GMHC Oral History Interview, De La Cruz recalls her experience of first coming into a community of HIV-positive women. She recalls that "I would take the subway and walk around thinking I had this giant 'A' that flashed on my forehead and everyone that looked at me could tell I had AIDS. I would look at families and lovers together and think that these are options that are no longer open to me (not anymore). I would get real depressed, seeing happy people, and I wasn't the only one that felt like that." De La Cruz not only illustrates how

community forums lessen these feelings of isolation, but she explains how support groups encourage women to assert personal agency, especially in relation to their own treatment and health. She recalls how “I started going to women’s group and this sounds real cliché but I learned self empowerment—I learned that I was responsible for my own health or my own lack of health and didn’t need to worship at the alter of the AMA, my doctor didn’t have all the answers.” De La Cruz presents self-determination and community support as necessary precursors to health, asserting that:

Women have to be in control of their own treatment, their own health care, because [. . .] if women don’t act on their own, it won’t get done, if you’re going to sit there and wait for this magic pill that’s going to make everything all right, it’s not going to happen. You have to do it. And it’s hard work, but now at least there is support. And there has to be some unity. [. . .] You can’t go about taking care of this on your own. And there are a lot more women who are either undiagnosed or who they’re in a closet about this [. . .] and they need to get together, just like they did in the late 60s early 70s in the women’s health care movement they need to do it with this.

De La Cruz shares Carlomusto’s observation that issues of women and HIV/AIDS can be connected to the feminist health movement, which views self-help and personal control as necessary precursors to physical well-being. De La Cruz, accordingly, explores these issues in her writing, revealing how self-determination and educated decision making consistently inform her own choices regarding treatment and care.

For instance, in her monthly column for the People with AIDS Coalition’s *Newsline*, “Kool AIDS with Ice,” De La Cruz adopts a witty, comedic tone to engage readers with issues

about HIV/AIDS. Writing about AIDS treatments prior to the introduction of combination therapies in 1996, De La Cruz confronts issues ranging from medical negligence to the prescription of excessively toxic doses of (what we now know to be largely ineffective) drugs. In spite of the dismal nature of health care and treatment options open to people living with HIV/AIDS, De La Cruz uses humor not only to address difficult topics directly, but to demonstrate strategies for sustaining personal agency within the medical system. De La Cruz opens with the punchy: “Welcome to my delusions. I just got off DDI and I feel a lot better [. . .] the dosage was too high and after I totally poisoned my body, they'd come up with some jive statement that a half dose is just as effective. Sounds familiar? Sounds like the ol' AZT follies? I ain't goin' for it. So me-n'-AZT are going steady again.” Though De La Cruz jokes about “going steady” with AZT, her linguistic plays reveal how her health care choices reflect her personal desires rather than decisions imposed from without. De La Cruz uncovers that in spite of inadequate drug testing on the part of the medical profession, people can nevertheless actively determine the course of their treatment by deciding what is ultimately best for their bodies and health. This notion of being in touch with one's body can also be traced back to the feminist health movement that views self-determination as essential to effective care. De La Cruz draws this connection between corporeal awareness and overall well being, observing that “my body and I have a deep, personal relationship (after many years of being at war) and the body lets me know when shit is wack. I've learned to listen to her. The body said the DDI was not what we needed. She refused to even negotiate a 1/3 dose. Hopefully, she'll calm down with the AZT since they got along well before.” By humorously yet unapologetically providing a concrete example of how one can take control of treatment decisions, De La Cruz not only criticizes the

hierarchies inherent to Western medicine, but also sets up an alternative model through which patients can actively advocate for the course of their care.

An indispensable element of De La Cruz's work, accordingly, focuses on how shortcomings of the health care industry intersect with issues related to gender. In her interview with GMHC, De La Cruz recounts the stigma reinforced by medical providers who believe that "I'm a patient with AIDS, and I'm a female, so that means I'm either a dope fiend or a slut. And if I had to go back, I would have never told people that my risk factor was drug addiction, because that colored every treatment I ever received." De La Cruz's writing serves as testimony to the behavior of health care providers during the first decade of the pandemic. She recalls how "I've had doctors—gynecologists—refuse to examine me because of the virus. I had a dentist- I waited all day, I was in all kinds of pain, and [. . .] they said 'come back tomorrow' and they gave me a prescription, I think for Demerol; It was easier for the doctors to keep me sedated than to treat me." De La Cruz also shows how such discriminatory practices specifically affect women. She describes how, in the medical industry, the needs of men, especially in regards to research, are frequently prioritized. For instance, she recounts how "they did all kinds of testosterone studies—that was the first thing, god forbid that guys can't get hard ons—they'll look at that from morning to night. I didn't menstruate for the first year of this virus and I would ask doctors and they would say, 'I don't know why.' Well, why don't you know why? If you don't know why, find out why!"

De La Cruz, furthermore, connects such medical stratification to conceptions of gender underlying the health care system. Coming from a background of sex work activism and feminism, De La Cruz links HIV/AIDS-related stigma to larger cultural beliefs about female sexuality. She asserts that "this is a sexist society from the beginning. A man can go around and

sleep with nine-million women and he's macho, a woman does that she's a slut—and there's no middle ground—you're either the good woman or the bad woman.” De La Cruz demonstrates how these truisms of female sexuality shape how HIV-positive women regard themselves and their health. She recounts that in her support groups, “I've had women—low risk people, and transfusion people—who would have to start off every group explaining they were low risk or they got it through a transfusion.” De La Cruz recalls that “it got to the point where I said, ‘this isn't the issue in this group, it might be your issue, the thing is, how are you dealing with the virus? I don't care if you fucked the Green Bay Packers. How are you dealing with this virus?’” De La Cruz grounds women's treatment issues within a cultural framework, illuminating the connections between personal conduct and those narratives which shape medical knowledge and beliefs. De La Cruz illustrates that deconstructing these historically entrenched narratives about female sexuality encourages women to move past feelings of stigma in order to cope with the virus and manage their health.

De La Cruz pinpoints “issues of racism” as well. She explains that “I'm white. I have a Spanish last name. And what I found happening—I was treated okay until they saw the last name, and then all of sudden I was treated as if I was brain dead—if you're a Latina you're not going to understand technical terms. I could see the difference: ‘these people,’ ‘those people,’ and all of a sudden I wasn't a person, I was a germ. I was a virus.” In *In Our Own Hands*, McCarthy and Kirshenbaum similarly observe how race overdetermines access to healthcare, recounting histories and current realities of racialized populations facing sterilization abuse and barriers to reproductive freedom. They emphasize how “the women who are most at risk for HIV infection are those who have traditionally been denied access to health care and health care decisions” (34). By relaying her personal experiences of racism in a medical context, De La

Cruz uncovers that her mistreatment by doctors is not an individual instance of personal discrimination but an institutionally based form of prejudice perpetuating unequal access to care. De La Cruz confronts racial discrimination by providing concrete solutions for attaining self-determination within the health care system, advocating for clinical trials and family-based resources like support groups and community centered models of holistic care.

De La Cruz was also involved in the struggle to incorporate women's symptoms into the CDC definition of AIDS. In the "Invasion of the Patients from Hell at New York University Hospital or How I Spent My Summer Vacation," De La Cruz declares how:

Women shouldn't be getting sick and left to die because there is no research on women and HIV. Our women are dying untreated and without benefits because, although seropositive, PID is not considered an opportunistic infection by the Center for Disease Control. Women are going untreated because they can't afford what little treatment there is. As women are the caregivers, if we allow women to die, we are condemning society to the same fate. (116)

De La Cruz enumerates the larger ramifications of ignoring issues related to women's health. Using humor and an optimistic approach, De La Cruz depicts her personal experiences in order to connect caregiving and women's health to broader practices of discrimination. For instance, De La Cruz reveals how her own hospitalization for pelvic inflammatory disease was not diagnosed as HIV-related, and that, had it been, such a diagnosis could have saved her life. She recounts that:

I'm back at work, went to Washington yesterday with ACT-UP for benefits for women with PID, and am generally acting crazy again. The sad fact is that I should have been tested seven years ago for HIV. And the infection that I had been complaining about for

almost two years prior to the hysterectomy should have been addressed. Doctors should really examine the reasons why they entered the 'healing art' of medicine and maybe read the Hippocratic Oath once in a while. (116)

De La Cruz, moreover, connects her medical experiences to her activist work. She writes that "yeah, I'm angry. Blood is dripping from my eyes. But I guess that's why we have ACT UP" (116). Through her writing, De La Cruz inspires readers to undertake community organizing and to build networks of peer support. By connecting personal experiences of illness to a larger political framework, De La Cruz demonstrates the importance of talking openly about sexuality while maintaining the optimism and humor essential to sustaining both activist movements and personal health.

Like De La Cruz, Brown's heroine in "A Good Man" demonstrates the impact of women working within the AIDS crisis, not only as caregivers but as advocates for sexual and medical reform. This short story compellingly fictionalizes the more polemic political project of documentary writings by activists like De La Cruz. This queer representation of gender, caregiving, and HIV/AIDS can further be contrasted with Brown's full-length work, *The Gifts of the Body*. Unlike "A Good Man," where the narrator's community and queer sexuality are essential to the narrative, *The Gifts of the Body*, published only two years later, presents us with a female protagonist whose private life we learn essentially nothing about. While *The Gifts of the Body* provides an intimate portrait of people living with HIV/AIDS, its narrator reveals very little about her own identity. *The Gifts of the Body* presents an analogously themed narrative to "A Good Man," depicting the process of providing care to gay men with HIV/AIDS. Brown's novel, however, does so without any mention of the narrator's romantic pursuits or sexual

preferences. In contrast to "A Good Man," an independently published work receiving virtually no critical attention, Brown's full-length novel was picked up by Harper Collins, a major publishing house, receiving much improved publicity and acclaim. The omission of the narrator's queer sexuality in this revisiting of Brown's earlier themes raises questions not only about the marginalization of outwardly queer works within the publishing industry, but also regarding the position of women and queerness within representations of HIV/AIDS.

Connected to Brown's refusal to label her narrator's sexual identity is her decision also to conceal this narrator's actual name. Though first person narrators like that of "A Good Man" can still attain intimacy with the reader without explicitly introducing themselves, *The Gifts of the Body's* narrator's namelessness indicates her more general hesitancy to disclose details about herself to her reader. Compared to the subtle absence of "A Good Man's" narrator's name (though she is nicknamed by Jim), the absolute and prolonged anonymity of *Gifts'* narrator is far more perplexing, precisely because her namelessness accentuates her ongoing withholding of details connected to her personal life. Because naming and the use of given names throughout the novel signifies vulnerability, both interpersonally and in terms of illness, Brown's narrator's namelessness is more significant than one might initially presume. *The Gifts of the Body's* evasion of its narrator's sexual orientation can likewise be connected to what Juhasz argues is a greater invisibilizing of queer female sexuality in the context of HIV/AIDS. As Juhasz reveals, "in the media's pictured world, lesbians should not, and therefore do not, lead sexual lives. They are desexed through non-imagery" (170). In is this "non-imagery" that becomes particularly vexing in *The Gifts of the Body*, as naming practices participate in a greater erasure of queerness itself.

The significance of naming in *The Gifts of the Body* is first exemplified through the narrator's interactions with Connie, an elderly suburban client who was infected with HIV through a blood transfusion. Connie's request to be called by her given name is indicative of the level of intimacy she reaches with the narrator, an intimacy marked by the disclosure of her late husband's death and how she survived it. The narrator recalls that "after she told me all that, she told me to call her Connie instead of Mrs. Lindstrom. That took me a while to get used to, but I did" (20). This period of adjustment between the use of the formal "Mrs. Lindstrom," and the familiar "Connie," actually transpires instantly in the narrative, as it takes only one paragraph for the narrator to achieve a first name basis with her new client. As a result, the intimacies exchanged between the two women during this period also remain unnamed. This level of comfort, additionally, permits the narrator to provide better services as a caregiver. She relays that "then after I'd called her Connie for a while, she said would I help her with her bath. That was the last thing she'd kept doing herself" (20). This act of naming and the use of given names is what cements the connection between caregiver and client, permitting Connie the vulnerability of revealing not only the presence of cancer signified by her missing breast, but also the site of exposure to HIV: "there was a big flat dent on half her chest, and a long white scar where they'd cut it off. The scar wasn't shiny, but it was old. They'd cut it off before they tested the blood supplies" (20). While initially the narrator admits to feeling "afraid of the scar" (22), her ability to connect to Connie on an interpersonal level instills a sense of trust, allowing her to "wash the place around the scar" (22), an act of intergenerational intimacy that could itself be read as transgressive and perhaps even as queer.

As Connie and our narrator become increasingly intimate, the act of naming also continues to take on greater significance. While our narrator conceals nearly everything about

her own personal life, she nevertheless discloses a plethora of minute but private details concerning Connie's illness. The narrator names all of Connie's children, "Diane and Ingrid and Joe" (19), and even her cat, "Miss Kitty" (19), while also enumerating in great detail her physical symptoms, such as her rapidly diminishing appetite: "she looked down at the plate. She took a deep breath, let it out, took another bite, chewed, swallowed. For the third bite she tried some egg [. . .] On the fourth bite I heard her hold it in her mouth. After a few seconds she swallowed some but not all of it. Then after a few more seconds she swallowed the rest of it" (63-4). The macabre feeling established by the relaying of the specificities of Connie's eating patterns conjures the sinking feeling we develop upon reading the gothic horrors typical of Brown's earlier work. Such moments also leave us discomfited by the extent of our voyeuristic presence which mirrors the narrator's own feigned distraction during this scene: "I was still looking toward the TV, but I could hear what she was doing" (63). While the narrator names none of the figures central to her own life, leaving no mention of her lovers, friends, or family members, she demonstrates her growing bond with Connie through naming itself. For example, Connie's increasing comfort with the narrator is signified through the act of naming her husband: "she used to refer to him as her late husband, but now she just called him her husband, or John" (56). Connie also attempts to solicit details about her caregiver's life by asking the narrator a series of cursory questions: "she started talking. She asked me where I lived in town, in a house or an apartment, if I had pets and so on, all nice polite questions someone that age would ask" (15). While introductory questions such as these are indeed "polite," they can potentially play a complex role for queers, as innocuous questions about one's living situation or pet ownership can easily precipitate a risky moment of disclosure related to coming out. Politeness, especially in relationships mediated by power structures such as the client/caregiver dynamic, can become

quite precarious, as revealing the seemingly mundane details of day to day life could actually indicate sexual preference, a detail potentially too intimate for the first moments of one's acquaintance.

Yet, as their relationship develops and the narrator and Connie learn an increasing amount about one another's lives, the questions relayed for our benefit remain disappointingly "polite:" "she asked me where I'd gone to college and what my interests were and about my family and hobbies and pets" (19). Under this potentially revealing rubric of "family," a category that could include our narrator's lover, no comment is made regarding the narrator's private affairs. While one might initially presume that the narrator hesitates to disclose her sexual preference because Connie's response could be homophobic, Connie's closeness with her gay son and his partner demonstrates otherwise. Connie even laments the fraught relationship between her husband, John, their queer son, Joe, and Joe's partner, Tony (who unlike the narrator, are all named): "I wish he and Joe had been able to see through their differences before John died. I know they'd have come to understand and forgive each other.' Her voice shook. 'it's been very hard on Joe.' Her mouth was trembling" (159). Connie explains to the narrator that "John died of a heart attack.... There were things left unresolved. He hadn't seen Joe in ages. And he'd only met Tony that once" (158). While the narrator's lack of disclosure in response to Connie's intimate confession might seem to carry "politeness" to an unnecessary level, a closer examination of Brown's sparse prose proves far more telling than any information we directly receive. Though *Gifts* certainly lacks the unabashed queerness characteristic of Brown's earlier work, a closer reading of this cryptic novel sheds insight on the ways in which the narrator's sexuality remains indirectly implied and yet highly influential throughout.

For instance, upon learning of John's rejection of his gay son, the narrator subtly reflects that: "I hadn't known any of this before, but I understood" (158). These understated but deceptively important words, "I understood," could signify a link between Joe's homosexuality and the narrator's own queerness, a link that could be quite apparent to Connie but not to us. In fact, the narrator's paltry self-disclosures point to the fact that Connie holds far more information about our narrator than is disclosed. We must, accordingly, recognize that those details the narrator willfully omits could be as important as those she provides. One major set of details that Connie knows, which we do not, are the physical attributes belonging to the narrator—the contours of her face, her style of hair, her mode of dress—factors all visibly clear to Connie but hidden from the reader. While queerness in literature is signified through linguistic symbols, sexual preference in everyday life is often also determined through a series of visual cues that "inscribe the body [. . .] in ways that offend the perceived sexual and embodiment norms of heterodominant culture" (Pitts 444). As theorists like Judith Halberstam demonstrate in their work on queer subcultures, such visual cues are readily apparent as sexual indicators to those who themselves participate within queer communities. Gleaning information thus requires more maneuvering on the part of the reader than simple visual recognition could readily provide. Because textually, such visual cues are unavailable, we rely on our narrator to disclose information regarding her own appearance, which time and again she does not.

However, as Halberstam outlines in *In a Queer Time and Space*, narratives depicting queer subcultural lives need not label themselves overtly as queer. Halberstam argues that "we have become adept within postmodernism at talking about 'normativity,' but far less adept at describing in rich detail the practices and structures that both oppose and sustain conventional forms of association, belonging, and identification" (4). Halberstam's discussion of Silas

Howard and Harriet Dodge's independent film, *By Hook or by Crook*, illustrates how radical work by queer and transgender artists can create queer identifications without explicitly naming them as such. Halberstam observes how "in the film, [protagonists] Shy and Valentine visit cafes, clubs, shops, and hotels where no one reacts specifically to their butchness. This narrative strategy effectively *universalizes queerness* within this specific cinematic space" (94).

Halberstam further clarifies that the universality achieved by the film is not the same universalism endemic to mainstream productions which represent queer subcultures as being 'just like everyone else,' watering down queer experience in order to produce films that "look exactly like every other Hollywood feature angling for a big audience" (94). *By Hook or by Crook*, Halberstam reveals, "actually manages to tell a queer story that is more than a queer story by refusing to acknowledge the existence of a straight world [. . .] represent[ing] a truly localized place of opposition—an opposition, moreover, that is to be found in committed performances of perversity, madness, and friendship" (94). Paradoxically, in omitting overt labels of sexual orientation and gender presentation, queerness emerges in complex ways, encompassing a broad and unfixed range of experiences. Brown's novel can be read as one such narrative that places queer subjectivity as the universal center of its discourse, extending queerness beyond reductive depictions of identity politics and coming out.

This maneuvering, moreover, is not endemic to *The Gifts of the Body*, as many of Brown's queer narratives reject outright naming in favor of more intricate systems that render Brown's deceptively simple writing so complex in its craft. For instance, in *Annie Oakley's Girl*, the second person pronoun, "you," often replaces gendered pronouns that would fix identity onto a given subject. In depicting queer sex in her short story, "Folie A Deux," Brown evades the use of female pronouns or bodily signifiers of femininity through the use of this "you." "you had told

me how you liked the leanness of my body, the way the ribs were hard and near the surface of my skin, and the spaces between them soft and giving” (52). Brown’s “you” complicates female sexuality by refusing to use conventional signifiers, (i.e. - he/she) that serve to reinforce gender binaries or essentialist conceptions of identity. Queerness, by extension, is tied not to the presence of two “women,” but to sex acts and transgressive experiences that move beyond gender alone. In an interview with Matthew Stadler, Brown reflects on her use of this “you,” explaining how “in a lot of the stuff I wrote in the the late ‘70s and early ‘80s—the I-You narratives in *Evolution of Darkness* and the sections of *The Terrible Girls* written then—there was a very specific person I was addressing in my mind, a girlfriend with whom I was obsessed” (8). Brown traces the progression of this literary strategy as a move from addressing these girlfriends to broader considerations that stem out of queerness but extend beyond her personal experience of love and loss: “Now I am interested in the notion that there’s some huge, amorphous ‘You’—God or longing or the past—that I’m addressing. Which was probably also what I was seeking from those poor, decent-but-only-human girlfriends I got so insane about back then” (8). Pointing to the far-reaching and multifaceted significance of the “you,” Brown speaks to the importance of resisting the act of naming and correlatively, of fixing signifiers and identities within her work.

In *Witnessing AIDS*, Sarah Brophy’s reading of *The Gifts of the Body* further complicates this “you” by positioning it as an indication of Brown’s authorial proximity to the personas she creates. Brophy depicts *The Gifts of the Body* as “a fictionalized memoir” (115), “written from the perspective of a lesbian caring for people with AIDS” (115). While no concrete textual evidence supports Brophy’s observation that the narrator is “a lesbian,” she draws this conclusion by regarding the narrator as a “fictionalized (but autobiographically based)” (116) version of

Brown herself. This default assumption of homosexuality provides a refreshing alternative to the all too prevalent standard which renders every subject as straight unless declared to be otherwise. Refusing the need for this narrator to come out in order to be gay, Brophy names the narrator's lesbianism as the starting point of her analysis, supporting Halberstam's vision of the universal queer. As a result, queerness informs Brophy's investigation of the succeeding themes and concerns raised by Brown's novel and its representation of HIV/AIDS.

Brophy, accordingly, identifies the narrator's queerness as it covertly emerges throughout the text. She regards the relationship between the narrator and her gay client, Rick, as a queer exchange. In fact, we might read this relationship as parallel to the narrator's friendship with Jim in "A Good Man." Brophy illustrates how queerness is expressed not merely through the swapping of caring and affection, but through the exchange of fluids as well: "this bodily fluid, sweat, becomes a sign of the passionate connection that Rick and the narrator express for one another through labour, a relation of bodily 'flow' that works across gendered oppositions and casts labour in the context of caregiving as passionate, mutual, ethical" (116). Reading caregiving as a reciprocal and transgressive locus of queer community building, Brophy reclaims *The Gifts of the Body* as a queer text that subverts normative standards of caregiving by presenting readers with alternative familial arrangements. Brophy laments the return to heteronormative kinship models at the novel's conclusion, where the narrator bestows Connie's body to her biological children. Brophy observes how Brown's ending "risks re-installing the nuclear family at the centre" (116). Yet Brophy's reading overlooks the queerness explicit in Connie's own family, as her other primary caregivers are her gay son and his partner, complicating the relationship between the queer outsider and the biological (male) kin that comprise Connie's caregiving team. Through her insightful analysis, however, Brophy

successfully reveals how, in spite of the narrator's lack of explicit testimonies to her own sexual orientation, Brown nevertheless creates an opportunity for us to read this queer text against the heteronormative structures within which it operates. In so doing, we begin to challenge the illusory "simplicity" of the narrator's writing style and the (lack of) personal information she provides.

In her analysis of touch and shame in *The Gifts of the Body*, Jennifer Blair also addresses this lack of disclosure characteristic of Brown's writing style. Identifying caregiving as a relationship of "not-quite-exchange" (523), Blair observes how the narrator "does not share the kind of emotional feedback readers might expect from a caregiver, especially one who is also the narrator" (521). Blair argues that in refusing to posit caregiving as "free-flowing exchange" (523), Brown constructs "radical relationship[s]" (542) which challenge notions of reciprocity or indebtedness associated with providing care. Through the absence of personal detail, or what Blair terms the "rhetoric of restraint" (523), Brown evokes "a strong sense that an ill, dying or dead body should by no means be viewed as just some raw material for anyone else's representation" (523). The narrator's emotional detachment, moreover, mirrors the ways in which readers have also become inundated with representations of HIV/AIDS. Just as the narrator becomes so accustomed to witnessing AIDS that she can no longer sufficiently react, the novel's lack of responsiveness becomes symptomatic of a larger trend within the social experience of HIV/AIDS itself. As Blair observes:

In reproducing this mainstream attitude toward AIDS in 1990s America by claiming that she is used to it, the narrator inadvertently points to an important cluster of questions: what it actually might mean to get used to AIDS; how we come to imagine that this is possible; what makes us think that people with AIDS are capable of accomplishing this

feat—even those who might be privileged enough to receive life-prolonging treatment.
(533)

Exploring this complex opposition between such acclimatizations to HIV/AIDS and the reality of persisting stigmatization and inadequate treatment, Brown undertakes the task of representing HIV/AIDS in an unsentimental way without undermining the need for concrete resources in prevention and care. Brown's novel resonates further still within our contemporary setting, as this oversaturation of HIV/AIDS representation has been replaced with an increasing sentiment that because of drug treatments nominally available in North America, AIDS is now "over." This misguided sentiment points to the necessary re-politicization of the pandemic within our present context. Indeed, Brown recognizes that overemphasizing empathy or catharsis could risk burying the novel's political motives under a desire to identify with the characters and plot. By thwarting the reader's emotional reactions, the narrator refuses this desire for identification. The reader instead is encouraged to turn their attention to larger social and political issues rather than on identifying with the narrator herself.

Brown's narrator, accordingly, exposes the realities of poverty and isolation faced by those who have "been abandoned by their families, or never had families" (97), and are denied an acceptable standard of living or the dignity of receiving adequate care. This sense of human expendability is embodied by Roy, the neighbor of Francis, a client living in a government building for people dying of AIDS. Raised in institutional settings like this one, Roy is characterized by his uncanny ability to recite the first and last names of all the building's past and present residents. Although we never become privy to the narrator's own name, a particularly eerie moment transpires when she discloses it to Roy: "I told him my name and he made this spitting sound; it was him giggling. 'I know,' he said, like I'd just fallen for this

incredibly funny joke. Then he said very seriously, ‘I know you. I’ve seen you before’” (88). The narrator relays the discomfort she derives from this disquieting situation, recalling how “it felt weird to think of this guy watching me from the elevator when I’d been in the building before” (88). While throughout the novel, it is our narrator that occupies this omniscient position, sharing confidential details of her clients’ private lives she nonetheless becomes protective and even feels violated in response to this gesture of recognition.

While, initially, the narrator’s defensiveness appears somewhat unwarranted, Roy’s relationship to names and naming soon becomes quite haunting to the reader as well. Not only does Roy remember an unusual number of names, his mode of recitation figures him as a sort of grim reaper, summoning the residents toward their inescapable deaths. Feeling increasingly uncomfortable with Roy’s ability, the narrator tries to disarm him by belittling his savant achievement: “‘that’s a lot of names,’ I said. ‘I know your name too,’ he said. I felt my skin crawl” (90). This chilling sensation is actually characteristic of some of Brown’s other works which feature similarly haunting and uncanny scenarios like finding oneself participating in a never-ending honeymoon or having one’s studio apartment invaded by an infinitely multiplying pack of dogs. Not only does the narrator manage to relay this entire sequence without actually disclosing her own identity, but her observations solidify the connection between naming and memory. Another caregiver, Andrew, who is also present during this interaction, characterizes Roy as an “archivist” (91), joking that Roy not only documents the building’s tenancy but that “he also does the obits” (91). When the narrator disdainfully observes how “it’s amazing he remembers all the names” (91), Andrew sighs, lamenting how “it’s nice someone does” (91). By embracing naming as a means of remembering, Brown confronts the political injustices

underlying the virus, attempting to pay homage to those whose lives were unnecessarily ended in dismal institutional spaces like these.

Through such encounters, Brown's fiction maps the social conditions made evident by HIV/AIDS. Her novel moves beyond merely documenting the role that service providers must play in the face of diminishing resources, exposing larger forms of marginalization that enable this dearth of essential services to exist. Brown presents a caregiving narrative to contribute to a better understanding of the larger issues contributing to the lack of public housing, hospice programs, care services, and social support unveiled by the crisis of AIDS. Brown's narrator observes how HIV/AIDS provides an opportunity for everyone from community activists to political leaders to recognize the need to improve existing conditions of health and care. The narrator, for instance, reflects how "one of the things the epidemic has done for a lot of us is expose us to how many people need the kind of help we can provide them" (140). The narrator also recognizes that such services need not be restricted to people living with HIV/AIDS. In asserting that "I'm really glad we'll be offering our home care chore services to a wider community" (140), Brown's narrator reflects concerns raised by non-fiction publications from the period during which the novel takes place. For example, "In Our Own Hands," a collectively-written feminist column about women and AIDS published in *Outweek Magazine*, similarly presents the AIDS crisis as "a unique opportunity to equate systematically bad health care with racism, sexism, homophobia, reproductive rights, urban economic and social collapse, [and the] repression of sexuality" (Denenberg 31). Recognizing how "many of our health problems are caused by the unequal distribution of resources, labor, and power resulting from discrimination based on sex, race, class, sexual orientation and dis/ability level" (Christensen

34), *In Our Own Hands*, like *The Gifts of the Body*, draws connections between HIV/AIDS and the pre-existing disparities in resources and access to care.

In their Introduction to *Women Resisting AIDS*, Schneider and Stoller similarly reveal how in confronting the social inequalities made apparent by HIV/AIDS, we acquire an opportunity for community organizing and resistance. They observe how “those conditions in the wider political economy and culture that shape women’s subordination simultaneously foster activism. Consequently, women are in strategic positions to affect the course of HIV’s spread” (1). Documentary writing, like Brown’s fictionalized account of her own caregiving work, reveals how women spearheaded a wide range of activist movements and community services in response to HIV/AIDS. In the “Invasion of the Patients from Hell at New York University Hospital or How I Spent My Summer Vacation,” Iris De La Cruz charts some of these efforts, depicting how solidarity among people living with HIV/AIDS can provide opportunities for activism and support, even in settings as dismal as hospitals. For instance, De La Cruz inverts the notion that being recognized at the hospital should be a moment of shame. Her article jokingly mimics a celebrity gossip column, reporting on the various sightings from her hospital stay: “well, low and behold! The guys hanging out read like a Who’s Who of the HIV community. Sitting in the middle of all the madness, holding court, was my very own *Newsline* editor, Phil. And he was surrounded by some very impressive people, like the activists Vito Russo and Damien Martin and some other guys that aren’t gonna talk to me ‘cause I didn’t mention them here” (111). In relaying her own experience, De La Cruz explores the opportunities for friendship and even humor that can be found in the hospital ward. She recalls how once, in the middle of the night, “we proceeded to decorate all the IV poles with pink ribbons and balloons. Everyone woke up to party IVs” (112). Refusing standards of

passivity and submission associated with receiving medical care, De La Cruz reveals how in actively combating HIV/AIDS, women can simultaneously challenge normative gender conventions as well.

Like De La Cruz, numerous HIV-positive women came together to provide their communities with resources, services, and support. For example, groups like the Women's Action Coalition (WAC) undertook projects varying from combating mandatory testing to unblinding newborn screenings, and uncovering how medical policies can serve as a form of racial targeting without ameliorating access to care. In addition to working with issues directly related to HIV/AIDS, like providing pre- and post- test counseling, the WAC also created programs addressing preexisting women's health issues that worsened or became more starkly apparent as a result of the AIDS crisis. These issues include domestic violence, separation from children, and sterilization abuse, as well as related struggles like constitutional protection of privacy and job security. The WAC also organized community activities such as marches, anti-violence meetings, discussion groups, fundraising efforts, and testing opportunities, allowing women to participate directly in their own advocacy and education through networks of peer support.

Another such organization that formed in response to the growing number of HIV-positive women in the 1990s was WARN, the Women and AIDS Resource Network. As described in their mission statement, the purpose of WARN is "to serve women, children and families affected by AIDS, especially those living in New York City. WARN works to alleviate the impact of AIDS on all women—particularly women of color and economically disadvantaged women- by providing advocacy and comprehensive services." Based on feminist models of care, WARN, like the WAC, was established as a self-help organization encouraging

women to take charge of their own health needs while ensuring the survival of their communities. The organization operated around the philosophy that educating women to conduct prevention efforts themselves would prove more effective than attempting to teach a population to which they did not belong. In addition to identifying and addressing the “unique medical needs of women with AIDS, the participation of women in clinical trials, medical debates concerning the transmission of the virus as they relate to women and children, infection control policies (e.g., in child care settings) and implications of pending legislation,” WARN also directed its energy to reforming those social structures that determine women and children’s health. Viewing HIV/AIDS as a catalyst for intervention in public policy, education, and social services “on a local, national, and global level,” WARN exemplifies Brown’s prescription that HIV/AIDS act as a starting point toward the implementation of a myriad of services necessary for the adequate provision of care.

This notion that HIV/AIDS should serve as a catalyst to broader health care reform also presents a potential locus of political contention. For instance, in ACT UP, members were divided as to whether the focus of the group was to provide immediate care to those infected (the drugs-into-bodies philosophy) or whether the group should ultimately strive for universal access. In conducting interviews of former members of ACT UP for the *Oral History Project*, Schulman inquires into the nature of this split, emphasizing its historical implications as well as the current consequences of this debate. In her interview with Schulman, Ann Northrop observes that:

I think the universal right to healthcare was a supposed platform playing for ACT UP early on. I think it was too difficult. I think it's natural to reach for the easier, faster thing,

and that became the specific drugs and once better drugs were available, a lot of that stuff did fall away. And, when the group split, that diluted the ability or willingness to demand universal healthcare. I think that's just too high a mountain to climb, or was, for ACT UP and its particular configuration. And, we haven't seen much progress on it in this country since then, either. So, I think that difficulty is real and frustrating. (39)

Northrop points to the barriers faced by groups like ACT UP whose achievements, though monumental, did not bring about universal health care in the way many members had initially desired. In an article predating ACT UP, from a 1985 edition of *The Village Voice*, this connection between the AIDS crisis and wider reform is articulated as an uncontestable link, as "stories of people being prematurely discharged or refused adequate services are part of the systemic problem of health care in the United States [. . .] AIDS 'is a pressing, poignant metaphor for a system in crisis'" (18). It is, therefore, a point of interest that in Brown's fictional representation, this desire to view HIV/AIDS as impetus to providing health care "to a wider community" (140) is expressed literally without the use of any metaphorical or allegorical device. By expressing this sentiment directly, Brown does not risk readers overlooking the message that HIV/AIDS should elucidate larger issues related to the provision of care.

While Brown unwaveringly connects the dismal conditions made apparent through HIV/AIDS to the greater need for health care reform, she certainly does not diminish the present effects of the pandemic or the struggles of those who are fighting against HIV/AIDS itself. Brown's writing illuminates how issues related to homophobia and queerness exist both within and beyond HIV/AIDS. Though Brown's novel unapologetically deals with the ramifications of the AIDS crisis on homosexual identity, to include the narrator herself within this framework of queer identification we must again pick up on extremely subtle textual cues. Upon meeting

Francis Martin, the narrator shares another moment that although not overtly named as such, can be read as queer. This exchange, once again, centers upon issues of identity and names. After introducing herself to her client, he responds that "I don't remember your name, but I know you.' He tried to raise his hand. I took it to shake. 'I'm Marty,' he said. But his name was supposed to be Francis, Francis Martin" (93). The discrepancy between the client's official name and the name he chooses poses a problem for the narrator, a dilemma linked to recognition: "'we've met before,' he insisted. 'Uh-huh,' I said vaguely. There was no point in trying to correct someone with dementia. He kept looking at me very intently. 'I was Carlos's friend,' he said. I was still shaking his hand, not getting it" (93).

When the narrator finally clues in to the fact that she has met this man before, we experience yet another uncanny moment of recognition. She relays that: "he clutched my hand to stop shaking. Then I remembered and I got a horrible chill. My skin prickled. 'Oh—right!' I said. 'Marty!'" (93). Experiencing yet another moment of terror, the narrator recalls that this Marty is the same Marty who once struck the narrator as appearing "pear-shaped" (94), with "baby fat on his face" (94). The narrator realizes that the signs of Marty's illness are apparent only through knowing Marty before he became sick: "if you saw him for the first time you might not think he was sick, just trim" (94). Though naming and recognition breed understanding, they also become the locus of fear about Marty's condition: "I tried to smile like it was nice to run into him again but it was horrifying" (94). Comparing this moment to her earlier shock at hearing her own name pronounced by Roy, the narrator again associates recognition and naming with an inevitable reaction of fear: "I thought of how strange I felt when Roy told me he knew my name. It was nothing compared to what Marty must have felt" (96). Yet like Andrew, Marty does not share the narrator's assumption that the presence of illness

should necessarily elicit a reaction of “horror.” Instead, Marty calmly registers the narrator’s reaction and attempts to alleviate her discomfort through further disclosure: “I saw him recognize the look on my face. But he was polite. He tried to make conversation” (94). In parallel to the meeting between the narrator and Connie, small talk and “polite” conversation are again figured as antidotes to the discomfort around illness and death.

As demonstrated by the narrator’s earlier interactions with Connie, this practice of “polite” conversation can also bring about an unspoken acknowledgment of queer identity. Once they commence their conversation, Marty and the narrator share a subtle exchange that permits for the mutual recognition of queerness. As the two discuss the caregiving relationship that existed between Marty and Carlos, a moment of identification transpires between them: “he looked at me again like he was checking me out. ‘Have you ever had a friend like that?’ ‘Yes,’ I said immediately” (98). While on the surface, the two appear to be politely discussing the nature of friendship, Marty’s “checking me out,” and the narrator’s “immediate” response, recalls the queer dyke-fag bonding characteristic of “A Good Man.” It is this identification, furthermore, which allows the narrator to provide genuine recognition and understanding toward her client: “‘It’s nice to see you again too, Marty,’ I said, and I meant it then. I felt something when I thought about Marty and Carlos” (94). Queerness, though unspoken, plays an integral element in buffering and naturalizing what could otherwise become a forced relationship between caregiver and recipient.

While such moments subtly point to the narrator’s queer sexuality, we receive no information about her actual partners until she encounters her new client, Keith. Unlike in previous chapters where clients are introduced in a humanizing and respectful manner, “The Gift of Sight” opens with a startling dose of judgment and distance: “This guy was the scariest to look

at. This guy really looked like the plague” (117). Like medical and social discourses that frame AIDS as a gay plague, stigmatizing and reducing HIV-positive subjects to symptoms of contagion, the narrator suddenly becomes unable to see past Keith’s symptoms. While the narrator remains most removed from this client, it is their relationship that ultimately allows her to open up to her readers. Though “frightened” (117) by the sores that cover his body, it is while applying salve to Keith’s wounds that the narrator finally begins to speak of her own personal life: “part of it felt good, like a normal conversation you’d have with someone you met at a party or with a new neighbor. But also it was like there were four different people there. The two people having the normal conversation and the person touching the body with the salve and the person with the body with the sores” (121). This fractured intimacy forces the narrator away from the comfortably stoic role she assumes as a caregiver. The distance that forms between her and Keith actually fosters some of the self-reflection conspicuously absent from the rest of the text. Faced with this client’s condition, the narrator begins to concede her own limitations and guilt, revealing that “I hated myself for thinking that but I also kept telling myself that even if I wasn’t feeling or thinking the right things, at least he was getting fed, at least he was getting his sheets changed, at least his kitchen was getting cleaned, at least his body was getting salve” (122). It is not until the narrator confronts the power imbalance inherent to caregiving that she becomes able to open up. In admitting that, in spite of her best intentions, she still harbors insecurities and prejudices toward her clients, the narrator can finally disclose her own experiences as well: “I started in on the salve. While I did it I told him about what I’d been up to that week, about a movie I’d gone to and hiking with Chris and a new string game I taught my cat” (123). Though these details remain rather sparse, they provide a great wealth of

information in comparison to the meager tidbits we have received up to this point, making us cherish even the smallest allusions to the narrator's personal life.

As Valerie Miner claims in her book review, Brown's reader is intended to feel dissatisfied with the details we are given, producing a strong yearning to learn more about our narrator. Miner observes how "gradually the narrator emerges from the interstices as a self-contained, understated woman. We learn that she has a friend named Chris, has been to college, is planning to visit San Francisco and has lost someone close to AIDS. For the most part, this indirect self-presentation works, but occasionally I wanted to know more about her" (14). Miner, perhaps not so well-versed in the details of Brown's own life, takes her depiction of "Chris" as the narrator's "friend" at face value. However, any reader familiar with Brown would glean that the Chris in the text alludes to the Chris in the novel's acknowledgements, which read: "to Chris Galloway: Thanks for the gift of the heart" (165). This dedication leads us to wonder why this "gift of the heart" is so heavily veiled in the text, failing to constitute a chapter title or even an overt recognition of a queer relationship between the narrator and a long-term partner. Although they can certainly be read as queer, the caregiving relationships between the narrator and practically everyone else she interacts with are professional, not casual friendships like the relationship in "A Good Man" between the narrator and Jim. Nonprofessional bonds between intimate lovers and friends are relegated only to secondary characters such as Marty and Carlos or Tony and Joe. While many of these relationships are certainly queer, those named outwardly as such are exclusively male.

Brown's minor character Margaret, however, provides a noteworthy exception to such trends. Margaret's name appears again and again, though we do not actually meet her until the end of the novel when we discover that she too has become sick with AIDS. It is not until

Margaret falls ill that the narrator suddenly understands how it feels to know someone who is diagnosed with AIDS, rather than knowing someone because they are already sick. This painful revelation allows the narrator to seek comfort in Connie, complicating their unidirectional relationship as caregiver and care recipient: “I held her longer than usual. I kept holding her and couldn’t let go. When she felt me holding her like that she started to stroke my hair. Her hands were thin but stronger than I thought” (135). Connie’s support allows the narrator to acknowledge that the detachment that exists between her and her clients (and by extension, her readers) becomes a protective shield that falsely separates her from those she helps under the guise of professionalism. At the novel’s conclusion, the narrator finally recognizes how queer relationships and platonic intimacies alike are essential not only to providing care, but also to surviving. As Brown reveals in an interview with Carol Guess, it is this type of intimate emotional support that Brown receives from her lover Chris, allowing her to confront the difficult subject in her books: “I am also very very fortunate that my partner of 15 years is a great person, both very independent and very loving. That I have been able to make a home with her has, I think, enabled me to keep living and writing, especially writing really sad stuff that, were I not in this good relationship, might just sink me down to somewhere I couldn't come back from” (6). The absence of such a character from the novel appears rather conspicuous, especially in relation to Brown’s commitment to remaining out and queer in her own life and work.

Though the *The Gifts of the Body* veils its narrator’s sexual identity, interviews with Brown demonstrate her unyielding commitment to queer literary community. She explains that: “I feel connected to a community in Seattle. Which for me means sweet personal friendships and excitement about each other’s work” (7). Although such friendships are curiously muted

within *The Gifts of the Body*, Brown unabashedly contests that “I also feel, politically rather than aesthetically, the importance of being a writer who is an out lesbian, connecting myself to that community. I hate closeted writers” (7). Though Brown’s fictional projects differ greatly from the HIV/AIDS manifestos and polemic activist writings of nonfiction work on this subject, Brown’s craft is nevertheless rooted in a queer political project dedicated to creatively and often understatedly exploring queer female embodiment and experience. Brown shows how being out in one’s work not only serves to represent queer realities but also builds ties to other authors dealing with issues related to sexuality and HIV/AIDS: “gay and lesbian writing [has] [. . .] given me an awareness of some terrific books by gay guys, books I wouldn’t pay attention to or read if I was a straight gal or guy. And I think some of the most interesting writing going on these days is done by homo men: Robert Gluck, Dale Peck, the late David Wojnarowicz, the late Bo Huston, the glorious Kevin Killian, the present Matthew Stadler” (7). Like the relationship between Jim and the narrator in “A Good Man,” Brown’s literary community transcends gender lines, linking lesbian and gay writers within this framework of queer. Her conception of such a community is by definition, transgressive, as it includes “D.I.Y culture. Small presses. ‘Zines. Work that does not attempt to synthesize or bring things together, but insists on its own incompleteness, its own—if I can yank a word back into another, older meaning—‘queerness’” (8). Brown identifies independently published, do-it-yourself formulations as ideal outlets for expressing queer desires. As Brown reveals, “I hate how dismissive mainstream arts, money, and power are of work by and about out lesbians. I am excited about small presses and experimental writing and feel I and my work fit in there more happily than elsewhere” (7). While “A Good Man,” is published by City Lights, an independent small press which prides itself as “a champion of progressive thinking, fighting against the forces of conservatism and

ensorship” (2008), *The Gifts of the Body* is published by Harper Collins, a mainstream venue whose wider readership may occur at the cost of eliminating lesbian content. Thus, the contrast between the queerly published, “A Good Man,” and the more mainstream, *The Gifts of the Body*, reflects the greater normalizing trends of cultural industries at large.

The absence of lesbian identities in *The Gifts of the Body*, accordingly, can be better understood in relation to the broader marginalization of queer women by mainstream publishing companies. As Schulman explains in an interview with Carol Guess, “In this current environment, many of America's best and most respected editors have never published a lesbian novel. The most successful lesbian writers are either closeted or don't have lesbian content” (16). Schulman traces the repercussions of the “chilling effect of the industry's indifference and neglect” (16), explaining how lesbian writers are faced with a lack of support and community, and are often impelled to remove overt lesbian content from their writing. (16) “The best presses in this country” (16), Schulman reveals, “have shown a frightening, extremely dramatic decline in their publication of lesbian novels over the last fifteen years” (16). This decline, moreover, reflects a bigger shift in the politics of representation in the United States. As Juhasz observes, “the ‘cultural wars’ which began during Ronald Reagan’s and George Bush’s administrations continue to this day. The nation is split on issues of morality, sexuality, and culture: abortion, the rights of gays and lesbians, the impact of sexual harassment and pornography, sexual liberation, feminism, the meanings of AIDS. To a great extent these wars continue to be waged through cultural production” (144). Publishing, Juhasz shows, reflects a greater trend in the censoring of queer identities, further perpetuating misrepresentations of HIV/AIDS.

Brown's work contests harmful representations of queerness and of HIV/AIDS, politicizing and sexualizing queer female subjectivities in relation to the pandemic. In depicting queer bodies and desires, Brown sacrifices commercial success. In an interview with Carol Guess, Brown addresses the dearth of funding and grants awarded for her work: "I've always done miserably, ie. not gotten them, with all those grants like Guggenheim, NEA, etc. Oh well.... I bet Gertrude Stein wouldn't have gotten any of them either (6)." Radical queer content, Brown humorously reveals, stands in opposition to works more suited to critical acclaim, for instance, those that reflect the values of the status quo. In a British review of Brown's autobiographical *Excerpts from a Family Medical Dictionary*, Ali Smith also discusses *The Gifts of the Body*, observing that Brown displays "a sense of truthfulness not found in the work of many writers" (1). Smith shows how reviews of Brown's work, characterized by epithets like "unflinching" (1), consistently fail to "do justice" (1) to her literary accomplishments. Smith further notes that "Brown is a great writer, a quiet, uneasy trailblazer, who hasn't really received her due of critical attention either here or in the States. Her latest book will probably also be labeled unflinching" (1). This lack of due recognition hinders the ability for queer female writers to represent their own lives. As Schulman argues, the publishing industry inhibits "how a moment is perceived and experienced by the character, her right to be the authorial center of her own universe" (Guess 16).

This veiling of queer female sexuality in *The Gifts of the Body* is connected to the broader erasure of the unique perspectives of women in relation to HIV/AIDS. Those who write HIV/AIDS literature should be encouraged to produce an accurate record of their lived realities and sexual practices, bolstering those communities to which they belong. Yet, from fictional narratives to scientific discourses, such representations are repeatedly wrestled away from those

women who are infected and affected by HIV. Although Brown's novel evades the naming of both lesbianism and of the intimate details of the narrator's identity, *The Gifts of the Body* nevertheless provides a transgressive queer perspective on caregiving and HIV/AIDS. This refusal to name queer female sexuality in relation to the pandemic will be explored further within transnational works by Patricia Powell and Jamaica Kincaid. Such accounts, like those of De La Cruz and Brown, are crucial to constructively conceptualizing women as HIV-positive, as caregivers, and as healthy, sexual queers, reclaiming health care advocacy and narrative representation to oppose inequalities made apparent by the pandemic itself.

Chapter 3

Policing Contagion: Borders and Prisons as Spaces of HIV/AIDS

Moving from an investigation of caregiving and domestic manifestations of queerness in the work of Rebecca Brown, an examination of the pandemic also requires a transnationalist consideration of the spaces through which HIV/AIDS is imagined to spread. HIV/AIDS narratives call attention to spaces perceived to contain and restrict the spread of disease. National borders and prisons are two such zones devised to control the self-determination and mobility of bodies deemed “illegal,” “alien,” “foreign,” and otherwise “infectious.” Justifications for the continued existence of such spaces are tied to the culturally constructed belief that by segregating and criminalizing outlawed bodies, those defined as “legal” US citizens will be protected from crime, immorality, and even disease. Illness narratives, furthermore, point to the historically entrenched understanding of epidemics as always originating elsewhere and arriving at the “general population” via the “Other.” Like these epidemiological mythologies, scientific narratives of how HIV enters the human body are also conveyed through similar metaphors, as the virus is characterized as “invading” and “penetrating” the inadequately defended borders of bodies and cells. Our national borders, as an extension of such narratives, become a hyper-vigilant site of contagion, creating mass hysteria around racial otherness and immigration as it is perceived to relate to the transmission of disease. Prisons, also heavily characterized by racialization and surveillance, similarly create a closed setting rife for the transmission and proliferation of HIV. As a result of erroneously perceiving prison as a removed social entity (or quarantine, even) whose infection rates will not affect those outside of its walls, prison populations face enormous risk for HIV/AIDS. The criminalization of queer sex combined with the lack of access to prophylactics and proper drug treatments within

these institutions breeds dire consequences for how the pandemic will affect non-inmates as well. In parallel to the indifference displayed toward the HIV/AIDS crisis in prisons, there exists a troubling prioritizing of concerns about the unidirectional importing of HIV into our own borders. As a result, the United States fails to meet the crucial imperative to provide affordable treatment to the millions dying worldwide, while concurrently overlooking the needs of those infected within its own national bounds.

Countering harmful distortions of HIV/AIDS as that which only affects cultural and sexual outsiders, narratives like Jamaica Kincaid's *My Brother*, and Patricia Powell's *A Small Gathering of Bones*, challenge these institutionalized mythologies by illustrating that a global health crisis cannot be abated merely by policing borders. Reading these narratives in conjunction with archival writings by prisoner activist, Katrina Haslip, further uncovers how the pandemic presents a concrete opportunity for medical revolution through which ground up, grassroots campaigns can effectively halt the spread of HIV. Providing models for community building and resistance to the violent maintenance of borders and prisons, HIV/AIDS narratives by Haslip, Kincaid, and Powell demonstrate the urgent need to move outside of nationalist, profit-based, and punitive frameworks and toward an understanding of queer, immigrant, and prisoner health as a human right and immediate need.

While borders and prisons may appear to represent two incongruous zones, the commonalities between these spaces extend beyond their physical constitution and into their parallel function of enforcing a distinction between legal and illegal bodies and between spaces envisioned as inside and out. Examining these structures in tandem effectively exposes the ways in which such binary oppositions between citizen and non-citizen and between law-abiding subject and outlawed criminal are far more complex than these edifices suggest. This

juxtaposition also reveals how the structures that physically enforce these distinctions breed surveillance and violence, contradicting the edicts of justice and safety they claim to protect. In *Are Prisons Obsolete?* Angela Davis argues for the abolition of the prison system, illuminating that not only does “mass incarceration [have] little or no effect on official crime rates” (12), but that “larger prison populations [lead] not to safer communities, but rather, to even larger prison populations” (12). Davis points to the fact that by “focusing myopically on the individual” (85), the process of incarceration elides any consideration of the social problems underlying the incidence of criminal behaviors, shortsightedly failing to recognize the structural factors that criminalize these behaviors themselves. Davis shows how the prison industrial complex is, globally, “an important source of profit” (85), within which “the racialization of prison populations [. . .] is not an incidental feature” (85). Tracing a history of the criminalization of black bodies from emancipation to the present day, Davis demonstrates how the criminal justice system functions as a modern form of constricting and enslaving people of color with ramifications extending beyond national boundaries or prison walls. In viewing the prison industrial complex within the larger context of racial oppression and economic stratification on a global scale, Davis reveals how spaces like borders and prisons become fundamental to containing racialized bodies by marking them both historically and literally as criminal and in need of restraint.

This conception of the prison or the border as a means of protection hinges upon narratives of illness as well. As Priscilla Wald observes, the “stigmatizing of immigrant groups is justified by their association with communicable disease; it implies the almost superstitious belief that national borders can afford protection against communicable disease” (8). Prisons are similarly regarded as a “fixed barrier” (Brophy 3) between those incarcerated and the so-called

‘general population.’ Like narratives of HIV/AIDS and of disease more broadly, the prison as an entity is represented as apart from “what is proper to the self and what threatens the self’s boundaries” (Brophy 3). Borders too are ultimately linked to this concept of self versus other as the national body is also figured as in need of protection against the spread of disease. As Julia Epstein demonstrates, “nation-states as we know them came into being at about the same time that clinical practice was solidifying into an organized medical profession. Both systems are experiencing stress as they become increasingly subspecialized” (186). Epstein argues that this simultaneous construction of bordered nations and the compartmentalization of modern medicine exhibit the parallel concern with leakage and containment central to narratives of disease. Epstein illuminates that although such narratives of containment are paramount to our understanding of HIV/AIDS, they certainly did not originate with our present pandemic but are rooted within a long history of disease.

Just as Epstein connects the policing of national borders to the interrelated discourses of leakage, contagion, and illness, Wald similarly traces the impact of medical advancement upon conceptions of national identity. Engaging with the seminal work of Benedict Anderson, Wald examines the “nationalist implications of the germ theories and the incorporation of communicable disease into the imagining of the nation” (52). As Anderson argues, the role of narratives and images in producing an “experience of communion with strangers in a shared political space” (Wald 52) catalyzes the interrelated outcome of envisioning the nation as its own “immunological ecosystem” (53). Wald explains that in conceiving of the nation as an insular entity, “the community to be protected is thereby configured in cultural and political as well as biological terms” (53). Outbreak narratives as a result, “actually make the act of imagining the community a central (rather than obscured) feature and the ecological perspective of the germ

theories stresses communal transformation, the *conspicuously imagined* community is certainly in danger of dissolution” (Wald 53). Wald uncovers how the permeability of nation-states and by extension, their borders, becomes inevitably tied to conceptions of contagion and disease: “if epidemiologists map the imagined community of the global village, charting infectious diseases as they cross national borders, the depiction, as much as the management, of those diseases reinforces the boundaries [. . .] disease assumes a political significance, while national belonging becomes nothing less than a matter of health” (Wald 67). Through her reading of Anderson, Wald elucidates how the discourses connecting border policing to fears of contagion are historically determined and narratively linked.

Indeed, prisons and borders together manifest a long history as emblems of containing and constricting disease. As Paul Farmer observes, the current movement of HIV across international borders is tied to a larger historically predetermined system of globalization with its accompanying trends of economic marginalization and colonization. Farmer writes that although “the spread of HIV across national borders has taken place within our lifetimes” (183), we must recognize that “the conditions favoring the rapid, international spread of a predominantly sexually transmitted disorder were established long ago and further heighten the need to historicize any understanding of this pandemic” (183). As Farmer posits, a historical analysis points to the incidence of narratives that criminalize border crossings and racialize disease, a pattern that can be traced back to essentially every illness on record. Jeanette Farrell, for instance, reveals how the plague was repeatedly blamed on immigrants and other national outsiders—on Arabs in Spain, religious pilgrims in Portugal—and “all across northern Europe, it was Jewish people who were accused of bringing on the plague” (84). Farrell documents that “in Southern France, where the plague accusations seem to have begun, Jews were already being

killed in mass attacks in the years before the plague. The plague gave this hatred an excuse, and the hatred gave people's fear of the plague a focus" (84). These narratives of plague demonstrate the intersection of criminalization and disease, as once Jews were ideologically stigmatized as disease vectors, they were then targeted for mass roundups and executions. Farrell also notes that these murders were not met without resistance. She recalls that "Jews in Frankfurt fought back, killing two hundred of their persecutors" (85). Such histories of stigma and resistance, as Farrell shows, accompanied nearly every infectious disease from leprosy and cholera to tuberculosis and AIDS.

While the Plague exemplifies how illness narratives have been employed for centuries to criminalize and extricate those who are positioned as antithetical to the national body, this particular illness represents merely one of many analogous discursive trends. As Elaine Showalter observes, "in the United States, the rising tide of immigration was held responsible for the spread of syphilis" (189). Similarly, in her study of Typhoid, Wald recalls how "immigrants and tenements became a focal point of the threat, even though the medical literature regularly established the inassociability of typhoid with a particular class or group of people" (82). Conflating immigration and "the products of industrialization" (82) with the "national burden" of both capitalist waste and of communicable disease, Wald reveals how contagion became a literal embodiment of the fear of leakage between "them," (immigrants), and "us," the national body dependent on immigrant labor. Just as the horror of HIV/AIDS was articulated as being able to transcend gay communities by "leaking" into the general population by way of major urban centers, Wald relays the corresponding historical fear that "the communication within the ghetto could readily mutate into a dangerous contagion with any threatened blurring or illicit crossing of its boundaries" (152). "Communicable-disease outbreaks" (152), illustrates Wald, "suggested an

underlying social violation of the quarantine model that represented a threat to the larger ‘community’ of the city or nation” (152).

Such narratives, Wald extends, culminate in the figure of ‘Typhoid Mary,’ a symbolic icon embodying the fear that “undocumented women, immigrants, and carriers, all in their fashion, posed a distinct danger to the reproduction of white America” (112). Wald demonstrates how the story of ‘Typhoid Mary’ “presumed general acknowledgement of the need for documentation and state surveillance” (112). Contagion, Wald explains, become impetus for the legal implementation of the “reassuring fantasy that surveillance works, that the subject was eventually apprehensible, comprehensible, and manageable” (112). The result not of illness, but of its accompanying narratives that pinpoint the source of contagion on undocumented immigrant workers like Mary Mallon, disease became justification for stricter border controls and increasing surveillance. As Wald observes, paralleling the narratives of contagion around industrialization and outbreaks of diseases like typhoid, “officially tracking individuals, especially immigrants, was the object as well of the reforms of the census in the late nineteenth century and early twentieth” (83).

In addition to becoming grounds for the surveillance and policing of immigrants, illness also became rational for the quarantining and incarceration of already targeted and racialized groups. Farrell, for example, recalls the history of tuberculosis, charting the ways in which “separate hospitals were built for blacks and Native Americans” (121). These sanatoriums, Farrell reveals, bore a direct likeness to prisons. Farrell describes the parallels of these stratified “health” facilities to the modern prison documenting that:

The patients were all dressed in striped uniforms, like prisoners. Meals were beans and cornmeal spotted with mouse droppings. The healthier patients spent the morning bathing the sicker ones, and they all spent the afternoons from one to five lying on their beds with bean bags on their chests” (122)

Farrell depicts how at one such facility, the Sioux San, “no patient left alive—no one even went out on leave: the only patients to leave were the dead” (122).

This historically prevalent employment of illness as justification for the targeting and incarceration of national outsiders can also be observed in relation to the policing and criminalization of sexual transgressors as well. In “Picturing Deviancy,” Stuart Marshall links the construction of homosexuality as a medical disorder to new forms of surveillance made available through the emerging technology of photography. Marshall notes that “the medicalization of homosexuality—a transition from notions of sin within ecclesiastical law to notions of sickness and deviancy which was to result in a proliferation of new social identities, a whole set of new species of human beings, many of which were witnessed and catalogued in the evidence of photography” (25). Marshall argues that the congruous advent of photography and that of homosexuality are not coincidental, but are hinged upon the ability to document queerness as a criminal type. Marshall asserts that “the history of photography and the history of medicine are both deeply implicated in the growing systems of surveillance, control and regulation which facilitated the extension of the state’s supervision and social management of the population as a whole throughout the nineteenth and into the twentieth century” (24). With photography, marks Marshall, came the pathologizing and vilification of “the new characters” (25) of “the prostitute, the criminal, the mentally enfeebled and the homosexual” (25).

As Marshall reveals, the historical criminalization of both queers and sex workers is interrelated to racialized systems of policing as well as to narratives of medicalization and disease. Phillippa Levine links the criminalization of sex work to colonialism by revisiting a history of narratives of sexually transmitted infections among British troops in the Caribbean and in India. Levine traces the interconnectedness of homophobia, colonization, and the British government's regulation of sex work, illustrating the discursive correlation between a surplus of "young unmarried soldiers" (293) and "an increase in unnatural crimes" (293). Levine documents those historical narratives depicting that "same-sex activity among men was perhaps the most threatening of all unmanly practices, a danger to family, nation, and empire" (292). Queerness, like sexually transmitted infections, was framed in terms of "a contagion, though even harder to regulate" (293). Sentiments regarding homosexuality expressed fears through the language of illness and spread, cautioning that "if a taint of this kind once gets in amongst young men and boys, it is almost impossible to eradicate it" (Levine 293). Levine recalls that "supporters of regulated prostitution had argued that without access to prostitution in colonial environments, men's natural urges were such that they would choose sex with one another over celibacy" (292). Through a racist schema that positioned colonial women as mediators against British homosexuality, there arose a system of policing and surveillance mirroring that of the medical photography depicted by Marshall. As Levine observes, "laws regulating prostitution all sought to unveil and uncover women by listing them on registers, issuing them with tickets, keeping their photographs on file, posting their names in the brothel, but meanwhile they intended to keep the sex business from spilling over into the world of acceptability and respectability" (321). Through this process of criminalization, legal procedures established that "only women were responsible for disease transmission and thus liable to legal and medical

surveillance” (Levine 2). This surveillance and policing of sex workers along class and racial lines is also tied to the explicit gendering of transmission narratives themselves. Levine demonstrates that “the laws punished working-class women, drawing a veil over the more discreet and hidden forms of sexual servicing exclusive to the wealthy” (2). In positioning women as vectors of disease, such discourses also highlighted how sexual illness transmission became narrated as not only “affecting individuals, but as something that would weaken the ‘race.’ Health thus became a moral and national problem [. . .] the spread of disease was potentially ruinous to Britain’s powerful empire as well as to its alleged racial superiority” (2). Levine thus demonstrates how narratives of illness, race, and sexuality all converged to establish a system of policing national borders and of incarceration in order to establish a heteronormative and racially regulated system of colonial rule.

These historically rooted parallels between borders and prisons further extend into our contemporary context. In *Global Lockdown: Race, Gender, and the Prison Industrial Complex*, Julia Sudbury argues that “the global prison is a local manifestation of transnational flows of people, products, capital, and ideas” (xii). Drawing links between prisons and other “spaces of confinement” (xii), Sudbury discloses how the prison industrial complex operates in tandem with institutions including “immigration detention centers, psychiatric hospitals, juvenile halls, refugee camps, [and] Indian boarding schools” (xii) to restrict and restrain gendered and racialized subjects. Drawing on a framework of transnational feminism, Sudbury links the process of incarceration to “popular and official discourses that equate immigrant status with criminality” (xix). One such connection between prisons and borders becomes apparent when migrant bodies are incarcerated for the act of crossing national boundaries themselves. Sudbury outlines the ways in which “globalization and free trade have generated borders that are

(selectively) porous. In this context, anxieties about nonsanctioned border crossings have led wealthy nations to expand the reach of their policing and surveillance operations” (xx). This process of policing and criminalizing those who attempt to transgress national lines reinforces the function of the prison industrial complex itself. Sudbury explains how “the survival strategies adopted by women of color under the constraints of colonization, gendered racism, and neoliberal globalization have been criminalized and policed, thus producing the ‘criminals’ necessary to fuel the transnational prison-industrial complex” (xix). As David Gilbert, a New York State prisoner, concurs in “A System within the System,” “we can’t understand the explosion of imprisonment in the US since 1971 without looking at imperialism’s urgent needs and goals” (31). In illuminating the connections between colonization, migration, and criminalization, Sudbury not only connects globalization to the operation of prisons, but also shifts our focus within antiglobalization and antiprison discourses to become more reflective of transnational concerns. From this perspective, Sudbury reveals, we can also become more attuned to “the immediate survival concerns of communities of color and indigenous people in the global North” (xii).

This process of policing and criminalization is further complicated by HIV/AIDS, as incarceration dramatically exacerbates rates of infection. The rapid and unabated spread of HIV within prisons illuminates the dire consequences of policing and imprisonment itself. Not only are prisoners’ lives devalued as a component of the carceral system, but the lack of HIV prevention and education efforts in prisons also reflects the erroneous belief that the segregation of prisoners from the so-called “general population” will ensure that the only people who will be affected by HIV/AIDS are those whose lives have already been labeled and discarded as criminal. A 1986 Annual Report from Philadelphia’s *Bebashi: Blacks Educating Blacks About*

Sexual Health Issues, confirms the links between HIV/AIDS, incarceration, and the preexisting targeting of racialized communities. The report observes that “at the Philadelphia prisons, efforts to implement meaningful AIDS education efforts have been hampered by bureaucratic delays and fear of change” (9). Like Davis, the report calls for a radical restructuring of carceral systems themselves in order to intervene in the pandemic. The report insists that “only through new vision and creativity at the top – and a change in archaic attitudes which, for example, treat condoms as ‘contraband’ and pretend that sex in prisons is nonexistent—can progress be made in preventing an epidemic of AIDS among the predominantly black population of the city’s prison system” (9).

In addition to overlooking the health needs of those who are already racialized, criminalized, and discarded into the prison system, the egregious lack of proper testing, treatment, and prevention efforts targeted toward inmates reveals the sentiment that prisons as an institution can contain the pandemic of HIV/AIDS. This fallacy can be observed in many forms. For instance, prisons frequently fail to administer antiretroviral drugs in a timely or consistent fashion, creating virulent mutations of the virus that become resistant to medications. While the inadequacy of treatment regimens in prisons evidence the lack of concern about such mutations, these strains can easily surpass prison walls and contribute to a greater medical crisis. These factors, moreover, extend beyond medical and biological implications as the stigmatization of queer sexuality within prison has a deleterious effect on communities on the outside as well. In her analysis of black lesbians in the juvenile detention system, Beth Ritchie addresses how the criminalization, police targeting, and incarceration of young queer women renders them increasingly susceptible to HIV infection and sexual abuse. Ritchie observes how “the lack of response to these young women as victims *and* as targets of harsh law enforcement strategies has

heightened their vulnerability” (79). Ritchie employs a queer framework to illustrate how “deviance and, by extension, criminalization have been socially constructed to serve people in power” (82), facilitating the incarceration of “people who are arrested for nonnormative sexual identity or practices” (81). Ritchie’s analysis demonstrates that rather than reducing risk through policing and incarceration, the panoptic surveillance characteristic of prisons and urban patrolling only leads to the magnification of violence and abuse. By criminalizing prisoners and their sexual practices, incarceration succeeds not in curtailing crime, but in abetting the spread of a global pandemic.

In likeness to prisons, the policing and surveillance of national borders analogously poses an increased risk not only for unwarranted violence but for transmission rates of HIV/AIDS. As Maria Ruiz observes in “Border Narratives, HIV/AIDS, and Latina/o Health in the United States,” the health of refugees and recent immigrants is directly at stake when nations criminalize and patrol the border as a potential site of infection. Those who arrive in the United States with or without status are impelled to avoid medical institutions while concurrently facing an escalating risk of seroconversion. Ruiz illustrates how “focusing on the border as a portal for infectious diseases obscures the health risks that immigrants face and promotes factors—including fear, stigma, and discrimination—that deter immigrants from seeking education, testing, and treatment for HIV/AIDS” (51). As Anne Christine D’Adesky concurs, policies affecting the policing of borders and immigration control directly impact access to HIV/AIDS treatment and prevention. D’Adesky reveals that:

On a global level, there is an important question—a contradiction—that is being ignored by global leaders and activists alike. In pushing for treatment, we are asking millions of people to come forward for testing, to risk disclosure. Yet almost every nation has laws

that track those with HIV, and that prevent their easy passage across borders. By advocating access to treatment, are we also asking people to risk the loss of their civil rights?" (17)

The border, Ruiz extends, is not merely a metaphor for disease, but that which literally connects the permeability of the nation-state to the presence of illness. Discourses linking the border and HIV/AIDS shift blame away from perpetrators of state-sanctioned violence and racism and onto those who are at risk or sick.

In response to this stigmatization of migrant bodies and those at risk for HIV/AIDS, Jamaica Kincaid's *My Brother* addresses these links between national boundaries and the spread of disease. A narrative of border-crossing, transnationality, and resistance, we can read Kincaid's work as an opportunity to break down the notions that HIV/AIDS only affects those located "elsewhere" while also unraveling the paradigm that illness always arrives in the US from without. As Ruiz observes, immigration and border anxiety is "multidirectional" (39) in spite of the ways in which narratives focus largely on the implications of crossings into but rarely out of this country. Kincaid's narrative subverts this practice by illustrating the complex ways in which regardless of nationality, gender, or sero-status, we are all affected by the global ramifications of the pandemic. Kincaid begins her account of her brother Devon's illness by mapping her own migration away from the Caribbean. Her narrative bounces between depictions of her brother's condition and recollections of her own relationship to her family and her childhood in Antigua. While Kincaid spends much time describing the ravages of HIV/AIDS upon her brother's health, her narrative without much straightforward motivation lends equal weight to recounting the tumultuous interactions and insurrections between herself and her mother. Through these unconventional maneuvers in plot, Kincaid connects illness to

transnationality and to a highly complex understanding of selfhood and home. She reflects that when she was growing up, “I decided that only people in Antigua died, that people living in other places did not die and as soon as I could, I would move somewhere else” (27). Although the trajectory of her brother’s illness and death from AIDS appears to support this juvenile belief, Kincaid’s narrative actually fulfills the reverse function of illustrating how one cannot migrate away from death. The sense of mortality Kincaid attempts to escape upon leaving Antigua effectively follows our heroine across international borders, complicating her seemingly impenetrable new life in Vermont.

Devon’s infection with HIV, moreover, forces Kincaid to confront the border itself. In one instance, Kincaid discusses her brother’s lack of access to treatment with a friend in America who also maintains a complex relationship to national identity as “a British woman of African descent” (48). Through this interaction, which Kincaid remembers while “going through Customs” (48), she becomes starkly aware of the ways in which viruses and bodies can move across borders, challenging the false sense of stability they suggest. Kincaid relays how upon hearing of Devon’s dire circumstances in Antigua, her friend “said, as if it were the most natural, obvious suggestion in the world, that I should take him to the United States for treatment” (48). In response to this apparently startling suggestion, Kincaid cites the border as the barrier to adopting her brother into her American life. She recounts how “I said, Oh, I am sure they wouldn’t let him in” (48). This exchange takes an interesting turn when for our benefit, Kincaid adds that “I didn’t know if what I was saying was true, I was not familiar really with immigration policies and HIV, but what I really meant was, no, I can’t do what you are suggesting—take this strange, careless person into the hard-earned order of my life: my life of children and husband” (49). Crossing borders becomes a threat to the stability of Kincaid’s marriage and her otherwise

conventional familial arrangement. In contrast to this “husband” who exists within a legally recognized framework, the border and the act of crossing it poses a threat to the state-sanctioned structure of Kincaid’s new life. In imagining her brother crossing not only the US border but also the nuclear family border of her kin in Vermont, Kincaid feels the need to assure us of the bonds that exist between herself, her partner, and her kids. She emphatically details that “they love me and love me again, and I love them” (49).

This persistent reassurance of the stability Kincaid finds in her American family resurfaces whenever she discusses her brother or his illness in an explicitly sexual way. For instance, when Devon tells his sister about his teenage exploits with public sex, her narrative jarringly jumps from Antigua to her other life the United States. While one moment Kincaid is “walk[ing] back to my mother’s house” (81), in the following paragraph without any transition, she tells us that “I returned to my own home in Vermont with my children” (81). Kincaid also positions her brother as a foil for her own conservative sexual practices. She humorously discloses that “my own life, from a sexual standpoint, can be described as a monument to boring conventionality. And so because of this, I have a great interest in other people’s personal lives. I wanted [my brother] to tell me what his personal life had been like. He would not do that” (41). Despite this claim to her brother’s secrecy, we come to realize that barring this definitive statement, Kincaid discloses many instances where her brother not only shares his sexual experiences but Kincaid actually witnesses him flirting, propositioning, and even dating multiple women. We also learn at Kincaid’s conclusion information we could have received far earlier in the narrative: Devon also leads a closeted existence as a homosexual. Kincaid’s earlier assertion of her “great interest” in such matters is similarly underwritten by her constant reversion in these moments of disclosure back to the “boring conventionality” (41) of Vermont. This disconcerting

shuttling back and forth between the Caribbean and North America accentuates the migratory and often tenuous nature of factors like nationality and access to health care. This jarring narration, moreover, indicates how Kincaid's personal relationship to family and identity cannot be pitted only in Vermont or in Antigua, as her narrative refuses to claim either location as mutually exclusive or as singly "home." The HIV/AIDS pandemic, by extension, is revealed as a global problem that must be addressed transnationally rather than left to the devices of the local populations wherein it enacts its most dire effects.

In "Text as Trading Place," Ross Chambers addresses precisely this challenge of depicting "the reality of an epidemic that is ravaging the populations of a broad equatorial swathe around the globe" (110). Chambers outlines the difficulty of conveying the global scope of HIV/AIDS within a literary context that is based in the West. In his reading of *My Brother*, Chambers views Kincaid's narrative as an effective, transnational reminder that we "are not disconnected from Antigua or AIDS or death" (113). In "Writing AIDS in Antigua," Diana Davidson concurs that "Kincaid's book brutally points out the HIV-related inequities between a postcolonial nation and the wealthy countries that have colonized it" (122). Devon's illness, Davidson argues, serves to connect Antigua's colonial and postcolonial histories to the pandemic of HIV/AIDS. Kincaid's work demonstrates how the financial inequalities, homophobia, and the lack of access to health care highlighted by the pandemic must be curbed not only locally, but on a global scale.

While HIV/AIDS certainly challenges the inculpability and impermeability of the nation-state, reactions to the pandemic also affect the policies governing borders themselves. In "Moving Metaphors: The Representation of AIDS in Caribbean Literature and Visual Arts," Ivette Romero-Cesareo illustrates the ways in which the HIV/AIDS crisis served as justification

for the mistreatment of migrants and refugees. She documents how “Haitian migration to the United States was likened to a plague, the HIV scare served as justification for returning of boatloads of people to the island and isolating hundreds of Haitians in makeshift refugee camps on U.S. military bases” (106). Romero-Cesareo not only examines the tangible effects of HIV/AIDS stigma on immigration policies but she also unpacks the metaphors used to justify the criminalization of those who threaten national boundaries, not only literally, but on a conceptual level as well. Romero-Cesareo draws on Julia Kristeva’s notion of “the abject,” pointing out that it is “not a lack of cleanliness or health that causes abjection but what disturbs identity, system, order. What does not respect borders, positions, rules. The in-between, the ambiguous, the composite” (121). HIV/AIDS, Romero-Cesareo ascertains, not only threatens the stability of national boundaries but poses a further threat to normative sexualities and sexual practices themselves.

It is precisely this sexual threat of national otherness that continually resurfaces throughout *My Brother*, as Kincaid repeatedly depicts HIV/AIDS as antithetical to legally-sanctioned practices of monogamy, family, and marriage. Even in Antigua, Kincaid problematically views heterosexual marriage as a safeguard against illness and infection. In one instance, she deems one of her brother’s friends as an emblem of health because he appears in public with a wife and child. She observes how “the three of them were together and they were a family and they looked so very nice, like a picture of a family, healthy and prosperous and attractive, and also safe” (112). HIV/AIDS, according to Kincaid, threatens the so-called “safety” not only of her own life in Vermont but also of the nuclear family itself. In “The Operations of the Closet and the Discourse of the Unspeakable Contents in *Black Fauns* and *My Brother*,” Jennifer Rahim addresses Kincaid’s questionable position in relation to HIV/AIDS and

to her brother's sexuality. Rahim situates *My Brother* in a larger context of queer Caribbean literature, identifying the trend of "foreign-based, 'openly lesbian writers' in the 'ventriloquising of male homosexuality'" (12) to express not only the unspeakable gay male culture but also to use male homosexuality as a stand in for female queerness within their works. Rahim argues that in light of such practices, alongside the "virulent homophobia' of the [Caribbean] context" (12), "Devon's outing by his foreign-based writer and sister" (12) becomes quite intriguing indeed.

In this context, Kincaid's earlier longing to transcend the "boring conventionality" (41) of her own sexuality can complexly be read as a nod to her inability to engage in practices that might render her queer. As Rahim observes, in Kincaid's examination of her brother's queer identity, she "makes the point of self-consciously establishing her position as an 'ignorant' outsider" (12). Rahim shows that as a mere "reporter of an account of her brother's sexuality" (12), Kincaid "thereby maintain(s) a third-removed narrative positioning from that 'truth'" (12) and from the sexual possibilities that "her recognition of that knowledge apparently implies" (12). Rahim argues that "homosexual subjectivity is relegated to the ambivalent territory of unknown and known knowledge that is subject to a persistent heterosexual overwriting of its surfacing" (18). Just as HIV/AIDS and the idea of her brother's crossing the border threatens the stability Kincaid finds in her family and in her life in the United States, the queer sexuality manifested by Devon also challenges the sexual borders and normative order of Kincaid's own life.

In contrast to Kincaid's discomfort with her brother's queerness and its possible implications for the stability of her own heterosexuality, Patricia Powell's *A Small Gathering of Bones* employs gay male relationships to validate the expression of queer sexualities across

gender lines. In an interview with Faith Smith, Powell reveals that her intention in writing this novel is to address homophobia and its effects on queer lives. Like Kincaid's observation of how her brother's illness and death are connected to his need to hide his male lovers, Powell's characters demonstrate the importance of coming out and coming into one's homosexuality in a supportive environment. Just as our hero Dale warns his lover Alexander that he should not encourage his own children to "stay closet like you" (41), Dale's friend Ian's illness and death from HIV/AIDS are incontestably connected to his complete and devastating rejection by his own mother for being gay. When Dale puts his faith in medical doctors to save his dying friend, Ian's sister exclaims, "but Dale, she push him" (134), recounting the culpability of their mother's violent rejection of her son as the immediate cause of his death. Like Schulman, Powell locates familial homophobia and community rejection as a catalyst for HIV/AIDS. While the novel focuses on the experiences and sexualities of this Jamaican community of gay men, Powell reveals that "my work is completely autobiographical. Even if the shell or the plot of my work doesn't match up with my own experiences, the underlying emotions in many of the scenarios are ones I've lived through and which have affected me in the most profound ways" (328). Powell's novel, as a result, not only utilizes HIV/AIDS to draw connections between homophobia, self-esteem, national identity, and sexual health, but its depictions of gay male desire can also be read as an outlet through which Powell subtly addresses queer female sexualities as well. As with the work of Schluman and Brown, reading HIV/AIDS within a gay male context can also create a point of entry for representing the experiences of queer women and the related gendering of HIV/AIDS.

Nowhere is Powell's narrative encoding of queer female sexualities within the experiences of gay men more apparent than in her depictions of sex itself. For instance, when

Dale imagines his partner Nevin having sex with another man, he relays that “all of a sudden it became clear that Nevin’s kisses didn’t belong to just him anymore. His lips press against other fellow’ mouths, alongside navels, between thighs with just as much fervency; just as much ferocity” (56). Powell’s use of erotic language and stock phrases traditionally associated with female sexuality, for example—calling our attention to places “between thighs”—are not isolated to this one instance, but they surreptitiously surface every time her male characters have sex. In an earlier depiction of a sexual encounter between Alexander and Dale, we very effortlessly again can imagine the two men’s bodies as women: “The gold pendant [. . .] at the base of Alexander’s throat, graze Dale’s neck, trail alongside earlobes, slide in and out between his lips. Him feel Alexander’s tongue wet, prodding, as it dart into the hollow of nostrils, circle up over eyelids, linger by temples, entangling itself among the folds of Dale’s softness” (45). Lips, wetness, folds, and softness—longstanding literary tributes to lesbian sexuality—queer these sex scenes by transcending essentialist indicators of gender in representations of sex. These signifiers, furthermore, challenge the representation of maleness as a requisite for gay sexuality, celebrating the sex and sexual imagery not only of these male characters, but of queerness more broadly.

As with Kincaid, Powell’s depictions of queer sexuality and HIV/AIDS can also be tied to questions of national boundaries as well. In “The Novels of Patricia Powell: Negotiating Gender and Sexuality Across the Disjunctures of the Caribbean Diaspora,” Timothy Chin reveals how in Powell’s writing, “questions of sexuality are inevitably tied to concerns [. . .] about national identity” (533). The complexities of national and postcolonial identities are raised throughout as Powell’s characters are constantly discussing the flow of Jamaica’s people and commodities to and from England. As a student of Geography, Dale is constantly tracing the

origins of anything from his and Nevin's "peach lace curtains" (13) to "obnoxiously dressed" (106) "English-accented-tourists" (106), to the speech patterns of those whose dialects he "couldn't place" (35). Dale also reveals how his sexual and emotional relationship with Nevin is always best while the two are mobile or abroad. Concerns connecting these everyday experiences of migration, borders, and national identity are also interwoven into Powell's characters' queer sexual lives.

Chin, accordingly, calls our attention to the "linkage between dominant constructions of nation and the erasure of certain forms of sexuality" (533). Chin argues that "Powell's novels strategically exploit the border zones [. . .] in order to challenge constructions of Caribbean identity that presume dominant forms of masculinity, heterosexuality, as well as racial/ethnic homogeneity as normative" (534). Like Kincaid, Powell illustrates the importance of creating a broad range of possible sexual and gender expressions, an openness antithetical to the rigidity of national borders themselves. As Robert Corber observes in "Nationalizing the Gay Body," the frequent practice of positioning queer sexuality and racial otherness as oppositional to national belonging "cannot account for the fluid, mobile, and permeable terrain of desire, terrain that cannot be easily contained within the fixed boundaries of a stable identity" (111). In challenging the stasis and impermeability of sexuality and gender, Powell presents us with "a form of sexuality that might otherwise disrupt the institutions and practices of American national identity" (Corber 111). As Johanna Garvey concurs, Powell "interrogate[s] not only categories of 'race' but also binaries of gender and sexuality, and in the process [disrupts] stable notions of nationality and origins" (95). In "AIDS and the Politics of Queer Diaspora," Simon Watney similarly reminds us that "wherever the nation is popularly envisaged as if it were a closed family unit, homosexuality may also be perceived as similarly threatening, a refusal of

homogeneity and sameness understood as indispensable aspects of properly ‘loyal’ national identity” (61). Recognizing the need to incorporate our understanding of sexuality and HIV/AIDS as inseparable from questions of nationality and migration, Watney calls our attention to “the diasporic nature of our culture” (59). His work urges queers “to account for differences of needs and strategies” (65) for combating a pandemic that differs regionally and unequally affects diverse populations worldwide.

In illustrating the transnational and unbounded nature of queerness, national identity, and HIV/AIDS, Kincaid and Powell counter the myth that HIV must remain antithetical to the national body. Situating the pandemic as an impetus toward the reconfiguration of sexual and national belonging, these novels also offer opportunities for resistance to state-sanctioned overdeterminations of identity, sexuality, and health. As Ruiz aptly observes, “we are not trapped in the world of the dominant culture and mainstream media: artists and cultural critics are producing alternative and critical representations of borders, bodies, and disease [. . .] deconstructing the narrative of immigrant-as-reproducing-pathogen” (54). Following Gloria Anzaldúa’s tactic of envisioning the border as “a more heterogeneous transnational space of identity formation” (Castillo 3), these novels resituate the pandemic as an opportunity for building queer diasporas and demanding access to improved prevention and treatment campaigns.

Such campaigns can be traced back to the 1980s and early 1990s, as there exists a rich history of community based organizing for HIV/AIDS prevention and education. Responding to the crisis of HIV/AIDS, prisoners are one such group who initiated a variety of programs to raise awareness of how the virus manifests itself in uniquely disastrous ways within the carceral landscape of prison. Like the policing of borders, the violent maintenance of prisons breeds an

institutional context wherein health concerns and HIV prevention efforts are overlooked in favor of surveillance, policing, and the de-valuing of prisoners' lives. In *Women Behind Bars*, Silja Talvi observes that “prisoners are eight to nine times more likely to be infected with HIV” (96) and that “these facilities are somewhat akin to incubators [. . .] particularly when prisoners [. . .] are given little or no information about the health consequences and transmission” (96). Tracing the emergence of grassroots organizing and activism initiated by prisoners themselves, we can uncover a history of resistance against the inadequate treatment of inmates around and beyond HIV/AIDS.

To recognize the history of in-prison organizing against HIV/AIDS, we can recall the contributions of inmate activist, Katrina Haslip, who spearheaded one of the premiere peer education campaigns at New York's Bedford Women's Prison during the first decade of the pandemic. ACE (AIDS Counseling and Education), was led by Haslip and other HIV-positive inmates, later becoming a model for similar programs within other institutions nation-wide. The HIV/AIDS archives in the New York Public Library house a variety of literature, films, and ephemera documenting the formation and achievements of ACE. For instance, the “Women and AIDS Project Newsletter,” published in 1990, describes ACE as an “extraordinary project” which “exemplif[ies] the strength and importance of community, wherever those communities are located.” This newsletter provides some contextual history for the ACE program, recounting that:

More than two years ago a group of inmates at Bedford requested more info on AIDS/HIV. They wanted to make sure that HIV-positive women felt safe from discrimination and, more importantly perhaps, supported and loved. With the approval and leadership of the superintendent, Elaine Lord, the women formed an organization

ACE (AIDS Counseling and Education), which today offers support to HIV- positive women, educates all women entering the state correctional system about AIDS, and celebrates, in community, the strengths and courage of all women.

In commending the organizers at Bedford for their work in ACE as well as in a family violence prevention program, the newsletter declares that “we at the Women and AIDS Project have learned much from Bedford and strive to create community in all our meetings and in the way we do business.” In forging connections between activist women both inside prison and out, this newsletter both preserves the history of ACE and also records the ways in which in-prison organizing influenced and challenged the work that took place within affected communities on the outside.

In conjunction with these firsthand accounts of ACE, an analysis of archival activist video complements printed records of Haslip and her work. The “Katrina Haslip Memorial Tape,” produced by ACT UP/New York members Catherine Gund and Debra Levine, commemorates Haslip’s life through interviews and footage documenting the contributions of ACE. In one interview, Haslip explains that ACE was conceived in 1985, prior to her arrival at Bedford. Haslip details that she began doing HIV/AIDS support work before she discovered her own positive status, emphasizing the importance of allied organizing by sero-negative folks alongside those affected by and frustrated with the lack of appropriate responses to the crisis of AIDS. Haslip emphatically depicts the climate that incited women to organize formally around HIV/AIDS. Haslip recalls that “the original core group was living with seeing people physically or verbally abused, seeing people isolated [. . . and] seeing people with AIDS’ cells being burnt up. I think [. . .] that was beginning to get them to start talking about it: how do we change this? What role can we play in this?” Haslip also

recalls that at first, “we knew very little about AIDS.” In order to provide support and services, Haslip explains how “we knew that we would need education from outside resources [. . .] and we got that training, we got volunteers to come in from [the] hospital, from the department of health, from ACT UP, from HEAL, and they did an education process with us.” Haslip traces the roots of AIDS outreach work within a prison setting, observing how initially, the structure of this work to place in an unofficial capacity, operating at the level of day to day life: “we were doing counseling one on one—informally, in the yard, in the shower—you know, wherever people ask questions. And we just tried to be supportive to one another.”

Haslip proceeds to trace the progression of how this support work evolved from these makeshift networks into formally organized programs. She recollects how:

We began to link PWAs (People with AIDS) up with buddies who would go up to the hospital to see them, who would do their shopping or clean up their cells, or help them in the shower, or take them out for recreation. And we noticed that it was really becoming something, it was changing the community. And we were seeing ourselves as a community, and we were very hyped about it because we were the community that was invisible, that no one thought could help themselves, and yet we were doing it.

In mapping the creation of ACE, Haslip not only addresses discrimination related to HIV/AIDS but she also incorporates an examination of how inmates are dehumanized and vilified by the prison system itself. She observes that “We were strangers. We were these supposed ‘criminals’ [. . .] the outcasts of society that [were] responding to the epidemic in a way that some communities out here were not even responding, and that really made us hyped.” In *Breaking the Walls of Silence*, a published volume documenting ACE’s history

and work, Haslip similarly notes how “we were building [ACE] from behind a wall, from prison. We were the community that no one thought would help itself. Social outcasts because of our crimes against society, in spite of what society inflicted against some of us” (10). Haslip links the criminalization of prisoners to the vehement attitudes held toward inmates in general, and by extension, prisoners living with HIV/AIDS. Haslip demonstrates that rather than accepting their outlaw status as justification for the apathy around HIV-transmission and a lack of humane treatment, inmates instead came together to improve their living conditions and access to care. In the *Memorial Tape*, Haslip recalls that “as a result of all of that, the agencies noticed that we were responding, and they rewarded us a quarter of a million dollars to run a program for the staff and to set up office equipment and supplies that we really needed, and that’s how we actually became ACE.”

Evidencing the links between women’s HIV/AIDS organizing and the work being done by gay men, Haslip also connects her role within women’s prisons to the grassroots organizing that emerged within gay male communities during the first decade of HIV/AIDS. In *Breaking the Walls of Silence*, Haslip reveals that “we were inspired by the example of the gay community coming together to fight AIDS. From publications such as *The PWA Newslines* and *Surviving and Thriving with AIDS*, we learned about PWAs who were fighting to transcend their condition as victims” (25). The People with AIDS Coalition’s *Newslines*, for instance, featured columns like “Prisoners’ Perspectives” and “Letters from Prison,” bringing prison-specific issues into community discussions of HIV/AIDS. In *Cultural Analysis, Cultural Activism*, edited by Douglas Crimp, there remains a published “Statement of Prisoners in the AIDS Ward on Rikers Island” which originally appeared in the PWAC *Newslines*. This statement begins with the intention of prisoners in linking their movement with AIDS activists on the outside, “to add our

protest to yours as you stand before the post office and raise your voices against the lack of spending on AIDS research” (161). The authors share their experiences as incarcerated people living with HIV/AIDS, calling attention to prison-specific issues of HIV prevention. The statement, for instance, documents that:

Although we are in the hospital building, we have been relegated to the top floor, where the roof leaks whenever it rains, and the old windows do not keep out the cold winds that come off the river. We do not have hospital beds or reside in a hospital unit. Each AIDS unit is a regular cell unit. When one inmate complained about the large amount of pigeon shit that collects on the sills and blows in through the cracks in the window, even after writing to the grievance department, he was given a window scraper and told to do it himself. (161)

The writings of prisoners themselves reveal that “there is no doubt that the system is not providing us with proper medical care [. . .] up here and behind bars, that society has shown what it is truly capable of” (161). In addition to exposing the need for dramatic reform of HIV/AIDS policies inside prisons, such publications also built important links connecting the stigmatization of prisoners to the discrimination faced by those living outside prison walls.

As a result of such collaborations between incarcerated HIV-positive people and community organizations like the PWAC, coalitions began to form, providing access to resources and to communities otherwise unavailable to those locked inside. Haslip, indeed, spoke publically about these connections between her status as a prisoner and her role within interconnected organizations and communities outside. Upon introducing herself to a panel of health care advocates, Haslip remarks that “I represent the excluded and underrepresented groups

of women, minorities, and HIV-positive individuals and also prisoners, of which I am a member of all of the above” (*Memorial Tape*). Demanding access to treatment and education, Haslip advocated for prisoner participation in experimental drug trials and prevention campaigns. Haslip was also recognized for her instrumental role in changing the CDC definition of AIDS to include symptoms experienced only by women. As a *New York Times* article commemorates, “since her release in 1990, [Haslip] has talked about her infection at conferences, protests, and in one-on-one outreach work. She has met with CDC officials in private, and berated them in public, as she doggedly pushed for the new definition that she says will help get women tested and the disease diagnosed early, when treatment is more effective” (*Breaking the Walls* 170). Haslip asserts that “we want something to happen, we refuse to remain silent; we’re not just going to go away.” In demanding change within prisons and within the health care system more broadly, Haslip unapologetically declares that “I’m an activist and I’m going to speak up about it.”

Like Schulman’s establishing a direct correlation between frustration, anger, and the birth of an AIDS activist movement, Haslip, through her involvement in ACE, emphasizes the political dimension of the pandemic. For example, ACE coordinated a series of prisoner peer education workshops that draw connections between issues ranging from sexual abuse, parenting, access to health care, gender, race, and AIDS. Haslip and the members of ACE reflect that “as we discussed each of these issues, we began to see ourselves as women in a new light. Many of us usually see things in individual and private terms. Now we were thinking in social and political terms. It made us angry and emboldened. We wanted to act” (*Breaking the Walls* 86). Like Schulman’s fictional representations of the formation of movements like ACT UP, Haslip’s work uncovers the conditions under which activists began to view the AIDS crisis as a

political moment necessitating a collective response. The *Memorial Tape* documents footage of Haslip at an ACT UP demonstration wherein she announces that:

I'm here because I'm an ex-prisoner and I'm also HIV infected. And I learned my status while being confined and because I want adequate health care for prisoners that I left there and it shouldn't be a death sentence that they have HIV. I don't want them harassed or isolated as a result of that, I want education for them, peer education, which includes condom distribution and dental dam distribution. I want Cuomo to acknowledge that he needs that there, and to provide it for them, and because the prisoners themselves are taking the initiative to change things and are being harassed and penalized as a result of that.

By pinpointing the social and political roots of HIV/AIDS, Haslip further reveals how the pandemic uniquely affects those living within the prison system. In *Breaking the Walls of Silence*, Haslip *et. al.* succinctly outline how HIV/AIDS stigma is reinforced by “the closed prison environment” (202). For instance, this volume traces the history of abusing and segregating prisoners as a result of their HIV status. ACE documents that “in an Alabama prison, in the early period of the AIDS epidemic [. . .] a prisoner who was HIV-positive had to wear a gown, gloves, and mask, and spirt disinfectant over each step every time she left her cell” (202). Direct action and education, Haslip reveals, is an indispensable element in addressing how stigma becomes a form of physical suffering, affecting the lives of prisoners living with HIV/AIDS.

Providing a historical record of the appalling mistreatment of prisoners, Haslip *et. al.* document how HIV-positive inmates have been and continue to be subjected to harassment and

quarantine as well as to more systematic forms of discrimination such as lack of access to employment and care. *Breaking the Walls* also depicts how HIV-positive inmates are denied low level-security classification, participation in early release programs, and conjugal visits, programs that can be withheld from all inmates for arbitrary reasons such as one's positive serostatus. *Breaking the Walls* further connects this institutionally sanctioned violence around HIV/AIDS to the discriminatory social structures that breed imprisonment to begin with. The members of ACE illustrate that:

The women in prison who suffer with AIDS are usually the same women in the community who are most vulnerable to HIV infection. They are overwhelmingly black or Hispanic, and they must cope with a combination of problems: drugs, homelessness, family violence, racism, and poverty, with the additional pressures motherhood brings, especially that of being a single mother. When they come to prison, they bring enormous needs that have not been met in the outside society: education, preparation for employment, drug treatment, rebuilding families in crisis. AIDS is only one of many pressures they face. (344)

By drawing tangible associations between the violence that occurs within prisons and the social forces that necessitate incarceration itself, ACE blurs the boundaries between prisoners and those who exist seemingly outside of the prison industrial complex. The ACE documentary, *I'm You, You're Me*, (which can also be found within the AIDS Activist Videotape Collection archive), features the work of ACE and ACE OUT, a group which facilitates the re-integration of HIV-positive ex-prisoners during the transitional period following their release. The film's title emphasizes the commonalities between those housed inside of prisons and those who appear to be removed from these carceral structures. In

exploring the commonalities and shared struggles of women inside and out, the film documents the ways in which prison support work and organizing can successfully address HIV/AIDS as well as larger structural problems that allow the pandemic to flourish. In an interview for the film, Haslip explains how “we must always find a way to motivate ourselves, we must find a way to use the smallest success as an incentive to keep on doing this work, and by all means, we must not allow prisoners to be invisible. Let’s keep the pressure on.”

To concretely outline these intersections between incarceration, marginalization, and HIV/AIDS, ACE formed a series of workshops and educational tools to explore the social dimensions of stigma. In *Breaking the Walls*, Haslip *et. al.* explain that “the HIV/AIDS epidemic is a medical problem. But along with this comes a social problem, a second epidemic: the epidemic of stigma, prejudice, scapegoating, persecution, discrimination, and blame” (185). Through their prison outreach and peer education work, ACE aims to uncover the ways in which “the medical problem is affected by racial and national prejudice and discrimination, by sexism and homophobia, combined with fears and stigma about illness and death” (185). ACE recognizes the necessity of discussing how the cultural dimensions of the pandemic have “an impact on the medical problem—on money for research and health care, on stress that an individual with HIV infection experiences, and on a community’s ability to support people who are sick” (185). By developing and orchestrating these conversations, ACE not only links HIV/AIDS stigma to the prejudices of criminalization and imprisonment, but these workshops also provide a forum through which to situate HIV/AIDS within a longer history of disease.

ACE indeed demonstrates that in order to adequately intervene in the pandemic, we must recognize its commonalities with a broader history of medical and social discrimination. In illustrating how stigma and blame are based on “already existing attitudes and biases” (187), ACE exposes how racial minorities and national outsiders have throughout history been designated responsible for causing and spreading disease. In educating inmates about HIV/AIDS, ACE discusses how anti-Semitism featured into historical representations of plague, observing that “while the Black Death swept across Europe in the fourteenth century, blame was placed especially on Jews and was followed by the massacre and burning of all the alleged culprits” (187). Building off this discussion, the workshop considers the role of national prejudice in relation to other diseases like syphilis. ACE traces how:

Foreigners were usually blamed, especially foreigners who were particularly disliked. The Russians blamed the Poles; the English and the Turks called it a French disease. The French called it the Italian illness, and the Italians called it the Spanish disease. The Spanish called it the sickness of Hispaniola, believing it to have come from what is now Haiti, when Columbus returned from his voyage to the Americas” (187).

This history of syphilis illuminates associations between colonialism, the fear of disease transmission, and the criminalization of those who transgress national borders. Like the autobiographical and fictional projects of Kincaid and Powell, the work of Haslip and ACE exposes how “blaming others has characterized the HIV/AIDS epidemic” (188). This process breeds hysteria over queer sexuality and immigration by exposing the permeability of these so-called spaces of protection against the transmission of illness. Such reactions are not, this workshop shows, specific to HIV/AIDS but are rather characteristic of a history of unwarranted blame and fear toward those who threaten national, racial, and sexual norms.

ACE addresses this phenomenon by providing examples of how racialization and stigmatization converge through HIV/AIDS. The ACE workshop materials include a discussion of how “in mid-1982, the federal Centers for Disease Control (CDC) defined Haitians—along with homosexual and bisexual men, hemophiliacs, and IV drug users—as a ‘high risk’ group for HIV/AIDS” (188). Although this so-called scientific finding was revealed by Haitian physicians as a statement rooted in “cultural biases and ignorance” (188), it remained in the CDC publications for three more years, even as it was disproved and removed from The New York City Health Commission by 1983. Cathy Cohen, moreover, notes the importance of recognizing that “the CDC’s decision to take Haitians off its list of high-risk groups was not just a response to new data or better evidence, but arose more directly from dialogue or political actions, in particular mass protests of Haitians around this policy” (139). Cohen also observes how “in contrast to the CDC’s rigid limitations on the disease framework in the early 1980s, its seemingly haphazard and what Haitian political leaders called racist categorization of all Haitians as a ‘risk group’ [. . .] highlighting demographic characteristics and not behavioral practices, targeted all Haitians and not the actions that put one at risk, making it inappropriate for the purpose of detailing and designating *transmission routes*” (139). ACE, similarly, traces the evolution of the “3-H risk factors” (the notion that Haitians, hemophiliacs, and homosexuals are ‘risk groups’ for AIDS), explicating how “by 1985 the CDC removed [Haitians from the list] but by then the damage was already done, and health officials and the population at large saw Haitians as a risk group” (189). In establishing the inaccuracy of placing Haitians within these classifications, ACE actually uncovers the fallacy of creating these risk groups themselves. ACE argues that “not only is the concept of a ‘risk group’ misleading, not only does it give people a

sense of false safety, it also contributes to stigma by focusing on particular groups as dangerous” (203).

ACE further reveals how community leaders and activists rejected these classifications in order to expose the racism and homophobia motivating their construction. For instance, in response to a civilian picket of blood banks for allowing Haitian donors and their sexual partners to give blood, Joseph Etienne, director of the Haitian Centers Council, stated that “today they are targeting Haitians. Tomorrow it will be all Blacks” (189). ACE, accordingly, links the racial-based targeting of Haitians to the corresponding etiological belief that AIDS arrived in the US from Africa. ACE uncovers how “Western research into the possibility that HIV/AIDS originated in Africa has been partially based on slipshod science, motivated by a desire to prove that HIV/AIDS started somewhere other than the United States” (190). As demonstrated through a reading of Kincaid and Powell, this view of HIV/AIDS as that which necessarily arrives always from elsewhere propagates the criminalization of crossing borders. ACE, indeed, outlines the impact of HIV/AIDS stigma upon US immigration policies and by extension, incarceration. ACE also surveys the consequences of immigration hysteria upon employment opportunities both in the United States and in places whose tourism and production industries have been damaged not only by the tangible health consequences of the pandemic but by its culturally stigmatizing effects.

Drawing on Watney’s notion of the queer diaspora as a conceptual link between national and sexual stigmatization, we can consider how these ‘risk groups’ have also established homosexuality rather than unprotected sex as a risk factor for HIV transmission, targeting queers for spreading disease to the so-called ‘general population.’ ACE, consequently, also explains how religion and homophobia have together nurtured the impetus “to blame homosexuals and IV

drug users for bringing HIV/AIDS upon themselves” (192). Just as HIV/AIDS reflects a longer history of regarding illness as that which originates from elsewhere, there exists a similarly entrenched belief that disease is the product of sexual deviance, moral lasciviousness, and the vengeful wrath of God. ACE argues that this view of illness as God’s punishment “has inflamed homophobic attitudes and led to discrimination, assaults, and stigmatization” (192). Connecting sexual discrimination to concerns of gender, ACE outlines how “women with HIV/AIDS have also suffered from this argument, for they are labeled promiscuous just because they are HIV-infected” (192). Recognizing that the stigmatization of women and queers for spreading disease reflects a long history of discrimination pre-dating HIV/AIDS allows us to reconfigure our own historicization of the pandemic. Though revisiting the work of Haslip and ACE provides only one example of how HIV-positive prisoners intervened in these cultural discourses, such investigations pair this history of stigmatization with a counter-narrative of resistance. Through an archival analysis of leaders like Haslip and the women of ACE, we can reposition those who are criminalized, incarcerated, and HIV-positive as educators and activists rather than as passive victims or criminal perpetrators of disease.

Forging connections between diaspora, queerness, incarceration, and HIV/AIDS exposes illness narratives as the product of historically rooted practices of racializing and criminalizing queer sexuality and national transgression as the so-called origin of disease. Addressing these fallacies in conjunction with narratives like those of Haslip and ACE allows for a redefinition of the sexual, racial, and national considerations raised in the work of Kincaid and Powell. As Epstein reveals, narrative can serve as an effective means of countering historically entrenched discourses that criminalize queers, migrants, and borders themselves. She observes that “while monitoring our narratives is only one place to start, the stigmatizing stories that have been

assigned to contain people living with AIDS within policed borders must be eradicated almost as urgently as we need to eradicate the virus itself” (“AIDS, Stigma” 304). These narratives also uncover the ways in which those who are presumed to be risk groups are separated both physically and conceptually from the so-called ‘general population,’ calling attention to the increased “need to fight the virus, instead of working so hard to categorize the people infected with it” (Epstein 304). This discursive situating of HIV-positive subjects as metaphorical Others will be explored in relation to the work of Octavia Butler in the following chapter. Situating the writings of Kincaid, Powell, and Haslip as counter-narratives of carceral resistance provides a space for the queering and de-criminalization of border crossings and sexual expressions. Queer, transnational, and prisoner narratives challenge historical understandings of risk groups, national boundaries, and carceral systems, calling for the abolition of such structures toward the treatment and prevention of disease.

Chapter 4

AIDS Vampires: Reclaiming Illness in Octavia Butler's *Fledgling*

While the work of Schulman, Brown, Kincaid, and Powell connects HIV/AIDS narratives to critical histories of activism, caregiving, borders, and prisons, an investigation of Octavia Butler's *Fledgling* uncovers how sexualized and racialized narratives of illness are neither an isolated nor a contemporary phenomenon. HIV/AIDS narratives reflect a long history of depicting illness through a framework of sexual deviance and national outsiderhood. An investigation of the metaphors and narrative strategies connected to HIV/AIDS creates a site of intervention to revise and reclaim these historically embedded tropes. Butler's anti-racist, feminist vampire novel exposes the latent cultural fears attached to female sexuality and inter-racial relationships. Though AIDS is never explicitly mentioned in *Fledgling*, the underlying terror of disease and race-related anxiety allows us to view Butler's vampires as a culture of the HIV-positive. An HIV/AIDS reading of Butler's novel challenges the metaphorical connections between the vampire and the HIV-positive subject, combating the racial and sexual stigmatization central to contemporary depictions of the pandemic itself.

As Nina Auerbach argues in *Our Vampires, Ourselves*, the vampire figure evolves alongside our ever-changing cultural preoccupations and fears. Drawing on a literary tradition of vampire fiction, an analysis of our contemporary blood-swapping, sex-crazed vampires should not be conducted without considering our cultural reactions to HIV/AIDS. AIDS is linked to a variety of metaphors that shape our understandings of illness, encouraging the social reproval of those who test positive for HIV. One such metaphor may be found in the vampire. Like the vampires of the nineteenth-century, people living with HIV/AIDS are all too frequently

represented as social pariahs and as the walking undead. Those who are sero-positive are figured as ghosts, haunting the “general population” with sexual or racial otherness. A reading of *Fledgling* reveals that HIV/AIDS might be recognized as a site of personal growth or as an opportunity for community enhancement, emphasizing the utility of harm reduction models in creating effective models for treatment and prevention. Rather than metaphorizing HIV-positive subjects as horrifying carriers of infection, we can instead challenge stigmatizing individualistic models of personal blame to expose the social and linguistic constructions underlying our experiences of disease.

Fledgling is narrated by Shori, a black, female vampire. Suffering from amnesia, Shori must re-learn all there is to know about the “Ina,” the tribe of vampires from which she descends. Shori ridicules the canonical ideas of the vampire as sexual threat or unwanted predator. She asserts that “we have very little in common with the vampire creatures Bram Stoker described in *Dracula*” (69). Unlike in *Dracula*, the Ina vampires do not drain the life from their human blood-sources, but rather exchange blood for sexual pleasure and emotional support. The Ina select people of various classes, races, ages, and genders to become their “symbionts,” who live happily among the Ina for the remainder of their lives. Shori observes how “we don’t have to injure the humans we take [blood] from [. . . and] we can’t magically convert humans into our kind. We do keep those who join with us healthier, stronger, and harder to kill than they would be without us [. . .] lengthen[ing] their lives by several decades” (69). Demonstrating that vampirism represents a symbiotic relationship between the Ina and their human hosts, *Fledgling* shares much in common with Butler’s earlier short story, “Bloodchild.” Though “Bloodchild” is not a vampire tale, it traces the violent physical invasion and use of the human body by the non-human Tlic to create a symbiotic bond between the two species. This theme of alien

appropriation of human bodies for increased health and survival appears throughout Butler's corpus. For instance, in *Dawn*, Oankali aliens cure cancer in their host, Lilith, in exchange for the use of her reproductive capacities to interbreed their offspring with the human race. Butler continually raises questions of whether we can continue to survive without technological and cultural invasion of other species, a threat to those essential components of whatever it is that makes us truly "human." Like the Oankali of the *Xenogenesis* series, "Bloodchild's" Tlic provide their human symbionts an escape from aging and suffering as well as an unparalleled pleasure offered through the consumption of intoxicating Tlic-procured eggs. In return, the Tlic co-opt humans as incubators for the creation of their own spawn, a process revealed to "consume" (15) their hosts through "painful and bloody" (16-17) "torture" (15) that nevertheless inspires inseparable closeness and the physical intimacy of sex.

Unlike the emotionally conflicted, hierarchical bonds between the humans and the Tlic in "Bloodchild," the exchange of fluids with the Ina in *Fledgling* is highly pleasurable and rooted in mutual desire. Although Shori's symbionts are initially bitten against their will, the fulfillment they receive from their Ina counterparts transforms their physical and emotional capabilities, sustaining their continued desire to remain in the relationship. As in "Bloodchild" and in the *Xenogenesis* series, this immensely enjoyable exchange is characterized by feelings of addiction; physical need, and erotic transcendence occlude the possibility for escape. Yet in *Fledgling*, humans are given an opportunity to evaluate their initiation into vampirism, appearing "to make up [their] own mind" (92) to continue this arousing relationship. The sexual bond between humans and Ina, performed through genital stimulation and simultaneous biting, can indeed result in death if humans are divorced from their Ina blood source: "they die if they're taken from us or if we die, but their death is caused by another component of the venom. They die of

strokes or heart attacks because we aren't there to take the extra red blood cells that our venom encourages their bodies to make" (80). In light of this dire physical dependency, the overwhelmingly positive and pleasurable nature of these relationships raises questions of sexual consent. By positioning erotic coercion and addiction as factors that may not be necessarily negative, even for the individual who is addicted or coerced, Butler complicates conceptions of consent and desire as they relate to the transmission of HIV. Not only is HIV/AIDS commonly associated with substance use and with sex predicated upon addiction to illegal drugs, but current debates about the criminalization of HIV transmission itself raise questions about the capacity for sexual consent between two adults. By criminalizing the individual with HIV for transmitting the virus, even when their partner consents to the possibility of sexual transmission, such laws reflect the inability to concede that we as humans could ever consent to inoculation with a virus that could mark our bodies as diseased, as alien, as dependent, as addicted, as Other, or as queer. The possibility that humans might actually *choose* to engage in unprotected sex or illegal drug use fails to consider what Butler reveals as an honest, transgressive, and even liberatory way of regarding sexuality and sexual behavior.

HIV/AIDS, moreover, is also frequently framed as a democratizing virus that blurs the boundaries between heterosexual identity and same sex desire. Attempting to counter the stigmatizing myth that HIV/AIDS affects only those who self-identify as homosexual men, slogans like, "AIDS has no sexual preference," became popular modes of consciousness raising about the fluidity of, if not human sexuality, than at least the versatility of our sexual diseases. Like HIV/AIDS, the Ina force otherwise straight-minded humans to reconsider the linearity of their sexual capacities. As exemplified by her relationship with the elderly Theodora, Shori advocates that attraction between the Ina and their symbionts need not be constrained by age or

by sexual preference. As one straight-identified symbiont observes of his sexual connection with an Ina man, “it doesn’t seem to matter what our lives were like before we meet you. You bite us, and that’s all it takes” (210). In addition to rejecting enforced heterosexuality, the Ina also champion equality across gender lines, forming a matriarchal social configuration wherein Ina females are free to sustain relationships with multiple human partners. In *Dawn*, the Oankali similarly expand Lilith’s practices around sexuality and sex, urging her to incorporate multiple partners at once and to have sexual relationships with those whose gender identities cannot be labeled as either female or male. These novel forms of sexuality are highly pleasurable to Lilith, yet she continuously fears the implications of having one’s sexual capacities extended “beyond ordinary human experience” (161). In *Fledgling*, conversely, such practices are rendered not as discomfoting, but as overwhelmingly positive. Lacking Butler’s earlier novels’ ambivalence toward sexual freedom as being somehow “other-than-human” (162), *Fledgling* reclaims gothic metaphors to refigure sexual and gender transgression, racial difference, and even illness as potentially empowering sites of resistance.

A feminist visionary and self-proclaimed outsider, Butler’s work radically redefines the boundaries of science fiction. Through she rejects labels, discrediting generic constrictions as “marketing tools” (Kenan 495), Butler concedes that “most of what I do is science fiction” (Kenan 495) because she “uses science, extrapolates from science as we know it to science as it might be to technology as it might be” (Rowell 55). In their analysis of Butler’s position within the science fiction genre, Gregory Hampton and Wanda Brooks argue that “Butler’s fiction presents methods of imagining the body that allow us to question how and why we must be categorized as male, female, black, white, or ‘other’”(73). They argue that in directly confronting categories gender and race, Butler’s writing allows “these terms [to be] seen for

what they are, arbitrary markers de-signed to give stability to that which is unstable and ambiguous” (73). Science fiction becomes “the window” (Hampton and Brooks 73) through which Butler conflates fantasy and reality, promoting imaginative alternatives to seemingly intransient constructions of ‘otherness’ and difference. While her vampire novel certainly fits the generic conventions of the gothic, Butler narrates her vampires’ epistemological and racial differences through scientific discourses including genetics and evolution. *Fledgling*, accordingly, can also be classified in relation to Butler’s earlier works that figure difference as the locus of resistance and transgression. As Butler’s “unapologetic” (Okorafor) science fiction writing reveals, racial and gender difference can be positioned as that which “forces the reader to grapple with the notion of ‘otherness’ as more than a metaphor of allusion” (Hampton and Brooks 73), destabilizing essentialist conceptions of self.

Fledgling also shares much in common with Butler’s 1984 novel, *Clay’s Ark*. Set in the future, *Clay’s Ark* traces the emergence of a foreign disease that emaciates and weakens its hosts until they “contaminate” new carriers through scratching and biting. While this disease alters its carriers, stripping them of certain traits that make us “human,” it also enhances sensory function and combats other illnesses, increasing longevity and strength. These infectious microbes create not an illness, per se, but a true sense of dis-ease with established human conventions. Those infected, for instance, begin to display an insatiable appetite as well as rejection of established culinary conventions (i.e.- enormous quantities of raw meat becomes a preferred snack). Those with the disease also find difficulty with the domestication of animals and display a near inability to practice sexual restraint. In similarity to *Fledgling*, those who are infected with the Clay’s Ark disease form a close knit, symbiotic community wherein they can reproduce and re-infect one another to ensure that their bodies (as well as the disease organisms) survive. Though the

disease results from futuristic space travel and alien invasion, those who carry it actually revert to an idyllic and pastoral state of being. As the protagonist Blake observes of this alien-like community, “they had adopted a nineteenth-century lifestyle. Perhaps they had contracted a nineteenth-century disease” (33). *Clay’s Ark* plays on werewolf and vampire mythologies popularized in the nineteenth century, adopting such narratives to address contemporary concerns of poverty, violence, gender, and race. The novel reveals how difference, though a potential source of stigmatization, is actually that which sustains health, both genetically and socially, as organisms can only survive if they are amenable to biological and ideological adaptation.

As with metaphors of illness underlying Butler’s earlier work, race and gender in *Fledgling* are inextricably connected to vampirism. In her reading of Jewelle Gomez’s *The Gilda Stories*, Miriam Jones concedes that vampire fiction often expresses a cultural fear of “African Americans and other people of color, women, lesbians and gays, and others written as monsters” (165). As Kathy Patterson concurs, “those whom the dominant society has marginalized are often labeled monstrous in the iconography of popular discourse” (35). Rather than embodying a single fear or concern, the vampire serves as “a floating category” (Jones 154) that encompasses a broad spectrum of all things that defy normative constructions of culture and self. As such, the vampire may embody a variety of fears attached to race, sexuality, and gender, a symbol of all those perceived as “sexually exotic, alien, unnatural, oral, anal, compulsive, violent, protean, polymorphic, polyvocal, polysemous, invisible, soulless, transient, superhumanly mobile, infectious, murderous, suicidal, and a threat to wife, children, home, and phallus” (Hanson 325). In construing the vampire figure as “the embodiment of evil sexuality” (Hanson 325), its demise within the narrative becomes essential to the maintenance of the sexual

status quo. Thus the slaying of the vampire also represents the triumph of “dominant” (Jones 165) culture, sustaining ideologies that privilege those already in positions of power.

In order to counter this conception that difference should be met with a reactionary response, Shori explodes the misguided notion that all things unknown are necessarily a manifestation of evil. Shori connects vampire legends to the mythologies of the werewolf. She ponders that the “Ina are probably responsible for most vampire legends. I wonder what started the werewolf legends” (129). After contemplating the matter with Celia, her symbiont, Shori arrives at the conclusion that “it was probably rabies. People get bitten, go crazy, froth at the mouth, run around like animals, attacking other people who then come down with the same problems [. . .] That would probably be enough to make ancient people come up with the idea of werewolves” (129). Werewolves are construed as a fictional manifestation of the cultural fears derived from rabies, an illness whose etiology was misidentified, and whose cure was unknown. Much like her understanding of the werewolf-as-illness, Shori’s depiction of Ina vampires is saturated in references to healing and health. The Ina, for instance, can heal their symbionts through the venom unleashed in their bite. Shori’s father informs her first symbiont, Wright, that his “immune system will be greatly strengthened by Shori’s venom, and it will be less likely to turn on you and give you one of humanity’s many autoimmune diseases” (69). Published in 2005, *Fledgling* emerged in a context wherein “humanity” was quite aware of a certain deadly “autoimmune disease.” However, unlike in the case of werewolves and rabies, the virus endemic of Shori’s time here remains unnamed.

Fledgling conspicuously addresses a broad spectrum of issues concerning illness, sex, queerness, and racism, without once explicitly mentioning HIV/AIDS. Diana Davidson addresses this refusal to name HIV/AIDS as a narrative decision that “can be read as both

reactionary and revisionary” (223). Davidson argues that while naming HIV/AIDS is a positive act that forces people to acknowledge it, not naming the pandemic allows for the redefinition of its culturally constructed assumptions. In *Vamps, Virgins, and Victims: How Can Women Fight AIDS?*, Robin Gorna shows how AIDS narratives, even those not explicitly mentioned as such, can benefit those who are HIV-positive by revising the debilitating discourses currently available to talk about “the disease that has no name” (4). In “Refusing the Name: The Absence of AIDS in Recent American Gay Male Fiction,” James Jones similarly contests that in refusing to name HIV/AIDS, queer literature can “break the equation in which AIDS = homosexuality = general moral decay = death” (228). The complete omission of the pandemic in *Fledgling* allows for a reading of the Ina as a culture of the HIV-positive. Although it does not overtly present itself as such, *Fledgling* can be read as an HIV/AIDS narrative that challenges and inverts the metaphors attached to the disease.

This desire to read *Fledgling*'s vampires as a metaphor for HIV/AIDS without concrete evidence to support such a claim is addressed by Nicola Nixon in her analysis of the 1983 vampire film, *The Hunger*. Nixon observes that “if we examine *The Hunger* now, it seems considerably less remarkable for its depiction of an early 80s vampirism than for its stunning resemblance to an extended AIDS allegory” (117). Nixon posits that although “in terms of chronology [. . . it is] virtually impossible to make any case at all for *The Hunger*'s containing an oblique or embedded reference to AIDS” (118), such an analysis is nevertheless tempting because the iconography of “New York nightclubs and leather bars, anonymous sex with ambiguously-infected strangers, transmitted and undiagnosable blood diseases [. . .] and same-sex sexuality add up, now, to only one thing” (117). Nixon explores this connotative yoking of vampirism, sexuality, queerness, and contagion. She also points to the “long history” (118) of

vampirism's conflation with venereal diseases like syphilis. Because HIV/AIDS, as Nixon demonstrates, "has been represented consistently through an 'appropriation of the iconography of syphilis'" (119), vampirism, consequently, "has always contained the constellation of signifiers currently clustering around HIV/AIDS" (119). Thus contemporary readings of vampires cannot be performed without regarding such metaphors in conjunction with our current pandemic.

In *Illness as Metaphor*, Susan Sontag argues that cultural constructions of illness determine social and personal experiences of suffering. Sontag begins with an examination of tuberculosis in the Victorian era, a condition linked to a plethora of symbolic associations because of its unknown cause and effects. Tuberculosis, argues Sontag, was "a disease thought to be intractable and capricious—that is, a disease not understood—in an era in which medicine's central premise is that all diseases can be cured" (5). In their introduction to *Blood Read: The Vampire as Metaphor in Contemporary Culture*, Gordon and Hollinger trace the linking of the vampire figure with illnesses including tuberculosis. They explore the various ways in which the vampire becomes a "metaphor for consumption" (6). They reveal that since Dracula "in the nineteenth century [. . .] the vampire functioned as a natural metaphor for the symptoms of tuberculosis: consider its associations with wasting, with paleness, with the flow of blood from the mouth, night restlessness, alternate burning and chills, even with the victim's rumored sexual energy" (6). As Sontag observes, the unknown etiology and treatment of illnesses creates "thoroughly old-fashioned kinds of dread" (6), allowing those who are sick to become stigmatized as figures of evil, such as the vampire and the werewolf. As Sontag contests: "any disease that is treated as a mystery and acutely enough feared will be felt to be morally, if not literally, contagious" (6). Illness metaphors foster unprecedented fears of people

who carry a disease, rendering patients as monsters who threaten the status of anyone who is, or appears to be “healthy.”

In “The Tale of Plagues and Carnivals,” Samuel Delany also undertakes these questions of monstrosity, queerness, and illness, challenging our metaphorical understanding of HIV/AIDS. Responding to Sontag, Delany writes that “when diseases generate such metaphors, the host of misconceptions and downright superstitions that come from taking them literally [. . .] makes it impossible, both psychologically and socially – both in terms of how you feel and how others, with their feelings, treat you” (184). Like Butler, Delany constructs a fantastical AIDS narrative, transporting us back to ancient *Neveryóna* to expose that plagues have always accentuated fears of queerness and sexual freedom. Painting a world overcome by a “plague that has much of the monstrous about it” (327), narrators Zudyuk, Pheron, and the Master learn through their quests that “monsters are real. And, they are us” (327). Delany’s simultaneous interspersing of documentary style accounts of New York City street culture and firsthand lived experiences of AIDS-related violence serve to “break up, analyze, and dialogize the conservative, the historically sedimented” (348) metaphors of HIV/AIDS. Delany inspires his readers to reclaim these metaphors to destabilize our current attitudes toward AIDS, sexuality, and illness. As David Morris contends, “the public discourses of distinct historical communities shape and constrain how we talk about suffering, how we talk when suffering, and, ultimately, how we suffer” (63). Julia Epstein terms this phenomenon “altered conditions,” arguing that how cultural narratives render illness shapes our individual experience of suffering. As Paula Treichler famously contends, because AIDS is “an epidemic of meanings and signification” (11), “our social constructions of AIDS [. . .] are based not on objective, scientifically determined ‘reality’ but on what we are told about this reality: that is, on *prior* social constructions routinely

produced within the discourses of biomedical science” (Treichler 15). As Delany reveals, challenging these narratives and metaphors, therefore, can alleviate the social stigma and even physical symptoms associated with illnesses like HIV/AIDS.

In *AIDS Narratives: Gender and Sexuality, Fiction and Science*, Steven Kruger investigates the narrative modes available through which to depict HIV/AIDS. Kruger outlines two dominant forms of AIDS narratives, illustrating how both are disempowering to those living with HIV. The first, the “personal narrative” (77), is problematic because it can lead to the “dangerous conflation of individual illness with the larger growth of the AIDS epidemic” (Kruger 77). The second form, the “population narrative” (78), becomes detrimental when “the person with HIV or AIDS is seen simultaneously as weakened (queer) ‘victim’ and powerful (queer) ‘threat’” (Kruger 78). Both narratives, illustrates Kruger, lead to the stigmatization of the HIV-positive subject, especially when the two forms are combined:

Population and personal narratives come together in a particularly disturbing way when the agent of the epidemic’s spread is identified with the body of the ‘infectious’ patient him- or herself. In such depictions, the person with AIDS, seen as irremediably given over to death, becomes the source of others’ deaths; he or she is, simultaneously and paradoxically, the active bearer of disease and its passive sufferer. (77)

Kruger points to the need for new narrative forms that neither victimize those who positive, nor assert blame for the spread of disease. Such narratives could be constructed by resisting the outright naming of HIV/AIDS, subverting the narrative expectations this naming entails. An HIV/AIDS reading of the Ina vampires suggests a new type of AIDS narrative in which HIV-positive subjects are figured as active agents in their own healing, mourning, community-

building, and sexual relationships. Just as Shori recognizes the fallacy of imagining rabies sufferers as werewolves, her readers can deconstruct the vampire metaphors and misconceptions attached to those surviving and thriving with HIV.

Like Kruger, Morris outlines how AIDS metaphors all too frequently present the Human Immunodeficiency Virus as “an indestructible cosmic force” (71) intended to punish its helpless victims. Metaphors are employed to render people living with HIV/AIDS as embodiments of evil. The gothic, argues Morris, is a genre adeptly suited to this purpose, showcasing an unstoppable “legacy that lives on in vampires, swamp creatures, and ax murderers” (71). Elis Hanson’s “Undead,” similarly traces the parallels between vampires and those who are HIV-positive. Hanson observes that “in media representations of AIDS, I find neither people who are living with AIDS nor people who have died with AIDS. What I find, rather, are spectacular images of the abject, the dead who are to speak and sin and walk around, the undead with AIDS” (324). Through the vampire metaphor, those living with HIV are dismissed as irredeemable and harmful, even before they exhibit symptoms of sickness. In linking HIV/AIDS with “living ghost[s]” (Davidson 223) and “late-Victorian vampirism” (Hanson 324), “vampirism, like AIDS, consequently becomes a ‘lifestyle choice,’ where the vampire, like the homosexual, is potentially curable, and if not curable, then certainly deserving of death” (Nixon 127).

In “Fluid Frontiers: AIDS, Vampires, and a Cultural Analysis of Our Fear of Wetness,” Kathy Penzenstadler and Alix Birkley support Hanson’s thesis that cultural reactions to HIV/AIDS are connected to the “resurgent popularity of the Vampire myth” (147). They contend that “historically, Vampire stories have continually resurfaced in times of plague and epidemic. Anne Rice’s Vampire trilogy begins in San Francisco, one of the places where the ‘gay plague’ was thought to have originated in unsafe sexual practices” (147). In “Coming Out

of the Coffin,” Trevor Holmes similarly traces how “in the age of AIDS and the sex-phobia it has engendered, come a revival of gothic culture and a widespread interest in vampires” (184). Holmes, accordingly, positions HIV as “the virus that has conditioned much of the vampire fiction and vampire analysis being written today” (188). In their reading of the vampire as metaphor, Gordon and Hollinger concur that vampires “thriv[e] in this postmodern milieu of dissolving borders, between the virtual and the real, between private and public personae, in the breaking down of cultural and national boundaries, while a plague transmitted by the penetration of bodily boundaries—and often through blood—sweeps the world” (7). Penzenstadler and Birkley also connect the vampire myth to “our fears and shame of fluid” (147). It is not only bodily fluids, they contend, that create social unease, but the fluidity of identity that vampires connote: “it is these wet places, where our borders become fluid, that we fear to go [. . .] in the fluid realm, the boundary of individuation is lost and there can be no differentiation between gay and straight, clean and strung out, self and other” (148).

As Stacey Alaimo demonstrates in “Skin Dreaming,” Butler’s work exemplifies this process of slippage by transforming the body into a “liminal space” (130) that breaks down stable, dichotomous understandings of what it means to be human. Butler represents bodies as fluid and unstable, “challeng[ing] the dominant dichotomies by envisioning bodily transgressions and corporeal crossings” (Alaimo 136). In her reading of Butler’s *Xenogenesis* Series, Sherryl Vint likewise observes the “extremely fluid” (59) boundaries Butler establishes around issues of identity, genetics, and personal choice. Vint examines how Butler’s writing connects scientific advancement to underlying issues of eugenics, politics, and social control. Embodied metaphors in Butler’s work, Vint reveals, raise questions central to queer and feminist projects that figure the body as a locus of personal agency and fluidity, rather than a site of scientifically justified,

governmental restriction. Vint illustrates that through scientific discourse, Butler advocates for a diverse range of sexual and gender expressions, as well as for our ability to maintain self-determination over our bodies and reproductive capacities. Butler's work, as a result, champions human variety, rather than adhering to hegemonic restrictions that figure difference as undesirable.

Fledgling fictionalizes these concerns by advocating for the gender, sexual, and racial fluidity embodied by Shori's status as a genetically hybrid, black vampire. Like the Oankali of the *Xenogenesis* Series, Shori's biological make-up results from genetic interbreeding between the Ina and humankind. Unlike conventional gothic narratives wherein vampires are hated and feared for their uncanny similarities to humans, *Fledgling* endorses the blurring of such binaries by celebrating the ambiguity between categories of human and vampire, straight and queer, female and male. For instance, when Wright meets Shori, he cannot determine her biological sex. He soon learns that in addition to her unfeminine aggressiveness and androgynous appearance, she maintains a sex-positive, polyamorous practice of having sex whenever and with whomever she wants with others of varying ages, races, and genders. Though at first, Wright perceives Shori's unabashed sexuality as a personal threat, he later learns to respect her sexual freedom. Like the fin de siècle villain, Dracula, Shori calls the sexual norms of the past millennium under scrutiny. Rather than portraying sexual freedom as immoral, *Fledgling* exposes the twentieth-century's cultural codes as restrictive and warranting revision.

Because vampires embody the unrestrained expression of sexuality, they also perpetuate the popular misconception that sexual deviancy causes HIV/AIDS. Davidson contends that "any body that is HIV+ is ascribed a new and potentially threatening sexuality because it is viewed as polluted and contagious" (224). Converting the person living with HIV into a vampiric outsider

allows for those who are seropositive to be blamed for their own medical condition. The vampire metaphors connected to HIV/AIDS accentuate the sense of fear and xenophobia linked to the disease. As Gorna observes, the people most severely affected by illness are those who are “othered” and disenfranchised within our society—drug users, sex workers, immigrants, and people of color. Those already lacking access to resources thus become susceptible to further marginalization through HIV/AIDS. Rather than recognizing the need to invest in prevention and treatment programs, governments and media officials metaphorize HIV/AIDS as an evil, mysterious ailment whose sufferers have transgressed and should therefore be punished. As such, HIV/AIDS is regarded as a moral threat, rather than a social or health concern. Rendered as sexual deviants, people living with HIV/AIDS become gothic vampires who must be exiled and feared rather than supported in promotion of recovery and health. In emphasizing that vampires need not be connected with fear or harm, Butler breaks down the stigma assigned to the metaphor. Although the Ina can be seen an HIV-positive community who promote health and mutual support, those with HIV/AIDS need not be metaphorized at all, as HIV/AIDS in the novel is never actually named. *Fledgling*, as a result, allows for a powerful reconception not only of vampires but also of illness itself.

Morris, accordingly, argues that in order to separate HIV/AIDS from its gothic metaphors, we must recognize that suffering is “not a permanent, ungraspable mystery of the human condition [. . .] but rather an event [. . .] that expresses much of what our cultures have taught us” (71-2). Activist organizations such as ACT UP, TAG, and CRIA “redefine suffering as social – reconceiv[e] it as social suffering – structured in part by the public discourses and institutions that offer us various scripted roles and plots” (Morris 70). These roles and plots are performed and hence reinforced through narratives of vampires who inflict suffering upon their hapless

victims. Like the fictional status of the vampire, however, the evil associated with the gothic and with HIV/AIDS is not an immutable truth, but rather “a cultural artifact” (Morris 71). HIV/AIDS, argues Morris, need not be viewed as unstoppable evil, or as the social death of its victims. Instead, metaphors of HIV/AIDS should be conceived as culturally constructed and thus amenable to redefinition. Calling attention to the highly contrived properties of both the gothic genre and of HIV/AIDS mythologies themselves, *Fledgling* allows for an empowering reconstitution of HIV as a virus that need not lead to victimization or death. Imagining HIV/AIDS apart from its gothic metaphors allows us to reclaim social constructions of illness toward self-empowering and anti-oppressive ends.

Fledgling challenges both our preconceptions of vampires and of HIV by depicting the Ina as a community of HIV-positive beings who do not develop symptoms of AIDS. In educating Shori about her people’s history, Hayden explains that the Ina were once nearly wiped out by an unknown and mysterious disease, “an Ina-specific epidemic illness that made it difficult or impossible for our bodies to use the blood or meat that we consumed” (195). Hayden recalls that “our bodies were no better at dealing with this illness than our human contemporaries were at dealing with their illnesses [. . .] but while our attentions helped them deal with their infections [. . .] they could not help us deal with ours. We died in greater numbers than we could afford” (195). Though Hayden does not name this “epidemic” (195) as HIV/AIDS, he alludes to the sexual nature of its transmission, as well as its terminal spread: “we weren’t reproducing well” (195), he recollects, “it got harder and harder for us to find mates” (195). The Ina, explains Hayden, found a way to conquer this retrovirus-like infection, resisting its symptoms in a manner their human counterparts could not. He recalls that “gradually, we began to heal. Perhaps we had simply undergone a kind of microbial winnowing. The illness killed most of us. Those left

were resistant to it, as were their children (195). Thus rather than embodying evil or fear, the Ina vampires represent an HIV-positive community who learn to safely exchange blood and sex while sustaining one other's health.

In his analysis of queer vampire fiction, Holmes connects this trope of the vampire as a healer of HIV/AIDS to notions of the gothic as a potential site of sexual and cultural resistance. Through a reading of Gary Bowen's *Diary of a Vampire*, Holmes illustrates how queer love between men inspires the novel's vampire-protagonist to "donate his blood to end the fight against AIDS, thus effecting a cure which he would not allow to be co-opted for corporate gain" (180). Presenting a "vampire [that] can cure AIDS" (180), Bowen's novel illustrates how "vampires function as more than just metaphors or archetypes in contemporary culture; in the case of at least some subjects in the boundary-crossing moment that is both queer and goth, vampires are sources of self-invention and the very much *out* staging of the problematic of gender identification and sexuality" (Holmes 188). Holmes not only traces instances of queer community building within vampire fiction, but his analysis also reveals how fan fiction and queer identifications forge a sense of communal identity as a product of reading vampire fiction itself.

Throughout the larger corpus of her writing, Butler continually reinforces this emphasis on community building as essential to maintaining physical and emotional well-being. In her short story, "The Evening and the Morning and the Night," Butler situates illness and difference as sites of potential creation and community development. This narrative reveals that while illness can mark carriers as "lepers" (39), breeding segregation and violence, difference can also become a productive force that allows for artistic and scientific innovation. Illness, moreover, provides an opportunity to forge lasting bonds between those who share the physical and socially

determined characteristics of a disease. The protagonist, Lynn, marked emotionally and physically by her genetic disorder, “DGD,” creates a communal living situation for others with her condition. The bonds formed herein lead to Lynn’s discovery of a special pheromone that can assist other DGDs to lead productive, healthy lives from within an idyllic, bucolic setting opposite from the dismal institutions where those with DGD are traditionally housed. In an interview with Marilyn Mehaffy and AnaLousie Keating, Butler herself reflects that “I always automatically create community. This has to do with the way I've lived [. . .] My own feeling is that human beings need to live that way and we too often don't” (51). As Ann Fowell Stanford observes of Butler’s *Earthseed* Series, “it is community and not individualism that ultimately makes survival possible. These two novels [. . .] call medicine into a renewed sense of community with the people who are most removed from it: the historically and socially marginalized” (217).

In *Fledgling*, Butler likewise reveals the practical necessity of cooperative living toward the maintenance of health. For instance, the Ina communities reeducate and protect Shori who remembers nothing of her deceased family and cultural identity. Through her ties to the Gordon community, Shori rediscovers her capacities to heal. Healing, Shori discovers, is a two-way process between the Ina and their human symbiont lovers. She explains that “my saliva [. . .] pacified people and pleased them [. . .] help[ed] them heal [. . .] I could [. . .] help the people who helped me” (32). Shori builds herself a family of human symbionts who become tied to her through the exchange of blood. Shori’s bites give her symbionts a “pure pleasure” (167) akin to orgasm. Yet, in complicating the relationship between pleasure and consent, the involuntary roots of these familial connections between humans and the Ina raises questions of whether pleasure can ever be “pure” among the enslaved. Revealing community to be a complicated and

potentially even involuntary or inflexible construction, Butler nevertheless uncovers the strengths of collective society. In communities provide lifesaving support to those with whom they share their blood, encouraging responsible and pleasurable sexual relationships without the threat of self-interest or abandonment. Shori's symbionts are bonded by the exchange of fluids, subverting traditional vampire narratives that view this process in a negative light. *Fledgling*, furthermore, also inverts the gendered and racialized connotations that accompany preconceptions of what vampires and their communities look like. As Shori's symbiont Theodora playfully acknowledges, "according to what I've read, you're supposed to be a tall, handsome, fully grown white man. Just my luck" (97).

In spite of such contemporary representations of vampires as white, straight, and male, vampires since *Dracula* have been figured as emblems of miscegenation and racial otherness. Fixated upon the mixing of blood, historical discourses of race such as the 'one drop rule,' are reflected metaphorically within the vampire. Critics including Teresa Goddu and Kathy Patterson trace this connection between racism and the gothic, exposing "society's tendency to conflate Blackness with vampirism" (Patterson 40). Goddu connects the stylistic elements of the literary gothic to the racism underlying American culture: "the gothic's focus on the terror of possession, the iconography of imprisonment, the fear of retribution, and the weight of sin provided a useful vocabulary and register of images by which to represent the scene of America's greatest guilt: slavery" (133). Butler takes up these questions in her slave narrative, *Kindred*, using fantasy as a mechanism to illustrate how slavery remains central to our contemporary experiences of embodiment and self. *Fledgling*, similarly, uses the gothic to reveal how race is metaphorized within American fiction and how such narratives can in turn be revised and reclaimed. Butler's fiction also demonstrates how such concerns become

particularly apparent through depictions of illness, exposing the racialization of diseases like HIV/AIDS.

While science and medicine position themselves as a neutral and objective fields, illness narratives pervade scientific language and thought, creating “a story to explain the unknown, the foreign, alien, [so] we can be reassured that it will remain safely unknown, foreign, alien” (Epstein 186). Illness is construed in opposition to national boundaries and identities, as Morris observes that “wherever you are, plague always comes from somewhere else” (67). Sontag concedes that HIV/AIDS narratives reflect the racism and fear of difference underlying North American society. She contests that “every feared epidemic disease, but especially those associated with sexual license, generates a preoccupying distinction between the disease’s putative carriers (which usually means just the poor and, in this part of the world, people with darker skins) and those defined [. . .] as ‘the general population’” (115). In separating oneself from those who are infected on the basis of class and race, xenophobic fears will increase while the epidemic continues to spread. As Kruger observes, “other communities, the ‘general population,’ too often seem content to let the disease ‘run its course’ as long as they themselves remain more or less unaffected” (80). This them-not-us perception of HIV/AIDS only perpetuates suffering, placing more and more people at risk.

The pandemic, moreover, affects people unequally, as access to sex-education, condoms, needle-exchange programs, and drug therapies is determined by race, location, and class. While those with greater financial means have increased access to treatment and care, low-income groups face greater cultural stigma and remain far more susceptible to infection. As Harriet Washington illustrates in *Medical Apartheid: The Dark History of Medical Experimentation of Black Americans from Colonial Times to the Present*, racial discrimination influences medical

discourse as well as the treatment options available to those living with HIV. As exemplified by systems like privatized medicine and drug patenting, the pandemic is fueled by those heavily racialized, class disparities central to the operation of our economic system itself. As Stanford observes, “Butler underscores medicine’s vulnerabilities by linking disease, illness, and injury with the social conditions that inertia and profit have allowed to run rampant” (213). Butler’s fiction illuminates how the racist ideology fundamental to both capitalism and globalization allows for the proliferation of illness and its associated metaphorical threads. Illness narratives exploit these fears of this “threatening otherness” (Morris 67) that links HIV/AIDS to the vampire myth.

In her reading of *The Gilda Stories*, Patterson also addresses the racialized connotations of vampirism within literary texts. Like Goddu, Patterson acknowledges that black vampire narratives can reclaim the harmful connotations set in place through the gothic genre. She observes that:

The gothic has served as a useful mode for African-American authors to resurrect and resist America's racial history. As the producers of terror instead of its text, African-American writers use the gothic to haunt back, re-working the gothic's conventions to intervene in discourses that would demonize them. (37-38)

As with narratives of HIV/AIDS, harmful discourses perpetuated by conventional literary practices can be inverted toward anti-oppressive ends. As Gomez herself observes in “Recasting the Mythology: Writing Vampire Fiction,” “My character, Gilda, is a lesbian because I’m a lesbian. Even though some lesbian-feminists have challenged my choice, suggesting it was too negative an idea to connect to lesbians, I feel I can remake mythology as

well as anyone” (86). The vampire figure, Gomez argues, provides a heroic fictional means to explore “bottom line” (87) issues like poverty, sexism, racial discrimination and access to housing. Gomez asserts that “the vampire figure’s identification with both sensuality and power proved to be an ideal way to re-examine a black lesbian feminist relationship to those two issues which are at the center of our liberation” (92). In likeness to the *Gilda Stories*, *Fledgling* figures a black vampire as the tale’s savvy and benevolent hero, rather than as its object of horror. Shori subverts racial preconceptions of the vampire genre, demonstrating a biological advantage over her white contemporaries: “I can withstand the sun better than [. . .] others of my kind. I burn, but I don’t burn as fast as they do” (37). Unlike the white vampires, Shori can stay awake and alert during the day. As the powerful Preston observes, “Shori Matthews is as Ina as the rest of us. In addition, she carries the potentially life-saving human DNA that has darkened her skin and given her something we’ve sought for generations” (278).

In addition to celebrating the merits of multi-racial vampirism, Butler directly addresses issues of racial prejudice and violence. While Shori’s friends initially believe that because vampires are “not human [. . .] they don’t care about white or black” (168), the narrative later reveals that some vampires share the same bigoted beliefs held by human society. The Silk family attempts to murder Shori and her entire family line. Katherine Dahlman, a friend of the Silks, taunts the white Gordons for allowing their sons to join Shori’s tribe: “you want your sons to mate with this person. You want them to get black, human children from her. Here in the United States, even most humans will look down on them. When I came to this country, such people were kept as property, as slaves” (289). Reproducing racist ideology among vampires, Butler illustrates that because racism is so deeply rooted in American mythology, it necessarily spills over into the gothic fictional realm. It is through the gothic genre, however, and through

science fiction, that such tropes can be subverted and ultimately changed. Butler rewrites the gothic as a space wherein black women occupy a self-determined position of leadership and self-defense. Reclaiming gothic metaphors also challenges harmful discourses of racial stigmatization and HIV/AIDS.

Fledgling, furthermore, also demonstrates how sex and gender play into the construction of Shori's racial identity. These factors, correlatively, determine the treatment of those living with HIV/AIDS. Gorna, for instance, addresses concerns raised in the previous chapter on Brown, in which women are made invisible by media representations and medical discussions of HIV/AIDS. She observes how: "little attention [is] paid to the real lives of women with HIV who live in the margins of society – drug users, sex workers, prisoners, African refugees, queers – nor to the women whose family, friends or partners have HIV, nor the hundreds of women dedicated to working in the AIDS epidemic" (49). Like the reinscription of the vampire figure in *Fledgling*, the misrepresentation of HIV-positive women within mainstream media can also be reclaimed through cultural production. As Alexandra Juhasz argues in *AIDS TV*, outlets like alternative video can be used to counter dominant, reductive portraits of women living with HIV/AIDS. Juhasz reveals how activists and community based organizations can demand the accurate representation of women in arenas from drug trials to safer sex materials, securing women's inclusion in medical studies and in clinical understandings of HIV/AIDS.

In depicting the marginalization of women within the AIDS epidemic, Gorna also identifies gothic metaphors that figure women as "vamps who have too much sex, even enjoy sex and endanger society through their lasciviousness" (50). She observes that women are "demonized" (50) by mainstream media as "rampant, sexual [. . .] a guilty whore, or a dangerous vampire" (58). These metaphors of HIV-positive women as vampires can again be

reappropriated through narratives like *Fledgling*. By literally embodying this stereotype, Shori both legitimizes and simultaneously challenges it. Because *Fledgling* is self-referentially presented as a work of fiction, Butler's reader can easily identify Shori's metaphorical status, applying its radical portrayal of female sexuality and HIV/AIDS to those within our own communities. As Morris contends, "the challenge [. . .] is to discover postmodern genres and narratives that validate, illuminate, and authenticate suffering while seeking to alleviate and oppose it" (71). By embracing a feminist, sex-positive, anti-racist spin on the vampire narrative, *Fledgling* reworks vampire metaphors while holding their underlying assumptions up for scrutiny. In suggesting that HIV might actually be something positive or desirable, *Fledgling* inverts the overrepresented logic popularized by discussions of "bug chasers" or people who are intentionally trying to become HIV-positive. The Ina demonstrate how rather than conceding to this model of carelessly attempting to acquire or failing to prevent the transmission of an illness, communities work to protect themselves and their partners from suffering by collectively mitigating and minimizing harm while reclaiming the negative metaphors attached to disease.

As De Witt Douglass Kilgore observes in "Beyond the History We Know: Nnedi Okorafor-Mbachu, Nisi Shawl, and Jarla Tangh Rethink Science Fiction Tradition," feminist science fiction featuring black heroines does not merely add a "diverse" spin to traditional narratives but actually serves to "change what and how we read [. . .] to tell stories that have been impossible to imagine" (120). Within this realm of the unimaginable lies the challenge of conceptualizing HIV/AIDS apart from destructive metaphors of disease. Paradoxically, it is those narratives most heavily dependent upon metaphor, such as science fiction and the gothic, that allow us to detach illness from the detrimental grounds upon which it repeatedly appears. As Kilgore observes, the history these writers recover "can potentially become future history. It

is now possible to identify a new pattern of expectation, one that emerges from long-suppressed voices” (127). By inverting the vampire metaphor, *Fledgling* envisions precisely such futures, providing alternative models through which to reconceptualize HIV/AIDS without linking it to metaphors of illness. HIV/AIDS activist movements and communities, similarly, challenge those historically rooted inequalities that allow diseases to flourish, positioning HIV/AIDS not as a gothic horror but as an impetus for re-envisioning institutions connected to health care provision, sexual representation, and the history of conceptualizing disease.

Through her radical reinscription of the black, female vampire figure, Butler inverts the trajectory between vampires and death, escaping the conceptualization of illness as metaphor. Butler’s novel uncovers the fallacy of rendering those who are HIV-positive as vampires. While the Ina might represent a community of the HIV-positive, they also embody impeccable health, thus challenging the connections between gothic fiction and actual human disease. Though HIV/AIDS remains unspoken throughout the text, the vampires who carry it are self-aware manifestations of viral resistance, collectively promoting disease prevention among humankind. In exploding the AIDS metaphor through a literal manifestation of the Ina, illness can be divorced from its metaphorical grounds and linked instead to the social inequalities within which the pandemic exists. In *Fledgling*, illness and difference provide an incentive for racial equality and community building, rather than a locus of fear or death. Butler’s novel forces us to move beyond the metaphorical tenants of HIV/AIDS, focusing instead on how systems of capitalism, racism, and homophobia demonize and sustain a preventable disease.

Conclusion

Toward a Model of Cultural Production as HIV Prevention

An archival and textual analysis of HIV/AIDS literature draws attention to the social and political structures that continue “to fuel” (*Ayala Corpus* 3 vi) the pandemic. HIV/AIDS writing in its multiple forms becomes an instrumental tool toward accurately representing the history of the pandemic as well as locating its position within a broader trajectory of writing about illness. Not only do literary documents record the activist contributions of communities responding to and living with HIV/AIDS, such accounts of queerness, racialization, and embodiment remain elemental to recognizing the correlations between cultural production and physical health. Through representations of care giving, border crossing, policing, incarceration, and resistance, HIV/AIDS literature uncovers that there is far more to combating this pandemic than a scientific understanding of biology, pharmacology, or medicine could possibly provide. In juxtaposing the fictional works of Schulman, Brown, Kincaid, Powell, and Butler with the archival texts of Haslip and De La Cruz, interrelations emerge between the production of literary narratives about HIV/AIDS and the educational materials intended to prevent the spread of the virus itself. While many prevention campaigns focus singularly on condom use and on the ‘risk level’ of individual sexual acts (for instance, the current preoccupation with “barebacking”), HIV/AIDS literature points to the fallacy of reducing human sexuality to a series of isolated physical events. Literary and artistic production accentuates the importance of situating HIV prevention within a broader cultural context. Indeed, the vast spectrum of social determinants that shape and represent our identities converge to influence our sexual behavior. Cultural production, therefore, becomes a locus through which to openly acknowledge and validate queer sexual identities themselves, becoming an effective site of intervention against the transmission of HIV.

Corpus, a HIV prevention journal produced by AIDS Project Los Angeles (APLA), recognizes the importance of understanding HIV prevention as an endeavor requiring positive and relevant representations of queer sexualities. A visually appealing and aesthetically compelling publication, *Corpus* is available free of charge within bars, clubs, and community venues throughout urban Los Angeles with eclectic distribution across North America. *Corpus* showcases a wide variety of visual art, poetry, fiction, essays, interviews, photography, and editorial writing that broadly address HIV/AIDS. Dedicated to reaching queer, racialized urban communities of young men who continue to experience the highest incidence of HIV infection, *Corpus* covers a variety of topics in relation to the pandemic. Included within the journal are discussions of gender identity, homophobia, urban/rural identities, policing and criminalization, youth issues, aging, globalization, diaspora, queer subcultures, cruising, sex work, racism, community, and resistance. *Corpus* recognizes that without an acknowledgement of how these issues and their representations (and in the mainstream media- lack of representations) affect our sexual practices, we cannot create a successful intervention in the pandemic of HIV/AIDS.

In the forward to the debut issue of *Corpus* in 2003, George Ayala reflects that “one of the great ironies of the AIDS era (or perhaps logical outcome) is the inordinate attention given to understanding the biology of HIV in the body without regard to the bodies hosting the virus” (vii). Countering the “pre-occupation with ‘science-based evidence’” (*Corpus* 7 v) that dominates discourses of HIV/AIDS, *Corpus* refuses to reduce “the lives of gay, bisexual men, and other men who have sex with men (MSM) to isolated, behavioral acts in need of intervention, the way that science in the name of prevention tends to do” (*Corpus* 7 v). As editor Jamie Cortez explains in his introduction to the first volume, “in the past twenty years, epidemiologists, doctors and scientists have contributed immeasurably to our understanding of

HIV/AIDS and have shaped the discourse around it. While their contributions have been remarkable, they are incomplete” (xi). There thus exists a “knowledge gap” (xi) in relation to HIV/AIDS that, Cortez argues, “can only be filled by artists, with their peculiar field research that is irreproducible but constantly duplicated, unverifiable but full of truth” (xi). Outlining the capacities for cultural production to provide new insights into the pandemic, Cortez declares that:

I like this part of the HIV response spectrum. I like it because I want to learn of new strains of faggotry. I like it because I want to see queer male life strategies transmitted and reproduced with virulence. I want pathology reports, Miss Thing. I want to know we’re present even when undetectable. I want us to survive in the millions. (xi)

Pushing the limits of scientific discourse, Cortez reveals that in order to effectively represent the sexual complexities experienced by gay men, HIV prevention must assume the form of cultural production.

Corpus, accordingly, recognizes “the importance of film, literature, art, and song—indeed, our voices—being heard and privileged” (Horowitz *Corpus* 5 vi). As Ayala contends, “see[ing] ourselves reflected on the written/painted page” (vii) allows for a broader consideration of both how we envision our sexual identities, and how our individual practices affect others as well. As Paula Treicher acknowledges, “an effective response to an epidemic (as to any widespread cultural crisis) depends on the existence of identities for whom that epidemic is meaningful—and stories in which those identities are taken up and animated” (235). Providing “a space for established and new artists to speak about and show desire between men” (Quan *Corpus* 7 xiv), *Corpus* locates visual and written materials as a nuanced and effective form of HIV prevention. In his introduction to *Corpus* 7, Andy Quan affirms that in artistically representing queer desire, *Corpus* presents “an appropriate and intriguing” (xi) setting for

discussing HIV. Quan declares that “I loved the *possibility* of an arts journal, that by moving beyond the language of science and research, that art, in the form of words or images, would illuminate our lives through both reflection and contrast, that stories of shared experiences would move us beyond statistics, that a revelatory photo or phrase might bring enlightenment” (x-xi). Quan argues that “responding to HIV is not about a condom or a poster or a pill. It is about understanding our desires, our sexual lives, how we take care of ourselves and others (xi).

Like *Corpus*, *Holding Open Space* is another publication of AIDS Project Los Angeles that calls for a radical re-envisioning of HIV prevention efforts. The product of a nationwide summit on HIV/AIDS, *Holding Open Space* culls together the collaborative work of over fifty professional and community-based service providers working to prevent HIV/AIDS. This publication provides a concrete mandate toward reassessing priorities for ensuring the health and survival of gay and bisexual men of color. *Holding Open Space* mirrors the aesthetic project of *Corpus*, interspersing its text with the portrait photography of Giovanni Koll and the Mpowerment youth program members to create an affirmative visual representation of queer men of color in conjunction with a discussion of HIV. Echoing *Corpus*, *Holding Open Space* calls attention to the overwhelming trend in prevention efforts to “focu[s] on changing individual behavior with little regard to interpersonal, social, cultural, environmental, and/or other influences” (3). The authors of *Holding Open Space* reflect that “taken together with the strong cultural propensity for individualism in the U.S., it is not surprising that HIV prevention campaigns predicated on personal responsibility took hold and retain powerful popularity” (3). This publication calls attention to the ways in which prevention messages ask the individual to remain wary and mistrustful of their own intentions and decision-making capabilities, as well as those of their partners. In *Altered Conditions*, Julia Epstein similarly exposes the faults in the

premise that “individuals must take responsibility both for their own well-being and for the public health, that behaviors and ways of life can harbor and promote disease” (171). Like *Holding Open Space*, Epstein argues that:

This individualist explanation proposed that disease could be cause and/or exacerbated by deviant behavior, and such behavior could also result from the disease process—a lose-lose proposition, because deviance would make you sick but at the same time meant that you were already sick. Sexual promiscuity, poverty, racial or ethnic identity, alcoholism, homosexuality, addictions, criminality itself—these could explain disease and could be simultaneously explained by disease, leaving a chicken and egg problem with conflicted social implications. (171)

Reliant upon sentiments of fear and shame, this individualistic, behavior-based model of HIV prevention also fails to consider how sexuality is inseparable from broader interpersonal and systematic factors including: “homophobia, racism, criminalization, stigma, violence, sexism, gender role expectations, addiction, isolation, and poverty, among others” (*Holding Open Space* 5). Exposing the shortcomings of dominant prevention paradigms, *Holding Open Space* emphasizes how “the current state of the HIV epidemic among gay and bisexual men of color is not a question of individual behavior; it is the natural outcome of the social forces that shape their lives” (47).

Existing prevention campaigns, argues *Holding Open Space*, fail to recognize how “sex is a social process that is larger and longer than the actual sexual act” (32). In focusing almost exclusively on promoting adherence to condom use, current prevention programs fail to validate and represent the myriad of experiences predicating and influencing sexual decisions. As Allan

Brandt observed in 1985, “most of the current discussions of sexually transmitted infections in the popular press [. . .] rest on the essentially simplistic view that the problem can be solved if individuals act more responsibly in their sexual conduct” (185). Brandt pinpoints the still predominant assumption underlying mainstream prevention campaigns that “an individual’s behavior is free from external forces—that life style is strictly voluntary” (186). Rebuking these presumptions, Brandt demonstrates the importance of recognizing how “behavior is subject to complex forces, internal psychologies and external pressures, all not subject to immediate modification at all” (186). “Sexuality,” argues Brandt, “is subject to a number of powerful influences, social and economic, conscious and unconscious [. . .] for which, of course, individuals can in part be held accountable, but the question of to what extent, and whether they should be is not as simple” (186)

Mirroring the position articulated by Brandt, the authors of *Holding Open Space* discuss further negative outcomes connected to the monolithic message of individual agency and condom use in relation to HIV prevention. The authors posit that “the barrage of messages regarding condom use may have imbued anal sex with cultural meaning, making anal sex both highly stigmatized and exclusively desired for some gay and bisexual men” (26). *Holding Open Space* outlines how prevention programs’ implicit focus on anal sex not only heightens its cultural valiance, but in the process obscures and underemphasizes alternate sexual activities that carry far lower risk for viral transmission. (26) The authors surmise that these behavior-centered messages also limit the conversations that occur around the topic of ‘safer sex,’ reducing discussions of sex and sexuality to reflections of what sexual activities occurred and whether condom use was achieved. Within this framework, there remains little space for recognition of

the cultural and interpersonal dimensions of sexuality that largely impact sexual behavior, including condom use itself.

In conjunction with this analysis of sexuality and HIV prevention, *Holding Open Space* also calls for a reconsideration of how substance use is addressed in relation to HIV transmission. The authors, firstly, recognize that substance use not only poses a risk as a potential site of HIV transmission (ie- through the sharing of intravenous drug works) but that substances can also lead to infection by compromising decision-making capacities during sex. The authors emphasize that:

Interventions and conversations should not be about stopping substance use, but rather about defining and exploring spaces where gay and bisexual men of color understand risk, danger, and loss of personal agency – the ability to take control of and exert power over one’s life. The goal is not to forcibly and unrealistically stop the use of substances, but to help men regulate their functional use, prevent dysfunctional patterns of abuse, and reduce its potentially harmful consequences. (38-9)

The authors, further, acknowledge that because substance use often occurs as a means of social cohesion between gay men, outreach must continue to focus on “building HIV prevention interventions around the multiple possible connections in gay and bisexual men of color’s lives, including family, lovers, friends, neighborhoods, and social/sexual/drug-using networks” (39). As with sex, it is essential to recognize substance use as a facet inseparable from the cultural components determining individuals’ broader experiences. By corollary, it becomes necessary to address the more difficult questions of racism, poverty, homophobia, and violence, as these factors all propagate the incidence of substance abuse and by extension, HIV/AIDS.

In calling attention to the social and cultural determinants of HIV/AIDS, *Holding Open Space* urges us to invest in prevention strategies that privilege the voices, resources, and experiences of queer communities of color themselves. The authors assert that:

HIV prevention interventions need to engage gay and bisexual men of color in an open dialogue about what they already know, already do, and already believe [. . .]

Components of the discussion should include understanding the concepts of sexuality and masculinity; the emotional aspects of sex; sexual identity and sexual behavior; and desire as a culturally coded and creative force (i.e. two-spirit, activo/pasivo, rough trade, leather queens, bears, radical fairies, butch queens, etc.). (29)

Prevention efforts, furthermore, must provide community-based spaces for these conversations about sex and sexuality to occur. The authors observe that owing to factors like racism and homophobia, many queers lack access to educational, familial, or social forums wherein they can openly discuss issues concerning their sexual practices and desires. Because they are elemental to the formulation of sexual identity and self-esteem, such conversations should be encouraged through venues including “art workshops, field trips, mentoring, peer-to-peer dialogue, sex education workshops, planned social events, critical thinking discussions, book groups, movie nights, etc. (34).” Most importantly, prevention efforts should not undermine the agency and capacity of “gay and bisexual men of color [to] make the best decisions for their own lives” (43). Prevention campaigns must, therefore, draw upon the already existing support networks and “resiliencies of the many communities to which a gay or bisexual man of color belongs” (43).

Both *Holding Open Space* and *Corpus* , moreover, call attention to an indispensable component within discussions of HIV transmission: these publications underscore the importance of re-centering considerations of queer sexuality itself. In exposing the follies of

narrowly regarding HIV prevention from within a limited biological framework, *Corpus*, like *Holding Open Space*, uncovers the ways in which representations of queer subjectivities and gay sexualities have been erroneously omitted from contemporary prevention materials. Ayala explains that although “the HIV/AIDS epidemic in the United States continues to concentrate itself among gay men” (*Corpus I v*), explicitly gay prevention materials have become increasingly sparse. In “Loving in the War Years: The De-Gaying of HIV/AIDS,” Ayala observes that:

There is no question that AIDS is being actively de-gayed. The wreckage is far too evident: the invisibility of gay men in public representations of the HIV/AIDS epidemic (except when gay men are being stigmatized); the de-legitimization of community based, open-ended, and participatory HIV prevention strategies that focus on gay men’s feelings and relationships in favor of “evidence based” behavioral interventions; and the absence of basic information about sex, anal health, condoms, AND lube. (2-3)

Ayala argues that the erasure of queer representation in relation to HIV/AIDS must be viewed in conjunction with those culture wars that also produced “the steady erosion of personal liberties, the dismantling of public education, the privatization of public health, the systematic perpetuation of poverty, and the politicization of science” (2). “The de-gaying of AIDS” (2), Ayala reveals, “is but one battle in this larger war” (2). In *Corpus*, Ayala ties this “de-gaying” to shortfalls within prevention messages themselves. While linguistic categories like “Men who have Sex with Men” (MSM), and men “on the Down Low,” exist to target prevention efforts towards those whose identities and sexual self-conceptions do not fall under the spectrum of gay or “queer,” such categorizations, Ayala argues, produce “watered-down” (*Corpus v*) prevention campaigns which “fail to address the subjective experiences of gay men in visible and affirming

ways” (v). Moving beyond essentialized notions of identity politics, *Corpus* seeks to re-center explicitly gay representations within HIV prevention discourses. Recognizing that until homosexuality can be openly acknowledged, displayed, condoned, and discussed, HIV prevention will remain irrelevant to those for whom such campaigns could have the most beneficial effects.

In acknowledging this flagrant deficit, Colin Robinson similarly reflects that “those of us who work in the AIDS industrial complex have got another public secret, something we all know is true, but that our programs and organizations and policy work don’t really address – that homophobia causes AIDS. I’ll say it again: Homophobia causes AIDS” (7). Emphasizing the connections between sexual and gender based discrimination and the incidence of HIV in black communities, Robinson stresses how “homophobia undermines everything we are trying to do in HIV prevention” (9). Robinson discusses homophobia in relation to the occurrence of “risky” sexual practices, raising interconnected questions of safety, value, and identity. He urges us to consider: “How can we ask folks to have safer sex when they don’t feel safe in the rest of their lives? When the intimacy and vibrancy that sex provides is often the only place they feel alive?” (9). Robinson recalls the words of writer Joseph Beam to illuminate the indisputable connections between racism, cultural identity, and sexual behavior:

As Joe Beam put it back in the ’80s, long before I could grasp the largeness of what he meant, we must know that ‘we are worth wanting.’ What is the meaning of HIV prevention, of telling someone to use a condom in order to live, when as Black gay folks our worth is challenged daily in school, in the media, on the street, from the pulpit, and by our families? HIV prevention doesn’t work when the social value of the lives of the people we are trying to keep alive is in question. (9)

Through a discussion of the “Down Low” (DL) debates and the onus placed upon black gay men who are not open about their sexuality and/or sexual behaviors, Robinson asserts that “homophobia limits the choices that Black men can make about their same-sex desire, constrains their expressions of that desire, and ultimately exacts a price for whatever choices and expressions are made” (10). Rather than stigmatize individuals for their actions or choices, it is crucial instead to understand how homophobia becomes “one of our most important battlegrounds” (Robinson 11), as it is social forces and not individual practices that truly perpetuate the prevalence of HIV/AIDS.

In light of Robinson’s observations, the lack of explicitly gay prevention materials thus indicates a reluctance to adequately validate the experiences and practices of queer men of color. *Corpus*, accordingly, calls attention to the interconnected social factors permitting the very existence of the pandemic. Ayala illustrates that “we have largely failed to understand the probability of exposure to HIV in the context of internalized homophobia, substance use, violence, sexual assault and other social forces that are constantly at play in the sexual exchanges between men” (vi). Linking HIV transmission to a wider range of cultural determinants that render marginalized individuals increasingly susceptible to disease, *Corpus* outlines the political dimensions of HIV prevention itself. In the forward to *Corpus*’ second volume, Ayala explains that “it is risky to honor and respect gay men’s lives at a time when doing so can mean governmental retribution and diminished private funding. *Corpus* therefore functions as a political placeholder for the requisite loving discussions and discoveries we must make about gay men’s sex if we are to see HIV transmission among gay men halted” (vii).

Corpus’ current and possibly entire run of only seven issues over the span of five years attests to this difficulty of funding a prevention campaign dedicated to positively representing the

sexual desires, practices, identities, and experiences of gay men of color. Fundamental to its prevention message is *Corpus*'s necessary disruption of hegemonic systems of power. As Ayala reveals, in combating HIV/AIDS, "*Corpus* also complicates sexuality, gender, race, ethnicity and class by publishing work that de-centers whiteness, destabilizes heterosexism, explodes notions of masculinity, and questions class privilege, which identity politics sometimes fail to do" (vi-vii). *Corpus* emphasizes the importance of recognizing "the beautifully diverse ways" (Ayala *Corpus* 7 v) we present ourselves, contesting categories of "gender, race, and class through the sex that we have" (Ayala *Corpus* 7 v) while creating "new understandings of gender, desire, aesthetics, and language" (Hebert *Corpus* 3 vii). In his forward to what will likely become the final issue of *Corpus*, Ayala emphasizes that this political project of anti-normative sexual representation and social intervention is precisely "why *Corpus* is important. This is also the reason so many cultural workers, artists, poets, service providers and activists alike have long pushed for alternative co-existing ways of knowing, understanding and troubleshooting AIDS" (vi-vii).

In spite of its relatively brief existence, *Corpus* brought about a crucial shift in HIV/AIDS prevention, reframing discussions of how sexuality intersects with sexual illness prevention. As Cortez compellingly attests:

Corpus is an HIV prevention magazine. You may find it beautiful to look at and hold, but the contents are not about the elegance and tidiness of man-to-man sex. *Corpus* is about the physically and emotionally messy sexuality we sometimes practice. We use gestures and single words to negotiate immensely complicated sexual unions. We creep. We surrender to the need for skin on skin. We sweat our manliness. We sweat our sissyness.

We transfer fluids. We age and grow and assign new meanings to sex. We treat each other's bodies as meat or sacred vessels, sometimes in the same sexual act. (*Corpus* 2 ix)

As the authors of *Holding Open Space* similarly articulate, sex cannot be confined to the reason-based, linear framework upon which scientific prevention discourses depend. Like Cortez's eloquent observation, this publication calls our attention to the fact that:

The rational or cognitive parts of a person are not usually the ones leading him/her to sex. Gay and bisexual men of color may move in and out of complicated sexual situations well equipped with behavioral skills and highly rational and logical plans for protecting themselves and their partner from HIV. However, sex can be beautifully irrational, impulsive, spontaneous, spiritual, messy and emotional. Individual behavior change interventions are limited because they do not expressly address how men affectively experience sex. (29)

Just as our experiences of sex cannot be detached from the affective dimensions of our lives, prevention materials must too explore the complex nature of sexuality in its broadest forms. Although HIV/AIDS is not always explicitly mentioned in every artistic or literary piece featured in *Corpus*, the pandemic remains central to each work's unique means of addressing "pleasure and desire, the place each occupies in our lives, and the meaning that we bring to each" (Ayala *Corpus* 7 vi).

In the premiere issue of *Corpus*, painter Timothy Cummings discusses this practice of sexual self-representation, illuminating how artistic production can become explicitly queer. In this interview with Jamie Cortez, Cummings describes his position as an artist whose career evolved "in the midst of massive HIV infection and death" (Cortez 30). Commenting on the "queer part" (34) of his art, Cummings reflects that queerness emerges as "an awkward beauty in

the work. A beauty that is not standard. Not a typical kind of gay magazine beauty which is very masculine, beefcake” (35). Cummings explains that while his depictions of masculinity are androgynous and unconventional, “people are glad to see something awkward. Something that is not the status quo” (35). Cortez draws connections between Cummings’s belonging within a “gender-fluid” (30) San Francisco art movement and his childhood in New Mexico. Cortez discusses one of Cummings’s early works, “Car Crash,” which features “two boys having oral sex in a car that had just crashed, with a Virgin Mary hovering in the air above them and a text that read something like ‘Holy Mother, please protect me from this sex that feels like a motor crash’” (31). Referencing “the Mexican *retablo* (folk paintings on tin with accompanying prayers to the Virgin, Jesus or saints)” (31), Cummings’ work integrates questions of national identity and migration with complex representations of “homo desire” (31). In his “Spot Portrait Series,” Cummings explodes notions of sexual identity, maturation, and illness, reflecting the “very immediate” (30) influence of HIV/AIDS. Cummings observes how his work reflects a sense of “light-hearted beauty” (33) that appears alongside “ongoing threats of disease, war, terrorism” (33). Cummings explains that “I love painting a pretty picture, but always the darkness is seeping in. It kind of makes it all the more beautiful” (33).

These connections between artistic representation, queer desire, and HIV/AIDS are also central to the work of Emily Roysdon. *Corpus 5* features Roysdon’s photo series, “Untitled,” in which Roysdon pays tribute to HIV/AIDS artist and legendary activist, David Wojnarowicz. The series emulates Wojnarowicz’s own “Rimbaud in NY,” wherein Wojnarowicz dons a mask of poet Arthur Rimbaud to depict his own existence within the queer underworld of New York City. In Roysdon’s series, the artist occupies a range of similar locations and visual aesthetics while instead assuming the mask of Wojnarowicz. In visually becoming Wojnarowicz, Roysdon

commemorates his groundbreaking influence upon the representation of queer subjectivities and HIV/AIDS, linking the contemporary queer movement to earlier histories of HIV/AIDS.

Through cultural representation, Roysdon's photographs link young queers and those mentors, like Wojnarowicz, who were lost to HIV/AIDS.

As with the paintings of Cummings, Roysdon's work is deliberately queer. Roysdon depicts "Untitled" as "explicitly a queer project, a queer gender and sexuality project. So I am attracted to David, I am supposed to be a woman, supposed to be a lesbian, but this project hopes, among other things, to bring gender and performance into the frame of gay and lesbian politics" (75-6). Citing the AIDS crisis as an early collaborative moment between lesbians and gay men, Roysdon rejects essentialized notions of sexuality and identity politics in favor of a queer model of desire that challenges the stability of gender itself. "A call to queer trans politics" (76), Roysdon frames her identification with Wojnarowicz as rooted not merely in influence but also as a performance of queer sexual longing. Through photography, Roysdon conveys the "desire to work with David, stitch myself into bed with him, turn myself into a fag. Yes, turn myself into a fag, allow my desire to move my body, change my body, to make something that gets me closer ..." (78). For instance, in referencing a photograph of Wojnarowicz as Rimbaud with a needle in his arm, Roysdon poses as Wojnarowicz with a needle in her thigh. Roysdon suggests that bodily modification, elation, and addiction can be attained not only through the intravenous injection of heroin but through the intermuscular injection of testosterone. Posed naked with her chest exposed, Roysdon demonstrates how she can take on the (queer) female position in conjunction with the ultimate masculine signifier (or shall we say, the pan-ultimate signifier, since Roysdon's penis here is deliberately silicone), strapping on her desire to become, and also to have sex with, David Wojnarowicz. Roysdon

reflects that “I think especially from the ravaging of our communities through AIDS and the straight world we live in, queers are less willing to forgo our icons and the lessons from the past” (78). In playing with gender and calling attention to the connections between queer longing, identity, and HIV/AIDS, Roysdon reveals the importance of recalling transgressive figures like Wojnarowicz as paramount to understanding queerness in relation to the pandemic today.

Just as the work of artists like Roysdon and Cummings links the past and present of HIV/AIDS, *Corpus* too traces the evolution of the pandemic through its shifting visual and textual representation. In his introduction to the fourth edition of *Corpus*, Robert Reid-Pharr compares early manifestations of HIV/AIDS with its current incarnation. Reid-Pharr observes that:

There have been significant and sometimes dramatic changes in what many of us took five, ten or twenty years ago to be the absolute reality of HIV infection. Pain, disease, shame, frightful and frightening death, the ridiculous become real. These are certainly realities with which we continue to grapple. At the same time, however, we have entered a moment in which it seems the ugly face of AIDS has been rouged and powdered. (ix)

Reid-Pharr examines the discrepancy between lived experiences of HIV/AIDS and those images disseminated through pharmaceutical marketing which feature “handsome models, sporty and grinning as they extol the virtues of competing HIV medications” (ix). Placing these advertisements within a context of aging and maturation, Reid-Pharr confronts the “strange dissonance” (ix) that exists between such images, “overflowing with mountain bikes and the outrageous fun of surprise birthday parties” (x), and the historical and present realities that fail to gain representation within a “diseased public” (ix). Raising questions of how to represent aging and wellness within a queer landscape fraught with the tensions and devastations of HIV/AIDS,

Reid-Pharr remarks that “the answers are certainly not easy or obvious, but then again neither are we” (x).

Like Reid-Pharr, Patrick “Pato” Hebert also points to the utility of visual and textual production in mediating the complexity of articulating our relationships to HIV/AIDS. Hebert remarks that “although our reading experience may be quite personal, even private, *Corpus* is nevertheless a very public pageant. The public space of the page is where contributors courageously share their vulnerabilities and visions, thereby encouraging us to engage” (*Corpus* 3 xi). *Holding Open Space* similarly emphasizes the importance of cultural narratives in representing and preventing HIV. The authors observe that:

The role of storytelling is valuable in that it increases the potential for connectivity between people; it increases the language available for audience and storyteller to discuss HIV/AIDS and its myriad issues in their own lives; it increases situational options for audience and storyteller in navigating the world and their own sexual experiences; and it documents the actions, goals, and history of gay and bisexual men of color during the AIDS epidemic. (42-3)

Holding Open Space points to the importance of narratives in preserving those histories of communities who dynamically and effectively responded to the crisis of HIV/AIDS. The authors articulate how “the history of HIV prevention is punctuated with examples of courage and collective will that can serve as a beacon of hope to guide us forward” (49). In *Corpus*, Hebert similarly articulates the innovation and momentum that can be attained through the transmission of narratives. Hebert observes how “as readers, we might enjoy what we see, but all this flesh and fucking also gets under our skin [. . .] It seeks to pull back the curtain and invite us to the stage. Here we might remember and reimagine what matters most, all while having a bit of

fun in the spotlight” (xi). By creating “meaningful connections between people, places and possibilities” (Hebert *Corpus 6 xi*), *Corpus* situates the HIV/AIDS crisis as an irrefutable opportunity for the transformation of queer communities, activist movements, and health reform more broadly. Hebert writes that “AIDS is a disaster. It is also an opportunity. As global trends in the pandemic and the movements in our own personal lives have shown, AIDS continues to require a more comprehensive, inclusive and holistic approach toward prevention and health” (*Corpus 6 x*). Providing a nuanced approach to the pandemic that prioritizes dialogue with affected communities themselves, artistic production becomes a site for queer sexual representation as a means of intervention with HIV/AIDS.

In emphasizing the capacity of cultural and literary production to represent the multiple realities of HIV/AIDS, *Corpus* points to the necessity of situating HIV prevention efforts within broader representations of queer sexuality, migration, identity, racialization, gender, and embodiment. Uncovering activist histories and literary accounts from the first decade of the pandemic speaks to this ongoing project of understanding HIV/AIDS as a product of the social and political contexts within which it exists. The pandemic, moreover, must not be viewed as an isolated medical moment, but as a cultural crisis rooted within a much longer historical trajectory of conceiving illness as the consequence of sexual and racial deviance. By revisiting these historical narratives of illness from within our contemporary context, we can connect individual acts of resistance to HIV/AIDS to the social stratification the pandemic unveils. In regarding cultural productions like *Corpus* as a means through which to historicize, to reclaim, and to prevent illness, literature becomes a concrete tool through which to illuminate how disease has been constructed and how it continues to be understood.

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