

The Discursive Construction of LGBTQ+ Women in Australian HIV Documents, 2014-2017

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ABSTRACT

In the Australian HIV landscape, lesbian, gay, bisexual, trans*, and queer (LGBTQ+) women have undertaken a number of roles: as HIV-positive citizens, carers, health professionals, and activists. However, Australia's epidemiological categories do not recognise 'female-to-female' sexual transmission of HIV. Instead, LGBTQ+ women are forced to occupy alternate categories of 'risk'. In light of their discursive invisibility, this thesis explores how LGBTQ+ women are constituted as particular kinds of subjects in *The Seventh National HIV Strategy* (2014-2017) and 2014-2017 publications of a Sydney-based LGBTQ+ women's magazine, *Lesbians on the Loose* (LOTL). Drawing on Carol Bacchi's poststructuralist model of policy analysis, entitled 'What is the Problem Represented to Be?', this thesis pursues an analysis of the 'problem' of HIV, its presuppositions, histories, and constitutive effects, in order to illuminate the complex, culturally contingent ways that LGBTQ+ women are rendered (un)intelligible in Australian HIV discourses. Finally, this thesis will focus on the (few) moments in LOTL where LGBTQ+ women are rendered 'at-risk' of contracting HIV. In doing so, it will begin to question how normative conceptions of 'risk' might be 'done', 'redone', and 'undone' in moments of discursive silence and from identities, desires, and practices that are otherwise 'unthinkable'.

STATEMENT OF ORIGINALITY

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Ethics approval was not required for this thesis.

(Signed)_____

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Katherine Smith

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GLOSSARY OF KEY TERMS AND ACRONYMS

ACON	Formerly the AIDS Council of NSW, a government-funded organisation which specialises in LGBTQ+ health.
Cisgender	An individual whose assigned sex matches their gender identity.
LGBTQ+	Lesbian, Gay, Bisexual, Trans*, and Queer.
LOTL	Lesbians on the Loose.
PEP	Post-Exposure Prophylaxis.
PLWHA	People Living with HIV/AIDS.
PrEP	Pre-Exposure Prophylaxis.
TasP	Treatment as Prevention.
Trans*	An individual whose assigned sex is different to their gender identity.
WPR	Bacchi's (2009; 2016 with Goodwin) methodological tool, entitled 'What is the Problem Represented to Be?'.

INTRODUCTION

By what norms am I constrained as I begin to ask what I may become? And what happens when I begin to become that for which there is no place within the given regime of truth? (Butler 2004: 58)

In 2015, I enrolled in a medical anthropology unit which would – quite unexpectedly – unravel many of my prior assumptions about the nature and value of social research. I became quickly engrossed in rich, ethnographic accounts of HIV in Thailand and Laos; enthralled by the idea that disease could be an object of studies for the humanities. From then, I wrote each anthropology essay on HIV discourses and their effects on ‘at-risk’ populations in South East Asia. But I am a cultural sociologist at heart and, upon returning to complete a Master of Research, I found myself again entangled in the Australian literature on gender, sexuality, and HIV. However, it was not until August 2017 that I began to question whether I – as a queer woman – was ‘at-risk’ of contracting HIV. Despite my involvement in lesbian, gay, bisexual, trans*, and queer (LGBTQ+) politics and social life, the question had simply never occurred to me. It is this failure to ‘think’ about LGBTQ+ women in HIV discourses that I am interested in exploring in this thesis.

In Australia, LGBTQ+ women have been ostensibly absent from legislation on (homo)sexual practices. In May 1997, Tasmania became the last Australian State to decriminalise homosexuality. However, while Tasmania’s anti-homosexuality legislation criminalised “sexual intercourse with any person against the order of nature”, it was only explicit in its condemnation of male homosexuality (cited in Morgan 1994: 741). Further, female-to-female sex has never received differential treatment in Australian age of consent legislation. This is despite Queensland’s separation of sodomy (legal over 18 years) and all other sexual practices (legal over 16 years), until 2016. Despite this, LGBTQ+ women have never been free from legislative stigma and discrimination. For instance, laws on adoption, fertility services, and marriage have disproportionately affected LGBTQ+ women, compared to heterosexual women (Millbank 2006).¹ In a slightly different vein, Foucauldian scholars have argued that “such legal silences may constitute a deliberate attempt to regulate lesbian sexuality through denial of its existence” (Lamble 2009: 114).

¹ Sarah Lamble (2009) has made this point, regarding the Canadian context.

Background to the Research: (LGBTQ+) Women and HIV/AIDS

In 2016, women accounted for 9.6% of new Australian HIV diagnoses; constituting 11.7% of the overall population living with HIV (The Kirby Institute 2017a). However, LGBTQ+ women are absent from the epidemiological categories in the Centre for Disease Control and Prevention's (CDC) HIV surveillance (Dworkin 2005; Fishman and Anderson 2003; Arend 2005; Logie and Gibson 2013). Instead, LGBTQ+ women living with HIV/AIDS are subsumed under alternate categories of 'risk', such as 'heterosexual transmission' or 'injecting drug use' (Marrazzo 2005; Montcalm and Myer 2000; Logie and Gibson 2013). In cases where an alternate risk cannot be identified, LGBTQ+ women's transmission route has been recorded as 'other' or 'undetermined' (Logie and Gibson 2013). A number of scholars have attributed this absence to the widespread notion of 'lesbian immunity'; wherein LGBTQ+ women are assumed to participate in strictly 'low-risk' behaviours and are, hence, deemed to be immune from HIV (see Richardson 2000b; Montcalm and Myer 2000; Dolan and Davis 2003; Logie and Gibson 2013).

Despite this, LGBTQ+ women *can* and *do* contract HIV and STIs. Among others, human papillomavirus (HPV) (Power et al. 2009; Diamant et al. 2000; Logie et al. 2015); chlamydia (Bailey et al. 2004b; Diamant et al. 2000; Marrazzo et al. 2005; Logie et al. 2015); bacterial vaginosis (Marrazzo et al. 2005; Bailey et al. 2004a; Bailey et al. 2004b); genital herpes (Diamant et al. 2000; Marrazzo et al. 2005; Logie et al. 2015; Bailey et al. 2004b); and HIV (Diamant et al. 2000; Logie et al. 2015; Matebeni et al. 2013; Logie et al. 2012) have all been identified in LGBTQ+ women.² Yet in part, due to their epidemiological erasure, scholars have debated how rare it is for LGBTQ+ women to contract HIV from their sexual practices with other women (see Chu et al. 1990). Indeed, as Richters and Clayton have noted, "[n]o cases of woman-to-woman sexual transmission of HIV have been reported in Australia" (2010: 103). In response to such arguments, a number of studies have established that some LGBTQ+ women participate in other, 'higher-risk' behaviours, such as IV drug (ab)use (Teti and Bowleg 2011; Logie et al. 2018; Stevens 1993); sex work (Teti and Bowleg 2011; Logie et al. 2018; Stevens 1993);

² These studies refer exclusively to LGBTQ+ or sexual minority women. For studies on WSW more broadly, see Marrazzo et al. 2000 and Pinto et al. 2005 for HPV; Chetcuti et al. 2012; Fethers et al. 2000 and Pinto et al. 2005 for chlamydia; Pinto et al. 2005 and Fethers et al. 2000 for bacterial vaginosis; Richters et al. 2002 and Fethers et al. 2000 for genital herpes; and Fethers et al. 2000, Pinto et al. 2005 and Richters et al. 2002 for HIV. These studies were divided based on their sampling frame, rather than their title or abstract.

and sex with men (Mooney-Somers et al. 2017; Stevens 1993; Smith et al. 2017). Nevertheless, the enactment of such behaviours does not negate one's identity as LGBTQ+.

Some have further suggested that women have a particular, "biopolitical vulnerability" to HIV (Ostrach and Singer 2012: 259).³ Indeed, receptors of penis-vagina sexual intercourse are more likely to contract HIV than penetrators; menopause can "increase vaginal vulnerability to lesion development"; and both female adolescents and individuals taking some hormone contraceptives are particularly vulnerable to vaginal tearing (Ostrach and Singer 2012: 260). In addition, women are often subject to structural inequalities, such as increased rates of poverty and sexual violences, which can contribute to their susceptibility toward HIV (Ostrach and Singer 2012).⁴ For LGBTQ+ women, such 'biopolitical vulnerabilities' are compounded with homophobia and transphobia. For instance, healthcare services are often permeated by hetero and cissexism, preventing LGBTQ+ women from receiving adequate information and care (Müller 2018; Logie et al. 2012; Arend 2005). It is hence at these intersections (and others) that any analysis of LGBTQ+ women and HIV must begin.

Thesis Overview

In this thesis I am interested in exploring how LGBTQ+ women become constituted as particular kinds of (non)subjects in Australian Government policy and LGBTQ+ women's print and online media documents. Drawing on Carol Bacchi's (2009; 2016 with Goodwin) poststructuralist model of policy analysis, entitled 'What is the Problem Represented to Be?' (WPR), I aim to understand how HIV has been problematised; that is, how it has been configured as a 'problem' to be both 'thought about' and solved. This will be followed by an analysis of the 'problems' presuppositions, discursive histories, constitutive effects, and "silencing practices" (Dahl 2017: 103), in order to illuminate the complex, culturally contingent ways that LGBTQ+ women are rendered (un)intelligible in Australian HIV discourses. From this standpoint I will, in the brief, final chapter to this

³ Ostrach and Singer's (2012) use of the term 'biopolitical' differs from its Foucauldian usage (explored in Chapter Three). For Ostrach and Singer (2012), biopolitics refers to the ways in which biology intersects with structural inequalities to render some individuals particularly vulnerable to certain diseases.

⁴ It is worth noting that a number of scholars have challenged the utility of constructing women as particularly vulnerable toward HIV. For instance, Higgins and colleagues have argued that such framing can "mask women's power and agency", hence (re)producing the gendered discourses they seek to overcome (Higgins et al. 2010: 435).

thesis, draw on Judith Butler's (2004) understanding of resignification, alluded to in the epigraph to this introduction, in order to question how LGBTQ+ women might persist as subjects of HIV, despite their unintelligibility in its dominant discourses. It is, here, that I aim to provide an account of how 'risk', 'gender', and 'sexuality' might be 'done', 'redone', or 'undone' in moments of discursive silence and from unintelligible positions.

HIV/AIDS as Discourse

While this thesis will contend that HIV/AIDS has been discursively constituted in particular ways, it does not intend to erase the realness of its lived effects. Since Australia's first identified case in 1982, HIV/AIDS has continued to permeate the lives of, in particular, gay, bisexual, and queer (GBQ+) men. However, as Paula Treichler (1999) has argued, it is crucial that we destabilise the apparent 'truths' of HIV. In doing so, we might begin to question our taken-for-granted assumptions and, if necessary, conceptualise the 'problem' differently (Bacchi 2009). Hence, if HIV is indeed "an epidemic of signification", it is this thesis' aim to interrogate its production in two Australian, textual domains; to contribute, that is, to our understanding of the multitude of ways in which HIV/AIDS has been thought about and enacted (Treichler 1999: 11).

Thesis Structure

This thesis is organised around six chapters. In Chapter One I will situate this thesis' research questions and methodology within the existing literature on LGBTQ+ women and HIV/AIDS. Following Alex Müller (2018), I will argue toward a poststructuralist understanding of absence and (in)visibility in order to provide a greater understanding of LGBTQ+ women's (non)position in HIV discourse(s). In Chapter Two I will outline this thesis' application of Carol Bacchi's (2009; 2016 with Goodwin) WPR approach, which utilises a Foucauldian focus on problematisations to analyse how particular 'problems', 'objects', and 'subjects' are (re)produced in policy documents.

In Chapter Three I will implement Bacchi's (2009; 2016 with Goodwin) WPR approach in order to determine how HIV has been problematised in the Australian Government's national, non-partisan HIV policy document, entitled *The Seventh National HIV Strategy* (2014-2017). In Chapter Four I will again implement Bacchi's (2009; 2016 with Goodwin) WPR approach in order to establish how HIV has been problematised in 2014-2017 publications of a Sydney-based LGBTQ+ women's magazine, entitled *Lesbians on*

the Loose (LOTL). In doing so, I aim to delineate how particular “dividing practices” and “problem representations” both symbolically annihilate and render LGBTQ+ women (un)intelligible in HIV discourses (Bacchi and Goodwin 2016: 100; 20).

In Chapter Five I will move beyond the dominant problematisations of HIV to offer an “abbreviated genealogy” of LGBTQ+ women’s (non)interpellation into HIV “risk discourse[s]” (Bacchi 2015a: 139; Race 2017: 104). In this chapter, I aim to establish that the dominant framing of LGBTQ+ in *The Seventh National HIV Strategy* and LOTL were not inevitable. As this chapter will argue, there are rich discursive histories to silence(s); ones which operate in symbiosis with particular power-knowledge relations (see Sedgwick 1990). Hence, in focussing on the discursive histories of LGBTQ+ women’s (non)constitution, it becomes evident that “things could have developed...differently” (Bacchi 2009: 10).

Following this analysis, in Chapter Six I will offer a brief analysis of the (few) moments in LOTL where LGBTQ+ women are explicitly spoken of in relation to HIV. To do this, I will supplement Carol Bacchi’s (2009; 2016 with Goodwin) WPR model with Giritli-Nygren and Olofsson’s (2014) performative theory of ‘risk’. Subsequently, this chapter will identify the incoherencies and emerging (re)productions of ‘risk’ that “survive at the margins” of discourse (Bacchi and Goodwin 2016: 22). It is, I will argue, in these alternate conceptions of ‘risk’ that LGBTQ+ women surface “*at the limits of intelligibility*” (Butler 2004, cited in Mitchell 2008: 427, emphasis in original).

I will then conclude this thesis with a brief consideration into whether it is desirable for LGBTQ+ women to become ‘visible’ in HIV discourse(s). This will be followed by an analysis of this thesis’ own “problem representation[s]”, which cannot be seen as objective, neutral observations, but rather as constitutive of the ‘reality’ it has sought to analyse (Bacchi and Goodwin 2016: 19).

Terminology

As a practical constraint, this thesis will exclusively concern women who identify as a sexual minority – for instance, lesbian, gay, bisexual, or queer. It will not include an extended analysis into how non-cisgender individuals (those whose gender identity does not match the sex they were assigned at birth) might be subjectivated by discourses of HIV. As some (queer) health scholars have argued, the discursive construction of non-

cisgender individuals is likely to differ greatly from their non-heterosexual counterparts (see Kaplan et al. 2016; Boellstorff 2011; Sevelius et al. 2016). This decision thus does not intend to comment on the essential nature of ‘woman’, but rather reflects my caution not to conflate the two within the confines of a Master of Research study. However, this thesis does implement the full LGBTQ+ acronym, in order to reflect the great number of trans* women who also identify as lesbian, gay, bisexual, and queer and are, hence, interpellated along these axes.

And finally, this thesis will refer, where appropriate, to HIV, AIDS, *and* HIV/AIDS. The slippage between each term was elected, first, to improve readability and, second, to reflect what Rosengarten has termed the recent “decoupl[ing]” of HIV and AIDS, following advancements in biomedical technologies (2009: 3).

CHAPTER ONE

Literature Review

This thesis intends to explore how LGBTQ+ women are constituted as particular kinds of (non)subjects in Australian HIV documents. As will be elaborated in Chapter Two, its contribution is, in part, theoretical and methodological. However, as an interdisciplinary study, it has also drawn extensively on the fields of health sociology, cultural studies, queer theory, and, to a lesser extent, medical anthropology. Due to the nature of a discourse analysis method, this thesis' review of the literature will be partly integrated with the analysis of case study materials. Hence, this chapter intends only to justify its research questions and theoretical approach within the literature on LGBTQ+ women and HIV, discursive silence(s), and (in)visibility. Further topics on risk, medicalisation, subjectivation, and HIV more broadly will emerge in Chapters Two, Three, Four, Five, and Six.

LGBTQ+ Women and HIV

In this section, the existing social science and humanities literature on LGBTQ+ women and HIV will be outlined to provide a brief delineation of its methodologies, arguments, and debates. There are however a number of difficulties in reviewing this literature. Perhaps most notable is the potential conflation of studies which refer to lesbian, gay, bisexual, trans*, queer, sexual minority, women who have sex with women (WSW), or other identity or behavioural categories. In their comparative analysis of the US National Survey of Family Growth (NSFG), Bauer and Jairam (2008), for instance, found that the health concerns of WSW differ greatly from those of LGB women. In turn, heterosexual, lesbian, and bisexual women experienced different "health risks" surrounding, in particular, STIs and tobacco use (Bauer and Jairam 2008: 401). Comparably, Chetcuti and colleagues (2012) have posited that WSW and 'women who have sex with men and women' (WSMW) have radically different experiences accessing healthcare services, with the former experiencing greater perceptions of institutional discrimination. Subsequently, both Bauer and Jairam (2008) and Chetcuti and colleagues (2012) have cautioned researchers against conflating multiple identity and/or behavioural categories. Hence, when possible, this thesis will use the author's terminology, in order to maintain transparency.

In the 1980s and 1990s, feminist scholarship on HIV/AIDS was pivotal in its critique of the heteropatriarchal systems under which women become constructed as particular kinds of subjects (see Richardson 1987; Patton 1994; Waldby 1996; Wilton 1997; Treichler 1999; Richardson 2000a).⁵ Heteropatriarchal systems, it was argued, were active in (re)producing dichotomous subject positions – such as ‘whores’/‘virgins’ or ‘good’/‘bad mothers’ – that position women only in relation to men (see Wilton 1997; Waldby 1996; Treichler 1999). For instance, when constructed as ‘whores’, women’s bodies are ‘uncontained’ and thus dangerous to both individual men and heteropatriarchal order itself (Wilton 1997). Yet as mothers, women are, above all, liable for ensuring that their children and fetuses remain healthy (Wilton 1997; Patton 1994). Subsequently, both Waldby (1996) and Wilton (1996) have suggested that the female (body) with HIV/AIDS is only represented as a carrier; never examined for her own illness, but only for her propensity to infect others. Under this construction, it was posited that LGBTQ+ women’s invisibility in HIV/AIDS discourses is, in part, due to their perceived detachment from both motherhood and masculine bodies (Richardson 2000a; Waldby 1996). It is this construction that I will explore in Chapter Three.

More recently, scholars have begun to investigate the lived effects of LGBTQ+ women’s invisibility in HIV discourses. Much of this literature has relied on a symbolic interactionist frame (see Dolan and Davis 2003; Dolan and Davis 2008; Power et al. 2009; Grant and Nash 2018), which aims to understand how individual behaviours are influenced by subjective understandings, “aris[ing] from social interactions and experience, as well as from culture” (Dolan and Davis 2003: 27). A number of studies have indicated that LGBTQ+ women perceive themselves to be at ‘low-risk’ of contracting HIV (Montcalm and Myer 2000; Fishman and Anderson 2003; Matebeni et al. 2013; Dolan and Davis 2003) and STIs more generally (Power et al. 2009; Marrazzo et al. 2005). In turn, others have delineated that LGBTQ+ women have an insufficient knowledge of ‘safer’ female-to-female sexual practices, including methods of barrier protection (Grant and Nash 2018; Logie et al. 2012; Power et al. 2009). Yet despite this,

⁵ In reference to these texts, I have excluded the ‘T’(rans*) from the LGBTQ+ acronym. This is, first, because many of these publications refer exclusively to lesbian and bisexual cisgendered women and, second, because some have taken an active stance against trans* women’s inclusion in HIV prevention information addressed to LGBTQ+ women. For instance, Tamsin Wilton (1997) commented on such inclusion in one sexual health booklet, stating “[i]t perhaps over-cynical of me to suggest that they had to get queer men in there *somehow?*” (1997: 95).

LGBTQ+ women and WSW continue to receive HIV testing (Chetcuti et al. 2012; Mooney-Somers 2017; Dolan and Davis 2008).

Others have demonstrated the difficulties for LGBTQ+ women in accessing HIV services and care. For instance, in their focus group study, Logie and colleagues (2012) found that LGBTQ+ women lacked tailored information and services regarding HIV prevention. In addition, female HIV support groups are often dominated by heterosexual women (Logie et al. 2012). Furthermore, Müller (2018) has argued in her interview-based study that queer individuals are often forced to render their identity ‘intelligible’ to healthcare professionals. Others have contended that WSW are less likely to receive “gynaecological care than WSWM and WSM”, in part, due to their fear of ‘coming out’ to their doctor (Chetcuti et al. 2012: 594). Subsequently, in the 2016 Sydney Women and Sexual Health Survey, more LGBTQ+ women (58%) reported to source sexual health information online than from a GP (53%) (Mooney-Somers et al. 2017). Still others have exemplified a quality and information deficit in health messages addressed to lesbian and bisexual women (Lindley et al. 2012; Faulkner and Lannutti 2016). For instance, Lindley and colleagues, in their content analysis on the “readability”, “volume[,] and scope” of online information pertaining to lesbian sexual health, have argued that such information is “often [both] incomplete and written at an advanced level” (2012: 474; 478).

Hence, much of the existing literature has conceptualised LGBTQ+ women’s relation to HIV as one of ignorance, whether in relation to medical practitioners, policymakers, epidemiologists, or LGBTQ+ women themselves. However, fewer have examined how such ignorances might operate in LGBTQ+ women’s subjectivation. In this next section, I will turn to critically examine the literature on ignorance(s) and discursive silence(s).

Agnotology, Silencing, and Invisible Subjects

Among the diverse scholarship on absence and invisibility is an emerging, interdisciplinary field surrounding “the study of ignorance” (Croissant 2014: 5). In 1995, Robert Proctor coined the term ‘agnotology’ to encapsulate this field, which he then expanded with Londa Schiebinger (2008) in their edited collection, *Agnotology: The Making and Unmaking of Ignorance*. In this volume, Proctor and Schiebinger (2008) argue for a taxonomy of ignorance, in order to illuminate the plurality of forms that ignorance can take. In one instance, cigarette companies might downplay the effects of smoking, which deliberately fosters ignorance among populations (Proctor and

Schiebinger 2008: 15). Yet in another, hiding planned terrorist attacks from the public can help quell national (and often irrational) anxieties (Proctor and Schiebinger 2008: 23). Elsewhere, Casper and Moore (2009) have used the term ‘exposure’ to encapsulate the degree to which bodies, lives, and losses are (in)visible in public perception. When bodies are rendered invisible (are ‘underexposed’), they remain ‘out of sight’ and lack the resources which they need to thrive (Casper and Moore 2009: 80). Conversely, when bodies are rendered too visible (are ‘overexposed’), they can become attached to a rhetoric of risk, blame, and danger, which can make their lives unliveable (Casper and Moore 2009: 80). Such an analysis does not necessarily entail a pre-discursive conceptualisation of the body but enables us to attend to the techniques (for instance, censuses and official statistics) through which (in)visibility is produced (Casper and Moore 2009).

Following Proctor and Schiebinger (2008), Blake Scott has elaborated on a taxonomy of ignorance, separated into four distinct categories: “known unknowns”; “known knowns”; “unknown knowns”; and “unknown unknowns” (2016: 3). While Scott’s (2016) focus is on developing a Žižekian understanding of ‘unknown knowns’, my interest lies in his conception of ‘known unknowns’ and their relation to LGBTQ+ women’s position in the knowledges of HIV. In Scott’s taxonomy, ‘known unknowns’ constitute a form of “conscious ignorance”, which we should seek to overcome (2016: 4). However, Scott’s (2016) use of the term ‘conscious’ elicits a reading of ignorance as an epistemological gap - for instance, a ‘gap’ in the literature – which promotes an understanding of knowledge as cumulative and objective. I argue that this reading does not allow for the complex power-knowledge relations that constitute knowledge; it does not attend to what is ‘(un)thinkable’ in any given scenario.

Instead, in the first volume of *The History of Sexuality*, Michel Foucault (1990) argued that silence(s) are multiple and operate alongside power-knowledge relations; always-already “circulat[ing] as particular regimes of truth” (Sedgwick 1990: 8; Sedgwick 1993). For instance, Eve Sedgwick (1990) has contended that forms of not-knowing can function to maintain particular gendered inequalities, through their focus on male ignorances in sexual assault cases. Here, male (non)knowledge of their female partner’s consent operate as the privileged statement; thus, delegitimising women’s bodily autonomy (Sedgwick 1990). Following this theoretical trajectory, Dahl has favoured the verb ‘silencing’ to the

noun ‘silence(s)’ in her study of elderly care, in order to maintain her focus on ongoing practices, rather than on fixed occurrences (2017: 90).

Extending on this Foucauldian frame, Sarah Lambie has directed her attention toward particular enactments of non-knowledge in one legal case “involving the police raid of a women's bathhouse” in Toronto, Canada (2009: 112). Here, Lambie identifies instances of “careless thinking”, “limited thinking”, and “refusal[s] to know” which, she argues, have been crucial in the regulation of lesbian and transgender subjects (2009: 119). Hence, while Mitchell Dean (1999) has contended that visibility is a necessary precursor to particular governing techniques, Lambie queries:

“But what if unknowing or limited knowing also function as regulatory techniques? How might discourses of ignorance work to produce certain kinds of subjects, orders and power relations” (2009: 188).

Subsequently, she posits that this ‘unthinkability’ of lesbian and transgender bodies and desires can “foreclose particular questions before they are even asked” (Lambie 2009: 124). In such instances, “silence[s] [function as] a ‘constitutive outside’” to discourse, which necessarily define its boundaries of (il)legibility (Dahl 2017: 94). Thus, as Dahl has argued, it is imperative that we focus on these “silencing practices”, in order to avoid “overlook[ing]” particular struggles (2017: 103; 162).

Theorising Absence: (Un)Intelligibility and Symbolic Annihilation

In health research, Alex Müller has recently offered a “queer critique of [the term] invisibility”, which, she states, does not probe far enough into “the epistemological and structural” drivers of a heteronormative healthcare framework (2018: 4; 20). Instead, she has suggested that invisibility should be examined along two interconnected axes: ‘unintelligibility’ and ‘symbolic annihilation’ (Müller 2018). In this final section, I will examine Müller’s (2018) distinction before offering this thesis’ theoretical trajectory.

(Un)Liveability and (Un)Intelligibility

In recent decades, queer theorists have raised particular concern over the degree to which queer lives are (un)liveable.⁶ For Sara Ahmed, this project is encapsulated in her concept

⁶ Judith Butler’s (2004) *Undoing Gender* is often attributed to the term ‘(un)liveability’.

of a 'bearable life': "a bearable life is a life that we can bear...[t]he unbearable life 'breaks' or 'shatters' under the 'too much' of what is being borne" (2010: 97). In this affective account, liveability is born through a relationship between a "subject", who must bear the conditions of their own life, and "the world", which determines the load that must be borne (2010: 97). For Ahmed, it is through the queer subject's relation to happiness – and, in particular, the happiness of others – that their life becomes, to use Judith Butler's term, "viable" (Butler 2004: 2; Ahmed 2010). In a slightly different vein, Butler's (2004) notion of an (un)liveable life is tied to forms of recognition; contingent, that is, on the subject's (un)intelligibility in particular (gender) norms. While this distinction is particularly pertinent to this thesis' analysis, I will direct attention toward the latter in this review.

Following J. L. Austin, Judith Butler has argued that gender is a performative enactment, which necessarily "produce[s] that which it declares" (1993: 107). For instance, an essential ideal of 'femininity' does not exist prior to one's gendered performance, but rather is (re)produced in and through such enactments (see Butler 1990; 1993). In addition, gender is always performed in relation to others and, "in part, without one's knowing and without one's willing" (Butler 2004: 1). For Butler, intelligibility is, then, endowed through entry into the 'heterosexual matrix'; that is, the "grid" wherein "bodies, genders, and desires are naturalized" (1990: 208). In Western societies, this naturalisation has relied on a normative coherency between one's 'material' sex (as male or female) and one's gendered performance (as masculine or feminine) (Butler 1990).

For Müller (2018), the heterosexual matrix is both (re)produced in and (re)productive of healthcare systems. As an exemplar, Müller details the experiences of her participant Dineo: a "butch-identifying black lesbian" who is dating a "femme-presenting" woman (2018: 20). In one interview, Dineo remarks that her healthcare provider does not refer to both herself and her partner as lesbians. Instead, Dineo is depicted as a butch lesbian, "possessing an imagined penis", and her partner is referred to as a female non-lesbian (Müller 2018: 8). It is in this heteronormative reconfiguration of Dineo's relationship that her queerness is rendered unintelligible (Müller 2018).

While this thesis does incorporate Müller's (2018) distinction between (un)intelligibility and symbolic annihilation, it will also engage with Judith Butler's (1993; 2004) notion of resignification (explored further in Chapters Three and Six). In Müller's (2018) account,

unintelligible subjects are provided with an ultimatum: to remain silent about their queerness or continually work to render themselves intelligible. Alternately, in what Youdell has termed a “*politics in subjectivation*” (2006: 526, emphasis in original), Butler (2004) has argued that it is within such spaces that agency becomes possible. It is here that subjects have the radical, subversive, and political potential to problematise claims to essentiality and to redo – or resignify – the norm (see also Mitchell 2008). For instance, Butler positions drag as subversive in its ability to, first, illuminate the ways that gender (re)produces itself and, second, critique “heterosexuality’s claim on naturalness and originality” (Butler 1993: 85).

Symbolic Annihilation

Symbolic annihilation was first referenced, albeit briefly, by communications theorist George Gerbner in 1972. He stated, “[r]epresentation in the fictional world signifies social existence; absence means symbolic annihilation” (Gerbner 1972: 44). For Gerbner (1972), hegemonic social values (and the positions of those who are socially valued) are particularly reflected in the representations of violence in the ‘fictional world’ of television. Six years later, Gayle Tuchman (1978) adopted the term in her introduction to *Hearth & Home: Images of Women in the Mass Media*. Influenced by the second-wave feminist movement, Tuchman (1978) was primarily concerned with the (mis-)representations of women in mass media and their subsequent effects on female socialisation (i.e. the way in which girls are ‘taught’ to behave). In her renewed, feminist application of Gerbner’s (1972) approach, she extended his definition to encompass three *kinds* of symbolic annihilation: ‘absence’, ‘trivialisation’, and ‘condemnation’ (Tuchman 1978: 8).

While arising in the 1970s, the term ‘symbolic annihilation’ has received relatively little scholarly attention; confined mostly to communications and media studies. Alex Müller’s (2018) study is one example of its expansion into health scholarship. In conducting in-depth interviews with both “healthcare users” and “representatives of...[LGBTI] organisations”, Müller provides instances of her queer participants’ ‘absence(s)’, ‘trivialisation’, and ‘condemnation’ within the South African healthcare system (2018: 5). First, queer sexual practices are erased from sexual health information; their non-existence constituting an ‘absence’ (Müller 2018). Second, the (sexual) health concerns of LGBTQ+ women become ‘trivialised’ when healthcare professionals remain indifferent to their anxieties (Müller 2018). And, third, patients become ‘condemned’ when, for

instance, one healthcare provider refused to believe that men could be raped, stating “[w]hy didn’t you fight back?” (Müller 2018: 23). For Müller (2018), such excerpts clarify the urgent need for structural interventions into South African healthcare systems.

Müller’s (2018) interrogation into instances of structural violence is echoed throughout the literature on LGBTQ+ women and HIV. In particular, Carmen Logie has emphasised the role of intersectional stigma and discrimination in LGBTQ+ women and WSW’s relation to HIV (see Logie et al. 2015; Logie et al. 2017; Logie and Gibson 2013; Logie et al. 2012). Under an intersectional approach, oppressions are deemed to occur within a “matrix of domination” and are both co-constitutive and inextricable from one another (Collins 2000: 18). For instance, Logie (2015) has contended that queer women’s position in HIV discourses is obscured in the “neoliberal and biomedical discourses” that permeate HIV research (2015: 535). Elsewhere, Logie and colleagues have posited that LGBTQ+ women’s ‘social exclusion’ can result in particular “silencing practices” (Dahl 2017: 103), leading to their participant’s feeling that they “don’t exist” (2012: 4).

Hence, while Müller (2018) does not explicitly refer to its brutality, the violence(s) enacted by symbolic annihilation extend beyond their representation on television; beyond the symbolic. For instance, Logie and Gibson (2013) have taken Judith Butler’s following passage on unintelligibility as their point of departure:

“[v]iolence against those who are already not quite lives, who are living in a state of suspension between life and death, leaves a mark that is no mark” (2004: 24).

From this standpoint, they argue that when an LGBTQ+ woman contracts HIV from an instance of (homophobic) sexual assault, its ascription as ‘heterosexual’ in epidemiological categories obscures both its “violence [and its] ...non-heterosexuality” (Logie and Gibson 2013: 33). It is in this moment of categorisation that the “[d]iscursive regulation” of LGBTQ+ women’s visibility in epidemiology takes place (Logie and Gibson 2013: 32).

Yet despite its efficacy in identifying structural violence(s), Müller’s (2018) use of the term ‘symbolic annihilation’ rests somewhat uncomfortably alongside a poststructuralist frame of (un)intelligibility. To question the (under-)representation of any given group is to assume the existence of a subject, prior to their (con)textual depiction. In contrast,

Butler's (2004) conception of (un)intelligibility relies on a subject that is constituted in their discursive (non)recognition.

However, this critique, I argue, does not render symbolic annihilation obsolete for this thesis nor wholly incompatible with an analysis of (un)intelligibility. Indeed, to be symbolically annihilated is not always to be rendered unintelligible. For instance, while Tuchman (1978) argued that financially stable, employed women were symbolically annihilated from 1970s television, this does not mean that such women were rendered unintelligible in discourse. Instead, this thesis will argue that modes of symbolic annihilation and (un)intelligibility operate in tandem; with the former often working to sustain the latter. Here, Müller's (2018) focus on identifying tangible moments of 'absence' insightfully attends to the ways that methods of "dividing people" can enact particular violences (Bacchi 2009: 135).

Conclusion

The existing literature in health sociology, cultural studies, queer theory, and, to a lesser extent, medical anthropology has powerfully illuminated the lived effects of LGBTQ+ women's invisibility in HIV discourses. However, to my knowledge, no studies have interrogated the ways in which LGBTQ+ are (re)produced as certain kinds of subjects in Australian Government policy and LGBTQ+ print and online media.

In Chapter Two I will argue that Carol Bacchi's 'What is the Problem Represented to Be?' (WPR) methodological tool, which operates through a Foucauldian analysis of problematisations, is particularly suited to identifying the discourses and "silencing practices" that enable LGBTQ+ women to become symbolically annihilated and rendered (un)intelligible in Australian HIV documents (Dahl 2017: 103).

CHAPTER TWO

Methods

Methodology

This thesis was conducted using Carol Bacchi's (2009; 2016 with Goodwin) poststructuralist model of policy analysis, entitled 'What is the Problem Represented to Be?' (WPR). Often, 'traditional' methods of policy analysis rest upon one positivist assumption: that in devising particular solutions, policy-makers are simply responding to tangible and objective social problems (for instance, drug [ab]use) (Bacchi and Goodwin 2016: 7). The WPR approach does not deny the existence of such 'issues' (Bacchi and Goodwin 2016). Rather, it suggests that the 'solutions' provided within policy necessarily "produce 'problems' as particular kinds of problems" (Bacchi and Goodwin 2016: 4). Researchers are implored to "work backwards" from the document's advised solutions in order to determine the "problem representation" as it inheres within the policy proposal (Bacchi and Goodwin 2016: 16; 11; 17).

By policies, Bacchi (2009) is referring to a Foucauldian conception of 'practical texts'; that is, those that aim to produce a particular effect in the "conduct" of its audience (Foucault 1992: 12). This definition thus incorporates a range of documents which might not otherwise be considered 'policies'.⁷ Drawing on the scholarship of Michel Foucault, subsequent analysis "consists in seeing on what type of assumptions, of familiar notions, of established, unexamined ways of thinking the accepted practices are based" (Foucault 1994, as cited in Bacchi 2015b: 2-3). In doing so, seemingly fixed problems can become destabilised, and we might begin to "think otherwise" (Bacchi and Goodwin 2016: 22).

Following Foucault's (1982) theoretical emphasis on subjectivation, Bacchi's (2009; 2016 with Goodwin) methodological concern lies in how governing transpires through 'problematizations'. Inspired by the work of Annemarie Mol, the WPR approach foregrounds a theory of "enactment" over one of "constructi[vism]" (Law 2004: 55). Constructivism is *done* in the past-tense (Law 2004: 55). While this position sees "subjects" and "objects" as brought into being through social processes, they are taken to

⁷ For instance, others have used the WPR approach to analyse campaigns (Nielson and Bonham 2015), symposia (Månsson and Ekendahl 2015), and websites (Marshall 2012) *as* policies.

become ‘fixed’ over time (Mol 2002, cited in Law 2004: 56). Enactment, on the other hand, positions “subjects” and “objects” as being always-already constituted through practices (Mol 2002, cited in Law 2004: 56). Meaning is thus always in flux; reliant on its continual (re)production. Hence, Bacchi’s focus is on “processes” – for instance, of ‘gendering’, ‘classing’, and ‘sexualising’ – analysed in conjunction with particular social categories – such as ‘drug (ab)users’ – which act to (re)produce individuals in an array of subject positions (Bacchi 2017: 20; 21).

Accordingly, Bacchi has developed six questions, designed to guide researchers through the WPR approach:

1. What’s the problem represented to be in a specific policy or policies?
2. What deep-seated presuppositions or assumptions underlie this representation of the ‘problem’?
3. How has this representation of the ‘problem’ come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the ‘problem’ be conceptualized differently?
5. What effects (discursive, subjectification, lived) are produced by this representation of the ‘problem’?
6. How and where has this representation of the ‘problem’ been produced, disseminated and defended? How has it been and/or how can it be disrupted and replaced?
7. Apply this list of questions to your own problem representations.

(Bacchi and Goodwin 2016: 20)

These questions enable a methodological framework that draws on both Foucault’s earlier archaeological (see Question 2) and later genealogical (see Questions 3 and 4) scholarship (Goodwin 2010).

Subjectivation⁸

Bacchi’s conception of subjectivation, while insightful in its vision of ‘(un)making subjects’, is limited – for this thesis’ aims – in its strict adherence to Foucauldian theory (Bacchi and Goodwin 2016: 69). For Foucault, subjects are simultaneously repressed and

⁸ Elsewhere termed ‘subjectification’.

produced through power-knowledge regimes: both subjected and subjectivated (Butler 1997: 83). Here power is not conceived as an object and cannot be possessed by any one individual, party, or organisation (Bacchi and Goodwin 2016). Instead, power circulates through discourse(s) and, in turn, resistance can only occur from practices “at the micro-level” (Bacchi and Goodwin 2016: 31). In particular, Foucault’s theory of resistance has been productive in identifying how GBQ+ men have enacted a ‘reverse discourse’ of (male) homosexual sex (see Wilton 1997). That is, by using “the same categories by which [they] were medically disqualified”, they have been able to perform a radical resignification of their practices, bodies, and identities (Foucault 1990: 101; Wilton 1997).

However, while Foucault’s oeuvre (and, in particular, his later work) has provided us with an insight into modes of subjectivation; the place of the *unintelligible* subject remains undertheorised in his interpretation. Indeed, for Bacchi (2009; 2016 with Goodwin), silence(s) are identified by attending to what is *not* problematised in any given document. This practice is productive in its potential to examine how “silencing practices” function as part of particular power-knowledge regimes (Dahl 2017: 103), but it does not enable a theorisation of resistance from such positions. Hence, in order to follow this line of inquiry, this thesis will supplement Bacchi’s (2009; 2016 with Goodwin) WPR approach with Judith Butler’s (1993; 1997) theory of performative resignification, through her reading of Althusser.

Althusser’s (2008) theory of subjectivation occurs on the footpath: an individual is walking down the street and behind them a policeman calls out “hey you”; the subject turns toward the policeman. In this act of turning toward the policeman, the individual recognises that the call was intended for them and, in turn, becomes a subject of the law (Althusser 2008). As Judith Butler has elaborated, the individual is not obliged to turn toward the ‘hailing’, but “it is compelling...because it promises identity” (Butler 1997: 108). Yet she argues that interpellation is not always a straightforward “unilateral” practice (Butler 1993: 82). Instead, the call might be rejected – the individual might continue walking without turning their head – or the ‘wrong’ individual might answer; might become the subject for which they were not intended (Butler 1993). It is, then, through this alternate occupation of subjectivity that the subject’s performance can produce “a repetition of the law into hyperbole, a rearticulation of the law against the authority of the one who delivers it” (Butler 1993: 82). Hence, Butler’s interest is in the

moments of disruption between the performative intention and its actual effect, which enable forms of “*disobedience*” to arise (1993: 82, emphasis mine). It is in this alternate occupation of the norm that Butler (2004) argues we might unsettle particular regimes of power-knowledge and produce alternate modes of being.

Research Questions

This thesis aims to investigate how LGBTQ+ women are constituted as particular kinds of subjects in Australian HIV documents. As a comparative analysis, it further intends to delineate how these subject positions might be (re)produced, (re)negotiated, or potentially subverted within and between Australian Government policy and LGBTQ+ media documents. This will rely on the following research objectives:

1. To understand how HIV is problematised in Australian Government policy and LGBTQ+ media documents.
2. To describe how these problematisations (do not) subjectivate LGBTQ+ women.
3. To consider how such problematisations and modes of subjectivation might be (re)negotiated, (re)produced or subverted within and/or between Australian Government policy and LGBTQ+ media documents.

In particular, the WPR approach has gained significant traction in drug and alcohol research (see Pienaar et al. 2018; Seear and Fraser 2014; Moore and Fraser 2013; Bacchi 2015a). In Australian HIV research, Kane Race has used a similar focus on problematisations to explore the symbiosis between scientific practices and “the sexual and other” enactments they take as their object of concern (2017: 21). Hence, while the problematisations in this thesis are not entirely unexpected, I argue that it is important to examine such enactments, in light of LGBTQ+ women’s specific relation to HIV.

Data Collection and Sampling

This thesis relied on two sources of data: the *Seventh National HIV Strategy* (2014-2017) and a Sydney-based magazine, *Lesbians on the Loose* (LOTL).

The Seventh National HIV Strategy

Released in 2014 under the Abbott Coalition Government, *The Seventh National HIV Strategy* (2014-2017) is the seventh iteration of the Australian Government’s national,

non-partisan policy response to HIV (Department of Health 2014).⁹ The National HIV Strategies are currently released every four years under the Department of Health and intersect with four other Australian Government strategies: *The National Hepatitis B Strategy*; *The National Sexually Transmissible Infections Strategy*; *The National Hepatitis C (HCV) Strategy*; and *The National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy*.

Since their inception in 1989, the National HIV Strategies have been developed under an innovative “partnership between affected communities, professional and community organisations, government, researchers and health professionals” (Department of Health 2014: 12). Yet due to a division of governmental responsibility, the National HIV Strategies are responsible only for directing partners toward a series of common goals, objectives, and targets (Department of Health 2014). These are then actualised under individual State and Territory HIV Strategies, which direct government resources and assign each policy output its accountable ‘partners’. Due to this combination of factors, *The Seventh National HIV Strategy* influences and is influenced by an array of stakeholders, thus, making it the most appropriate selection in lieu of a more comprehensive sample, which would not be permitted under the Master of Research. At the time of writing, *The Seventh National HIV Strategy* was publicly available at no cost on the Australian Government Department of Health’s website.

Lesbians on the Loose (LOTL)

Founded in 1989, *Lesbians on the Loose* (LOTL) is the largest LGBTQ+ women’s magazine in Australia. The rationale behind its development was twofold: it aimed, first, to provide a social calendar for the Sydney lesbian community and, second, to contribute to a field of Australian journalism, written by and for lesbian women (Calder 2016). While LOTL’s print magazines are available in all Australian states and territories, its readership is concentrated in NSW (55%) (LOTL 2014a). LOTL further produces both print magazines and online articles, the latter advertised at those who “can’t always wait for their next issue” (LOTL 2014b). In recent years, LOTL’s print magazine has undergone changes in publications. Prior to 2016, LOTL was published monthly. Then, between January 2016 and December 2017, it was published once every two months.

⁹ The Coalition (or LNP) describes a partnership between two centre-right Australian parties: the Liberal Party of Australia and the National Party of Australia.

These editions were free; subsidised by advertising revenue alone and available from inner-city LGBTQ+ women's venues (Calder 2016).

This thesis' data corpus includes all print and online pages in LOTL that were published between 1 January 2014 and 31 December 2017 and contain the words 'HIV' and/or 'AIDS'. For print articles, the terms 'HIV' and 'AIDS' were entered into the 'search function' of LOTL's online archive (www.lotl.com/Digital-Archive/). Similarly, for online articles, each term was entered into the search bar on LOTL's website (www.lotl.com). Search results were then manually selected, including all material with reference to HIV/AIDS and eliminating those which only incidentally contained the letters 'HIV' or 'AIDS', for example 'arcHIVe'. Subsequently, 32 pages of print magazine and 84 pages of online material were downloaded in PDF format into NVivo 11. A one-year digital subscription of \$17 was purchased and archival access was provided manually after I emailed their Operations and Subscriptions Manager.

Data Analysis

This thesis relies on an unobtrusive "analysis of discourses", analysed under Carol Bacchi's WPR approach (2005: 199). Unlike certain iterations of Critical Discourse Analysis, the WPR approach defines 'discourse' as "socially produced forms of knowledge", which constitute 'objects', 'subjects', and 'problems' in particular ways (Bacchi and Goodwin 2016: 35). To conduct this analysis, I first imported all data into NVivo v.11. All data then underwent five rounds of open coding, where I identified each text's solution to the 'problem' of HIV and hence its subsequent "problem representation" (Bacchi and Goodwin 2016: 19). For instance, if the solution is to reconcile GBQ+ men's 'risky' behaviours, then the 'problem' is deemed to inhere in the actions of GBQ+ men. Following this identification, this series of open codes was organised into themes and grouped with texts that offered similar problematisations. Questions 2 through 6 of Bacchi's WPR method (presented above) were then applied to the texts within each thematic category.

As an ethical responsibility, Bacchi has emphasised the importance of undertaking practices of 'self-problematisation' (Bacchi 2012; Bacchi and Goodwin 2016). Under the WPR approach, researchers are not objective analysts (Bacchi and Goodwin 2016). Rather, our interpretations, proposals, and conclusions are historically and culturally contingent; necessarily stemming from the societies in which we are rooted (Bacchi

2016). Thus, Bacchi (2009; 2016 with Goodwin) recommends implementing her six questions (identified above) to one's own analysis once an initial draft has been completed. Engaging in practices of 'self-problematization' enable us to maintain transparency as we contribute to an "ontological politics", in which our own research constitutes the 'reality' it seeks to analyse (Mol 1999 cited in Bacchi and Goodwin 2016: 44). This exercise was included in the conclusion to this thesis.

Limitations

The WPR approach is limited in its ability to examine practice; that is, the implementation and reception of a particular policy proposal. Instead, this thesis could have relied on a more conventional form of policy analysis, which might question how LGBTQ+ women interact with HIV policy outputs. However, I argue that WPR's focus on problematisations provides this thesis with a unique entry point into a consideration of how LGBTQ+ women are governed in contemporary Australian Government and LGBTQ+ media documents.

And finally, this thesis does not, and cannot, intend to speak from the position of LGBTQ+ women living with HIV or AIDS. Nor does it claim to account more broadly for the ways in which LGBTQ+ women living with (or around) HIV are interpellated. Rather, LGBTQ+ women are relentlessly pushed and pulled; hailed from multiple locations that differ dependant on their standpoints. Hence, this thesis can only examine how LGBTQ+ women are spoken to as particular kinds of (non-)subjects in two data sources, analysed from the perspective of one white, female, and queer researcher. As Bazzul has suggested, citing Lather, such an analysis cannot tell us who LGBTQ+ women *are*, but it can ask "who these [documents] *think* we are" (Lather 2012 cited in Bazzul 2016: 15, emphasis mine). But it is indeed these 'thoughts' that might contribute to our constitution.

CHAPTER THREE

The Seventh National HIV Strategy

In this chapter I argue that LGBTQ+ women are both symbolically annihilated and rendered unintelligible through the ways in which HIV is problematised in *The Seventh National HIV Strategy* (2014-2017) (hereafter referred to as ‘the Strategy’). To do this, I will first provide a brief history of HIV/AIDS in Australia, in order to contextualise the Strategy. Second, I will demonstrate how LGBTQ+ women have been symbolically annihilated from epidemiological presuppositions of who is constituted as ‘at-risk’ of contracting HIV. It is, I will argue, through a “refusal to know” LGBTQ+ women’s desires, identities, and practices that this symbolic annihilation takes place (Lamble 2009: 124). And third, I will implement Carol Bacchi’s (2009; 2016 with Goodwin) ‘What is the Problem Represented to Be?’ (WPR) methodological device in order to undertake a detailed analysis of the ways in which HIV has been problematised in the Strategy. From this standpoint, I will examine the presuppositions upon which the problematisations are based; the kinds of subjects that are ‘called’ into being; and the forms of thinking that become silenced through its particular representation of the ‘problem’. Subsequently, I will argue that the Strategy’s reliance on a neoliberal implementation of health promotion, combined with an appraisal of ‘evidence-based’ epidemiological knowledges, work to render LGBTQ+ women unintelligible as medical subjects of HIV.

HIV/AIDS in Australia: Contextualising the Strategy

Australia’s response to HIV/AIDS is commonly hailed as the international ‘gold standard’ (Ballard 1998). This success is mainly attributed to the groundwork of gay communities in creating effective, sex-positive prevention practices (Kippax and Stephenson 2016; Brown et al. 2014). In addition, government funded prevention campaigns were released early in the epidemic and formulated in conjunction with ‘at-risk’ communities (Kippax and Stephenson 2016). As noted by Leonard, materials that combine explicit sexual portrayals of GBQ+ men and/or ‘gay’ colloquial language have been highly effective in producing a “shared gay male identity”, surrounding safer sexual practices and “based on an ethics of mutual care and support” (2012: 835). Moreover, Australian HIV educators were sensitive to emerging practices of safe sex within gay

communities, such as ‘negotiated safety’ and ‘strategic positioning’ (Race 2009: 146; Kippax et al. 2013; Aggleton and Parker 2015).

Following this early success, Australia’s HIV transmission rates have remained comparatively low and “concentrated” among GBQ+ men and men who have sex with men (MSM) (Kippax and Stephenson 2016: 47). For instance, in 2012 an estimated 47,989 new HIV diagnoses were confirmed in the United States (1.5 per 10,000 population) (Centers for Disease Control and Prevention 2014: 18-19); 6,360 in the United Kingdom (“1.0 per 10,000 population”) (Aghaizu et al. 2013: 8); and 1,253 in Australia (0.6 per 10,000 population) (The Kirby Institute 2013: 11). In addition, Australia has maintained high rates of antiretroviral therapy (ART) uptake and adherence. In 2012, 88% of people living with HIV/AIDS (PLWHA) in Australia were on ART and, of those, 88% had an undetectable viral load (The Kirby Institute 2013: 31). Despite this, Australia’s 2012 diagnostic rate signalled a dramatic (10%) increase from the previous year (The Kirby Institute 2013). This increase was evident in both “gay [male] communities” and other “emerging epidemics”, surrounding, for instance, individuals “travelling to and from countries with high HIV prevalence” (Brown et al. 2014: 35).

Epidemiology and the Presupposition of ‘At-Risk’ Subjects

Theorising Risk: Governmentality and ‘The Body Politic’

In health sociology, it has been widely accepted that risk categories are necessary for reducing the incidence of HIV transmission. They enable governments, researchers, and public health practitioners to manage time, money, and drugs, and allow “comparisons [to be made] across time and space” (McKay 2016: 902). When tied to prevention campaigns, risk categories are extremely effective in targeting specific sub-groups that may otherwise be irresponsive to population-wide advocacy work (see Leonard 2012; Wilton 1997). Yet this acceptance has not been without interrogation nor critique. ‘Sociocultural’ approaches toward ‘risk’ have interrogated both the construction and implications of purportedly ‘natural’ categories (see Lupton 2013). In her germinal book, entitled *Risk*, Deborah Lupton (2013) identifies three such approaches: a ‘cultural-symbolic’ perspective, exemplified by the anthropologist Mary Douglas; a ‘risk society’ standpoint, propagated by Ulrich Beck and Anthony Giddens; and a ‘governmentality’ approach, developed by Michel Foucault. This thesis will employ the latter, which is most common among poststructuralists due to its ‘strong social constructionist’ orientation

toward power-knowledge relations (Lupton 2013). In this section I will, first, outline Foucault's use of the terms 'governmentality' and 'biopower', second, examine their critique from within feminist cultural theory and, third, demonstrate their application in the Strategy.

Foucault (2007) first coined the term 'governmentality' in his 1977-1978 lecture series at Collège de France. In these lectures, 'governmentality' might best be understood as the "ensemble" of techniques that have enabled forms of 'biopower' to persist in contemporary Western societies (Foucault 2007: 108). In privileging "political economy as its major form of knowledge, and apparatuses of security as its essential technical instrument", governance is enacted at the population level, rather than at the individual level (Foucault 2007: 108). Subsequently, individuals are constituted as 'entrepreneurial' subjects, who perform a "voluntary compliance with the interests and needs of the state" (Lupton 2013: 118). For instance, in HIV research, epidemiology has enabled us to identify the 'normal' rate and dispersion of disease across populations (Foucault 2007). This has allowed for a more targeted form of prevention, aimed only at those deemed most 'at-risk' and calculated against the population norm (Foucault 2007).

For Catherine Waldby (1996), forms of biopower are encapsulated in 'the body politic'. Like Foucault, Waldby (1996) does not understand 'the body politic' as the compilation of individual subjects into one coherent population but, rather as a 'population body', distinct as an entity in itself. However, while Waldby (1996) agrees with Foucault that health has become one 'knowledge' through which 'the body politic' is produced, she critiques his conceptualisation for lacking a theory of sexual and gendered difference. Drawing instead on Moira Gatens, she argues that 'the body politic' has been sexed as male (Waldby 1996). As a consequence, women (and other non-masculinised subjects) become omitted from productions of 'the body politic' and political interests become synonymous with those of the hegemonic male (Waldby 1996). The masculinised body, then, "presents itself as a sex-neutral 'human' body" around which all interests of health are organised (Waldby 1996: 93). Hence for Waldby (1996), 'risk' is (re)configured along gendered and sexual lines; (re)producing and (re)produced by heteropatriarchal discourses. It is at this intersection of feminist cultural theory and governmentality studies that this thesis will understand LGBTQ+ women's '(non)risk' toward HIV.

'Priority Populations' in the Strategy

The Strategy identifies eight ‘priority populations’ in the Australian HIV landscape (see Table 1.). These may be separated into three categories: people living with HIV; groups that have sustained high rates of HIV transmission (i.e. gay men and other men who have sex with men, people from high HIV prevalence countries and their partners, and travellers and mobile workers) and groups within which an outbreak is feared (i.e. Aboriginal and Torres Strait Islander people, sex workers, and people who inject drugs). In this “dividing practice” (Bacchi 2015a: 139), ‘risk’ is implemented as a technology of governance; subjectivating individuals into neoliberal discourses that aim “to discipline the future” (explored later in this chapter) (Ewald 1991 cited in Lupton 2013: 118).

Table 1: ‘Priority Populations’ in the <i>Seventh National HIV Strategy</i>
People Living with HIV
Gay Men and Other Men Who Have Sex with Men
Aboriginal and Torres Strait Islander People
People from High HIV Prevalence Countries and Their Partners
Travellers and Mobile Workers
Sex Workers
People Who Inject Drugs
People in Custodial Settings

(Department of Health 2014: 13)

Like all categorisations, there are a number of potential epidemiological ‘risk’ groups absent from this framework. The most striking is, perhaps, ‘heterosexual individuals’ or ‘men who have sex with women’ (MSW) and ‘women who have sex with men’ (WSM), who comprised 15% of new Australian HIV diagnoses in 2012 (The Kirby Institute 2013). In particular, heterosexual men and other MSW remain unnamed in the Strategy, even when heterosexual women and other WSM are foregrounded – for instance, as ‘people from high HIV prevalence countries and their partners’. However, while the “homosexual history” of Australian HIV discourses has had profound, lived effects for heterosexual men living with HIV/AIDS (see Persson 2012: 312), their absence in the Strategy differs radically from that of LGBTQ+ women. Heterosexual men are not depicted as ‘carriers’ of the HIV virus, but “are rather the ultimate end point of infection” (Waldby 1996: 109). It is this eventual transmission of HIV to the ‘general population’ that epidemiology aims to prevent (Waldby 1996).

Similar to the Centre for Disease Control and Prevention (CDC) (Dworkin 2005; Fishman and Anderson 2003; Arend 2005; Logie and Gibson 2013), The Kirby Institute (2017b) in Australia has produced a flowchart, used by health practitioners to determine how an individual likely became infected with HIV. For women, exposure categories range from vertical transmission (i.e. mother to child), to IV drug use, and ‘heterosexual sex’ (The Kirby Institute 2017b: 96). Under the “same sex exposure pathway”, if the individual is female and does not use IV drugs, her HIV transmission is recorded as ‘undetermined’ (The Kirby Institute 2017b: 97). Moreover, if a woman reports to have had “sexual contact with people of both sexes” and is not an IV drug user, her transmission is recorded as ‘heterosexual’ (The Kirby Institute 2017b: 98). As Bloor (1995) has noted, such hierarchical flowcharts force medical practitioners to assume that an instance of HIV transmission has occurred from ‘high-ranking’ sources of exposure which, in turn, reproduces the legitimacy of such hierarchies. It is through this epidemiological practice that LGBTQ+ women are symbolically annihilated from HIV discourse; produced as heterosexual, else erased and rendered an ‘unknown’ other (see also Logie and Gibson 2013).

Indeed, LGBTQ+ women might be living with HIV, be Aboriginal or Torres Strait Islander, originate from a high HIV prevalence country or have a partner who does, travel, be a mobile worker, be a sex worker, inject drugs, or live in a custodial setting. However, women cannot be classified under two or more exposure categories: they cannot, for instance, identify as heterosexual *and* an IV drug user, have sex with men *and* identify as LGBTQ+. As Logie and Gibson have argued, if LGBTQ+ are to be included in HIV discourses, “their queerness must be subsumed” (2013: 32). Hence, while it is likely that few LGBTQ+ women contract HIV in Australia each year, their symbolic annihilation is not simply the unfortunate result of an intense focus on other population groups; a consequence of “inattention” (Proctor and Schiebinger 2008: 7). Instead, it is only through an epidemiological “refusal to know” their desires, practices, and identities that categories of ‘risk’ might be sustained (Lamble 2009: 124).

What is the ‘Problem’ of HIV Represented to Be?

At the heart of Carol Bacchi’s ‘What is the Problem Represented to Be?’ (WPR) approach is the identification of a ‘problem representation’, followed by an interrogation of its presuppositions, discursive histories, silences, and effects (Bacchi and Goodwin 2016:

23). While the WPR method can be undertaken “systematically”, with each question answered individually, I have adopted a thematic, “integrated” approach (Bacchi 2009: 128). In addition, this chapter can only interrogate a small number of the Strategy’s “problem representations” (Bacchi and Goodwin 2016: 24). Hence, I have chosen only to focus on those which hold particular salience for the *gendering* and *sexualising* practices that are pertinent to LGBTQ+ women’s (un)intelligibility. This includes its solutions to amend the ‘risky’ behaviours of its ‘priority populations’, provide an “enabling environment” against stigma and discrimination, and increase the number of HIV-positive individuals on antiretroviral medications (Department of Health 2014: 26). In doing so, I have excluded its further solutions to, for instance, “provide support for general practitioners” (Department of Health 2014: 23), deliver “HIV testing and treatment providers [with]...adequate training” (Department of Health 2014: 24), and implement “harm-reduction strategies” to address IV drug use (Department of Health 2014: 17).

Safe Sex, Testing, and Treatment: Problematising ‘Risky’ Practices

In keeping with the United Nations’ goal to “achieve...the virtual elimination of HIV transmission by 2020”, the Strategy argues that its ‘priority populations’ must practice safer sex, receive more frequent HIV testing, and increase their uptake of antiretroviral therapy (ART) following an HIV diagnosis (Department of Health 2014: 5). In particular, it aims to:

- “Increase safer sex practices among priority populations, particularly among gay men and other men who have sex with men, through the delivery of effective health promotion and prevention activities” (Department of Health 2014: 17),
- Provide “innovative, targeted messaging...to improve testing in at-risk population groups” (Department of Health 2014: 21), and
- “Improve access to and uptake of antiretroviral medications at earlier stages of infection” (Department of Health 2014: 22).

These solutions represent the ‘problem’ of HIV as originating in GB men and MSM’s ‘risky’ sexual practices, combined with an inadequate rate of testing and treatment from all ‘priority populations’. Further, in proposing to reconcile this ‘problem’ through the provision of education initiatives, the Strategy presupposes, first, that ‘priority

populations’ – and in particular GBQ+ men and MSM – have a deficit in their knowledge of such practices and, second, that as ‘rational’, responsible actors, such individuals can (and will) alter their behaviour when presented with ‘objective’ evidence.

In addition, the Strategy contends that such education “[i]nitiatives [should be] aimed at informing people of the personal and public health benefits of early diagnosis” (Department of Health 2014: 21). Here, individuals in ‘priority populations’ are always assumed to be potentially HIV-positive and, hence, have an “obligation to know” how HIV is transmitted, particular strategies of risk mitigation, and their duty to undergo HIV testing (Patton 1990: 103). Not only does this constitute a “dividing practice” between prudent, responsible ‘higher-risk’ populations and “unsuspecting sexual actor[s]” in the ‘general population’, but its assumption that HIV lies dormant in particular populations has the ability to stigmatise ‘at-risk’ individuals (Bacchi and Goodwin 2016: 23; Race 2017: 116).

Despite their interpellation as responsible, prudent subjects, GBQ+ men are not represented to seek out this information independently, but rather require targeted initiatives “to reinvigorate cultures of safe sex practices”, provided by ‘affected communities’ (Department of Health 2014: 18). Indeed, this solution is consistent with both the Australian HIV partnership and the contemporary literature on HIV prevention (see Leonard 2012; Kippax et al. 2013; Aggleton and Parker 2015). But as Brown (2015) has cautioned, in partnership approaches, the responsibility for solving identified ‘problems’ rarely lies with the partnership in itself. Instead, this model renders its constitutive units responsible for their own conduct, while tying them to the governing interests of the State (Brown 2015). Hence, in positioning affected communities as responsible for providing education to ‘at-risk’ groups, the Australian Government is able to “govern ‘at a distance’” (Rose and Miller 1992, cited in Ballard 1998: 8).

Stigma and Discrimination: Barriers to the Neoliberal Subject

Consistent with current, global definitions of ‘health’ and ‘well-being’, the Strategy is situated under the “[g]uiding [p]rinciple” of health promotion (Department of Health 2014: 10). Contributing, in part, to the “‘new’ public health movement”, health promotion endorses a definition of health which extends beyond strict biomedical designations of ‘disease’ to account for a range of social and structural impediments to ‘well-being’

(Lupton 1995: 49; Who 1986). These include, for instance, ‘peace’, ‘income’, ‘equity’, and ‘justice’ (WHO 1986).

In line with a health promotion paradigm, the Strategy posits that particular structural barriers must be addressed, in order to improve the accessibility of HIV services and care:

“Programs should be promoted that address advocacy and empowerment of priority populations to access HIV prevention, treatment, care and support in community, education, workplace, healthcare, and legal settings” (Department of Health 2014: 27).

The Strategy’s commitment to reducing stigma in institutional and interpersonal contexts is both laudable and consistent with the contemporary literature on HIV (see Gupta et al. 2008; Logie 2015; Brown et al. 2014; Logie et al 2012). Such solutions can dismantle neoliberalising discourses of responsibilisation, which tend to position individuals as “risk takers” who become clouded by moments of irrationality (Brown et al. 2014: 39). Indeed, the Strategy does further indicate that reformations outside the Department of Health are required to overcome ‘priority populations’ “barriers to access and equal treatment” (Department of Health 2014: 27). In particular, protection is deemed to be provided through legislation, which protects particular individuals from stigmatising and discriminatory practices (see Department of Health 2014: 26). However, the Strategy’s solution to this ‘problem’ is the only policy ‘objective’ that is lacking an indicator of its ‘success’ (see Department of Health 2014: 8).

In addition, the Strategy’s iteration of health promotion is one bound to neoliberalising discourses, which aim to mobilise individual citizens to freely and privately exercise their own ‘healthy’ choices (Ayo 2012). Here the Strategy produces its ‘priority populations’ as responsible, prudent subjects, whose participation in “risk behaviours” can be explained through the identification of structural barriers (Department of Health 2014: 26). Yet this “dividing practice” (Bacchi and Goodwin 2016: 23), which aims to reconcile the subject’s existing stigma and discrimination, can act to stigmatise its ‘priority populations’; simply due to their being addressed as ‘at-risk’ subjects (see also Henderson and Fuller 2011).

CD4 and Viral Load Counts: Constructing the Biomedical Subject

Besides the medicalisation of the HIV virus, with its suite of medical terminologies, ontologies, and technologies, the Strategy positions HIV prevention, testing, and treatment as medical ‘problems’. For instance, as a mechanism of surveillance, the Strategy proposes to monitor the “[m]edian CD4 count at HIV diagnosis”, in order to estimate the number of individuals living with “an undiagnosed HIV infection” (Department of Health 2014: 8). In addition, it plans to surveil the “[p]roportion of people receiving antiretroviral treatment for HIV infection whose viral load is less than 50 copies/mL”, to determine the number of HIV-positive individuals with an ‘undetectable viral load’ (UVL) (Department of Health 2014: 8).¹⁰

In its emphasis on ‘Treatment as Prevention’ (TasP) and the attainment of an UVL, the Strategy constitutes its ‘priority populations’ as always-already directed “toward the future” (Race 2009: 114).¹¹ In particular, PLWHA must monitor their viral load count, in order to mitigate their risk of transmitting HIV to others (Race 2009; Diprose 2008). Similarly, while Pre-Exposure Prophylaxis (PrEP) is only briefly mentioned in the Strategy, as an “emerging biomedical intervention” (Department of Health 2014: 16), its existence implies that individuals are, first, continuously waiting for a threat to occur and, second, “pro-active in preparing” for a future that is always a potentiality (Diprose 2008: 142; Thomann 2018; Race 2016).¹² Here, the Strategy’s ‘priority populations’ are deemed to “have a[n individual and] moral responsibility” to uphold such biomedical methods of HIV prevention (Thomann 2018: 1000), in order to promote “an ideal world of zero risk” (Diprose 2008: 143).

Elsewhere, the Strategy does return to an agentic subject, who must elect to begin antiretroviral therapy (ART):

“Efforts to improve treatment uptake must respect decisions made by some people with HIV, in conjunction with their care providers, to defer therapy on the basis of clinical and/or psychosocial factors” (Department of Health 2014: 22)

¹⁰ To have an ‘undetectable viral load’ means that the amount of HIV in one’s blood is undetectable in an HIV viral load test (usually <50 copies/mL).

¹¹ TasP is an HIV prevention technique, which aims to increase the number of HIV-positive individuals with an UVL, who hence cannot transmit HIV.

¹² PrEP refers to the use of antiretroviral medication (such as Truvada) among ‘high-risk’ HIV-negative individuals.

However, the ability for individuals to ‘defer therapy’ is undermined by the Strategy’s goal to “increase treatment uptake by people with HIV to 90 per cent” (Department of Health 2014: 6). Instead, PLWHA are expected to begin antiretroviral therapy both to enforce their position as healthy, responsible subjects and “as part of their duty of citizenship to the state” (Ayo 2012: 103). In addition, while such ‘clinical’ and ‘psychosocial factors’ are not elaborated on in the Strategy, the state-based *NSW HIV Strategy* (2016-2020) does offer a proposal for their implementation. Here PLWHA are deemed to require individual support, thus locating the ‘problem’ within the individual’s inability to ‘cope’ with such factors (New South Wales Ministry of Health 2015).

Silencing LGBTQ+ Women

So far, this chapter has argued that HIV is represented to be a behavioural ‘problem’, requiring community-based education initiatives; a stigma and discrimination ‘problem’, which reconfigures a health promotion paradigm under neoliberalising discourses; and a biomedical ‘problem’, under which ‘at-risk’ individuals are interpellated as health conscious subjects, who are always-already directed “toward the future” (Race 2009: 114). Moving on from this analysis, this section will attend to the ways in which LGBTQ+ women are configured as a “constitutive outside” to these “problem representations” (Butler 1993: 8; Bacchi and Goodwin 2016: 19). As Bacchi (2009) has argued, it is in focussing on what has not been problematised that we might begin to direct our attention to that which becomes ‘unthinkable’.

While women are mentioned twice in the Strategy, they are only visible as ‘people from high HIV prevalence countries and their partners’. Such women are explicitly positioned as both heterosexual and at “higher risk of HIV than women in the general population” (Department of Health 2014: 14). Here, the Strategy enacts a “dividing practice” wherein (heterosexual) women from the Global South are deemed to require specific, targeted interventions (Bacchi and Goodwin 2016: 23). However, in its exclusive problematisation of women’s “heterosexual transmission” (Department of Health 2014: 38), the Strategy is ultimately (re)productive of the ‘heterosexual matrix’; silencing all identities and practices that are positioned outside its bounds (Butler 1990: 208).

In addition, the Strategy’s solutions to address stigma and discrimination are exclusively concerned with its impact on PLWHA and ‘priority populations’ ability to undertake HIV testing and treatment. Yet as Logie has posited, such problematisations foreclose an

analysis of the “larger contexts that...perpetuate heterosexism” and produce the very boundaries by which LGBTQ+ women become both unintelligible and ‘at-risk’ (Logie 2015: 529). For instance, due to gender inequalities, women can have trouble negotiating ‘safer’ sexual practices due to gender inequalities (see Gupta et al. 2008; East et al. 2011). Further, as Logie and Gibson (2013) have indicated, such problematisations can obscure the violences behind instances of (homophobic) sexual assault, such as curative rape, directed toward LGBTQ+ women (see also Lenke and Piehl 2009). It is, then, in its focus on “barriers” to the stigmatised practices of HIV testing and treatment that the Strategy diverts focus from the complex ways in which HIV is transmitted and, thus, silences LGBTQ+ women’s unique, intersectional ‘risk’ status (Department of Health 2014: 1).

Indeed, the de-identifying nature of CD4 and viral load counts does enable LGBTQ+ women’s bodies to be ‘read’ and analysed as individual subjects of HIV (see Foucault 1991). However, the HIV test has become an element of surveillance, used to construct a “‘normal’ distribution” of HIV, against which particular populations have become (in)visible (Foucault 2007: 62). In particular, the invasive questioning that accompanies the HIV test – requesting information on gender, sexuality, and ethnicity – has produced it as a “coercive technology of confession” (Patton 1989: 33); necessarily rendering PLWHA intelligible in particular epidemiological categories. As such, while LGBTQ+ women’s bodies are legible as individual carriers of HIV/AIDS, it is their invisibility *as* LGBTQ+ in diagnostic categories that has precluded their formation as a population body.

Furthermore, LGBTQ+ women’s unintelligibility in HIV discourse(s) has produced a number of lived and discursive effects. Carmen Logie (2015), for instance, has utilised a Critical Discourse Analysis to exemplify her lived experiences presenting on queer women at two HIV conferences. Following her presentation at each conference, an “older white male academic” offered a verbal response which, in the first instance, trivialised queer women’s risk of contracting HIV and, in the second, condemned Logie – a queer female researcher – for “trying to take money away from gay men” (Logie 2015: 530). As Logie (2015) has contended, her audience’s ignorance and subsequent “refusal to know” LGBTQ+ women’s relation to HIV results, in part, from constructing HIV as an individual, biomedical ‘problem’, rather than as a structural ‘problem’ (Lamble 2009: 124).

Finally, LGBTQ+ women have been precluded from accessing certain HIV prevention technologies. In particular, while PrEP has been available on the Australian Pharmaceutical Benefits Scheme (PBS) since 1 April 2018, it has only been made available to individuals designated as at a ‘high-risk’ of contracting HIV. This includes “sexually active gay and bisexual men, transgender people and heterosexual people with an HIV positive partner who does not have an undetectable viral load” (AFAO and ASHM 2018). As such, cisgendered LGBQ+ women cannot access PrEP in Australia unless they are in a ‘heterosexual’ relationship with an HIV-positive man.

Conclusion

In this chapter I have utilised Carol Bacchi’s (2009; 2016 with Goodwin) WPR approach to demonstrate how LGBTQ+ women are both symbolically annihilated and rendered unintelligible in the Strategy. It is, I have argued, through its demarcation of ‘priority populations’ that the Strategy enacts a “refusal to know” LGBTQ+ women’s desires, identities, and practices (Lamble 2009: 124). Additionally, the ways in which HIV is problematised in the Strategy enact particular “silencing practices” that render LGBTQ+ women unintelligible as medical subjects of ‘risk’ (Dahl 2017: 103). Indeed, such findings cohere with the existing literature on LGBTQ+ women and HIV (in particular, see Logie 2015; Logie and Gibson 2013).

Subsequently, a number of scholars have argued for the expansion of epidemiological ‘risk’ categories, in order to render LGBTQ+ women visible in discourses of HIV (see Stevens 1993; Arend 2005). However, “assimilat[ing]” LGBTQ+ women into the norms of HIV would not pose a challenge to the discursive limits of those norms (Olson and Worsham 2000: 744). Instead, this reconfiguration would simply expand the bounds of intelligibility; continuing to rest on other ‘unthinkable’ identities, desires, and practices that would become the “constitutive outside” to discourse (Dahl 2017: 94; Olson and Worsham 2000). Hence, what remains under-researched is how documents that specifically address an LGBTQ+ female audience might problematise HIV in ways that (re)enforce, (re)negotiate, or disrupt the normative assumptions and constitutive effects presented in this chapter. This will be the focus of Chapter Four.

CHAPTER FOUR

Lesbians on the Loose

In this chapter I move away from Australian Government policy to examine a Sydney-based magazine, *Lesbians on the Loose* (LOTL). While in Chapter One I argued that the Strategy enacts a “refusal to know” the desires, practices, and identities of LGBTQ+ women (Lamble 2009: 124), LOTL is distinct in its explicit orientation toward its assumed LGBTQ+ female audience. As such, where Chapter One outlined the “silencing practices” inherent in the Strategy’s dominant problematisations of HIV (Dahl 2017: 103), this chapter will highlight LOTL’s (re)production, (re)negotiation, and disruption of such “problem representations” from the position of those rendered unintelligible in HIV discourses (Bacchi and Goodwin 2016: 24). To do this, I will first offer a brief account of LGBTQ+ media outlets in Australia. Second, I will detail the value of using Carol Bacchi’s (2009; 2016 with Goodwin) ‘What is the Problem Represented to Be?’ (WPR) approach to analyse media documents. And third, I will implement the WPR approach in order to undertake a detailed analysis of the ways in which HIV has been problematised in LOTL. Similar to Chapter Three, I will subsequently examine the presuppositions upon which the problematisations are based, the kinds of subjects that are ‘called’ into being, and the forms of thinking that become silenced through its particular representation of the ‘problem’.

LGBTQ+ Media in Australia

In July 1981, the Sydney-based LGBTQ+ magazine, the *Sydney Star*, published Australia’s first news article on AIDS (Robinson 2011). In contrast to the sparse media attention HIV/AIDS was afforded in the United States, the Australian LGBTQ+ press is largely independent, which meant that their content could remain relatively unrestricted (Robinson 2011). Since the 1980s, the LGBTQ+ press has retained its importance for LGBTQ+ individuals. For instance, the *Private Lives 2* report found that 13.6% of lesbians and 9.6% of bisexual women access ‘GLBT’ print media weekly and 26% of lesbians and 23.5% of bisexual women access ‘GLBT’ online media weekly (Leonard et al. 2012: 51-52). These findings are similar to those produced internally by LOTL. In December 2017, LOTL’s readership was estimated to be 161 500 (LOTL 2014a). However, only 43 000 of these were estimated to stem from their print magazine (LOTL

2014). The remaining 118 500 derived from their website (53 000), social media pages (50 000), and ‘e-news’ (15 000) services (LOTL 2014a).

Using the WPR Approach to Analyse Media Documents

Media outlets are not passive entities, simply rendering complex information on HIV legible to lay audiences (Briggs and Hallin 2016). Instead, as Briggs and Hallin have suggested, ‘the media’ is actively bound up in the “co-production of medical objects and subjects” (2016: 5). Building on scholars such as Paula Treichler (1999), they argue that it is through ‘biomediatiation’ – a combination of ‘biomedicalisation’ and ‘mediatisation’ – that contemporary forms of biopolitics can produce their “broad social and political effects” (Briggs and Hallin 2007: 44; Briggs and Hallin 2016). Hence, any analysis of health, as it is constituted in ‘the media’, must be attuned to the “biocommunicable models”, through which certain ‘knowledges’ are produced and disseminated (Briggs and Hallin 2016: 25).

Carol Bacchi’s (2009; 2016 with Goodwin) WPR approach is aligned closely with Briggs and Hallin’s (2016) notion of ‘biomediatiation’. For Bacchi (2009; 2016 with Goodwin), media documents are ‘policies’ (or ‘practical texts’); that is, those that intend to produce particular modes of being and, hence, must be scrutinised for their role in the production of ‘problems’, ‘objects’, and ‘subjects’. In the WPR literature, there is a precedence for this kind of analysis. For instance, the WPR approach has been used by Nielson and Bonham (2015) to examine how particular conceptions of ‘youth’ are constituted in Australian cycling campaigns; by Moscoso and Platero (2017) to explore abortion debates in Spanish media articles; and by Horsti and Pellander (2015) (alongside a ‘news framing’ analysis) to examine how newspaper articles discursively construct ‘family migration’ in Finland.

What is the ‘Problem’ of HIV Represented to Be?

While the Strategy is comprised of a number of “problem representations”, as demonstrated in Chapter Three, it is organised as one, cohesive document (Bacchi and Goodwin 2016: 24). In contrast, LOTL contains a diverse range of texts, including paid advertisements; those composed by ‘LOTL staff’; those stemming from their U.S. sister magazine, *Curve*; and those compiled by individuals who do not work directly for LOTL. As a result, its “problem representations” are more disperse and conflicting (Bacchi and

Goodwin 2016: 19). Hence, this chapter will only focus on LOTL's dominant solutions to HIV; that is, those which occurred most frequently. These include LOTL's solutions to amend the 'risky' behaviours of LGBTQ+ individuals, to involve 'the LGBTQ+ community' in HIV charities, to overcome stigma and discrimination enacted toward LGBTQ+ and PLWHA, and to rectify LGBTQ+ women's invisibility in discourses of HIV. In doing so, I have excluded LOTL's further solutions which, for instance, surround AIDS in the Global South (Barker 2014), sex work(ers) (Kinnear 2014), and youth "apathy towards engaging in safer sexual practices" (LOTL 2015h).

Get Tested, Get Treated, Stay Safe

Consistent with the Strategy's proposal for affected communities to provide 'at-risk' individuals with information on HIV prevention, LOTL is active in its promotion of HIV and STI education initiatives. In this section, I will utilise Kane Race's (2009) conception of 'counterpublic health' to examine how HIV is problematised in three texts to which LOTL refers: ACON's *Ending HIV* website; Ducastel and Martineau's (2016) film, entitled *Paris 05:59 (Théo and Hugo)*; and Lady Sings it Better's music video, entitled *Closer*.

Following Michael Warner's (2002) thesis that (counter)publics "are arenas of discursive circulation" wherein particular modes of subjectivation occur (Race 2009: 159), Kane Race (2009) has argued toward an understanding of 'counterpublic health'. Here, Race posits that if counterpublics are defined as those that contain a "conflicted relation with the dominant public", then a conception of 'counterpublic health' might enable us to describe health initiatives which trouble particular moralising discourses that circulate in "the dominant public" (2009: 159).

One such initiative, I would argue, is ACON's *Ending HIV* website, which is promoted five times throughout this thesis' data corpus (see LOTL 2014a; LOTL 2015c; LOTL 2015i; LOTL 2014g; LOTL November/December 2015). In keeping with the Strategy's goal to "virtual[ly] eliminat[e]" new HIV diagnoses in Australia by 2020 (Department of Health 2014: 1), *Ending HIV* aims to provide GBQ+ men with the information to "test more, treat early, and stay safe" in their sexual practices (Ending HIV n.d.a.; LOTL 2015b; LOTL 2015c). In particular, their website endorses multiple negotiations of 'risk', centralised around diverse 'safer' sexual practices, such as 'pulling out' and ensuring that

the HIV-negative man is ‘fucking, while the HIV-positive man is ‘being fucked’ (Ending HIV n.d.b.).

In turn, Ducastel and Martineau’s (2016) independent film, *Paris 05:59 (Théo and Hugo)*, is praised in one online article for its adherence to “the HIV Foundation’s goals to reduce HIV transmission, educate about PEP, and reduce HIV stigma” (LOTL Staff 2017b). The film opens with a 20-minute, sexually explicit scene that takes place in a gay male sex club (Ducastel and Martineau 2016). Subsequently, the plot unfolds into a 90-minute real-time series of events, which navigate Post-Exposure Prophylaxis (PEP) and anonymous, serodiscordant sex, after Théo – who is HIV-positive – discovers that Hugo had not used a condom.¹³

Another article in LOTL promotes Lady Sings it Better’s music video *Closer* which, in conjunction with ACON’s *Claude* initiative, supports safer sexual practices between women (LOTL 2016c).¹⁴ In this video, Lady Sings it Better offers a (re)enactment of the conventional, phallogocentric ‘safer’ sex exemplar, where a condom is rolled onto a banana - instead, its women are armed with “latex gloves and a variety of [penetrable] fruits” (LOTL 2016c). Unlike the sterile environment of the classroom, Lady Sings it Better’s iteration portrays moments of feminine pleasure: one woman licks pomegranate seeds off her latex glove as its juice runs down her arm, another thrusts her gloved fist into a watermelon.

Aside from the unconventional modality of these texts, their pleasure-based, non-individualistic, and stigma-free content runs counter to the moralism behind conventional public health strategies (Race 2009). LGBTQ+ individuals are not called to abstain from particular sexual acts, but rather are encouraged to utilise ‘risk’ mitigation techniques that align with their existing practices. In addition, *Paris 05:59 (Théo and Hugo)* does not position its protagonists as strictly rational actors, who operate under a paradigm of prudent responsabilisation. Each protagonist is fallible: Hugo ‘fucks’ Théo without the use of a condom; Théo does not declare his HIV status prior to ‘being fucked’; and Hugo initially refuses Théo’s offer to accompany him to the hospital, against the HIV hotline’s advice (Ducastel and Martineau 2016). Yet, the film’s reliance on queer romance avoids

¹³ PEP refers to the practice of taking ART within 72 hours of potential HIV exposure.

¹⁴ To my knowledge, this video is no longer publicly available.

either protagonist being constituted under moralising discourses; the onus is on neither – or perhaps both – parties to declare their HIV status.

However, while counterpublic health can produce innovative, affective relations to HIV, its implementation continues to rely on ‘risk’ as a governing technique. For instance, *Ending HIV*’s website contains a ‘risk calculator’, where GBQ+ men can enter the characteristics of their sexual practices, in order to determine their ‘risk’ status (Ending HIV n.d.b). Inputs include whether they are “fucking” or “being fucked”, both their and their partner’s HIV status, and their current risk reduction technique (Ending HIV n.d.b). GBQ+ men are, then, expected to become prudent, responsible subjects (see Dean 1998); fashioning their behaviour in response to their designated ‘risk’ status. In addition, biomedical mitigations of ‘risk’ remain central to each initiative, evident in the promotion of PEP, PrEP, TasP, and latex barriers, including both condoms and gloves. Thus, for all LGBTQ+ individuals, HIV remains a behavioural ‘problem’, albeit one that troubles the conventional individualising and moralising interpellation of ‘at-risk’ sexual subjects.

LGBTQ+ Women as Charitable Allies: HIV and Community Responsibility

Between 2014 and 2017, LOTL contained 11 print and 28 online community notifications that invited its readers to attend fundraisers, charity events, to volunteer, or donate to HIV causes. The following excerpts are typical of this kind of notification:

“Want to help make a difference? By volunteering [in the Red Ribbon Appeal], you can help eliminate HIV transmission in NSW” (LOTL 2015c)

“This is our largest and most important fundraising event of the year. Monies raised from the Auction will support the most vulnerable people living with HIV in our community” (LOTL 2015d)

“Support ACON’s HIV services by attending this performance” (LOTL 2015k)

Among other scenarios, LOTL’s readers are asked to craft ribbons for World AIDS Day (LOTL 2014e), volunteer “to provide emotional and social support to people living with HIV & AIDS” (LOTL 2014b), and to engage in tourist activities that support HIV/AIDS charities (Bader July/August 2016: 32; Bader July/August 2015). In addition, LOTL’s

readers are called to contribute to HIV causes that support non-LGBTQ+ individuals. For instance, four online event notifications advertise ‘The Little Black Dress Run’ – an annual fundraiser organised by the LGBTQ+ group, the Sydney Frontrunners, which aims to raise money for children living with HIV (LOTL 2014f; Cornish 2014c; LOTL 2015n).

In doing so, LOTL constructs the ‘problem’ of HIV as one that belongs to the LGBTQ+ community; troubling the interpellations of GBQ+ men and other MSM as exclusively neoliberal, self-responsible subjects (see also Adam 2005; Leonard 2012). Instead, such notifications implore members of the LGBTQ+ community to erect systems of care, under which particular idea(l)s of community solidarity are (re)produced (see Adam 2005). Here, phrases such as “our community” constitute a “dividing practice”, wherein members of the LGBTQ+ community, within which LOTL’s readers are (re)produced, are distinguished from those in the ‘general population’ (LOTL 2015; Bacchi and Goodwin 2016: 23). Despite this, not one of these notifications directly refers to LGBTQ+ women as being ‘at-risk’ of contracting HIV or as the recipient of one these charitable events.

As such, LGBTQ+ women’s dominant constitution as charitable allies to the fight against HIV is, I argue, reliant on a neoliberalising ‘political rationality’ (Brown 2015). Political theorist, Wendy Brown (2015) has positioned women as both essential to the tactics of neoliberalism and vulnerable to its effects. In particular, where neoliberal policies have resulted in privatisation, women’s labour has become indispensable to both the family and the State (Brown 2015). In these instances, women are expected to care for (male) entrepreneurial subjects, in order to sustain neoliberalism as a viable political rationality (Brown 2015). Indeed, while Australian GBQ+ men’s affective response to HIV has troubled Brown’s (2015) assertion (see Adam 2005; Leonard 2012), I argue that the frequency of this interpellation in an LGBTQ+ women’s magazine is reliant on particular gendering presuppositions; ones which position women – above all – as carers.

LGBTQ+ Individuals and PLWHA: Stigma and Discrimination

Elsewhere in LOTL, HIV is produced as a stigma and discrimination ‘problem’, which primarily affects GBQ+ men and PLWHA. For instance, one article praises the NSW Government for funding ACON’s domestic violence program, which offers protection to those who fear having their HIV status ‘outed’ (LOTL 2015j). Another, promotes the

development of The Sexual Health Councillors Association of NSW, which aims to overcome LGBTQ+ individual's reluctance to visit healthcare services:

“It has been found that many people in the LGBTI community find it hard to access services where they feel comfortable discussing their sexual health needs in an open way without judgment or stigma” (LOTL Staff 2016c)

Yet another news article fears the stigmatising impact of a homophobic sticker that was placed on a Melbourne telegraph pole:

“The sticker...reads “Cure AIDS! Kick a p**fter to death!” ...Melbourne's gay community has condemned the sticker for aiming to create fear and stigmatise people who are HIV positive...I would request that authorities take the appropriate steps to remove these stickers and record this incident as a violent and threatening act” (LOTL 2016d)

In these configurations, the implicit, ‘nested’ problematisation of stigma is threefold.¹⁵ First, stigma is constituted as an “enacted” practice, where LGBTQ+ individuals and PLWHA are physically and/or psychologically threatened (Herek 2007: 908). Second, solutions are directed toward LGBTQ+ individuals and PLWHA's “felt” stigma, necessitating tailored HIV support groups and services (Herek 2007: 909). And third, there is an implicit potential for LGBTQ+ individuals and PLWHA to ‘internalise’ such stigmatised messages (Herek 2007: 910). This conception relies on both a model of social psychology and a health promotion frame, which illuminate the effect of stigmatising practices on the (in)ability of LGBTQ+ individuals and PLWHA to live a safe, “bearable life” (Ahmed 2010: 97).

However, with the exception of one article, LOTL's focus is on stigmatising and discriminating practices that are enacted toward one's already existent status; that is, as HIV-positive or LGBTQ+. In line with the Strategy, this problematisation diverts focus from particular structural violences that might precede one's HIV infection. For instance, as argued in Chapter Three, this conception silences the intersection of sexism and misogyny, wherein LGBTQ+ women can become vulnerable to HIV infection (see Logie and Gibson 2013; Logie 2015; Lenke and Piehl 2009).

¹⁵ Bacchi and Goodwin refer to ‘nesting’ as the phenomenon wherein particular problem representations occur within one another (2016: 24).

‘Yes, Lesbians Can Get Goddamn STDs’: Ignorance and Invisibility

Converse to their subjectivation as charitable allies, a small number of articles in LOTL aim to rectify LGBTQ+ women’s invisibility in discourses of HIV (and STIs). Among these are, for instance, a community notification which advertises “Were You There”, a “verbatim performance text” surrounding “[t]he story of women and HIV” (LOTL 2017h); an essay that examines LGBTQ+ women’s (in)visibility in UK discourses of ‘safer’ sex (Mongal 2014); and an article that informs LGBTQ+ women on how to practice ‘safer’ anal sex (Tallon-Hicks 2015a).

Such articles tend to presuppose that LGBTQ+ women are ‘at-risk’ of contracting HIV and thus must alter their behaviours to become prudent, rational, and responsible subjects (see Dean 1998). For instance, LOTL’s readers are asked to clean all anal toys before use (Tallon-Hicks 2015a), receive STI and HIV testing (Tallon-Hicks 2015b), and ensure that their partners have been tested for HIV and STIs (Tallon-Hicks 2015b). Yet unlike initiatives that target GBQ+ men’s ‘risky’ practices, LGBTQ+ women’s ignorance of ‘safer’ sex is not primarily represented as an individual ‘problem’. Instead, LGBTQ+ women’s invisibility in HIV discourses is positioned as a biomedical and “biocommunicable failure”; that is, one that originates in a lack of information surrounding LGBTQ+ women’s heterogeneous sexual ‘risk’ practices (Briggs and Hallin 2016: 43).

Subsequently, in one article, LOTL critiques the conventional presupposition that LGBTQ+ women are not ‘at-risk’ of contracting HIV (or STIs):

“As we embrace sexual fluidity and the sparkling spectrums that make up our community, we must also embrace the idea that two female bodies having sex together isn’t necessarily the safest way to play” (Tallon-Hicks 2015b)

This article provides an example of what Briggs and Hallin have termed a “public sphere model of biocommunicability” (2016: 71). This model of biocommunicability troubles the linearity of conventional health information, wherein biomedical authorities are deemed to simply transmit information to a passive, lay audience (Briggs and Hallin 2016). Instead, the author – in this instance, a sex educator and, more importantly, a member of the LGBTQ+ community – is positioned as the “privileged speaker”, who is

able to ‘debunk’ the knowledges of biomedicine (Briggs and Hallin 2016: 39). In this article, the author is valued for her identification as “an actively practicing bisexual babe”, which is given precedence over formal qualifications (Tallon-Hicks 2015b).

Here, LOTL’s readers are subjectivated into conflicting positions as both ‘laypersons’ and “citizen-spectators” (Briggs and Hallin 2016: 39). Indeed, in some articles, LOTL does implore its audience to adopt its health directions, in order to become prudent, responsible subjects under the authority of particular LGBTQ+ speakers. Yet, in others, LOTL requests its audience of “citizen-spectators” to mediate between biomedical knowledges, which have neglected LGBTQ+ women in HIV discourses under an assumption of ‘lesbian immunity’, and those arising in particular segments of the LGBTQ+ community (Briggs and Hallin 2016: 39). In this position, LGBTQ+ women are constituted as agentic subjects, who have the capacity to determine their own ‘risk’ of HIV infection.

Finally, each of these articles presuppose that LGBTQ+ women contract HIV exclusively through their consensual sexual practices. In doing so, not only is LGBTQ+ women’s risk of HIV infection constructed as ‘manageable’ through particular preventive methods, but instances of non-consensual HIV transmission are silenced (see Chapter Three). Further, this configuration diverts focus from other ‘high-risk’ practices, such as IV drug (ab)use. This absence is particularly troubling because, as indicated in the 2016 Sydney Women and Sexual Health (SWASH) survey, LBQ+ women experience higher rates of illicit drug use when compared to women in the ‘general population’ (Mooney-Somers et al. 2017).

Conclusion

In this chapter I have utilised Carol Bacchi’s (2009; 2016 with Goodwin) WPR approach to delineate how LGBTQ+ women are constituted in 2014-2017 publications of LOTL. In doing so, I have argued that LGBTQ+ women emerge in LOTL, first, as charitable allies to the fight against HIV and, second, as ‘at-risk’ sexual subjects, who have the capacity to mediate between biomedical and LGBTQ+ accounts of their HIV ‘risk’ status. Here, LOTL is able to both (re)produce and (re)negotiate the Strategy’s problematisations of HIV in ways that disrupt its biomedical and epidemiological foundations, while maintaining a health promotion orientation toward stigma and discrimination.

In the final two chapters I will begin to move beyond the dominant problematisations of HIV to examine, first, how LGBTQ+ women's (non)position in Australian HIV discourses emerged and, second, how LGBTQ+ women might enact alternate practices of 'risk'. In Chapter Five I will conduct an "abbreviated genealogy" of LGBTQ+ women's (non)interpellation into HIV "risk discourse[s]" (Bacchi 2015a: 139; Race 2017: 104). In doing so, this chapter will ask how LGBTQ+ women became constituted under notions of 'lesbian immunity', and how they subsequently became involved in an epidemic that is somehow not their own.

CHAPTER FIVE

An ‘Abbreviated Genealogy’ of LGBTQ+ Women’s (Non)Risk of Contracting HIV

In previous chapters I have applied Questions 1, 2, 4, 5, and 6 of Carol Bacchi’s ‘What is the Problem Represented to Be?’ (WPR) approach to the Strategy and 2014-2017 publications in LOTL. In doing so, I have argued that the Strategy’s problematisations enact a “refusal to know” LGBTQ+ women as medical subjects of HIV (Lamble 2009: 124). Then, in LOTL, LGBTQ+ women are interpellated, first, as charitable allies to the fight against HIV and, second, as ‘at-risk’ sexual subjects, who are able to mediate between biomedical and social ‘knowledges’ (Briggs and Hallin 2016). In this chapter I turn to Question 3 of the WPR approach, in order to interrogate the discursive histories of such constitutions, while maintaining a focus on the present.

Under Question 3 of the WPR approach – “how has this representation of the ‘problem’ come about?” – analysts are prompted to undertake a Foucauldian genealogy of the ‘problem representation’ (2016 with Goodwin: 20). The purpose of a Foucauldian genealogy is to understand, first, why certain problematisations have prevailed in policy discourses and, second, how “things could have developed...differently” (Bacchi 2009: 10). In this short chapter I will provide an “abbreviated genealogy” of the knowledges behind the construction of LGBTQ+ women as (not)at-risk of contracting HIV. While others have undertaken similar tasks as elements of more extensive analyses (see Treichler 1999; Patton 1994; Wilton 1997) none have been conducted in Australia. Given the historically and culturally contingent nature of discourses and problematisations, I argue that such an analysis is necessary. It is in these pieces of genealogy that the discursive sites of struggle behind LGBTQ+ women’s (non-)recognition can be clarified; providing some granule of intelligibility simply by virtue of their documentation. This chapter, however, has arisen from the (often raw) data available within the confines of a Master of Research thesis. As such, it is designed to illuminate some of the early, contested definitions, upon which further research should take place.

Suin ni Chrochuir, “ACON’s women and AIDS Project officer in the late 1980s and 1990s”, stated in a 2010 interview with LOTL that “[i]t’s a little known fact but four of

the people who were initially diagnosed with HIV in NSW were lesbians” (LOTL August 2010: 3). Indeed, in the mid-1980s a small number of (often single-case) medical journal publications suggested that HIV could potentially be sexually transmitted between women (see Sabatini et al. 1984; Marmor et al. 1986; Monzon and Capellan 1987).¹⁶ Yet their findings were undermined when “in the late 1980s[,]...a CDC physician” stated that “lesbians don’t have much sex” and, thus, do not require researching (Chiaramonte 1988 cited in Stevens 1993: 291). This position rests on the assumption that women are asexual, consistent with second wave feminism’s ‘political lesbianism’ – wherein women would renounce sex with men, but did not engage in sex with women (Patton 1994). As Patton has argued, “lesbianism [was believed to have] more to do with refusing to conform to gender roles than with any actual sexual behavior” (Patton 1994: 101).

In 1988 – one year prior to the first *National HIV Strategy* – the Australian Government compiled a ‘policy discussion paper’, entitled *AIDS: A Time to Care, A Time to Act - Towards a Strategy for Australians*. In this document, WSW are constituted as at potential ‘risk’ of HIV infection, with HIV stated to exist in “vaginal secretions” (Commonwealth of Australia 1988: 51). In particular, it specifies that “female to female [sexual] transmission” of HIV is an, albeit rare, possibility – particularly in instances of “traumatic sexual contact” (Commonwealth of Australia 1998: 51). However, while “orogenital intercourse” (i.e. oral sex) is presented as another potential ‘risk’ activity, it gives no further consideration to the aspects of female-to-female sex, which might entail behaviours of ‘risk’ (Commonwealth of Australia 1988: 52). Here, female-to-female sex is condensed into cunnilingus, ultimately obscuring the diversity of sexual practices that occur between women. This document, further, contributes to a heteropatriarchal “dividing practice”, where women are positioned as an oppressed group who require training in order to become more assertive and overcome their passivity in negotiating sexual and social relations (assumedly with men) (Bacchi and Goodwin 2016: 23; Commonwealth of Australia 1988: 146).

Between 1988 and 2000, LGBTQ+ women were particularly visible in HIV prevention campaigns created by ACON (then the AIDS Council of NSW). In 1988, ACON produced an information pamphlet on safe sex, entitled *Invisible Lesbians*. However, it was not until 1998 that ACON released its first “lesbian sex booklet”, which included

¹⁶ It is worth clarifying that, to my knowledge, no publications have included an Australian case study.

information on HIV. This booklet rests on the presupposition that lesbians “can and do transmit HIV and other STDs” (ACON 1998: 4). Yet in doing so, objective knowledges of ‘risk’ are destabilised; stating that “[e]veryone has to make up their own mind about what they consider ‘safe’ and what is an acceptable ‘risk’ for them” (ACON 1998: 1). In the same year, a group under Melbourne’s Victorian AIDS Council (VAC) – *Safe Womyn* – hosted a workshop on lesbian safe sexual practices (Jeffreys 1993). In contrast to ACON’s material, this workshop suggested that lesbians “had not contracted the [HIV] virus from lesbian sex”, but from other ‘higher-risk’ activities (Jeffreys 1993: 137). Nevertheless, by 2010, ACON had removed all information on HIV from their new safe sex booklet (compiled with Young Women’s Project), entitled *The Birds and the Bees: The Lesbian Sex Workbook*. Parallel to the VAC’s workshop, it instead suggests that “even though with some practices there’s *theoretically* a possibility of transmission, in actual fact there has never been a documented case of transmission of HIV between two women in NSW” (ACON & Young Women’s Project 2010: 28, emphasis in original).

Outside Australian policy and campaign discourses, the contested nature of LGBTQ+ women’s ‘risk’ of contracting HIV was evident in international practices. In 1992 the first meeting of The International Community of Women Living with HIV (ICW) took place in Amsterdam. In this meeting, the attendants (including one Australian) developed twelve statements; one of which pertained to the “recognition and support for lesbians living with HIV/AIDS” (ICW n.d.). Then, in 1993 the Centre for Disease Control (CDC) altered the entry for HIV/AIDS “to include gynaecological abnormalities and cancers which women [living with HIV/AIDS] had expressed or from which they had died” (Patton 1994: 13). Following this definitional shift, the number of women who were recognised as living with HIV/AIDS in the US grew exponentially (Dworkin 2005). Yet ‘LGBTQ+’ has never been afforded its own singular or intersectional HIV transmission category for women in the United States (Dworkin 2005; Fishman and Anderson 2003; Arend 2005; Logie and Gibson 2013) or Australia (see Chapter Three). Even so, medical journals continue to publish incidences of probable ‘female-to-female’ sexual transmission of HIV (see Chan et al. 2014).

In public health, the term ‘WSW’ emerged in the mid-1990s – a decade after its counterpart, MSM – to address women who had sex with women, but did not identify as

LGBQ+ (Boellstorff 2011).¹⁷ This move to behavioural ‘risk’ categories was exemplified in 1996, when the first Sydney Women and Sexual Health Survey (SWASH) was conducted to determine whether LGBTQ+ women (and other “women in contact with the gay community”) were at-risk of contracting HIV (Richters et al. 2001: 1). In its first iteration, the reader is reminded not to conflate epidemiological risk categories with sexual identity: lesbians, for example, can still contract HIV from an instance of ‘heterosexual transmission’ (Richters et al. 2001). Hence, in this initial document, Richters and colleagues suggest that “‘minimal risk from sex between women’ is not the same as ‘minimal risk for women identifying as lesbians’” (2001: 28). This knowledge was, further, reflected in ACON’s 1994 poster, entitled ‘New Fit for Every Hit’, which aimed to educate lesbian women about the ‘risks’ of IV drug use. While addressed to lesbian women, the individual’s identity is detached from their ‘at-risk’ practices.

Despite this notion that LGBTQ+ women are at (potential) ‘risk’ of contracting HIV, some gay men argued that lesbians simply had “virus envy”; a revamp of the Freudian ‘penis envy’ often waged toward LGBTQ+ women (Richardson 2000a: 147).¹⁸ In Australia, Richters and Clayton have, similarly, posited that ACON’s provision of safer sex information and materials (i.e. dental dams) for LGBTQ+ women was designed, first, to placate those who were afraid of contracting HIV and, second, to avoid the accusation that “AIDS service organisations were...ignoring and marginalising women” (2010: 104). Hence, ACON argues that WSW’s needs as carers should be attended to, rather than diverting resources toward ‘low-risk’ population (Richters and Clayton 2010). This construction was reflected in 2015, when Garret Prestage, an Associate Professor in the Kirby Institute, emphasised lesbian women’s role as allies to GBQ+ men during the HIV/AIDS epidemic, stating: “[g]ay men didn’t have a lot of allies at the time at the time...[l]esbians cared for their gay friends when no one else would” (Prestage 2015 cited in Ending HIV 2015, March 06). It is, for instance, under the knowledges of the latter that LOTL has primarily (re)produced LGBTQ+ women’s relation to HIV.

Conclusion

¹⁷ See Tom Boellstorff (2011) for a genealogy of ‘MSM’ as a public health category.

¹⁸ Some lesbian feminists, too, have ascribed to this framework. Sheila Jeffreys, for example, stated in her book *The Lesbian Heresy: A Feminist Perspective on the Lesbian Sexual Revolution* that lesbian women were perhaps eager to be included in ‘risk’ discourses of HIV/AIDS, in order to “maintain an outcast status” (1993: 137).

In this chapter I have established that LGBTQ+ women's *non*-interpellation into "risk discourse" has not arisen from an epistemological gap (Race 2017: 104). It is not an unintended consequence of "inattention" to a population that has suffered comparably little from HIV (Proctor and Schiebinger 2008: 7). Rather, while LGBTQ+ women's 'non-risk' status has been constituted in particular policy and campaign documents, it has been contested since the emergence of AIDS in the early 1980s, producing multiple and dispersed knowledges from (among others) sites of epidemiology, medicine, (LGBTQ+) communities, public health, and government. As this chapter has demonstrated, there are rich discursive histories to silence(s); ones which operate in symbiosis with particular power-knowledge relations (see Sedgwick 1990).

So far, Chapters Three and Four have highlighted how the Strategy and LOTL problematise HIV in ways that render LGBTQ+ (un)intelligible as particular kinds of subjects. Subsequently, in this chapter I have attempted to "de-inevitablize the present" by demonstrating the contingent nature of such discourses. (Bacchi and Goodwin 2016: 47). Following this analysis, in Chapter Six I will supplement Carol Bacchi's (2009; 2016 with Goodwin) WPR model with a performative theory of 'risk', in order to offer a brief analysis of the (few) moments in LOTL where LGBTQ+ women are explicitly spoken of in relation to HIV. In attending to these moments, I hope to illuminate some emerging contestations and incoherencies, which "survive at the margins" of discourse (Bacchi and Goodwin 2016: 22). It is here, I argue, that LGBTQ+ women might begin to (re)negotiate and disrupt normative assumptions of gender, sexuality, and 'risk'.

CHAPTER SIX

(Un)Doing Normative Assumptions of Risk

Throughout this thesis, I have implemented Carol Bacchi's (2009; 2016 with Goodwin) 'What is the Problem Represented to Be?' (WPR) methodological tool, to investigate how LGBTQ+ women are (un)done through the ways in which HIV is problematised. Then, in Chapter Five, I argued that LGBTQ+ women's constitution as *not* 'at-risk' of HIV is contingent on particular discursive histories and, indeed, could have developed otherwise. Following on from this analysis, in this chapter I supplement Bacchi's (2009; 2016 with Goodwin) WPR approach with a performative theory of 'risk', in order to examine the (few) moments in LOTL where LGBTQ+ women are explicitly spoken of as medical subjects of HIV. In doing so, I aim to investigate how such utterances might (re)produce (do), (re)negotiate (redo), or disrupt (undo) normative assumptions of gender, sexuality, and risk. While this analysis is necessarily partial and tentative, reaching no definitive conclusions, I argue that it is important to think-through the incoherencies, contestations, and emerging (re)productions that "survive at the margins" of discourse (Bacchi and Goodwin 2016: 22). It is here that we might begin to conceptualise the 'problem' differently.

Toward a Performative Theory of Risk

In response to the unsatisfactory use of intersectional theory in health risk research, Giritli-Nygren and Olofsson (2014) have recently developed a performative account of 'risk' (see also Montelius and Giritli-Nygren 2014; Olofsson et al. 2014; Giritli-Nygren et al. 2017). Grounded in West and Zimmerman's (1987) theoretical frame of 'doing gender', Giritli-Nygren and Olofsson argue that when 'risk' is conceptualised as an enacted practice, research might begin to illuminate the ways in which its performance can "simultaneously (re)produce and hide socio-political norms" (2014: 1122). Here, 'risk' is seen to operate in symbiosis with other axes of oppression, such as gender, race, class, and sexuality (Giritli-Nygren et al. 2017).

Subsequently, Giritli-Nygren and colleagues have posited that micro-level enactments can (re)produce (do), (re)negotiate (redo), and disrupt (undo) particular "norms of risk" (2017: 420). However, West and Zimmerman's (1987) definition of interactional

‘practices’ imagines a pre-discursive subject: one that might ‘do’ gender (or indeed ‘risk’) but is not constituted by these ‘doings’. This theoretical trajectory, while useful in its insights, is largely incompatible with the poststructuralist orientation of this thesis. Instead, I will emphasise Judith Butler’s (1990; 1993) theory of gender performativity, as elaborated in Chapter Two, in a similar fashion to Montelius and Giritli-Nygren’s (2014) expansion of Giritli-Nygren and colleagues (2017) original thesis.

Here I will understand such ‘doings’, ‘redoings’, and ‘undoings’ as follows. In scenarios where ‘risk’ is ‘done’, the performance acts to (re)produce normative structures, ultimately strengthening their claims to ‘naturalness’ (Giritli-Nygren et al. 2017; Montelius and Giritli-Nygren 2014). When ‘risk’ is ‘redone’, the parameters of ‘risk’ might be reshaped, but the performance does not contest its claims to ‘truth’. For instance, ‘risk’ can be ‘redone’ when previously unintelligible subjects are assimilated into discourse(s). And finally, in moments when ‘risk’ is ‘undone’, the performance acts to destabilise the norm, opening particular conceptions of ‘risk’ up for resignification. These processes do not occur in isolation. Instead, the multiplicity and fluidity of risk discourses allow for practices of ‘doing’, ‘redoing’, and ‘undoing’ to occur simultaneously (Giritli-Nygren et al. 2017).

The Emergence of LGBTQ+ Women and HIV in LOTL

While every piece in LOTL constitutes its reader in particular ways, only 7 online and 4 print magazine pages, published between 2014 and 2017, explicitly interpellate LGBTQ+ women as ‘at-risk’ of contracting HIV. In this chapter, I will focus on 3 such pages.

LGBTQ+ Women and HIV Testing: (Re)Negotiating the Norm

Between 2015 and 2016, two full-page advertisements were published in LOTL’s print magazine, which urge LGBTQ+ women to “take control of their [sexual] health” (ACON June 2015: 9). The first, compiled by Family Planning NSW, explicitly recommends that LGBTQ+ women undergo sexual health testing:

“It is...possible to be affected by hepatitis B, HIV, or syphilis. Regular sexual health testing protects you and your partners” (Family Planning NSW July/August 2016: 9; Family Planning NSW September/October 2016: 7)

The second promotes ACON’s (sexual) health facilities and HIV services:

“Since 1985, we’ve been helping people in our community take control of their health...Whether it’s HIV prevention, HIV support or LGBTI health, we’re here for you and we’re here for health” (ACON June 2015: 9)

In line with a health promotion paradigm, HIV ‘risk’ is conceptualised at both an individual and community level (Lupton 1995). Here, Family Planning NSW explicitly positions itself as a “safe and non-judgemental environment” (Family Planning NSW July/August 2016: 9; Family Planning NSW September/October 2016: 7) and ACON advertise their involvement in the LGBTQ+ community. Indeed, such advertisements, I argue, are both informative and performative: constituting LGBTQ+ women as ‘at-risk’ of contracting HIV (and STIs). In doing so, LGBTQ+ women are assimilated into normative conceptions of ‘risk’; (re)negotiating (or ‘redoing’) their parameters but not contesting their normative claims to ‘truth’. HIV, thus, remains a ‘risk’, which is primarily mitigated through biomedical testing and community-based prevention initiatives, yet one that includes LGBTQ+ women within its knowledges. In the remainder of this chapter, I will examine LOTL’s simultaneous production of LGBTQ+ women as ‘at-risk’ of contracting HIV and its ‘aversion’ toward dental dams.

Dental Dams as ‘Reluctant Objects’

Kane Race (2016) has recently scrutinised gay men’s ‘reluctance’ to adopt PrEP amidst its biomedical claims to revolutionise the field of HIV prevention. PrEP, he argues, poses a particular threat to gay men’s current practices of ‘risk’ mitigation (Race 2016). In contrast to condom usage, PrEP requires gay men to confess their “willingness” to participate in ‘higher-risk’ sexual practices, prior to the situation where ‘risk’ is encountered (Race 2016: 24). Here he defines ‘reluctant objects’ as those “whose promise is so threatening or confronting to enduring habits of getting by in this world that it provokes aversion, avoidance — even condemnation and moralism” (Race 2016: 17).

Drawing on Race’s (2016) theorisation of PrEP, I argue that dental dams might, in part, be conceptualised as ‘reluctant objects’ in LOTL. For instance, one online article, which offers advice on lesbian dating, states:

“Yes, lesbians can get goddamn STDs and we need to stop thinking we can’t. Dating a girl who is haphazard with her sexual health is a Deal Breaker and, although it’s an awkward

conversation to have, you need to know before you get active that she's wise with her choices and regularly checked. Dental Dams are the recommended weapon of choice for lesbians, but although I'm supposed to publicly advocate such measures I sure as hell have never used one. They're a bit like cling-film for the vagina and can sort of kill the mood... You can't un-do herpes, HPV, or HIV, so don't be stupid. Make sure you're dating an actual grown up who doesn't believe that 'Lesbians don't get STD's['] [sic]' (Rosetta 2015)

In keeping with the above Family Planning NSW advertisement, this article's author, Rosetta, urges LGBTQ+ women to ensure that their partner, first, undergoes regular HIV and STI testing and, second, is "wise with her choices" (Rosetta 2015). In doing so, Rosetta (re)produces (or 'does') an iteration of Australia's contemporary 'health society' (see Kickbusch 2007); wherein health has become a marker of our capacity to be "responsible and worthy...citizens" (Cheek 2008: 974). LGBTQ+ women who diverge from this model are punished, with their perceived ignorance counteracting the properties of 'good' sexual health citizenship (see Lupton 1995). Here, Rosetta constitutes a "dividing practice" between responsibilised, health-conscious "grown up[s]" and irrational, irresponsible others (Bacchi 2015a: 139; Rosetta 2015). In this configuration, Rosetta (2015) positions herself as prudent, knowledgeable subject of 'risk', albeit one that diverges from the recommended "weapon of choice" for HIV prevention.

In contrast to Race's (2016) discussion of PrEP, Rosetta's (2015) "affective reaction...of aversion" toward dental dams is, in itself, perhaps unsurprising (Race 2016: 18). Among LGBTQ+ women, dental dam use is resoundingly uncommon (Power et al. 2009; Richters et al. 2010; Fishman and Anderson 2003; Grant and Nash 2018; Formby 2011; Smith et al. 2017; Cox and McNair 2009; MacBride-Stewart 2004; Teti and Bowleg 2011), with dams perceived to be both "unsexy" (Formby 2011: 1172; Grant and Nash 2018; Cox and McNair 2009) and unnecessary (Power et al. 2009). These reservations were reiterated in Richters and colleagues' (2010) Australian study, which indicated that 87% of WSW had never used a dam. In addition, few Australian sexual health practitioners recommend the use of dental dams for 'safe' female-to-female sex (see Richters and Clayton 2010). For instance, in 2006, dental dams were removed from ACON's sexual health packages due to their underuse by LGBTQ+ women (Richters and Clayton 2010).

In response to this, Grant and Nash (2018) have investigated how young, Australian, queer women perceive notions of ‘safer sex’ and “‘good’ sexual citizenship” (2018: 312). In their relations with men, participants relied on “heteronormative, biomedical definitions” of ‘safe sex’ (Grant and Nash 2018: 311). Yet such biomedical discourses of ‘risk’ were rarely evident in their participant’s perceptions of ‘safe’ female-to-female sexual relations (Grant and Nash 2018). As such, Grant and Nash have subsequently argued that LGBTQ+ women have a “lack of language with which to discuss safer sex between women” (2018: 315).

However, while biomedical definitions of ‘risk’ are mostly absent in Rosetta’s (2015) article – with the exception of HIV and STI testing - I am hesitant to accept Grant and Nash’s (2018) position. Instead, in future research, I suggest that it is worth thinking-through Rosetta’s (2015) notion of being “wise with [one’s] choices” as a tacit knowledge; that is, one that remains unarticulated, but which circulates in LGBTQ+ women’s sexual relations. It is in such knowledges that Rosetta is able to enact a performance of ‘risk’ which neither (re)produces a heteropatriarchal model of penetration nor adopts its barrier method of prevention. In doing so, LGBTQ+ women become ‘at-risk’ subjects of HIV, but in ways that destabilise the conventional interpellations into HIV “risk discourse[s]” (Race 2017: 104).

Indeed, Grant and Nash (2018), Formby (2011), and Dolan and Davis (2003) have all established the centrality of ‘trust’ in sexual relations between LGBTQ+ women. This notion has, for Dolan and Davis, led to the perception that LGBTQ+ women are “[s]ocially inoculated” from HIV (2003: 31). While Rosetta does not enact an explicit relation toward trust in her article – indeed, her argument, at times, assumes that LGBTQ+ women’s female partners cannot be trusted – such concepts, I argue, are useful in their indication of alternate understandings of ‘risk’. That is to say, returning to Race’s theorisation: perhaps dental dams are positioned as “threatening” objects in Rosetta’s account, simply due to their ability to ‘undo’ LGBTQ+ women’s existing, embodied sexual practices which have, thus far, excluded such technologies (2016: 17).

Finally, it is important to distinguish such ‘tacit knowledges’ from Donna Haraway’s (1988) conception of ‘situated knowledges’. Haraway (1988) has argued that particular minority knowledges, such as those provided by women, produce a more truthful, objective understanding of ‘reality’. In contrast, this thesis’ employment of the term ‘tacit

knowledges’ does not imply that such knowledges are ‘better’ or more objective. Rather, as Foucault (1980) has argued, knowledges are co-constitutive of power and (re)produce multiple, unfixed ‘realities’. Hence, in future research, such ‘tacit knowledges’ must be examined for their capacity to ‘do’, ‘redo’, or ‘undo’ particular ‘risk’ discourses, rather than for the nature their subject matter.

Conclusion

In this chapter I have attended to the (few) moments in LOTL where LGBTQ+ women are explicitly spoken of as ‘at-risk’ of contracting HIV. In doing so, I have argued that such utterances motion toward alternate enactments of ‘risk’; ones that implicitly contain the ability to both ‘redo’ and ‘undo’ the biomedicalising practices of contemporary HIV prevention. Indeed, as both Foucault (1991) and Butler (2004) have contended, resistances must occur “at the micro level”; that is, from within the norms that threaten to render one’s life unliveable (Bacchi and Goodwin 2016: 31). As such, while this chapter’s conclusions are necessarily partial and tentative, I argue that it is in these incoherencies, contestations, and emerging (re)productions that LGBTQ+ women’s desires, practices, and identities begin to surface “*at the limits of intelligibility*” (Butler 2004, cited in Mitchell 2008: 427, emphasis in original).

CONCLUSION

The twin threats are now oblivion and diagnosis (Patton 1989: 32)

In 1989, Cindy Patton highlighted an inherent tension of gay men's (in)visibility in discourses of HIV/AIDS. To be invisible was to be 'annihilated'; absent in mass media and from the institutions where the knowledges of HIV were constituted (Patton 1989). Yet to be visible was to be known; public in one's HIV/AIDS status and the desires from which it had stemmed (Patton 1989). Indeed, as Butler (2004) has noted, there is an inarguable number of benefits to having one's desires, practices, and identities recognised in discourse. In societies of biopower, resources are directed toward populations who are perceived to deviate from an 'accepted' rate of disease transmission (Foucault 2007). For instance, in Chapter One I indicated that LGBTQ+ women have been foreclosed from accessing PrEP, unless they are in a 'heterosexual' relationship with an HIV-positive man. It is in these lived effects that the injuries sustained through LGBTQ+ women's symbolic annihilation from epidemiological knowledges are most salient.

Hence, while a number of scholars have been critical of medicalisation (see Illich 1997), their accounts tend to neglect the significance of medical knowledges to the liveability of LGBTQ+ lives. Outside HIV, for instance, some trans* individuals rely on the medicalisation of gender dysphoria in order to access hormone replacement therapy (HRT) and surgical procedures (Butler 2004). Thus as Morgan argues, medical definitions can enable individuals to enact a form of "medicalised agency": producing new modes of empowerment through granting them the right to make choices regarding their own body (1998: 96). However, as this thesis has demonstrated, LGBTQ+ women have largely been rendered unintelligible in the dominant problematisations of HIV. Instead, their practices, identities, and desires occupy a liminal state of *non*-medicalisation in Australian discourse – deemed to require neither medical solution nor definition. Subsequently, if the 'problem' of HIV were to be reconceptualised as 'medical problem' for LGBTQ+ women, it might legitimise their calls for preventative technologies, such as PrEP.

Despite this, I am inclined to follow Sarah Lamble's (2009) hesitance to promote LGBTQ+ women's 'visibility' in discourse. For instance, Foucault has posited that subjects who enter into discourse become liable to the tactics of disciplinary power:

“perfectly individualised and constantly visible” (1991: 200). This has led some to argue that “visibility has become ‘a trap’”, with instances of invisibility providing (moments of) shelter in a society structured around mechanisms of surveillance (Ruitenberg 2010: 619). In a slightly different vein, Judith Butler has argued that it is perhaps preferable to “escap[e]...the clutch of...norms [that are] loathsome” (2004: 3); that is, those that threaten to make one’s life “unbearable” (Ahmed 2010: 97).

And finally, as Daphne Patai (1992) has noted, when minorities become visible, they are often forced to endure forms of ‘surplus visibility’; that is, to live under the allegations that they are ‘too much’. For instance, (particularly feminist) LGBTQ+ women must tolerate their ‘surplus visibility’ when they are accused of being *too* loud, *too* angry, and *too* unfeminine. Indeed, a roll of the eyes (Ahmed 2017), an accusatory comment (Logie 2015), or an invasive question (Müller 2018) is all that it can take to unsettle one’s claims to forms of ‘moderate’ visibility.

Thus LGBTQ+ women’s inclusion in HIV discourses might prove more injurious than their exclusion. Instead, it is, perhaps, preferable to question the foundations of such power-knowledge regimes, in order to destabilise their normative claims to ‘truth’ (see also Lamble 2009). As emphasised in Chapter Three, this approach lies not in its “assimilation” of LGBTQ+ women into HIV discourses (Olson and Worsham 2000: 744), but rather in its ability to probe into particular “silencing practices” (Dahl 2017: 103). It is here that we might begin to conceptualise the relation between ‘risk’, ‘gender’, and ‘sexuality’ differently (see Lamble 2009; Bacchi 2009).

Self-Problematisation

My position as both researcher and social subject necessarily impact the way in which I am able to read and interpret data. Attending to these standpoints is to recognise this thesis’ participation in what Annemarie Mol has termed “ontological politics”; that is, the constitution of the ‘reality’ it has sought to analyse (1999 cited in Bacchi 2016: 2). In this brief section, I will undertake a short exercise of self-problematisation, as elaborated in Chapter Two, in order to make one of this thesis’ solutions – and its inherent problematisations, presuppositions, and effects – explicit.

Throughout this thesis, I have favoured structural solutions to the ‘problem’ of HIV. Aligned with my background in gender studies, I have thus conceptualised HIV as an

intersectional inequality and structural violence ‘problem’, rooted in complex, interlocking systems of (among others) homophobia, misogyny, and transphobia. This problematisation rests on the presupposition that social inequalities can impact on particular health ‘issues’ and, hence, must be solved at the level of the State. Here, the State is constituted as a responsible entity, operationalised through human rights and health promotion discourses. Not only does this entail an often Western presupposition of personhood, but this position radically configures the relationship between the individual and the State.

In addition, this thesis has rested on the presupposition that LGBTQ+ women exist and are affected by HIV. In doing so, I have participated in a “dividing practice”, where the needs of LGBTQ+ women are deemed to be different from others in the population (Bacchi 2015a: 139). Instead, I could have used the behavioural category, WSW, which aims to overcome the ‘problem’ of identity through a focus on ‘risk’ behaviours (Young and Meyer 2005). Yet this renewed focus has been critiqued for its assumption that the category ‘woman’ “is not an identity” (Kaplan et al. 2016: 825). Such categories can, too, silence the intertwined violences of misogyny and homophobia which become inscribed on LGBTQ+ women’s bodies (see also Logie and Gibson 2013; Young and Meyer 2005).

Concluding Remarks

While it is probable that LGBTQ+ women represent only a fraction of those diagnosed with HIV/AIDS in Australia, their absence in discourse is not negligible. Such invisibility is not simply the result of an epistemological gap or of warranted “inattention” as resources have (rightly) been diverted toward ‘higher-risk’ populations (Proctor and Schiebinger 2008: 7). Instead, this thesis has argued that LGBTQ+ women’s invisibility in HIV discourse(s) has required “wilful acts of ignorance”, enacted through the problematisations of both *The Seventh National HIV Strategy* and *Lesbians on the Loose* (LOTL) (Lamble 2009: 112).

Returning to the epigraph to this thesis’ introduction, I have subsequently argued that LGBTQ+ women have (re)emerged in particular enactments of ‘risk’ which “survive at the margins” of dominant discourse(s) (Bacchi and Goodwin 2016: 22). It is in these (albeit fleeting) moments that normative biomedical, phallogocentric understandings of HIV ‘risk’ might be disrupted.

Further research could thus delineate how such (non)risk subjectivities are managed in the lives of LGBTQ+ women living with HIV or AIDS. Such research could interrogate how LGBTQ+ women occupy the norms of HIV in ways that (re)produce its knowledges, (re)negotiate its parameters, or disrupt its claims to 'truth'. Hence, the question that remains does not concern whether invisibility is desirable. Rather it demands an examination into the forms of visibility that are required for Australian LGBTQ+ women to live with HIV: that is, to access preventative medications, services, and care without becoming violently ascribed to heterosexualised categories of 'woman'.

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