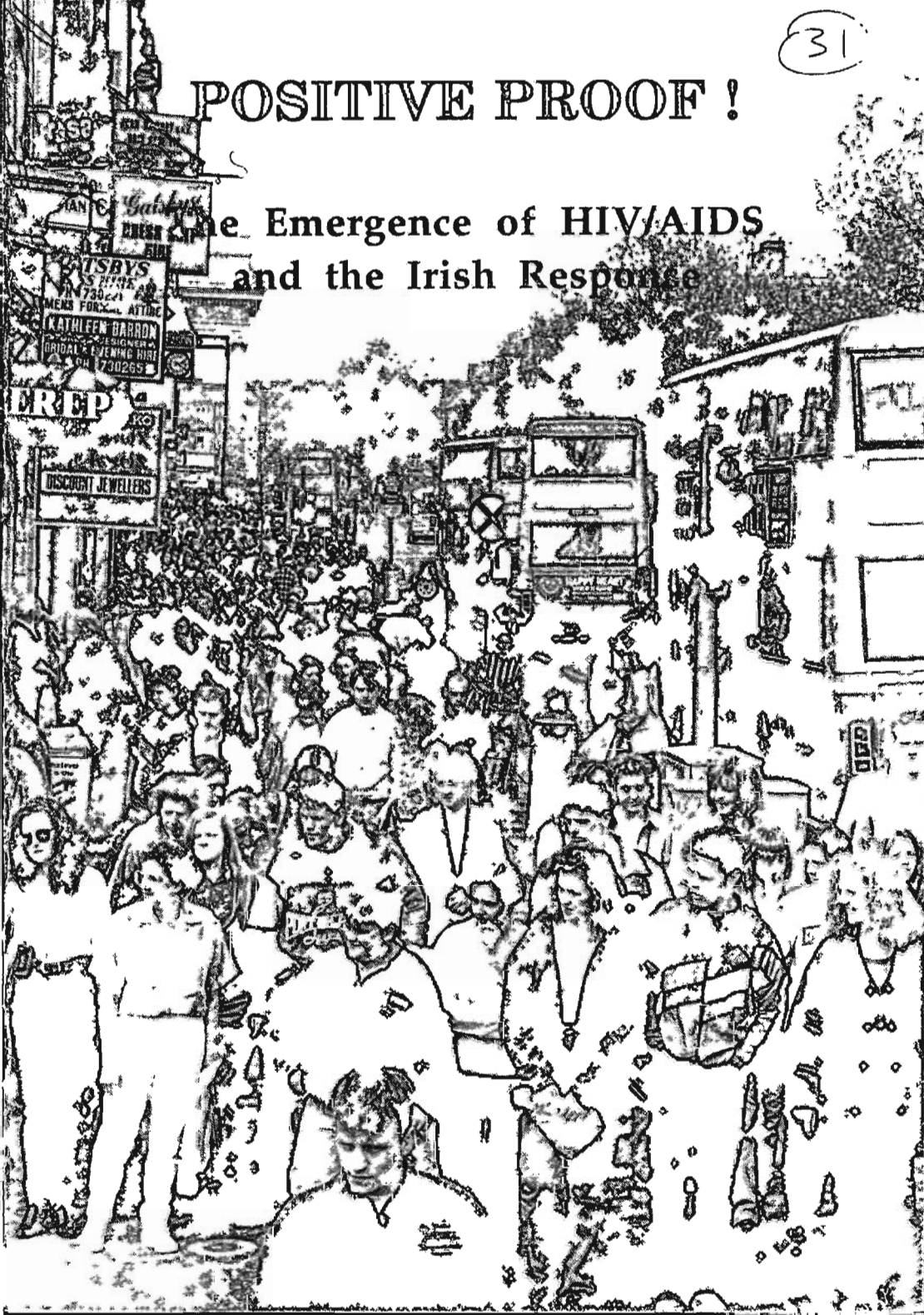


POSITIVE PROOF !

The Emergence of HIV/AIDS and the Irish Response

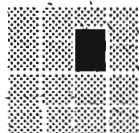


POSITIVE PROOF !

The Emergence of HIV/AIDS and the Irish Response

Marcella Duffy

APRIL 1993



**SOCIOLOGICAL
ASSOCIATION
OF IRELAND**

Acknowledgments

I am grateful to all those who gave of their time and energies in assisting me in this study. In particular, I would like to thank Dr Michael MacGréil who guided it, and Dr Mary Corcoran for her practical help and encouragement in preparing the manuscript for publication. The study would not have been possible without the cooperation of the staff and the service-users of the agencies working in the HIV/AIDS field. I am also thankful to the Sociological Association of Ireland for providing the opportunity to publish.

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Introduction

AIDS is an acronym that stands for Acquired Immune Deficiency Syndrome, a physical condition in which the body's immune system has been compromised by the activity of a virus called Human Immuno-deficiency Virus (HIV). The syndrome, which in itself is a purely medical condition, has implications that go beyond the realm of medicine and into the social sphere. The main reasons for this are the taboos surrounding the modes of transmission and also the fact that, since there is no cure or vaccine, the syndrome is usually equated with death. HIV/AIDS has been defined as pandemic, that is, a worldwide phenomenon, threatening the stability of every society.

HIV/AIDS is a complex phenomenon, not only in its medical aspects. It also unveils the structures of society, exposing poverty, attitudes towards sexuality (the myths and taboos), racism, xenophobia, and the socio-economic power structures. It forces society to question its attitudes towards these issues and to integrate the consequences of the syndrome in its midst. It is a stigmatised syndrome within society. This is primarily due to the frequent avenues of infection, that is, sex or rather certain sexual practices, and sharing of needles, a practice mainly found amongst intravenous drug users. The initial naming of the phenomenon, G.R.I.D. (Gay Related Immuno Deficiency), which conveys obvious implications, led to stereotyping and scapegoating which rendered most societies incapable of coping adequately with the syndrome.

The first section of this work reviews the socio-historical emergence of HIV/AIDS on an international scale. The second section analyses the Irish response to the phenomenon by government, governmental agencies and non-governmental organisations. This section also includes the perspective of those working in the field towards this response, and, through their experience, the reality of living with the syndrome. Within the Irish context, many of the services that have been provided to date have centred mainly around drug usage. This in effect negates all other modes of transmission, especially heterosexual

transmission. It also points to the difficulty of providing an inclusive service to homosexuals, since homosexuality remains criminalised in Ireland. At the same time, it is misleading to assume that homosexuals constitute an homogeneous group for, like heterosexuals, they are not. The research was carried out in the greater Dublin area over the period January to June 1992.

Appendix I gives the statistics of HIV/AIDS in Ireland to the end of 1992, and Appendix II offers a selected bibliography.

A New Phenomenon

"What started as a problem perceived to belong only to the gay community has become the nation's number one health concern; every sexually active person is at risk." (Lewis 1988)

The HIV virus knows no boundaries. The virus does not discriminate on the basis of colour, class or ethnic origins. Neither can the virus differentiate between sexual orientations. Both females and males can contract the virus through sexual activity. Religious affiliation or persuasion does not act as a protector from the syndrome. The virus is not an intelligent entity which can distinguish between diversities within human nature.

These facts were established in the early days of the history of HIV/AIDS. Yet stigma, fear, discrimination and denial of the existence of the phenomenon, have been the main characteristics of every Western society in dealing with it. Before seeking an understanding to this reaction, it is necessary to define HIV/AIDS and consider the socio-cultural treatment of the epidemic from its initial discovery in 1981.

What is HIV/AIDS?

The letters A.I.D.S. stand for Acquired Immune Deficiency Syndrome. It is a fatal syndrome that is thought to be caused by the Human Immuno-deficiency Virus (H.I.V.), "the generic term for two viruses known as HIV-1 and HIV-2" (Panos Dossier 1990). This virus damages the human immune system which ordinarily protects the body from infections. The damage or suppression of the immune system leaves a person susceptible to other infections. It is also the only known virus that can break through the wall protecting the brain, causing dementia, known as AIDS Dementia Complex.

While attempts have been made to categorise HIV infection into a series of stages (symptomless infection, swollen glands, AIDS-related complex (ARC), and AIDS), most individuals do not progress in this way (Miller 1990). Some people may develop dementia without showing other signs of illness. Others may develop swollen glands almost immediately upon being infected and have no other illness. Still some others may be infected and show no signs of illness. Not everybody with ARC, for example, develops AIDS (Mayer 1990). There is no step by step progression of infections and malignancies associated with the virus. No two individuals upon infection will develop the syndrome in the same way (Levine 1990).

For these reasons, there is a cloud of uncertainty surrounding an individual who is diagnosed as HIV positive. Each person needs to be treated in an individual way with the progression of the disease depending upon her/his health and ability to cope with the diagnosis.

How is HIV Transmitted?

Three modes of transmission have been established by the World Health Organisation (WHO):

1. "Through sexual intercourse¹ (from an infected person to his or her sexual partner -man to woman, woman to man, man to man, woman to woman) or donated semen
2. From exposure to blood, blood products or transplanted organs or tissues. Exposure to HIV-infected blood may occur as a result of the transfusion of unscreened blood, the reuse of contaminated syringes and needles, for example, by intravenous drug users, or in other settings.
3. From an infected mother to her foetus or infant, before, during or shortly after birth (perinatal transmission)." (WHO 1990)

The virus is **not** transmitted through casual contact with an infected person, such as sharing a house, or through social contact, contact at school, work or in prison or person to person contact (Shilts 1987, Panos

¹Sexual intercourse refers to penetrative penile-vaginal, penile-anal, or oral-genital contact.

Dossier 1990 and others). Neither is the virus transmitted through water, insects, swimming pools, food, or any objects which a HIV-infected person may use (WHO 1990). WHO further states that "AIDS is essentially a sexually transmitted disease" (WHO 1992).

Reactions to the Syndrome

Why do we find hostile reactions to the syndrome? The answer may be found in the taboos that surround sexuality and sexual practices. Elizabeth Kübler-Ross suggests that:

"AIDS has become our largest sociopolitical issue, a dividing line of religious groups, a battleground for ambitious medical researchers, and the biggest demonstration of man's inhumanity to man - even far exceeding the treatment of Lepers in Damien's day." (Kübler-Ross 1987)

This is reiterated by Hancock and Carim when they assert that "like leprosy or the Black Death in the Dark Ages, AIDS seems to work in mysterious ways, and like those ancient pestilences a terrible social stigma attaches to it" (Hancock and Carim 1986). Carl Miller expands this by stating that AIDS

"... stretches our conscious and unconscious selves to their limits. Our social, religious, moral and political concerns about death, sex, disability and race all combine in the acronym that will define the 1980's for future generations." (Miller 1990)

Discovery of the Phenomenon

The first AIDS cases were reported in the United States of America in 1981. The reporting was by accident rather than by design. Sandy Ford, a technician, had received nine requests for the drug 'pentamidine' at her office at the Center for Disease Control (CDC) in Atlanta, Georgia, in the space of a few months. The drug pentamidine had not been officially licensed for widespread use and it seemed that no interest was forthcoming from commercial companies perhaps because of the lack of profitability in the drug (Shilts 1987).

It was the inability of the doctors who requested the drug to explain the cause of pneumocystis carinii pneumonia (PCP) which they were treating, that drew Ford's attention. A task force, led by Dr James Curran, was set up to investigate the requests. Although PCP did exist prior to 1981, it was perceived to be a condition which was usually presented in patients after treatment for known diseases.

In Europe, there were eight deaths by 1980 which were retrospectively identified as AIDS-related. Shilts documents the eight cases: five women, two men and a child, all of whom had an African connection, either through working in Africa or being citizens from African countries. The knowledge available in Europe, especially in the Pasteur Institute in Paris which played a direct or indirect part in the care of these patients, was that the phenomenon was not gender-bound nor confined to one sexual orientation. As it will be seen, this was a fact that had delayed recognition of cases in the U.S.A.

By December 1989, 162 of the 166 WHO member states had reported AIDS cases to the Organisation and in 1991, China reported its first AIDS-related cases.

Initial Controversy

Where did the HIV virus originate? Renee Sabatier informs us that, "in theory it ought to be possible to find out where and when the first case of AIDS occurred. In practice, this is not easy." (Sabatier 1988). Why is it so difficult to locate the possible origin of this virus? The mode of transmission of the virus has led to controversy surrounding the possible source or sources of origin.

The WHO indicates that the main mode of transmission of HIV worldwide is sexual activity. The stigma that is often attached to sexually transmitted diseases (STD) may have rendered governmental agencies reluctant to deal with the phenomenon.

In some societies, such as Ireland, male homosexuality is a criminal offence. In others, while it is not criminalised, it is highly stigmatised. Both of these factors hinder the development of comprehensive, inclusive, preventive and educational programmes. Similarly, the categorisation of "high/low risk" groups hampered

governmental officials in viewing HIV/AIDS as a relevant subject matter for discussion by all citizens. This also impeded research into the origins of the phenomenon. The groups which were initially said to be at "high risk" are collectively known as the "4 Hs": Homosexual men, Heroin users, Haitians and Haemophiliacs.

Homosexual men

Patton (1985), Altman (1986) and others have argued that the virus was perceived to affect only male homosexuals due to what they call the 'overload theory'. This theory proposed that there was a connection between the perceived life-style of homosexual men and their susceptibility for HIV infection. This life-style included an over-indulgence in sexual activity whereby homosexual men had hundreds of partners/sexual encounters a year and the use of nitrates (poppers) for heightened sexual awareness (Shilts 1987). Patton views this as 'an anti-contagion' theory: the 'public' doesn't live the gay life-style and therefore can't get AIDS" (Patton 1985). In other words, if one does not have multiple sexual encounters one is 'safe'.

This was one of the first 'discoveries' at the CDC in Atlanta which led to the belief that life-style was a causal factor in contracting the HIV virus. As Shilts (1987) indicates, the initial research into the virus was predominantly focused on the life-styles of homosexual men. Bathhouses were credited as places where homosexual promiscuity took place. Criticism levelled against bathhouses and other places where anonymous sex could be obtained culminated in the suggestion that they should be closed. They were seen by the health authorities and others as potential health hazards. Masters et al, argue that:

"It is both puzzling and distressing to see that in a number of locations, including New York City, homosexual bathhouses are still in operation. The basic contention of those who advocate keeping the gay bathhouses open is that they serve as education centers, reaching an audience that otherwise wouldn't receive adequate public health warnings about high-risk behaviour. This notion of bathhouses as institute of higher learning is totally nonsensical since the primary purpose of gay baths has long been to provide a meeting place for anonymous sexual encounters." (Masters et al. 1988)

Opposition to the closure of bathhouses came not only from gay activists but also from the owners of the clubs (Altman 1986). Weeks informs us that:

"Although promiscuity has long been seen as a characteristic of male homosexuals, there is little doubt that the 1970s saw a quantitative jump in its incidence as establishments such as gay bath-houses and back-room bars, existing specifically for the purpose of casual sex, spread in all the major cities of the United States and elsewhere, from Toronto to Paris, Amsterdam to Sydney." (Weeks 1985)

The male homosexual life-style was generally perceived as being very promiscuous and homosexual promiscuity is apparently regarded as being different from heterosexual promiscuity. The connotations surrounding promiscuity differs for the two groups, leading one into a diversity of norms acceptable for one sector within society and not for another. Therefore to use the concept of promiscuity in a discussion of HIV or/and AIDS is to directly stigmatise an individual or group through their past sexual history. Sabatier suggests that

"... sex in nearly all human societies is surrounded by taboos. Few people discuss such a sensitive issue without making or implying moral judgments - or feeling that moral judgments are being made about them. And when people from one ethnic group discuss AIDS in another ethnic group, which inevitably involves discussing other people's sexual behaviour, suspicions of racial and ethnic prejudice are easily aroused." (Sabatier 1988)

The commercialisation of sex is a prominent feature of present day society for both heterosexuals and homosexuals as a response to the sexual revolution of the 60's. It has been pointed out that

"Promiscuity, ... is not the sole preserve of homosexuals and, although the scale may be less, multiple partners during the sexually active years are very much the norm for heterosexuals as well." (Hancock and Carim 1986)

AIDS was firmly linked to sex. Many felt it had something to do with the kind of sexual activity exclusively pertaining to homosexual males.

"In the fear and loathing that AIDS evokes, there is a resulting conflation between two plausible, if unproven theories - that there is an elective affinity between disease and certain sexual practices, and that certain practices cause disease - and a third, that certain types of sex *are* diseases." (Weeks 1985)

It was the initial discovery of the syndrome amongst a large proportion of the American homosexual male population that led to the nomenclature GRID (Gay Related Immune Deficiency). It was this nomenclature given to the new disease that gave rise to the popular impression of 'gay plague' or amongst medics 'gay cancer' (Altman 1986, Shilts 1987, Patton 1985 and others). The stigmatisation of gays was made possible because of the prevalent norm underlying the syndrome that "disease-stricken people are immoral, healthy people righteous" (Patton 1985).

In 1982, the term GRID was replaced by AIDS but the perceptions of the public do not appear to have fully changed. The perception remains widespread that, if one did not belong to the category or perceived oneself as not belonging to the category of homosexual male, then one was 'safe'. This, in turn, led to a false sense of security and, to a large extent, a slow response by authorities in dealing with the AIDS syndrome.

French doctors were the first to conclude that HIV/AIDS was not a disease confined to male homosexuals. Such an observation was slow to gain acceptance among American physicians who appeared unable to justify an AIDS diagnosis in patients other than male homosexuals. Doctors are not immune, by virtue of their profession, to society's beliefs, norms, values and attitudes. As Krech et al. indicate "attitude change is brought about through exposure to additional information, changes in the group affiliations of the individual enforced, modification of behaviour towards the object, and through procedures which change personality." (Krech et al. 1962). Attitudes towards treating HIV/AIDS individuals **did** change when further knowledge was available.

Meanwhile the gay community in America, as elsewhere, was coming to terms with the phenomenon, moving from a state of thinking that it was a scare tactic by those who suffer from homophobia; to one of anger (why us?); to one of guilt; finally to acceptance, whereby forces had to be mobilised to care for the increasing numbers of its members with sero-positivity, if, for no other reason than that the authorities were reluctant to do so (Sabatier 1988). In the U.S.A., Gay Men's Health Crisis (GMHC) was set up in 1982. Its aims were, firstly, to gather as much information as possible about the new syndrome and, secondly, to educate gay men about the virus and update them as the situation developed. Thirdly, they organised fundraising events for research, hospitalisation and care for those who were infected, as well as funds for informative leaflets and pamphlet distribution. In 1982, the Kaposi's Sarcoma (KS) Foundation was established and in mid-1983, was renamed the the San Francisco AIDS Foundation. Late 1982 saw the inauguration of the 'Buddy Program' which established teams of volunteers trained in the skills of caring for those who were ill. They also bridged the gap that was created for those who became isolated in the event of the diagnosis being known. The 'Buddy' befriended an individual and was on hand to run errands or sit with her/him.

These are just a few of the organisations set up to support and help the homosexual community to deal with the new phenomenon. Meanwhile, another less cohesive group had to deal with the phenomenon, namely, intravenous drug users (IVDUs) or, as first perceived, heroin users.

Intravenous Drug Users

The stereotype of AIDS as being a 'gay plague' or 'gay cancer' led to false reporting to the CDC in the U.S.A. and central administrations elsewhere (Shilts 1987, Altman 1986, Panem 1988, and others). Some physicians reported cases as being homosexual rather than heterosexual, as they perceived the patients to be falsifying their social history. The advent of the acronym AIDS paved the way for more accurate reporting. The realisation that the HIV virus did not harbour inclinations towards a certain group within society enabled medics to detect the virus in non-homosexuals.

Intravenous drug users became the second largest group to be detected with the virus. The mode of transmission, in their case, is twofold: through needle and syringe sharing, which is part of the ritual of IV drug use, and through sexual intercourse. This knowledge led to the call for policies that would prevent this group from becoming the bridge between AIDS and the 'general population' (Altman 1986, Collier 1987, Panem 1988). Those advocating such policies seemed, however, to ignore the fact that I.V. drug users have a sexuality, that they can be homosexuals, bisexuals or heterosexuals.

IVDUs are not a homogeneous group comprising of individuals who are long-term users: there may be individuals who occasionally use intravenous drugs but would not consider themselves as users. For example, a business woman/man may use I.V. drugs while on business trips as part of their relaxation but may never use them at home. Similarly, a college student may 'shoot up' while in college but cease on entering into the workforce. Cases such as these are not hypothetical but have been documented by people working in the field. The evidence to date implies that people who may have used I.V. drugs in the past are now presenting themselves as HIV positive. These individuals do not fit into the popular assumptions made about drug users: "antisocial, always use illegal drugs, criminal acts, unpleasant habits, infections, aggressive, unemployed, unskilled, educationally and emotionally disadvantaged" (Greenwood 1990). This renders the category 'general population' too vague, as many drug users (HIV or not) are integrated members of society.

At the same time, it would be a misinterpretation to presume that all IVDUs are individuals or groups using illegal drugs, such as heroin and cocaine. There are many who would never touch heroin but use 'legal' drugs such as palfium and diconal, procured either in a legal or illegal way.

Prior to AIDS, death was already quite common within the I.V. drug users' subculture. There are four main reasons for this:

1. Overdoses
2. Infections, such as hepatitis B and pulmonary diseases
3. Adulterants, that is the dilution of heroine with talc, amphetamines; barbiturates and other substances (As this cloggs the veins preventing the circulation of blood)
4. Malnutrition.
(O'Donohue and Richardson 1984, Young 1972).

As Des Jarlais, Casriel and Friedman (1988) inform us, the experience of death from an overdose is very different than death from AIDS. They illustrate this statement in Table 1 below:

Table 1: Comparison of Overdose Death and AIDS Death

Characteristics	Overdose Death	AIDS Death
Time duration	Immediate	Protracted
Physical characteristics	Euphoria	Pain, debilitation
Social reaction	Asocial	Isolation, strained relationships, potential intense guilt
Comparison to stressful life	Release	Worsening, leading to suicidal thoughts
Contingent on drug use	Stopping drug use eliminate risk	Often independent of continued drug use

("The New Death among I.V. Drug Users"; 1988)

But being an IVDU does not in itself make one prone to HIV infection, rather "intravenous drug users are at high risk because of the custom among them of sharing needles and syringes" (Prior-Jonson 1988).

Therefore, it is not a matter of the legality or illegality of the drugs consumed, or whether one is an occasional, long term or ex-user, nor the use in itself. Rather it is the custom within the drug culture of sharing their 'works' that places the users and others at risk.

A discussion of IVDUs should not ignore their sexuality. Needle sharing is just one avenue of infection, the other is sexual intercourse. Many studies speak of the lower sex drive of IVDUs, but low does not mean none. Partners of IVDUs, even if they do not use drugs, are at risk for HIV infection (WHO 1992). Similarly, the risk doubles if both partners are IVDUs and share their 'works' between them and others.

Given the life-style of the long term, occasional or ex-users, a distinctive community does not develop, which may further isolate a person upon discovery of being sero-positive. Unlike the gay community which created organisations to initiate a general awareness among their members, no organisation was forthcoming within the I.V. drug user subculture, thus rendering it difficult to get the necessary information across to them.

Haitians

By mid-1982, a number of AIDS diagnoses in the U.S.A. were made in men of Haitian origin. There appeared to be a cloud of mystery surrounding these cases, as "studies reported that homosexuality, injecting drug use and blood products did not appear to play major roles in the transmission of HIV among Haitians" (Richardson 1989). There was increasing speculation that, within Haiti, doctors were re-using needles for a number of patients.

The uncertainty surrounding HIV positive Haitians within the U.S.A. led to them being categorised as an 'at risk group'. This was the first time that a whole people was categorised and it had far reaching effects on the Haitian economy. The insensitivity amongst U.S.A. doctors towards Haitian culture led to their inability to obtain honest social histories. Homosexuality is a taboo subject both within Haiti and Haitian community in the U.S.A. - Medics also lacked knowledge of Creole and some Haitians were not fluent in English (Shilts 1987, Altman 1986).

Tourism is one of the main components of the Haitian economy. Like most of the poorest nations, the sex industry, comprising of female and

male workers, makes a major contribution to the economy. Being a male sex worker does not in itself imply homosexuality but rather, in poor nations, it is seen as a means of securing financial security.

Labelling all Haitian men who are sero-positive as being homosexual would be a gross error, for the majority are neither homosexual nor I.V. drug users. Altman (1986) points out that, by 1986, over a third of those diagnosed as HIV positive and/or having AIDS in Haiti or among Haitians in the U.S.A. were women. The controversy about the diagnosis of HIV among Haitians partially reflects the initial inability of U.S. doctors to look beyond the label of 'gay cancer'.

It appears that the U.S.A. tried to pin the origin of the virus on Haiti, but, as commentators argue, if this was so, the whole population of Haiti would soon be wiped out due to infection and the lack of financial resources to deal adequately with the phenomenon. Through pressure groups within the U.S.A. and pressure from the Haitian Government, however, Haitians were dropped from the official risk groups in 1985. But this was too late for the Haitian economy which collapsed with the dramatic fall in tourism in the intervening years. The American perception was that Haiti was an unsafe destination for vacation. It also indicates that the modes of transmission were not internalised. Vacationing in a certain country does not mean being 'at risk' for infection. Rather it is certain behavioural patterns that make the individual receptive to the virus, whether in ones own country or on vacation.

The high rates of infectivity amongst Haitians were linked to the sharing of needles and heterosexual promiscuity (Shilts 1987). Even with this assertion, the Haitian economy today is still trying to stay afloat. This is emphasised by WHO (1992):

"Poverty makes whole communities vulnerable to AIDS by forcing men to leave their families in search of work, by leaving people hopeless enough to turn to the solace of drugs, and by making prostitution a survival strategy for women and children. AIDS then completes the vicious circle by making the community even poorer."

What the Haitian experience did signal was an early warning that the poorest countries and the poor within Western societies would be

highly affected. This signal was not heeded and today, it is precisely these people who are the most affected. (Panos Dossier 1990, Sabatier 1988, Sadownick 1990). It also pointed to the type of xenophobia that is a characteristic of the phenomenon.

Haemophiliacs

By the end of 1982 it was becoming increasingly noticeable that the HIV virus was not contained within any identifiable group. Cases of HIV positivity were being seen in haemophiliacs and those who had received blood transfusions.

Haemophilia is a hereditary disease which is confined almost entirely to males. The cause of the disease is a defect in blood clotting or coagulation. The individual suffers from an insufficiency of the antihæmophilic factor or Factor VIII as it is commonly called. In the treatment of haemophilia, Factor VIII, which is derived from plasma, is administered intravenously.

Collier (1987) comments on the fact of haemophiliacs and those who received blood transfusions becoming HIV positive by asserting that

"contaminated blood products caused some people to become infected with the virus and this was a *most tragic* early development."²

It seemed as if it was acceptable that homosexuals and I.V. drug users were infected, for they had "been vilified, cast as expendable commodities best left to the ravages of contagion" (Masters et al. 1988). There appeared then to be two categories of people emerging with AIDS: the '*innocent*' and the '*not so innocent*'. Haemophiliacs acquired HIV positivity in the main through synthesized Factor VIII, a blood-clotting agent which was hailed as a revolution that would change the standard of life for all haemophiliacs as, prior to this, most of them had to undergo regular blood transfusions. Unfortunately, Factor VIII was sometimes contaminated with the HIV virus.

Less than two years after the initial discovery of the virus, the knowledge that synthesized Factor VIII and other blood products contained the HIV virus was gleaned and by December 1982

²The italics are mine.

"... virtually every patient with hemophilia in North America and Europe who had utilised Factor VIII (an extract of pooled plasma) manufactured in the United States showed evidence of exposure to the virus that causes AIDS." (Panem 1988)

Yet it took another three years before all Western governments declared their blood supplies HIV negative.

Since it is now known that there are three main routes of transmission (see p. 6 above), it might appear understandable why one would treat one infected individual differently to another. Some individuals can be thought of as not being responsible for their infection, "the innocent" (e.g. haemophiliacs) while others (such as male homosexuals and/or I.V., drug users) can be thought responsible, "the not so innocent". As Treichler points out,

"ambiguity, homophobia, stereotyping, confusion, doublethink, them-versus-us, blame-the-victim, wishful thinking; none of these popular forms of semantic legerdemain about AIDS is absent from biomedical communication." (Treichler 1988)

Individual responsibility for acquiring the virus has played a big part in people's responses. It led to stigmatisation, stereotyping, scapegoating and prejudicial attitudes towards individuals who are HIV positive. As Parmet succinctly puts it:

"For infected individuals, discrimination is a cruel and painful accomplice of HIV, affecting their ability to work, obtain health care, and live as equal members of the community. But discrimination does more than that. It colours all questions of AIDS policy." (Parmet 1990)

Infection of haemophiliacs and those who received blood transfusions marked the watershed which pointed to the fact that anyone could 'catch' AIDS.

HIV/AIDS in Ireland - Patterns of Response

The patterns of diagnosis that emerged in the U.S.A. were reflected in Ireland which registered its first case of HIV/AIDS in 1982. HIV/AIDS cases were first diagnosed in the homosexual male population, secondly in the Intravenous Drug User (IVDU) population, thirdly in the haemophiliac population and those who had received blood transfusions and finally, in the heterosexual population. Dr. Derek Freedman, a physician in Genito-urinary Medicine at St. James' Hospital, Dublin, informs us of the situation regarding the advent of HIV/AIDS:

"In some respects Ireland was ill-prepared and ill-equipped to deal with the AIDS epidemic. Our facilities for the control of sexually transmitted diseases were lamentable in the 1970s and 1980s." (Freedman 1987)

In the foreword to this text, Dr. James Walsh, Deputy Chief Medical Officer and AIDS Co-ordinator at the Department of Health³, states that

"AIDS, or at least infection by the virus that causes AIDS, is by now endemic in this country, though we do not have as many cases as some other European communities." (Freedman 1987)

The response patterns that emerged in other Western countries were mirrored in Ireland. The responses of Government and governmental agencies and secondly of non-governmental organisations to the phenomenon are reviewed in this section.

³This post was abolished in 1992.

Government and Governmental Agencies

As in Great Britain, the first major campaign initiated by the Irish Government was in 1987. A booklet was published, entitled *AIDS? Information Booklet*, which was updated in 1989 and retitled *AIDS The Facts*. The 1987 publication dealt with issues such as what AIDS is; what ARC is; groups at risk; how the virus can be contracted; the effectiveness of condoms; children with HIV/AIDS, and social issues. Under the heading of 'Groups at high risk from AIDS', the following is cited:

"Homosexual or bisexual men who are sexually active.
Intravenous drug abusers, particularly those who share needles.
Haemophiliacs and those who have transfusions in countries where blood screening services are inadequate.
Sexual partners of any of the above.
New born babies of mothers infected with HIV." (1987).

This was changed in the publication two years later, when it was stated that there were four proven ways in which HIV can be passed from person to person

- 1) "Intimate sexual contact - heterosexual or homosexual - involving exchange of body fluids with an infected person.
- 2) Sharing injection needles with an infected person.
- 3) From an infected pregnant mother to her baby.
- 4) Injection or transfusion of blood or blood products taken from an infected person." (Op. cit. 1989)

The emphasis had changed from 'at risk groups' to 'at risk activities'. Unlike their British counterparts, these booklets were not issued to every house in the country, but were made available through health centres and community pharmacists. Thus, the booklet was inaccessible to those who did not attend these centres. The 1987 campaign also utilised T.V., radio, and bill boards in creating public awareness of HIV/AIDS.

Prior to this, in 1983, the Blood Transfusion Board introduced a policy of self-exclusion from blood donating for all those belonging to 'at risk groups'. That is, all those who were initially categorised as belonging to 'high risk groups' were asked not to donate blood. This policy was consistent with those introduced in all western societies when it was discovered that the HIV virus was transmitted through blood products. The Board introduced the testing of all blood donated in 1985, when blood screening for HIV became available. All organ transplants are also tested for the HIV virus, thus eliminating the transference of the virus through blood transfusions and transplants. Ireland became self-sufficient in heat-treated Factor VIII in 1987.

The first Dáil debate on HIV/AIDS was held on 25th April, 1989, when a motion was brought on HIV-infected Haemophiliacs (*Parliamentary Debates*, Vol.389, Nos. 1 & 2). The second Dáil debate was held on 27th and 28th, November 1990. This was the first debate to deal with all aspects of the AIDS epidemic in Ireland (*Parliamentary Debates*, Vol.403, Nos. 1 & 2).

Various initiatives were undertaken by the Government and governmental agencies, such as the Outreach Programme in the AIDS Resource Centre in Dublin, established by the Eastern Health Board (EHB) in 1989. This was an extension of the EHB 1988 Outreach programme for IVDUs. The Centre provides a walk-in clinic for IVDUs. In 1992, a walk-in clinic for gay men was established. This was an interesting innovation, since male homosexual activity is a criminal offence in Ireland. The main thrust of the AIDS Resource Centre is a community-based approach to HIV/AIDS. The clinic is made up of a multidisciplinary team which includes a psychologist, a doctor, public health nurses, outreach workers, counsellors, and social workers. It also operates a drug users programme and educational programme for schools. Sexually Transmitted Diseases (STD) clinics were also established in Waterford, Cork and Limerick.

National Survey on AIDS Awareness

In the autumn of 1989, a pilot educational scheme on HIV/AIDS was launched in twenty second-level schools. This programme was included in all schools in 1990, produced by the Department of Education with the assistance of the Department of Health. The Department of Education provides one-day seminars for teachers on

the use of the material and also updates on information regarding HIV/AIDS. In 1989, a revised edition of the 1987 publication was issued.

In September 1989, the Department of Health, through its Health Promotion unit, commissioned a national survey on awareness of and attitudes towards AIDS. The survey was conducted as a follow-up to two similar surveys conducted in 1987 pre and post the launch of the Department's mass media campaign (Harkin 1990). Harkin indicated that the survey showed a high level of knowledge of the modes of transmission of the virus, but that there was still confusion surrounding casual transmission. In discussing casual transmission, the results indicated that

"Consistent with ignorance about casual transmission, considerable percentages of people said they would be worried, in a number of everyday situations, if in the presence of someone they knew to be infected with the virus." (Harkin 1990)

The most worried groups were farmers and those over 55 years of age, less than 50% of those groups were not worried by sharing utensils, being served food prepared by a sero-positive individual or by using the same swimming pool (Harkin 1990).

When asked who they thought was 'at risk' for HIV, the majority of the respondents estimated that IVDUs were at 'high risk' (95%), followed by homosexuals (88%), bisexuals (75%), haemophiliacs (44%), heterosexuals (29%), with 34% considering heterosexuals to be at moderate risk. When asked the extent they considered themselves to be at risk, 71% replied 'no risk', 25% 'low risk', 1% 'moderate risk' and 4% replied 'do not know' (Harkin 1990). This reflects the perceptions of people working in the field, that is, people do not perceive HIV/AIDS as a relevant issue for everybody in society.

When the respondents were asked how IVDUs could lessen their risk of infection,

"in general, the higher socio-economical groups were less likely than the lower socio-economical groups and farmers to

say 'give up drugs' and more likely to mention not sharing needles or using clean needles." (Harkin 1990)

The survey also asked about effective things that sexually active people should do to reduce their risk. 85% of respondents were aware that condoms were an effective way in preventing transmission of the virus. 78% were aware that the contraceptive pill did not help prevent infection. While the survey clearly showed that people were aware of the effectiveness of condoms, adequate legislation on their wider availability throughout the country is still awaited, for to look at the availability within the EHB area does not reflect the accessibility in other Health Board areas.

When the respondents were asked about their main source of information on AIDS to date, i.e. September 1989, the following was gleaned:

Table 2: Main Source of Information about HIV/AIDS

	% mentioning each source	% rating very good/good
RTE (TV)	69	83
Irish Newspapers	55	83
BBC (TV)	40	95
RTE (Radio)	33	80
UTV	28	92
Magazines	27	88
English Newspapers	27	84
EHB/Dep. of Health leaflets	25	75

(Harkin 1990)

The findings would indicate that the EHB/Department of Health leaflets were ineffective in reaching the population and creating awareness, and that the mass media campaign by the Department was relatively successful.

AIDS Task Force

In November 1991, an AIDS Task Force was set up in Ireland, although no legislation has been initiated with regard to HIV/AIDS on housing, employment, insurance and mortgages. The Department of Health's policy is that every G.P. and hospital in the country should be able to deal with clinical symptoms of HIV and AIDS. In reality, this is not the case. For example, the National Haemophiliac Unit is in St. James's Hospital, so that all haemophiliacs, regardless of location, must travel to Dublin. Similarly, others attend St. James' as they perceive it to be the best hospital for obtaining treatment. Only one consultant appointed in St. James to deal with HIV/AIDS, although she has a team of doctors working with her. While Cherry Orchard's 22 bed unit has been a welcome initiative, more beds are required as 10 times that number are diagnosed as having AIDS.

In May 1991, the *Government Strategy to Prevent Drug Misuse* was published. The report was produced by the National Co-ordinating Committee of Drug Abuse, comprising representatives of the Departments of Health, Education, Justice, Foreign Affairs, and Tourism and Transport. The Gardáí, Eastern Health Board, Customs and Excise Service, and the European Community Drugs Co-ordinators Group, as well as the National AIDS Co-ordinator, were members of the committee. This reflects the recommendations of WHO for countries setting up strategy committees.

The committee recognises that drug misuse in Ireland is a complex problem with no easy solutions. Eighteen strategies are proposed, including the establishment of a national database; the provision by the health boards of a mechanism for co-ordination and dialogue between the statutory and voluntary services in their areas; co-ordination at health board level of programmes in the related areas of drug misuse and AIDS; increased involvement of the statutory training and occupational rehabilitation services (FAS, NRB, VECs) in the rehabilitation of drug misusers; the development of community Drug Teams under the auspices of the health boards to operate with the involvement of general practitioners and other health professionals in the targeted area.

The implementation of training programmes for teachers and GPs is also proposed, as well as "the establishment of formal links between the educational, treatment and community services and the prisons" (G.S.P.D.M. 1991). In the area of demand reduction, that is, in relation to the use of drugs, the report recommends education (as a mean of primary prevention), outreach (as a mean of secondary prevention and reduction), treatment and rehabilitation.

In the area of education, it is proposed to utilise the formal and informal structures. The outreach services are to be extended to include links with prisons, welfare services and rehabilitation services. In dealing with rehabilitation, the report states that the "Government accepts that the provision of services aimed at the achievement of drug-free society *only* or harm reduction programmes *solely* are inappropriate" (Ibid). It is proposed to make services available that cater for the individual needs and circumstances of the drug user. In so doing, it is recommended that these services be both "attractive and accessible" to encourage drug users to avail of the services. This is reinforced when it is stated that the strategies implemented "must be community-based, client-orientated and, given the serious nature of the problem, of necessity, innovative". The Government also proposed that the "health boards will, as far as is practicable, co-ordinate their programmes in the AIDS and Drug Misuse areas and designate a senior officer as AIDS and Drug Misuse Regional Co-ordinator".

Since the publication of this report, a consultant for infectious diseases has been appointed for Dublin city to cover the Mater, Beaumont and Cherry Orchard hospitals with effect from, 1993. Two new clinics have also been established: Ashling, situated in Cherry Orchard and one in Amiens St. These clinics are satellites of the AIDS Resource Centre and comprise of a G.P., a needle exchange programme, HIV/AIDS addiction counselling and methadone treatment. The E.H.B. has set up an needle-exchange programme in Inchicore at the request of the residents.

Non-Governmental Organisations

While the first case of AIDS in Ireland was registered in 1982, the first organisation developed to deal with the phenomenon was not established until 1985. In that year, Gay Health Action (GHA) was set up as a voluntary organisation. It was formed to respond to

HIV/AIDS within the gay community and to counteract the misinformation or lack of information available to the community in Ireland. GHA aimed

"to provide information on AIDS and related issues, not only to the gay community, but to the media, the medical profession, health workers, Trade Unions, and the general public." (GHA 1986)

With the support of the Terence Higgins Trust (THT, England), the Gay Men's Health Club (GMHC, U.S.A.), the European AIDS Foundation, the Society for Sexually Transmissible Diseases in Ireland, and the Microbiology unit in University College Dublin, GHA sought to disseminate accurate and up-to-date information to the gay community. As a way of attaining this objective, it produced pamphlets and leaflets on various aspects of the issue, such as *AIDS* (May 1985, and April 1986), *AIDS, The HTLV-3 Test* (December 1985), and *Information AIDS Booklet* (December 1986, and June 1987). Its main aim was to change the sexual behaviour of homosexual men, and it sought to do so not only through the above publications but also by taking its campaign to gay meeting places, bars, and nightclubs. By making personal contact with the gay population, GHA members were able to respond to the fears and anxieties of individuals within the community and to counteract perceptions that HIV/AIDS was not 'their' problem. As one gay man reported on deciding to take the HIV-antibodies test,

"AIDS was over there and in London and in mainland Europe and amongst intravenous drug users and haemophiliacs and surely not among our small gay population in Dublin?" (Magill, July 1989)

GHA also gave advice on taking the HTLV-3 test, now called the HIV-antibody test. It produced cards on safer sex and posters for distribution in all gay venues. In August 1989, GHA published the results of its survey, dealing with the level of awareness amongst the gay community and knowledge of HIV/AIDS, sexual practices and practices that may lead to acquiring the HIV virus. The single most important result of the survey was the overwhelming change to safer sex. Changes were also recorded in all sexual practices, as well as

changes in patterns of relationships and of life styles (GHA Survey Results 1989).

While the GHA has been successful in disseminating information, fears regarding HIV positivity within the gay community still need to be addressed. As an individual working in the field indicated

"I heard recently that a guy went to have a drink with his friend in a gay bar in town and while they talked, another man tapped his friend on his shoulder and said 'don't talk to him, he has AIDS'. If that can go on in a public place in Dublin, then I ask where is their knowledge - to think that they believe that there is even a remote risk of contracting it like that. This is scary."

LHA (Lesbian Health Action) was set up to counteract the belief that lesbians were at 'low risk' for HIV. Their rationale was that lesbians use drugs and some are IVDUs and also that some have sex with men. In July 1990, GHA and LHA were disbanded, and later in the year Lesbian and Gay Health Caucus was established. They have produced *Hot and Healthy News* which looks at areas affecting women and men, such as safer sex, safer drug use, whether to test or not, and dieting issues.

At the same time, the gay community expanded its services to all those who needed them, regardless of the way in which the virus had been acquired, and to all those who were interested in the area of HIV/AIDS.

In October 1985, "Cairde" was set up as a support group for all those affected by HIV/AIDS. An offshoot of GHA, it became independent some time later. It mirrors the "buddy" system in the U.S.A. and elsewhere, befriending and providing emotional and physical support to sero-positive individuals. Cairde train individuals to work on the 'buddy' programme. All these people are volunteers, coming from all walks of life and representing all age groups.

Meanwhile, the Haemophilic Society set about distributing information on HIV/AIDS to all its members. As previously mentioned, haemophiliacs acquired HIV through Factor VIII, a blood clotting agent. Although since 1985 all blood products in Ireland were

being screened for HIV, 40% of the haemophiliac population was already infected. In April 1988, the society made a submission to the Government entitled *AIDS, Haemophilia and the Government*. It stated that of the "300 Haemophiliacs in Ireland, 106 are known to have been infected with the human immune deficiency virus (HIV), 9 have developed AIDS and 1 has died" (Ibid,1988). Individuals living with haemophilia and HIV/AIDS face financial, social, family, and personal burdens. The sero-positive haemophiliac has to cope with

- "Anger and bitterness at the cause of his SEROPOSITIVE status - his medical treatment.
- Fear of developing "full-blown" AIDS and fear of any symptom which can be construed as such.
- Fear of infecting his wife or girlfriend.
- Fear of losing his job or livelihood.
- Burden of not being able to share his fears with friends due to the danger of being ostracised." (Ibid 1988)

It should be noted that these issues, with little variation, not only pertain to haemophiliacs but to all those who are living with HIV/AIDS. The document stresses the needs of haemophiliacs and their families, paying particular attention to life insurance, mortgage, protection insurance, special ex-gratia payments and the setting up of a trust to distribute funds to families and individuals affected. The Haemophilia Society sought a compensation mechanism from the Government on a par with other countries, in cases where the virus had been acquired through public health agencies. It was not until mid-1991 that the Society's demands were met when an offer of eight million pounds was made by the Government.

In 1986, AIDS Action Alliance (AAA) and Western AIDS Alliance (WAA) were established; Cork AIDS Alliance (CAA) was set up in the following year, and 1990 saw the creation of Limerick AIDS Alliance (LAA). In July 1990, AAA changed its name to Dublin AIDS Alliance (DAA) as AAA was perceived to be representing NGOs not only in Dublin but also in all other areas. Each Alliance co-ordinates the work of NGOs being undertaken in their own area, supported by a co-ordinating committee. The NGOs that make up DAA, include Body Positive, Cairde, AIDS Helpline and Women and AIDS. They also partake in the Social Employment Scheme. In 1992, DAA received financial aid from the EHB facilitating the employment of a

secretary, an outreach co-ordinator and a bookkeeper. Up to then only the S.E.S. workers and the administrator were paid.

The Alliance works in the areas of care and support, lobbying, media, publications, outreach and training. Training is provided for both statutory and voluntary individuals/groups working in the area of HIV/AIDS. The training deals with the issues that arise from the day-to-day living with the virus as experienced by those who are sero-positive, including medical issues, and attitudes towards those who are HIV positive.

One important step in the development of an AIDS policy amongst NGOs was the Irish AIDS Initiative Conference (IAI) held in 1988 as a response to the workshop on 'Life, Death and the Challenge of AIDS' held in Benburb in February 1988. The aim of the Conference was to gather together those groups concerned with HIV/AIDS. A Bill of Rights was put forward covering the issues of health care, housing, social welfare, employment and external care. (Irish AIDS Initiative Report, 1988).

Maeve Foreman, social worker in St. James' Hospital, Dublin, detailed the social implications of having HIV/AIDS as well as dealing with issues affecting different subgroups. These include:

- "Loss of social support
- Isolation and loneliness
- Medical restriction
- Reaction of family, partner and community
- Loss of communication to "protect" families from own anxieties can add to isolation and hopelessness
- Occupational disruption - financial hardship
- Discrimination in
 - * Housing
 - * Insurance
 - * Employment
 - * Education
- Marriage and parenting prospects affected
- Sexuality: loss of sexual desire, fear of infecting
- Others: Emotive topic. Impose limits hard to accept
- Need for confidentiality."

Foreman's assertions were sustained in our research, that is, that society

"... treats them like lepers, and you wouldn't totally disclose that you are HIV ... families come into it, you sex life will be questioned, house, insurance, the lot, mortgages, they are totally restricted. Not totally, I suppose, but they are restricted in a lot of ways, so then they feel they are lepers as such, and won't tell anyone so they are encouraged to lie, be devious, people who have the virus."

Families too have been silenced by society's reaction to HIV/AIDS.

"... we talked about the kind of care that's needed in the home when people are dying and how great families can be. But there's the opposite there too. I sometimes see it pictorially - that inside someone's front door, there's this wonderful support but when they step outside the door all they see is negativity and rejection. How hard it is not to be able to go to neighbours to ask them for half an hour while they shop, they feel they have to explain the 'what ifs' - what if there was a concern, etc. The possibility of infection is minuscule but people don't feel that they can ask a simple favour unless they explain the whole story. If it was a person with a heart problem, with cancer, it's different, people are obliging. It is hard on families to go into the shop and have no-one ask how that sick person is. At this stage of the epidemic, we can't afford that anymore. There's too many people sick and dying for us to afford the luxury of turning away and ignoring it."

Foreman also cites the Howies code which was put into practice for those who died of an AIDS-related illness, stating that

"this is a code for people who have died of infectious diseases and the practice is that when people die, they are put into a plastic bag before they leave the ward. This is not meant to be opened again and the coffin is meant to be sealed before removal." (Foreman 1988)

This situation affecting those who have died in hospital⁴ has placed considerable strain on families, partners and friends, for if one dies at home, this practice is not undertaken. Within the report, it was noted that Civil Service employees were protected against dismissal on account of their sero-status which was not the same in other areas of employment.

Two other important NGOs that deal specifically with HIV/AIDS and drugs in Dublin are the Ana Liffey Drug Project, which was set up in 1982, and Merchant's Quay Project.

The Ana Liffey Drug Project was set up in 1982 to deal with the drug problem in the inner city of Dublin. Since the advent of HIV/AIDS, the Project developed to work with the phenomenon in relation to drug users. It aims to be individual-centred, acknowledging that the problem drug users are individuals first and foremost. It believes that drug users can engage positively in a change process and work on their own recovery. In its *Annual Report 1990*, the need for a pragmatic definition of the drug problem is emphasised. The definition used in the Project is as follows:

"Problem drug users are people for whom the continued use of psychoactive drugs creates profound difficulties for themselves and others. These difficulties include: addiction, in relation to drugs which create a psychological craving; withdrawal symptoms in relation to drugs which create a physiological dependence; financial hardship and an involvement with crime in relation to drugs which cannot be brought at a price which the user can afford; court appearances and imprisonment in relation to drugs which are illegal; isolation from family and community in relation to drugs which are not socially approved; serious illness and the risk of HIV infection in relation to drugs which have been administered intravenously with unclean syringes and needles; and, the prospect of being permanently labelled as "junkie", "alcoholic", "unemployable", "outcast" and "deviant" in relation to drugs which have caused problems over a prolonged period." (Ana Liffey Drug Project 1990)

⁴This information was gleaned from a reliable source working in the field.

The Project also states that it aims to be a drug service that is "user friendly" in the sense that "they should incorporate a positive, non-judgmental, non-directive attitude to work based on empathy, self-determination of need and the protection of confidentiality" (Ibid). The Project is engaged in operating a drop-in centre, counselling programme, family support, prison counselling, and a 'Le Chéile' support group for parents. All clients in the Ana Liffey Drug Project have access to the files held under their name thus building a relationship with drug-using individuals based on trust.

The Merchant's Quay Project, set up in 1989, deals with issues such as housing, benefits, medical care and safer sex. It also runs groups and support systems for individuals who want to become and remain drug free. The Project also operates a respite care in a centre in Dublin.

A policy statement on Drugs and HIV/AIDS, derived from a seminar on 'Drug Treatment Policies' in Trinity College, Dublin, in 1990, was submitted to the National Coordinating Committee on Drug Abuse on July 6th, 1990. The statement covers the areas of community drugs teams, priority areas, harm reduction, wider range of treatments, co-ordination/consultation, funding, and the need for a national forum on drugs. The committee's report was published in May 1991.

In 1991, the Drug Workers' Forum (DWF) was set up with the objective to unite all those working in the drug field in a single forum. The Forum produced a newsletter to inform drug workers on progress, needs in the field, and other issues relating to drugs workers. The aims of the Forum are threefold:

1. promote dialogue and formulate policies on problem drug use and other related issues (including HIV, health issues, housing and welfare services, etc.) As a pressure group, it will, in appropriate ways, promote these policies to a wider public, to media and to national policy makers.
2. provide opportunities for members to network, to provide support, to develop knowledge, and to exchange information on problem drug use and other related issues.
3. organise special interest groups, support meetings, publications, training seminars, and other appropriate activities in order to pursue its aims and objectives.
(*What's the Story?*; DWF: Issue no. 2, undated)

Prior to the development of DWF, most voluntary agencies worked separately from governmental agencies. By working together, NGOs and governmental organisations can exchange ideas and facilitate a better understanding of the issues arising, thus working more efficiently to curb the spread of the virus and combat the social problems that arise from the phenomenon.

Meanwhile, the medical profession has pursued its own initiatives in an attempt to deal with the syndrome. The *Irish Doctor*, a postgraduate medical educational journal, has published many articles on HIV/AIDS, under the heading 'The AIDS Programme', such as 'Testing for AIDS' by Professor I.B. Hillary, 'Diagnosis and Management of AIDS' by Brian Otridge, and 'HIV infection and women' by Catherine Hayes, to name but a few.

In 1987, this journal carried out a survey to find out how much doctors knew and needed to know about HIV/AIDS. Aileen Meade, in her article 'Results of Survey on AIDS', states that

"for any doctor to assume that because his practice does not cater for such people at risk there is no need to be alert and well-briefed about AIDS, is complacency bordering on negligence." (Sept. 1, 1987)

The survey found a difference between older and rural doctors in the knowledge of HIV/AIDS, stating that "clearly post graduate education opportunities are less appealing (though really more necessary) for our senior colleagues and less feasible for the rural G.P." (Ibid). It was also noted that 69% of the 400 respondents would not take a blood sample for HIV-testing prior to the patient's consent and 21% felt that insurance companies should be notified in the event of a sero-positive patient seeking insurance. The Irish Medical Organisation had recommended that no doctor should inform insurance companies of their patient's sero-status without the written consent of the patient.

In further issues of the *Irish Doctor*, Dr James Walsh wrote a two-part article on 'An AIDS strategy for Ireland'. In the first, he outlined the medical knowledge of HIV/AIDS and, in the second, outlined a

strategy for the control of the spread of the disease in Ireland. Dr. Walsh placed emphasis on pre- and post-test counselling, and, further, stated that

"these diseases are not confined to urban areas and in the rural or semi-rural situation it is the G.P. who will be dealing with the problem both in terms of treatment and contact tracing." (Walsh 1987)

Here, Dr Walsh reiterates Dr Meade's concern about the necessity of all G.Ps., regardless of location, to be informed about the phenomenon. Dr Walsh also indicated that it "seems unlikely that the HIV virus will spare us because of our difficulties in dealing with sexual problems" (Ibid).

In another contribution to the *Journal*, Dr Owen Carey indicated that a "team approach is essential regardless of who actually counsels the patient" (Carey 1987). He covers issues such as anxiety, depression, and suicidal ideas which can be a reaction to a sero-positive diagnoses. Similar issues are covered by Mary Russell in the article 'HIV Testing Counselling Aspects' (Russell 1988).

In October, 1991, *Forum* published the results of its survey 'Attitudes to HIV among Dublin G.Ps'. Dr Dominick Natin outlines that the main interest in carrying out the survey was to establish what GPs thought about "HIV testing and counselling; Confidentiality aspects of HIV disease; Referral of HIV positive patients; Homosexual patients and Intravenous drugs abusers" (Natin 1991). Some of the main results were:

"Almost 34% of GPs believe that they should not share the care of HIV positive patients.

85% of GPs would counsel a patient when they request a HIV test and only 11% felt that only high risk patients required counselling.

Almost 50% of the GPs felt that they themselves had not sufficient knowledge about HIV disease.

Almost 50% of the GPs felt that their practices would suffer if other patients knew that they looked after HIV patients in the surgery.

The above might explain why 21% of GPs would ask a HIV positive patient to see them outside of normal hours if they required an appointment." (Natin 1991)

While over one third of GPs surveyed felt that homosexual patients were hard to deal with, nearly nine out of ten felt that intravenous drug users were more difficult to manage. Natin calls on GPs to acquire the knowledge and the skills to deal with intravenous drug users. He also advocates that all GPs should be acquainted with the clinical aspects of HIV/AIDS. He concludes his survey with the following comment:

"It is difficult to learn new skills without having had some clinical experience but the next few years will provide us as GPs with a unique opportunity to use the 'consultation' to its fullest by educating all our patients about HIV infection. If we wait until we all have patients with AIDS, it will be too late." (Natin 1991)

Fergus O'Kelly, a G.P., outlined both his experience and the need of IVDUs in a paper entitled 'General Practice Experience'. He stated that "Intravenous heroin use has been a serious problem in Dublin since 1978. Those affected are mainly young people, unemployed with poor educational records" (1990). In the area in which he practices, he sees that the roots of the current drug problem as being social and environmental", and, further, he points out that

"the medical problem of AIDS should not divert attention from these social and environmental problems. IV drug users because of their life style and the fact that their habit is illegal, are poorly motivated and have few opportunities to organise themselves." (Ibid)

O'Kelly also observes that when a G.P. is dealing with a patient who is an IVDU, all aspects of the individual should be considered and, when necessary, directed towards the appropriate agencies. In developing a strategy on IVDU and HIV, he advocates the targeting of specific areas, where drug problems exist, for,

"drug users in this city [Dublin] are not a migrant group. They live in their neighbourhoods. They live in their homes.

They have families and they have networks of support. These areas have economic, social and environmental problems which require political action, not just medical and not just social action." (Ibid)

O'Kelly recommends co-ordination between statutory and voluntary agencies to maximise the projects and energies of drug workers. In doing so, he foresees an effective programme(s) germinating from their efforts.

Conclusion

Although eleven years have passed since the first case of AIDS was reported in Ireland, misconceptions, lack of knowledge and inadequate responses persist. The assertion of WHO that, on a worldwide basis, HIV is primarily spread through unprotected heterosexual practices, appears to have bypassed the Irish public. The perception of the disease being constricted to certain groups within society, namely I.V. drug users and gay men, is still very much in evidence. This in itself leads to a paralysis of action, for if we do not perceive the phenomenon as relevant to ourselves, we take no action. It is only when we do so that a more inclusive response will be made.

Due to this perception and at the same time indirectly reinforcing it, the responses of the Government and governmental agencies have mostly concentrated on these groups. Although at present the biggest number of individuals affected are I.V. drug users, the infection is mostly increasing through heterosexual practices. This will necessitate an inclusive rather than an exclusive approach in dealing with individuals who are sero-positive on the part of all agencies working in the field. It will also necessitate a more radical approach in all areas concerning HIV/AIDS prevention.

Similarly to other Western societies, the first responses to the disease in Ireland were made by NGOs. The work of the NGOs has also initially been orientated towards particular groups, but since their foundation they have expanded to meet the needs of their service-users regardless of their mode of infection. The government inaction on homosexual legislation has hampered NGOs in providing information. While it is relatively easy to provide accessible information for those who are 'out', it is not so to those who chose not to be open about their sexuality. To deal adequately with HIV/AIDS, it is necessary to be able to discuss the most taboo of topics, sex. Until we can deal with this topic in a non-judgmental manner, all the initiatives undertaken will bear little fruit.

As we have seen, the Irish Government was slow to act in the age of HIV/AIDS. In 1990, the first Dáil Debate was held in relation to all

aspects of the phenomenon. Legislation to protect individuals in relation to housing, health and life insurance, to name but a few aspects, has not been enacted. The services made available through the governmental agencies centred mainly around the use of drugs, to the exclusion of other areas. While the E.H.B. has appointed a Gay Liaison Officer, male homosexuality remains criminalized in Ireland.

Similar to other western societies, it was the quick and effective response of NGOs that facilitated many individuals with HIV. Without their awareness and the constant pressure which they brought to bear, the phenomenon could easily have gone underground in Ireland.

At present, services exist for certain groups. Services develop out of an expressed need for them, hence appropriate services will only develop for all regardless of mode of infection when HIV/AIDS is accepted as a relevant phenomenon for all.

APPENDIX I: IRISH HIV/AIDS STATISTICS

The data used in this section were obtained from the Department of Health, the *Irish Doctor* journal and Dr Freedman's text. The figures are cumulative totals for each year.

As Dr Freedman points out in his text, the incidence of HIV/AIDS was low between the years 1982-84. This can be attributed to the fact that the test to detect sero-positivity did not become available until 1985. Prior to this, the figures available account for all those who had AIDS-related illnesses which were detected by clinical manifestations such as PCP and KS.

**Appendix Table 1. No. of Sero-Positive -
Cumulative Totals 1985 -1992**

Categories of infection	Dec. 1985	Dec. 1986	Sep. 1987	Dec. 1988	Dec. 1989	Nov. 1990	Dec. 1991	Nov. 1992
Homo/Bisexual	37	50	60	88	121	145	188	224
Haemophiliacs	92	105	108	112	112	112	112	113
IVDU	219	336	377	462	520	568	619	678
Children at risk	-	-	26	49	63	75	78	84
Other	9	44	15	-	-	-	-	-
Contacts of Haemophiliacs	-	-	-	-	-	-	-	-
Hospital Staff	-	-	-	-	-	-	-	-
Transfusions*	-	-	-	-	-	1	1	1
Blood Donors	-	-	-	11	15	14	15	17
Organ Donors	-	-	-	-	-	-	-	-
VISA Applicants	-	-	-	-	-	-	1	1
Insurance	-	-	-	-	-	-	-	-
Prisoners	-	-	-	-	12	12	13	13
Heterosexual	-	-	-	-	67	87	129	158
Unknown	-	-	19	65	-	-	-	-
Total	357	535	605	787	910	1014	1156	1288

Source: Department of Health.

(* Transfusion done in U.S.A.)

Table 1 indicates that initially the categories for HIV infection were homosexual/bisexual, haemophiliac, IVDU, and others. This last category included transfusions, blood donors and organ donors. It was

not until 1989 that the category 'heterosexual' was introduced and the category 'babies of IVDUs' was changed to 'children at risk' in 1990.

A comparison based on sexuality cannot adequately be made, for the sexuality of all the categories is not known. By far, the biggest group affected has been the IVDU population, with a stabilisation within the haemophiliac population. Since the incubation period can be anything from 3 months to 8-10 years, an accurate picture may not emerge for some time.

Tables 2 and 3 indicate the number of AIDS cases in Ireland and the number who have died from AIDS-related illnesses. It is interesting to note that a new category appears - 'homo/bisexual also IVDU' - which is not utilised in the statistics for those diagnosed as sero-positive. The category 'babies born to heterosexual mothers' was also introduced.

Appendix Table 2. No. of AIDS Cases - Cumulative Totals 1987 - 1992

	1987	1988	1989	1990	1991	1992*
Homo/bisexual	11	32	49	71	94	106
Homo/Bi. also IVDU	4	5	7	7	7	7
I.V. Drug Users	11	21	42	69	100	123
Babies Born to IVDU	2	4	5	7	7	8
Haemophiliacs	7	10	16	17	20	21
Heterosexuals	1	2	4	12	23	29
Undetermined	1	1	2	3	5	5
Babies born to Heterosexual mother	0	0	0	0	1	1
TOTAL	37	75	125	170	258	300

(* November 1992)

Source: Department of Health.

**Appendix Table 3. AIDS Related Deaths -
Cumulative Totals 1987 -1992**

	1987	1988	1989	1990	1991	1992*
Homo/bisexual	8	12	19	26	33	43
Homo/Bi. also IVDU	4	4	5	6	6	6
I.V. Drug Users	5	7	8	19	28	48
Babies Born to IVDU	1	3	4	5	6	6
Haemophiliacs	5	5	6	9	11	12
Heterosexuals	0	1	3	5	7	14
Undetermined	1	1	3	4	4	4
TOTAL	24	33	48	74	95	133

(*November 1992)

Source: Department of Health

By 1987, 37 people had developed pathologies which indicated that the infection had progressed to a clinical diagnosis of AIDS. By November 1992, the number had risen to 300. If it continues to rise at this rate, we can expect to have a large number diagnosed as having AIDS in the next few years.

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