

Writing a Trans History of HIV/AIDS in Britain,
1985-1996



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Abstract

There is currently no trans history of the HIV/AIDS epidemic in Britain, despite modern transgender people being considered an ‘at-risk’ group. This thesis represents a first attempt to construct this history, focusing on archives over oral histories to contend head-on with how this history has been systemically un-seen. Analysing British gay and transfeminine organisations in the 1980s and 1990s – namely, comparing the relationship between The London TV/TS Group and the Lesbian and Gay Switchboard - this thesis argues that the pathological gaze of ‘transsexuality’ through the panopticon of NHS Gender Clinics prohibited subjects from conceiving trans people as susceptible to HIV/AIDS. In the style of Jules Gill-Peterson, this thesis introduces the framework of ‘transsexual eugenics’: the roots of transsexual medicine lay in eugenic science, and I argue that this relationship with eugenicism enforced its patients to rescind all attachments to life beyond heteronormativity, and AIDS was conceived as the antithesis of normativity through popular associations with homosexuality and sex work. After Chapter One establishes the theoretical basis in postcolonial and transgender theory, Chapter Two expands on ‘transsexual eugenics’ through arguing the largest trans organisations during the AIDS epidemic were too intertwined with Gender Clinics to realise their internalisation of eugenic rhetoric, thus rendering AIDS unthinkable alongside a diagnosis of transsexuality. Chapter Three concludes by analysing the reciprocal relationship between the London TV/TS Group and Switchboard to conclude that the transmission of eugenicist Gender Clinic rhetoric from the Group into Switchboard prevented Switchboard from delivering AIDS sexual health information to trans callers. This thesis hopes to inspire historical interest in the British trans history of HIV/AIDS, as well as further critiques of mid-twentieth century transsexual medicine.

To David,
Happy in the west of Ireland.

1976-2023

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*For our time is the passing of a shadow
And our lives will run like
Sparks through the rubble.*

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Lists of Abbreviations and Illustrations

Abbreviations

BI	Bishopsgate Institute
BL	Bodleian Libraries
HOTTC	Histories of the Transgender Child
LMA	London Metropolitan Archive
S.H.A.F.T	Self-Help Association for Transsexuals
TSQ	Transgender Studies Quarterly
WC	Wellcome Collection

Illustrations

Figure 1: United Kingdom, HIV/AIDS Design Archive, Other Minority Groups, Professions and Workplaces: Front and back of pamphlet from the Institute of Electrolysis, February 1987. © Siân Cook

Figure 2: United Kingdom, HIV/AIDS Design Archive, Other Minority Groups, Professions and Workplaces: Inside of pamphlet from the Institute of Electrolysis, February 1987. © Siân Cook

Introduction: Towards a Trans History of AIDS

In *Histories of the Transgender Child*, historian Jules Gill-Peterson noted that her research on the history of American trans childhood was fuelled by a desire to refute the myth that trans children are a new phenomenon. The presentation of trans childhood as an “emblem of futurity”, sanitised and without historical basis, “reinforces the rationality of medicine by allowing the twentieth and twenty-first centuries to be defined by the limiting parameters of transsexuality”.¹ Pathological definitions which policed, experimented on, and incarcerated (primarily Black) trans children are so all-encompassing that they overshadow the subjects they police. This analysis can be critically extended across populations of gender-nonconforming adults in the United States of America and Britain: how does the institutionalisation of transsexual medicine in the mid-twentieth century, a discipline deeply intertwined within the sexological “eugenicist imaginary”, affect the historicity of trans subjectivities?²

It is this, the “eugenicist imaginary” and presentist pathologisation of transgender history, that I argue has patrolled the potential parameters of a trans history of AIDS. Perceived as creatures of postmodernity, trans people cannot be historicised with AIDS but instead are futuristically depicted as faces of ‘HIV’ - the “bright, shiny tool of the present”, a “pharmacological futurity.”³ In Britain, transgender people are vectors of disease that appeared suddenly and without precedent. The HIV & AIDS Reporting System only began tracking trans patients accessing HIV/AIDS healthcare in 2017.⁴ Transgender people are an “at risk” group, yet there is “no specific data” for quantitative historical analysis because of how delayed government agencies were in attempting to track trans people and HIV/AIDS care.⁵ As of writing, there has been no attempt to historicise British trans experiences of the epidemic: no books, no art, no reference points. The only gesture towards the trans experience is from British HIV/AIDS historian George Severs, who noted that sources for such a history are “thin on the ground”.⁶ As will be unfolded, this much is true; approaching

¹ J. Gill-Peterson, *Histories of the Transgender Child* (Minneapolis, 2018), pp. 3-8.

² B. Velocci, ‘Standards of Care: Uncertainty and Risk in Harry Benjamin’s Transsexual Classifications’ *TSQ* 8/4 (2021), [doi: 10.1215/23289252-9311060 ,] p464.

³ C. Gossett, & E. Hayward, ‘Trans in a time of HIV/AIDS’ *TSQ* 7/4 (2020), [doi: 10.1215/23289252-8665171,] p533.

⁴ R. Pebody, ‘First data on trans people accessing HIV care in England’ (23 April 2019), <https://www.aidsmap.com/news/apr-2019/first-data-trans-people-accessing-hiv-care-england> (15 June 2023).

⁵ National AIDS Trust, *Trans* people and HIV* (2017), nat.org.uk/publication/trans-people-and-hiv (15 June 2023).

⁶ G. Severs, ‘HIV/AIDS Activism in England, c. 1982-1997’ (PhD thesis, University of Cambridge, 2021),

AIDS archives to find trans subjectivities is a futile “reaching and un-grasping”, an upward battle which consistently leaves one empty handed.⁷ Focusing on British trans women, this thesis places the eugenicist origins of transsexual medicine at the forefront of a trans history of AIDS, as the unspoken reason why trans subjects could not risk envisioning themselves at risk of sexual disease.

When approaching this potential trans archive of AIDS, one has to consider if this ‘absence’ represents an archival register which cannot ‘see’ transness, or if it represents the *conscious* separation of the trans subjects. Human rights researcher Sara Davis notes that in modern HIV/AIDS care, ‘key populations’ of trans people make themselves unknowable for fear of public exposure: “Remaining uncounted is self-preservation, and an everyday resistance to oppression.” This conscious separation creates a ‘data paradox’, wherein researchers assume “absence of evidence is evidence of absence”, and the transgender population remains “uncounted” - safer from public backlash, but without the healthcare they require.⁸ This concept must be constantly held by the historian when writing a trans history of AIDS in Britain, that the “absence of evidence” can be subverted into constructing a history, rather than being written off as irrelevant.

‘Eugenics’ are focused on through how its place within mid-twentieth century transsexual medicine shaped the parameters of an implicitly racialized gender binary, intertwined within heralding whiteness as the desirable, normative standard; most of my trans record’s present white trans experiences as the norm, discounting non-white experiences through their non-inclusion. ‘Transsexuality’ refers not to subjective experience, but rather the specific medical discourse that in the mid-twentieth century grew to consume and regulate all trans subjectivities; after Gill-Peterson, “I name ‘transsexuality’ to mark a *medical* discourse and biopolitical apparatus, a colonial form of knowledge with racialising and disenchanting effects.”⁹ The architects of mid-twentieth century transsexuality, John Money and Harry Benjamin, had backgrounds in the American eugenics movement and developed a model of built upon rejection, heteronormativity, and implicit racial purity. Emily Skidmore notes that whilst white trans women had the ability to perform acceptable transsexuality as it was easier to perform white womanhood through domesticity, respectability, and heterosexuality,

p185.

⁷ G. C. Spivak, ‘History’ in G. C. Spivak (ed) *A Critique of Postcolonial Reason* (Cambridge, 1999), p242.

⁸ S. Davis, *The Uncounted: Politics of Data in Global Health* (Cambridge, 2020), pp. 46-47.

⁹ Gill-Peterson, *HOTTC*, p9.

whereas non-white trans women had “less intelligible bodies” under the pathological gaze of transsexual medicine, and thus were much less likely to access Gender Clinics.¹⁰

Trans women are focused on because of the higher propensity of transfeminine records, and to not dilute a transmasculine history of AIDS within the short word count. My definition of ‘trans’ follows that of Kit Heyam - “what constitutes a man, woman, or gender itself is continually defined, contested and redefined.”¹¹ As such, this thesis takes an expansive definition of ‘trans’ to reflect historically specific identities and uses the terminology of the period – such as ‘transvestite’ and ‘transsexual’, which is often collapsed into ‘TV/TS’. This denotes a perceived contiguous trans experience, so as such this thesis considers all those under the ‘TV/TS’ umbrella as trans.

Transsexuality in Britain uniquely developed because of the National Health Service: America, its ‘birthplace’, lacked the unity of national, socialised healthcare which is free at the point of use. Whilst the Gender Clinics developed sporadically, these Clinics were nevertheless functioning within an institution that is “the closest thing the English have to a religion”, thus developing within a nationwide healthcare framework that was near-universally revered by the British.¹² This thesis thus seeks to in-part answer Andrew Seaton’s call for a “holistic interpretation” of the NHS that takes seriously the emotive and ideological qualities that are imbued onto our nationalized healthcare as a symbol of British post-war identity: namely, to distinguish how the fusion of transsexual medicine within NHS-funded clinics, rather than private clinics, affected the formation of trans identities in the late-twentieth century.¹³ The NHS should be central within histories of twentieth-century Britain, and this thesis is no exception – especially with how British trans subjects required life-long treatment, this historic trans-NHS relationship deserves further analysis beyond this work.

This thesis is thus rooted the methodologies of British trans historians who engage with how trans identity has been changed by systems of national control, within the NHS and beyond: British trans history has an alternate genealogy compared to American trans history, one

¹⁰ E. Skidmore, ‘Constructing the Good Transsexual: Jorgensen, Whiteness and Heteronormativity in the Mid-Twentieth Century Press’ *Feminist Studies* 37/2 (2011), [doi: 10.1353/fem.2011.0043,] p271.

¹¹ K. Heyam, *Before we were Trans* (London, 2022), p28.

¹² N. Lawson, *The View from No. 11: Memoirs of a Tory Radical* (London, 1992), p613.

¹³ A. Seaton, ‘Against the Sacred Cow: NHS Opposition and the Fellowship for the Freedom in Medicine 1948-1972’ *Twentieth Century British History* 26/3 (2015), [doi: 10.1093/tcbh/hwv011,] pp. 427-429.

which is still in its infancy. The recent works of both Mar Hicks and Adrian Kane-Galbraith have been essential in how this thesis understands the relationship between trans identity and the state.¹⁴ Kane-Galbraith's article on National Insurance Cards has been particularly incisive: this article focused on how obtaining gendered National Insurance Cards were incorporated into a mid-twentieth century transmasculine identity, and the devastating "loss" of identity when the Cards were rescinded in the 1970s; beyond being a "passport to employment", the cards symbolized their recognition "as a citizen and human being."¹⁵ Using this conceptualization of how symbols of cis-normative control can become central to legitimating a trans identity, this thesis builds upon that to argue that the necessary incorporation of pathological transsexuality into a trans subjectivity renders AIDS unthinkable, as the perceived processes of 'catching AIDS' was antithetical to 'transsexual eugenics'.

The title uses "HIV/AIDS" to reflect modern understandings of the disease. However, the thesis singularly refers to the 'trans history of AIDS'. This is to reflect historical terminology, such as records referring to 'AIDS transmission', and to challenge the presentist subtext of 'HIV history'. Interdisciplinary theorists Che Gossett & Eva Hayward theorised that, especially in the trans context, AIDS better encompasses the systemic malpractice:

"HIV is designed without attention to the structuration of AIDS. The shift to prevention - and a discourse of 'resilience' - is its own form of 'post-AIDS' existence wherein there is no unhappy or failed subject living with the devastation of AIDS, only the reformed subject of prevention. In the social imaginary, HIV is no longer a sign of the abjection of AIDS, but a symbol of pharmacological success and inclusion."¹⁶

This brings me to the core differences between 'TV/TS' organising versus gay rights movements: it is important to spell out the key differences as they stem from very different backgrounds. Unlike the gay rights movement, transsexual/transvestite organising in the late twentieth-century was predicated upon centering marriage and the nuclear family. The British Gay Liberation Front in the late-1970s perceived the capacity to have a sexuality beyond gay or lesbian as linked to the capacity for men to exploit women: as such, bisexuality was

¹⁴ M. Hicks, 'Hacking the Cis-tem: Transgender Citizens and the Early Digital State' *IEEE Annals on the History of Computing* Special Issue: Governance (2019), [doi: 10.1109/MAHC.2019.2897667,].

¹⁵ A. Kane-Galbraith, 'Male Breadwinners of Doubtful Sex: Trans Men and the Welfare State, 1954-1970' (unpublished paper, 2018), p21.

¹⁶ Gossett & Hayward, 'Trans in the time of AIDS', pp. 532-533.

“tainted” by proximity to heterosexuality, and thus conservatism and capitalism.¹⁷ Their 1979 manifesto notes that “the very form of the [nuclear] family works against homosexuality”, with a “slave wife” and children who are fed “propaganda” about the differences between men and women. The abolition of the family is necessary to cauterise the male-supremacy that is bred within the unit.¹⁸ The most influential trans organisations were the antithesis of this, reifying the heteronormative family unit. The Beaumont Society, founded in 1966 and exclusively for heterosexual transvestites until the mid-1980s, more explicitly expressed its dedication: its coordinator in 1979 wrote that gay people were excluded from the society because they “do not understand the pressures of convention that prevail in marriage”.¹⁹ In the 1980s, more liberal organisations such as the London TV/TS Group who allowed homosexuals to join spent most of their energy reifying heterosexual marriage.²⁰ I focus on how this heteronormativity stemmed from an internalisation of transsexual eugenics, but regardless: this appeal to heteronormativity is an entirely different foundation to gay liberation.

Chapter One forms the theoretical bedrock on how this thesis approaches trans history in British AIDS archives. Chapter Two introduces the frameworks of ‘transsexual eugenics’ to argue that the consolidation of Gender Clinic power over British trans experience in the mid-to-late-twentieth century is the overarching reason as to why the largest trans organisations could not envision their members at risk of sexual disease. Chapter Three finishes by applying these frameworks to two case studies, analysing the reciprocal relationship between the London TV/TS Group and the Lesbian and Gay Switchboard, to observe how the transmission of eugenicist Clinic rhetoric from the TV/TS Group into Switchboard’s working practices defined AIDS in relation to *tran-sexuality* – the medical discourse – and widening the divide between perceptions of trans experience versus gay experience.

My goal is simple: to construct the first historical analysis of the relationship between trans people, ‘transsexuality’, and the AIDS epidemic in Britain. But also, I hope for the reader to understand the current significance of forging relationships between trans subjects, past and present, and the established narratives of AIDS history. Over the last five years, the Overton window has shifted on trans rights into a place that is not only far more dangerous to be ‘out’

¹⁷ C. Wolff, *Bisexuality: A Survey* (London, 1977), p133.

¹⁸ Gay Liberation Front, *MANIFESTO* (London, 1979), p1; p5; p7.

¹⁹ London, WC, PP/KIN, F/5: Beaumont Bulletin 11/3 (1979) ‘Alice Purnell Editorial Reply’, p44.

²⁰ See Chapter 3 for an in-depth analysis of the London TV/TS Group’s practices.

but has also created divisions between trans and 'LGB' individuals. I have been personally insulted by individuals who know I study trans history and AIDS, because of an assumption that trans people – especially trans women – have no history. If the reader takes away one thing, I hope it is that a trans history of AIDS deserves more attention than 15,000 words.

“Transgender Studies is AIDS”: Trans History & Archives

In Gossett & Hayward’s essay ‘Trans in the time of AIDS’, the authors assert that “transgender studies is AIDS”. Transgender theory and AIDS emerged the same decade, and Gossett & Hayward note that early queer theorists used a “transgender position” to unify gay and lesbian theoretical responses to AIDS. And yet, they argue there has been little theoretical engagement with how to “think trans with AIDS”: “It would be impossible to *not* think transgender with AIDS, and yet, the refusal to think AIDS in transgender studies is pervasive.”¹ Transgender was useful in the theoretical, abstract sense, yet the notion of applying this theory to individual trans subjects was unthinkable. In the manner of Gossett & Hayward, this chapter attempts to “think trans and AIDS” and survey the position of ‘trans’ within contemporary British AIDS archives.

In lieu of an *historical* framework that “thinks trans with AIDS”, postmodern, deconstructionist and postcolonial archive theory have shaped my approach to trans and AIDS archival work – namely, Michel Foucault, Jacques Derrida, Gayatri Chakravorty Spivak, Anjali Arondekar and Nadia Ellis. In Spivak’s search for the Rani, who eludes the colonial archive, she observes that “retriev[ing] her as information will be no disciplinary triumph [as] there is no ‘real Rani’ to be found.”² This futile pursuit of ‘real’ has influenced how this thesis perceives the pursuit of trans subjectivity: transgender history, in general, has systemic problems with the nature of ‘authenticity’. Within AIDS archives, there is rarely ever a direct trans testimony which fuels belief in trans archival absence - Kit Heyam notes as the researcher holding an expectation of trans testimony, as the standards for proving transness are higher than proving cisness.³ As such, this thesis consciously critiques the expectation of personal testimony to focus on the structural, definitional problems of pathological transsexuality and archival erasure.

Ellis’s history of Black queerness in mid-twentieth century London provides a potential framework to understanding transsexuality’s treatment of non-white subjects. Her analysis of the only Black subject in the Hall-Carpenter Oral History Archive notes the subject’s refusal

¹ Che & Gossett, ‘Trans in the Time of AIDS’, p539.

² G. C. Spivak, ‘The Rani of Sirmur: An Essay in Reading the Archives’ *History and Theory* 24/3 (1985), [doi: 10.2307/2505169,] p271.

³ Heyam, *Before we were Trans*, p21.

to identify himself along a white definition of queerness: “‘I still can’t find it’ are his final words, and they are fitting to describe the open-ended effect of the archival search for Black, queer subjects.”⁴ This conscious separation adds to Sara Davis’s observation that the most ‘at-risk’ populations are often the least likely to reach out for help with AIDS , and the marked absence of Black British trans AIDS history within the popular contemporary trans organisations echoes the quiet refusal of “‘I still can’t find it’”, as a reminder that historians should not expect their actors to reveal everything upon first analysis.

“AIDS and Electrolysis”: on British AIDS archives

The UK HIV/AIDS Design Archive is an online archive of HIV/AIDS sexual health literature, compiled by a graphic designer.⁵ The archive is organised under original audience definitions to make references “clear for researchers”: for example, “Gay Men” and “Ethnic Minorities”. The curator notes that some audience groups are underrepresented, with trans being underrepresented as “there was little acknowledgement of transgender people in the printed matter, and terms such as ‘non-binary’ were not in general use.” As such, the curator intimates that there is little material relating to trans history and HIV/AIDS within this archive.⁶

Under the subheading ‘Professions and Workplaces’ is a record entitled *AIDS and Electrolysis* from The Institute of Electrolysis.⁷ Electrolysis is a procedure wherein thin wires are used to pass electric currents through follicles to remove hair, often on the face. In the website archive, only the first page of this record is visible, so I inquired for further images from the archivist. (Figure 1, Figure 2). *AIDS and Electrolysis* emphasised that the risk of cross-contamination is “negligible”, and any risk of infection is due to unskilled operators: “When done correctly, the skin is not pierced, although on rare occasions, depending on the skill of the operator, it may be pierced accidentally.” Consumers should only visit electrologists who display their “expensive” qualifications – the only, small, risk of infection is if electrolysis is

⁴ N. Ellis, ‘Black Migrants, White Queers, and the Archive of *Inclusion*’ *International Journal of Postcolonial Studies* 17/6 (2015), [doi: 10.1080/1369801X.2014.994547,] p911.

⁵ West Sussex Record Office, ‘Sian Cook interview’ *People with Archives: A Survey of HIV/AIDS records in the UK* 1/1 (2023), pp. 4-5.

⁶ ‘Terminology’, <https://www.hivgraphiccommunication.com/terminology> (15 June 2023).

⁷ ‘Other Minorities’, https://www.hivgraphiccommunication.com/other-minorities?lightbox=image_4pi (15 June 2023).

performed by an unskilled and cheaper electrologist.

I've chosen this record to frame this chapter as it draws into close focus several ways in which trans subjectivity is not theorised as archive potential. Electrolysis has been a long-standing treatment for trans women for many decades as a method to remove facial hair, or thicker body hair, to better 'pass' as a woman and achieve gender euphoria; in the present, it is the most commonly sought, and easily accessed, gender-affirming healthcare for trans women.⁸ The London TV/TS Group's journal *The Glad Rag*, which had a circulation of over 1000 readers by 1986, began regularly advertising home electrolysis treatments at "reasonable rates" from March 1988; in their penultimate issue, October 1992, there were four electrolysis advertisements in one issue.⁹ In 1992, the Group also launched its own electrolysis service for trans women: because electrolysis is expensive, many trans women could not afford qualified electrologists: "As I look around the group, I am more and more horrified at the results I see. Tissue damage that is beyond repair. People scarred for life. Some comparable to second degree burns."¹⁰ Within the conceptual frameworks of *AIDS and Electrolysis*, these trans women would be at risk of exposure to HIV/AIDS through being forced to use the services of unskilled electrologists. Yet because, as Sian Cook notes, trans audiences were not a target for the producers of AIDS ephemera, the trans proximity to electrolysis is not acknowledged - there is a trans *presence*, not a trans subjectivity.

With *AIDS and Electrolysis*, both the creation of the record and its archival register contributed to the elision of a trans interpretation – something common within the delivery of contemporary HIV/AIDS care. The 2006 UNAIDS Global Report demonstrated this conflation by defining M.S.M (men who have sex with men) to include trans women as 'transgendered males', which regardless of the misgendering is a definition which obscures how HIV is transmitted in those who surgically and hormonally transitioned.¹¹ The subsumption of transfemininity into maleness obscures how the experiences of trans women living with is discrete from the gay cisgender male experience, yet is considered interchangeable.¹² Sources for a trans history of HIV/AIDS are "thin on the ground" in part

⁸ D. Marks et al, 'Excess hair, hair removal methods, and barriers to care in gender minority patients' *Journal of Cosmetic Dermatology* 19/6 (2020), [doi: 10.1111/jocd.13164,] pp. 1494-1498.

⁹ Oxford, BL, Periodicals, 24731 c.13: *The Glad Rag*, October 1992, p9; p19; p22; p44.

¹⁰ 'Electrolysis at the Clinic!' *The Glad Rag Journal* 60 (1992), p19.

¹¹ UNAIDS, *2006 Report on the Global AIDS epidemic: A 10th anniversary special edition* (Geneva, 2006), p110.

¹² Prior to the 2004 Gender Recognition Act, most trans funerals recorded sex at birth rather than their lived identity. This is still an issue in 2023 because of unclear guidance - see: 'You Don't Need a GRC' Trans Safety

because of the conscious self-erasure of affected trans subjects, and this will not be remedied by approaching trans history as indistinguishable from gay history.¹³ But as Davis notes, these ‘key populations’ still exist. This trans history does exist somewhere, just perhaps not where historians would expect it to be, nestled in records about electrolysis, or constructed out of the conspicuous silences of AIDS archives.

The formation of AIDS knowledge in Britain is uniquely positioned towards heralding a particular form of archiving, as *the* source, and the repository, of the records of political and social histories of the epidemic. The first AIDS archive in Britain stemmed from the AIDS Social History Programme between 1988-1994, spearheaded by political historians Virginia Berridge and Phillip Strong.¹⁴ The archive was deposited at the London School of Tropical Medicine and Hygiene in 2004. Its aim was to “research and write the social history of AIDS as it happened” through focusing on “official” policy making in the statutory and voluntary sector, with the opportunity to document an epidemic as it unfolded. Janet Foster, the Programme’s archivist, noted in her book *AIDS Archives in the UK* that this project was “the first time an archivist has been directly involved in locating a variety of primary source material whilst it is being created, within contemporary history.”¹⁵ In the Derridean fashion, that the archive “determines the content’s relationship to the future”, the archiving of the epidemic as it happened creates a structure that presents itself to historical researchers as the rational, official baseline. This baseline is formed upon ‘official’ records such as “minutes”, “legal documents” and “annual reports” which are regularly “weeded’ of ephemeral material”, with the “personal recollections” of members being relegated to a “supplement to the main archives”.¹⁶ With the notable exception of the Bishopsgate Institute, most British AIDS archives follow Foster’s model: top-down policy in the statutory and voluntary sector.

I argue that this specific British context for the archiving of the AIDS epidemic has affected the research that has been prioritised by historians. Adrian Kane-Galbraith observes that *respect des fonds* metadata forces archives to deadname and misgender potential trans subjects by design, forcing historians to search for trans people by their old name and gender.

Network (20 Feb 2023), <https://transafety.network/posts/you-dont-need-a-grc-death-cert/> (17 June 2023).

¹³ G. Severs, ‘HIV/AIDS Activism in the UK’, p185.

¹⁴ V. Cranna, ‘AIDS Social History Programme Collection’, *Library, Archive & Open Research Services Blog* (1 Dec. 2014), <https://blogs.lshrm.ac.uk/library/2014/12/01/aids-social-history-programme-collection/> (15 June 2023).

¹⁵ J. Foster, *AIDS archives in the UK* (London, 1990), p5.

¹⁶ *Ibid.*, p7.

¹⁷This form of AIDS archive by design discards records that fall outside of their original categorisation, and trans identities or gender non-conformity do not fall within the *respect des fonds* of the AIDS archives: this is why most of the records I have consulted in Chapter 3 fall within the realm of a “gay” history of AIDS, because trans women were subsumed into the category of ‘homosexual’. Records are rarely originally identified as ‘trans’, or as in any way relating to non-cis gender identities. Records which could help formulate a trans history of HIV/AIDS could be concealed within misleading or offensive *respect des fonds* metadata.¹⁸ Public historian Harrison Apple came across this issue when explaining how they established the Pittsburgh Queer History Project: a donation of thousands of nightclub photographs entitled ‘Drag Shows’, upon being shown to trans volunteers, were actually photos of trans women performers which the cisgender male photographer had not picked up on - “[the photographer’s] categorisation of ‘drag show’ flattened a rich history of transsexuality, situating TS representation as gay entertainment.”¹⁹

This is seen within the UK HIV/AIDS Design Archive, whose contents is divided by the original intended audience such as ‘Ethnic Minorities’ and ‘Gay Men’ - the curator notes within their *Terminology* page how these categories can be limiting, a limitation which is visible for trans history when considering *AIDS and Electrolysis*. This record’s recommendations in terms of change in practice, hygiene, and requirements for the patient would directly pertain to the gender-affirming care of trans women and potentially alter how electrologists approached their clinical practice. Yet this provenance is not anywhere within the record’s metadata: it is simply subtitled as ‘Professions and Workplaces’. An acknowledgement that this record could contribute to a trans history of AIDS could undercut the curator’s belief that transgender material is “difficult to locate”: the target audience for this record is not trans people, but individuals that perform an integral part of trans women’s gender-affirming healthcare. The note that there was “little reference to transgender people” gives the incorrect assumption that the material within the archive is irrelevant to a trans history of AIDS, when in fact this record could be identified within a history of AIDS as it pertains to trans-affirming healthcare. How come records such as this one are never

¹⁷ ‘Documenting the HIV/AIDS epidemic: a survey of HIV/AIDS archives in England and Wales’ (April 2023) <https://westsussexrecordofficeblog.com/documenting-the-hiv-aids-epidemic/> (15 June 2023).

¹⁸ A. Kane-Galbraith, ‘What’s in a name? Metadata, Digital Ethics, and the making of a British trans archive’ *EuropeNow* (18 April 2022), <https://www.europenowjournal.org/2022/04/17/whats-in-a-name-metadata-digital-ethics-and-the-making-of-a-british-trans-archive/> (15 June 2023).

¹⁹ H. Apple, ‘The \$10,000 Woman : Trans Artifacts in the Pittsburgh Queer History Project Archive’ *TSQ* 2/4 (2015), [doi: 10.1215/23289252-3151484,] p559.

mentioned when acknowledging the paucity of sources for a trans history of AIDS?

To return to Gossett & Hayward, how has it been not possible to “think trans with AIDS?” when it comes to *AIDS and Electrolysis*? Why has it been thus far impossible to acknowledge that a trans history of AIDS could look mundane, as opposed to the individual, devastating personal testimony? The inability to acknowledge trans history, and trans history of AIDS, is the fetishisation of transgender absence and the lacuna of transgender archival records, the reification of the belief that trans histories are unrecoverable because of deterioration or deliberate destruction. It is thus difficult to consider trans history as part of the history of AIDS, and there is a paucity of theoretical frameworks with which to do so. *AIDS and Electrolysis* is not considered a part of a trans history of AIDS, because we have developed no frameworks with which to construct this history.

A Spectre is Haunting AIDS, the Spectre of Oral History

“I watched a lot of my friends die... and I wasn’t telling them that I [also] had AIDS. I already had enough stigma going on being trans. I remember a gay friend telling me ‘you used us to get where you are’. But I didn’t even know myself.”²⁰

The testimony of Rebecca Havilland with the National HIV Story Trust is, to the best of my knowledge, one of the only pieces of currently existing primary evidence that explicitly addresses the trans experience of contracting HIV/AIDS during the first epidemic. An Irish trans woman who moved to London in the mid-1980s, detailing her life from fashion and modelling to sex work and drug addiction and eventual recovery, Havilland’s testimony at times guided my archival research. Yet nothing else was found. Despite visiting the archives of many of the places Havilland mentioned in her testimony, there is little to no trans presence in British AIDS archives. Her testimony stands outside the AIDS archival episteme, an episteme that is incapable of seeing her; like Spivak’s Rani of Sirmur, it is a “reaching and an un-grasping” of a potential trans history.²¹

Havilland’s testimony is heart-breaking, informative and essential to understanding the subjective trans experience of AIDS in Britain. But this thesis does not focus on her. Oral history from self-identified trans people speaks to a different kind of information than found in traditional written archival sources. There has been a standardisation in the subjective trans experience which did not exist in this form the latter half of the twentieth century. Rebecca

²⁰ London, LMA, NHST 4801, A/03/095: 2017 Rebecca Havilland interview, 20:28-20:50.

²¹ Spivak, ‘History’, p242.

Havilland refers to her work with “trans women” in 2017, and her identification with that term, and states “we were better known as tr*nnies in those days”.²² This change in label and the connotations it brings can lead to a presentist conception of trans history wherein the 21st identity of trans, specifically transgender, is cast backwards to stand in for a range of trans experiences. She does not divulge if she identified as transsexual, or transvestite, or another term - her experiences as she relays them are through a filter of modern transgender identity formations, which bypass the thorny battles between ‘TV/TS’ identities of the 1980s and 1990s that are so crucial to this type of history. Moreover, if this thesis focused exclusively upon oral histories - either Havilland’s or through creating my own - this, in my view, would be admitting defeat. This focus would sidestep analysing how trans had been archivally conceptualised in its absence and, implicitly, reinforcing the “infantilising temporality” that transgender history is marginal to wider historical inquiries.²³ It is easier to ignore an “additive model” which fills archival gaps with a more diverse range of unread voices, but harder to ignore a systemic critique of the archives that uphold British HIV/AIDS histories.²⁴ And within every archive, either by structural design or in records themselves, there is a palpable elision of trans which cannot be theorised within a model of absence and recovery.

This thesis could have added further evidence in the form of oral histories or attempted to recover individual subjectivities to place within the timelines of trans history and the history of HIV/AIDS. But this wouldn’t have been enough. The trans archival ‘absence’ is not absent, and its tangibility reveals much about the relationship between trans and HIV/AIDS, as much as locating individual subjectivity; it is “no disciplinary triumph” to demonstrate trans presence in the overwhelming face of absence²⁵. A trans history also must contend with how and why trans has been rendered illegible in the records, histories, and archives of the British HIV/AIDS epidemic, and how this has impacted the consolidation of AIDS knowledges. Do we “confront archival gaps” by scouring for new records to increase the diversity of the archive?²⁶ Or can we as historians reflect on our genuflection to the order of the AIDS archive, on how we have produced a rigid system of historical knowledge of the

²² Havilland interview, 14:21-14:50.

²³ R. Kunzel, ‘The Flourishing of Transgender Studies’ *TSQ* 1/1-2 (2014), [doi: 10.1215/23289252-2399461,] p285.

²⁴ A. Arondekar, ‘Without a Trace: Sexuality and the Colonial Archive’ *Journal of the History of Sexuality* 14/1-2 (2005), [doi: 10.1353/sex.2006.0001,] p14.

²⁵ G.C. Spivak, ‘The Rani of Sirmur: An Essay in Reading the Archives’ *History and Theory* 24/3 (Oct. 1985), [doi: 10.2307/2505169,] p271.

²⁶ K.J Rawson, ‘An Inevitably Political Craft’ *TSQ* 2/4 (2015), [doi: 10.1215/23289252-3151475,] p546.

British AIDS epidemic, and produce a critique that propagates ways of reading trans that is built “not against the grain of archival work, but from within it”²⁷. A trans history of HIV/AIDS in Britain is situated at the nexus point of these archival knowledges, and contemporary healthcare issues around how ‘trans’ subjects deselect themselves for HIV/AIDS treatments.

²⁷ Arondekar, ‘Without a Trace’, p12.

Pathological Subjects: the formation of transvestite and transsexual activism in the late-twentieth century

“Think[ing] trans with AIDS” is something British AIDS archives were never designed to perform.¹ At the same time, there is so much trans history in British archives that speak to how a trans consciousness was formed within the late-twentieth century. The trans archive conversely is, as A. J. Lewis writes, an “extremely noisy archive” - but in Britain, what sounds does it make? The sounds coalesce around a consciousness that defined itself through the acquisition of legal and medical rights: the right to marry, to change gender documentation, better employment rights, and more transparent transitional healthcare. This activism was centred around a desire to “disappear in[to] the normal life” of cis-heteronormative culture, to push for concessions that allowed trans people to move freely in society *without* revolutionising the system.² The terms of this assimilatory consciousness was defined by the consolidated power of the Gender Clinic over its trans patients, aligning their activism along the rungs of pathologised trans-*sexual* medicine. I argue that the trans “noisy archive” rarely mentions AIDS because of this increasing scope, a panopticon built upon eugenic medicine that swallowed trans subjects whole. The idea of a trans subject having AIDS was unthinkable, by both patient and clinician, because of how enmeshed they became within a transsexual medicine that could not recognise them as coexisting.

The prehistory of transsexual eugenics, 1940-1970

What I refer to as ‘transsexual eugenics’ has a complicated prehistory. The core of ‘transsexual eugenics’ is that many of the “founding fathers” of transsexual medicine were deeply involved with the eugenic science movement of the early twentieth century – a connection that was not unusual, especially in British history; for example, how Marie Stopes’ Society for Constructive Birth Control fused eugenicism within new forms of contraception.³ Magnus Hirschfeld, who operated the Institute for Sexual Science in Weimar

¹ Gossett & Hayward, ‘Trans in a Time of AIDS’ pp 533-534.

² Pressing for Change: 25 Years Seeking Trans Equality, podcast, LSE Lectures (Jan 2017) web.archive.org/web/20170309182953/http://www.lse.ac.uk/website-archive/newsAndMedia/videoAndAudio/channels/publicLecturesAndEvents/player.aspx?id=3683, (16 June 2023), 7:55.

³ L. Robson-Mainwaring, ‘Family planning in the 1920s: Marie Stopes and the ‘wise precaution of delay’ *National Archives Blog* (29 March 2022), <https://blog.nationalarchives.gov.uk/20people-family-planning-in-the-1920s-marie-stopes-and-the-wise-precaution-of-delay/> (16 June 2023).

Germany, in 1913 cofounded the Medical Society for Sexology *and Eugenics*, and defended eugenic science even after the Nazi takeover of Germany: “*only* a eugenics freed of the traditions of caste, of slavery, and of colonialism can be a thoroughgoing and a true eugenics.”⁴ Gill-Peterson credits Harry Benjamin - influential sexologist who wrote *The Transsexual Phenomenon* and spearheaded ‘transsexualism’ as a clinically diagnosable condition in the 1950s - for “import[ing] the European racialisation of plasticity as the eugenic alterability of sex” - the malleability, adaptability and transformative qualities of *white* bodies can be used to improve the white race, either through increasing desirable individual’s virility or cauterising undesirable subjects reproductive abilities.⁵ As Benjamin began his career in the 1920s as a specialist in male rejuvenation - procedures for rich, influential white men to restore their vitality and extend their lifespans - the link between a desire to ‘improve’ the capacities of male white leaders and a desire to taxonomize gender nonconformity is an unbroken one.

Crucially, ‘transsexual eugenics’ did not attempt to eradicate trans people. It was a clinical gaze which attempted to control the borders of gender, to subsume nonconformity into a clinical model to push its patients into the margins of society. In Britain, diagnosed transsexuals could not: get married; adopt children, or have children, and they were forced into divorce to access surgeries and legal documentation.⁶ The diagnosis served as a conscious separation between the trans subject and their ability to participate in cisheteronormative society, reducing them into “proxies for working out broader questions about human sex that had little investment in their personhood” whilst presenting this path as the only available one.⁷ It attempted to control the parameters of gender, asserting the normalcy of cisgender identities, and *especially* invested in racial gatekeeping. Gill-Peterson has written extensively on the racialised genealogy of transsexual medicine, from how trans “plasticity” was racialised as a synonym for whiteness in clinical circles, to the lack of Black and trans of colour patients seeking help at Gender Clinics, to how the few Black patients who attempted to navigate this system were rejected and abused. Peterson describes the moment that John Money rejected a Black trans girl’s diagnosis of transsexuality, but still recommended hormone therapy as a “castrating agent”:

⁴ Quoted in: K. Amin, ‘Glands, Eugenics, and Rejuvenation in Man into Woman: A Biopolitical Genealogy of Transsexuality’ *TSQ* 5/4 (2018), [doi: 10.1215/23289252-7090059,] p604.

⁵ Gill-Peterson, *HOTTC*, pp. 66-67.

⁶ C. Burns, ‘Is There Anyone Else Like Me?’ in C. Burns (ed) *Trans Britain: Our Journey from the Shadows* (London, 2018), pp. 1-11.

⁷ Gill-Peterson, *HOTTC*, p4.

“Although this girl had been given a diagnosis of transsexuality... Money went on to disqualify her from the category altogether, turning to its latent overlap with homosexuality-as-inversion to deny herself knowledge that she was a girl, and to open the door to hormones only in order to further the eugenic goal of sterilisation as a form of racial hygiene.”⁸

Transsexual eugenics, as well as taxonomising into isolation, thus theorised sterilisation as practicing hygiene.⁹ This practice was eagerly taken up by Dr John Randell, the notorious clinician who founded the Charing Cross Gender Clinic in 1966, and who described his role as transsexual/transvestite psychiatrist as being “some form of eugenics” to “breed out of our genetic inheritance those with psychopathic and adverse genetic propensities”.¹⁰ When reading this alongside how he described many of his patients as homosexual “castrated males”, or how he recommended operation to one individual solely because they were “so much of a screaming homosexual in appearance”, his eugenic intentions become more apparent: sterilisation for patients, both homosexual and heterosexual, was beneficial to reduce the spread of their “adverse genetic propensities”.¹¹ The new Gender Clinics, one of which Randell founded, had built into their foundations the eugenicist rhetoric of the “founding fathers” of transsexual medicine.

Consolidation of Gender Clinic Authority

By the year 2000, there were seven practicing Gender Clinics in Britain that controlled NHS trans healthcare. Over thirty years, the Clinics consolidated power in several ways: firstly, persecution of transvestites and transsexuals deferred a huge amount of authority into the hands of Clinics, who then controlled the parameters of ‘TV/TS’ identity. Secondly, the rhetoric of the Clinic was mirrored by the burgeoning transsexual and transvestite community: elements of transsexual eugenicism were internalised by the patients themselves, transforming parts of the ‘TV/TS’ community into a self-policing panopticon. This creates a situation wherein the eugenic foundations of transsexual medicine are integrated within the

⁸ Ibid., p186.

⁹ This is typical of eugenic science, especially within the context of twentieth century Britain. See this book for a wider angle on the role of sterilisation and birth control within the British eugenics movement: R. Soloway, ‘Reform Eugenics, Population Research and Family Planning, 1930-1939’ in Soloway (ed) *Demography and Degeneration: Eugenics and the Declining Birthrate in Twentieth Century Britain* (Chapel Hill, 1990), pp.193-226.

¹⁰ J. Randell, *Sexual Variations* (London, 1973), p146.

¹¹ J. Randell, ‘Indications for sex reassignment surgery’ *Archives of Sexual Behaviour* 1 (1971), [doi: 10.1007/BF01541059,] p161.

self-knowledge of individual trans people, limiting the parameters of their own identity.

After the 1970 *Corbett v. Corbett* legal ruling, the *only* route to officially changing legal sex was through Gender Clinics - previously, all government departments had different criteria for accepting change in sex registration.¹² In 1973, John Randell noted that his Clinic maintained contact with the Social Security department to ensure changes were only made in “suitable cases where the change of sex is irrevocable.”¹³ Handing this legal responsibility to Clinics accelerated the growth of the Gender Clinic as a “non-consensual, no choice regime” that turned into “absolute control” after the 1970 ruling.¹⁴ These Clinics were all-encompassing, with intense regulation on its patients that enforced rigid gender stereotypes, but completely unsystematic on a national scale; instead of an overarching system of governance, GICs are better analogised as the personal fiefdom of the individual clinicians who founded them. Without standardised care, GICs were driven by the personal biases, standards and personalities of its psychiatrists and surgeons: “There was no agreed terminology, diagnostic criteria, care pathways, clinical standards or regulatory frameworks. GICs could simply do as they wished.”¹⁵ The parameters of the patient’s sex were down to the individual wishes of the clinician.

Overtaking *Corbett v. Corbett* thus became a rallying point within the burgeoning transsexual and transvestite rights movement, and a plethora of organisations, charities and advocacy groups erupted in Britain post-1970. The earlier organisations who opened doors before 1980 – S.H.A.F.T, the Beaumont Society, and the London TV/TS Group - focussed more on providing a social space, whereas groups established in the 1980s or 1990s, for example Press for Change, Mermaids or the Gender Dysphoria Trust, focused on advocacy. These latter organisations focused on bringing trans rights in line with cisgender rights, to ensure trans subjects were legally ‘seen’; being ‘seen’ refers to this assimilatory, not revolutionary, method of trans activism that coalesced. With this activism, we can see how elements of transsexual eugenicism were incorporated into the fabric of trans resistance. For example: Press for Change] was formed in the 1990s as a lobbying organisation to unify the various legal battles that trans people had been engaged in for two decades, primarily

¹² *Corbett v. Corbett* established a chromosomal test wherein trans people were confined to their sex at birth in all legal documentation, and the ruling removed many of the leniencies of the previous periods. See: C. Hutton, *The Tyranny of Ordinary Meaning: Corbett v. Corbett & the Invention of Legal Sex* (London, 2019), [doi: 10.1007/978-3-030-20271-2,].

¹³ Randell, *Sexual Variations*, p80.

¹⁴ Playdon, ‘Genesis and Unoriginal Sin’, <https://www.transactual.org.uk/blog/gender-identity-clinics-genesis>.

¹⁵ *Ibid*.

campaigning for a “right to marry”, to change legal sex across the entire spectrum of identity documentation, and legal protection from workplace discrimination.¹⁶ Co-founder Stephen Whittle stated that PfC was founded because, since his coming out in the early 1970s, “all transsexuals [had] wanted to do was to get their operation, get their birth certificates changed so they could get married, and *disappear into normal life*. But they had been prevented from this.”¹⁷ ‘Normal life’ here is positioned as being cisgender and heterosexual, as surgical and behavioural modification to become indistinguishable from anyone else, and above all as the primary goal of transitioning. The goal of ‘normal life’ is one that does not account for transsexual’s capacity to develop AIDS; submitting into cisheteronormativity precludes such a diagnosis from occurring.

To understand the extent of this ‘normal life’, one must turn to the Gender Clinic guidelines and their reciprocal relationship with trans organisations. Until the late 1980s, for a Gender Clinic to recommend a trans woman for surgery she must be: single, self-supporting (not unemployed), emotionally stable and “convincing” as a woman; unofficially, she also must not “work in a gay club with a social life based around the gay or transvestite social scene”.¹⁸ Dr Richard Reid of the Charing Cross Clinic, the psychiatrist who took over after Dr John Randell’s death in 1985, stated that he chose patients based upon their “general appearance and the likelihood of them being accepted into the mainstream of society... you need to be accepted, not just tolerated!”¹⁹ The Self-Help Association for Transsexuals - a trans women’s group active in the 1970s and 1980s - produced a Handbook which reinforced these beliefs, stipulating that a trans women is “successful” if she is indistinguishable from other women, and for those whom this was an impossibility a “less extreme compromise” should be sought as “*the object is to blend inconspicuously and not attract attention.*”²⁰ Trans individuals navigating the Clinic system were prescribed a “mainstream” life, removed from the “gay or transvestite” subcultures - and also, physically judged on their ability to be “accepted” within the seemingly unchangeable standards of cisheteronormative society. And this was internalised into the rhetoric of the trans patients themselves, who taught each other to “blend” with their surroundings; these guidelines policed every aspect of trans life so much that necessitated a heteronormativity that the clinic expected its patients to internalise.

¹⁶ ‘Press for Change History’, <http://t-vox.org/history/press-for-change>, (16 June 2023).

¹⁷ Pressing for Change: 25 Years Seeking Trans Equality.

¹⁸ London, WC, PP/KIN, C/14/3: S.H.A.F.T 1981 Handbook for the Male to Female Transsexual, p26.

¹⁹ ‘Dr Russell Reid at the TV/TS Centre, 11th July’ *The Glad Rag Journal* 36 (1987), p2.

²⁰ PP/KIN, C/14/3, S.H.A.F.T 1981 Handbook.

Those who were expected to “blend” came at the end of a long, discriminatory process of being *allowed* to blend and be diagnosed with transsexualism. Sir Martin Roth, renowned psychiatrist at Newcastle University 1956-1987, believed surgery for transsexuals was only correct in 15% of cases he had seen; “beyond that, you do not solve problems but cause them... Create new beings out of them? This was illusory.”²¹ J.R.G Edwards and A.J Evans, NHS surgeons who performed gender affirming surgeries in the 1970s and 1980s, reference a “close filter” that was used to weed out ‘bad’ clients for ‘sex-change’ surgeries - “good” results were when patients could live as cisgender without raising questions. Trans women who did not perform womanhood correctly were routinely told to “go back to the production line” and refused treatment: Edwards notes how a six-foot three trans woman came to his office “every day for eighteen months”, and he refused her the “mutilation of a ts” as he did not believe she could live ‘undetected’ as a woman.²² Surgery is still seen as mutilation, as Randall’s “castration”, with the patients seen as “fascinating surgical problems” instead of people.

The internalisation of this clinical rhetoric is seen most evidently within the pages of the London TV/TS Group’s journal *The Glad Rag*. Run by Coordinator Yvonne Sinclair, the Group was an organisation for transvestites and transsexuals in London which ran between 1978-1994, and their Journal routinely ran articles praising Gender Clinic standards: the Group hosted Dr Russell Reid in 1987 and praised his 30% referral rate for its medical gatekeeping, his requirement for “acceptance, not toleration” was praised, and the author of the write-up noted that Reid was relieved that the audience was not “hostile, disappointed would-be transsexuals.”²³ Despite being styled as the ‘TV/TS’ Group, the Group was intensely critical of individual transsexuals and often called for *greater* medical surveillance of those under Gender Clinic supervision. The “express check-out” of transsexual surgery was criticised as creating more problems than the “psychological, physical and euphoric” problems it solved: “many have broken their bones only to find out that what they sought was beyond their capability”.²⁴ By 1994, the Group was running events on the dangers of the

²¹ London, WC, PP/KIN, A/2/48: Sir Martin Roth 1980, p10.

²² London, WC, PP/KIN, A/2/18: JRG Edwards 1982, p27, p28; London, WC, PP/KIN, A/2/20: A J Evans 1980, p43, p42.

²³ ‘Dr Russell Reid at the TV/TS Centre, 11th July’ *The Glad Rag Journal* 36 (1987), p2; ‘An Evening with Russell Reid’ *The Glad Rag Journal* 35 (1987), p32.

²⁴ ‘Air of Superiority’ *The Glad Rag Journal* 60 (1992), pp. 14-15; Y. Sinclair, Issue 60, October 1992. P14-15; Sinclair, *Transvestism within a Partnership of Marriage and Families* (London, 1984), p12. The ‘express check-out’ did not exist in 1992, the average NHS wait time for trans-feminine gender confirmation surgery was around 4-5 years.

“medically invasive procedure” electrolysis and forums on “The Decision to Operate”, again ran by the psychiatrists at Charing Cross GIC.²⁵ Echoes of Roth’s “Create new beings out them? This was illusory” are woven throughout this commentary.

The similarity of rhetoric between Gender Clinics and the patients it purports to support speaks to Jules Gill-Peterson’s observation that “transsexuality arrogantly pretends to know and seize trans life as an object, making it a difficult concept to write with and against” – it is difficult to discern where transsexuality ends and the subject begins, or if that distinction existed at all.²⁶ The point at which the trans patient ceases to develop their individual conceptions of their gender independent of a transsexual framework is impossible to discern from many of the records of the British trans archive: the pathological, eugenic language of transsexuality, with its emphasis on assimilation and surgery as necessary mutilation, permeates throughout the output of the patients themselves. A trans history of AIDS, with all that the disease popularly signified in terms of sexual degeneration and non-normative sexual practices, must contend with the integration of transsexual medicine into the identities of the transsexual & transvestite patients: the records will rarely speak of AIDS, but as Sara Davis notes, “absence of evidence is evidence of absence”.²⁷

AIDS as Beyond Transsexual Comprehension

The above two sections, through focusing on the integration of transsexual medicine into a burgeoning trans consciousness in Britain, have attempted to lay foundations towards understanding the elision of AIDS from this ‘TV/TS’ consciousness. In this final section, I want to directly address how this construction of transsexuality directly prevented conceiving the transsexual patient as at risk of AIDS through analysing the response to England’s 1980s ‘kerb-crawling’ moral panic, and the tangible homophobia that runs throughout clinical and community output. Through this we can glean how transsexuality was delicately constructed to exclude those who participated in non-normative sexual practices, and thus how AIDS was beyond the purview of a pathological transsexuality.

Kerb-crawling refers to soliciting sex workers from the street, slowly driving through known

²⁵ ‘Friday Evening Forums’ *The Glad Rag Journal* 60 (1992), pp. 8-9.

²⁶ Gill-Peterson, *HOTTC*, p9.

²⁷ Davis, *The Uncounted*, p46.

areas with high-rates of public sex work to ‘pick up’ women. Street sex workers had long been subject to policing - primarily under Section 1 of the 1959 Street Offences Act which prohibited “persistent loitering in a public place for the purposes of prostitution” - but throughout the 1980s, male clients were legislatively targeted, which intensified a moral panic against ‘prostitutes’ and AIDS. The 1985 Sexual Offences Act criminalised such men, and was lambasted by the English Collective of Prostitutes for increasing the marginalisation of sex workers, and women assumed to be sex workers, as “the women are always the first to be arrested.”²⁸ The Act led to only 161 prosecutions against kerb-crawlers in 1986, compared to 9,404 prosecutions of women for loitering.²⁹ Even carrying condoms or AIDS literature could be used to justify a charge of loitering. In 1989, Conservative MP for Oxford West & Abingdon suggested that sex workers with AIDS, gonorrhoea or syphilis should have greater criminal punishment: the moral panic, far from focusing on male clients, increased hostility towards street sex workers.³⁰ Within this, trans women could be visible targets to be arrested for ‘loitering’, as a common prostitute, or for a breach of the peace: they were rarely profiled as transsexual or transvestite women, but often as male sex workers or gay drag queens.

The street sex worker during the kerb-crawling moral panic was invariably entangled with AIDS moralising. And yet, the commentary from contemporary trans organisations had no reference to AIDS, and barely considered those trans women who were arrested under these conditions as transsexual. Transsexual Action Organisation, a short-lived collective of transsexual activists, warned in their information booklet that trans women were often targeted if they “walked across certain streets at certain times of day”; yet, the TAO’s advice was to “not look too tarty”.³¹ S.H.A.F.T’s ‘News and Views’ section, which ran between 1982-1988 in their newsletter, used press cuttings to make ‘respectable’ transsexuals appear morally superior to “the other prostitutes”. In 1983, News and Views reported on the case of Linda Gold, a trans woman suspected of prostitution arrested for wearing a kissogram outfit in Soho:

“There was the usual prostitute on the game, this time Linda Gold... complaining about being strip searched in the male cells in front of ten police officers. ‘It’s wrong the way people like me are treated as an animal’ she told the magistrates - perhaps

²⁸ English Collective of Prostitutes, *For Prostitutes, Against Prostitution* (London, 1990), p6.

²⁹ G. Scambler, ‘Women prostitutes in the AIDS era’ *Sociology of Health & Illness* 12/3 (1990), [doi: 10.1111/1467-9566.ep11347156,] p268.

³⁰ [Hansard] *House of Commons Debates*, vol. 144, c1095, Prostitution in Streatham, John Patten MP.

³¹ London, WC, PP/KIN, C/16: Transsexual Information 1976, p3.

then she shouldn't act like one!"³²

Denigrating Gold as a "usual prostitute" and likening her to an "animal" for wearing a kissoqram outfit in public removes not only her humanity, but Gold's ability to be counted as a 'real' transsexual: the insinuation being that if Gold had "blended inconspicuously", then she deserved to not be treated like an animal.³³ Her proximity to an identity that was synonymous with HIV/AIDS infection, according to S.H.A.F.T, should preclude her from the identity of 'transsexual'. This rhetoric is the near-exact same as JRG Edward's comments on how one case made him decide to never take direct referrals that did not first come through a psychiatrist:

"There was a boy from Liverpool. He took me in, and I thought this is a female. No question I would have said this is straightforward. And then he came into [a psychiatrist's] hands, and his first question to the boy was 'Have you ever been to prison?' And apparently this boy had a record, and he was a homosexual male prostitute. So, I feel I am no good judge at all in that grey, twilight world of sex abnormality and crime."³⁴

Because of his patient's background as a sex worker, Edwards rejected them as a candidate for gender-confirmation surgery - and more broadly, from allowing them to be identified as 'transsexual', instead as a criminal sex abnormality. In contrast, he describes his own surgical procedures as one that gives transsexual women "good, fun sex": here, the implication is that the good, fun sex can only be heterosexual and within the boundaries of the law,³⁵ Trans women were conceptualised in the Gender Clinic as pursuing surgery to be better penetrated by heterosexual men; in the words of AJ Evans, who goes into detail about the "perfect" vaginal depth", his 'favourite' trans women were the patients who "wanted everything fully-functioning, who wanted to have sex"³⁶. The notion that trans women could be in situations where they could AIDS after this surgical process implicates heterosexual reproduction as a vector of disease: instead of entertaining that possibility, it is easier - as Edward's did - to preclude them from being transsexual altogether. The ideal transsexual woman's femininity was constructed against a perception of sexual degeneracy - there is no crossover for them being considered as the same person.³⁷ Both Edwards and S.H.A.F.T's devaluing of a

³² PP/KIN, C/14/3: S.H.A.F.T Newsletter 23 (Oct 1983), p8; For more information on Linda Gold, see: 'Sex op Linda's strip' protest, 10 Feb 1983', www.digitaltransgenderarchive.net/files/6395w719p, (16 June 2023).

³³ PP/KIN, C/14/3, S.H.A.F.T 1981 Handbook.

³⁴ PP/KIN, A/2/18: JRG Edwards 1982, p15.

³⁵ Ibid., 5.

³⁶ Ibid., p1; PP/KIN, A/2/20: A J Evans 1980, p30.

³⁷ Amin, 'Glands, Eugenics, and Rejuvenation', p601.

transsexual woman's identity stem from the same impulse: that which gatekeeps transsexuality as a diagnosable condition only for those who perform acceptable, middle-class white womanhood. The state of being transsexual can be revoked if one does not conform to these ideals.

Edward's comments on the "homosexual male prostitute" lead discussion towards the general homophobia found within the Gender Clinic and within transsexual and transvestite support groups. Surgeon A.J Evans argued that few doctors specialised in trans medicine because they assumed it was "homosexuals and perverts: they didn't understand that a difference there was between these TS and the others."³⁸ The homophobia and anxiety within the clinicians over trans proximity to homosexuality is seen through Sir Martin Roth's lamentation over how his most "disastrous" cases were invariably upon transsexual women involved in "gay culture" - Roth perceived these patients as unable to socially adapt to womanhood, and as "slippery" characters for whom transsexuality was "one of many roles" they played. This homophobic trans separatism emphasised the necessary differences between trans identities and homosexuality: the pursuit of surgery was perceived as the marked difference between the cisgender homosexual and the heterosexual transsexual, and only the latter was acceptable within the fragile boundaries of heteronormativity.

This clinical homophobia is increasingly found within the pages of London TV/TS Group's journal in the 1980s. Despite styling itself as for gays and straights and regularly calling out the Beaumont Society's homophobia,³⁹ the Journal routinely ran homophobic material sent in from its readers, be it a letter from 'Sandra' lamenting the TV/TS "limp-wristed poofter image" of trans people or a homophobic cartoon on the horrors of being catcalled by a man whilst not dressed as a woman, there is an undercurrent of anti-gay sentiment. But the Group's 1984 book *Transvestism within Marriage* openly displays an inability to conceive trans and homosexuality: transvestism is constructed as a solo act, and "sexual contact with either sex is no part of the compulsion." The author/coordinator Yvonne Sinclair also refutes that homosexual men could find transvestites attractive as they are "looking for a male image to relate to", with the only male encounter conceptualised as one wherein a "bisexual transvestite" targets heterosexual men: the bisexual transvestite sees the encounter as homosexual, but their partner "will see the act as non-homosexual, because the male is

³⁸ PP/KIN, A/2/20: A J Evans 1980, p53

³⁹ e.g., 'Yvonne's Bits' *The Glad Rag Journal* 30 (1986), pp. 15-16 - "a strange club [BS] belongs to, which makes use of gay venues but excludes gays from *their* transvestite world, which would flounder quickly without the tolerance they receive from the gays".

playing female (through image), and the act is not associated as homosexual.”⁴⁰ Even the constructed “bisexual transvestite” can only have heterosexual sex with non-homosexual partners. The trans sex act is can only be heterosexual, as conforming to British law and morality, as J.R.G Edward’s “good, fun sex” - and as never challenging the heteronormative boundaries that it constructs around itself.

This virulent policing of the borders of transvestism against associations of homosexuality clearly has implications for how AIDS is configured, however I argue that the reactionary backlash against trans women arrested in the kerb-crawling moral panic is better placed to understand how AIDS was configured within transsexuality: those tainted with the scourge of potential prostitution were cast out as “animals” or prevented from physically transitioning, and rarely affirmed in their transsexual identities. This is where it is crucial to distinct between trans women and gay men populations, especially within the history of AIDS: as women, trans women must be understood beyond frameworks of ‘men who have sex with men’, as different at-risk populations that were distinctly female. The association with AIDS, either through gay male or sex worker circles, would threaten transsexual identity through how it infringes upon the middle-class, white female identity necessary to adopt.

Conclusion

As I will discuss in the final chapter, I have found no records that deal with the material effects of HIV/AIDS on trans people. Instead, what I have found is an internalization of clinical discourses. For example, it can be assumed that the HIV/AIDS epidemic had an impact on gender-confirming surgery, and that the severity of its effects would vary by district. Tracing a blanket policy on surgery and HIV is difficult: Thatcher’s reforms saw general management introduced to the NHS in 1984, and whilst the District Health Authority was the key operational tier responding to AIDS “[historians] know little of this response” because of how rapidly the institution was being restructured between 1982-1991.⁴¹ A retrospective analysis of Royal Free Hospital in London found that 722 surgeries were performed on patients with HIV between 1986-2002: this included elective and emergency surgery ranging between intra-abdominal and anorectal surgeries. Cross-referencing with

⁴⁰ Sinclair, *Transvestism in Marriage*, p10.

⁴¹ E. Ferlie, ‘The NHS response to HIV/AIDS’ in V. Berridge (ed) *AIDS and Contemporary History* (Cambridge, 1993), p204.

Rebecca Havilland's oral testimony, she recalls the only time she was tested for HIV was in 1988, as part of the preparation for 'sex-change' surgery: "people wouldn't operate on you if you had it, it was that cut and dried."⁴² It was perhaps not "cut and dried", but Havilland's testimony could underscore a regional disparity within the NHS regarding HIV and surgery, and perhaps that the 'sex-change' surgery was not considered worth the 'risk'.⁴³

One might expect to see discussion around material issues of surgery and blood contamination within a trans history of the epidemic, and yet the records of both clinician and patient busy themselves with policing the bodies of trans women, casting out of transsexuality those who break the rules of its diagnosis. The eugenic foundations of the Gender Clinic, by design, could not envision its patients as being susceptible to sexual disease and AIDS. The ideal transsexual woman was transitioned from an "ill 'creature'" into a "healthy, young, feminine *woman*": the idea that, after this transition, the transsexual would be susceptible to AIDS undermines this core purpose of transsexual medicine.⁴⁴ Through rabidly gatekeeping the diagnosis of 'transsexual' and developing the diagnosis through a belief in (white) racial plasticity, the transsexual was necessarily separated from the wiles of sexual degeneracy'.

⁴² Havilland interview, 13:01-17:05.

⁴³ The perceived risk of surgery on patients with HIV stems primarily from the fear of healthcare workers contracting HIV from the patient. This risk is estimated to be 0.3%, however this was a legitimate fear in the late 1980s.

⁴⁴ Amin, 'Glands, Eugenics, and Rejuvenation', p601.

AIDS and the Eugenics of Transsexual Medicine

On 18 August 1978, 'Chris' from the London Friend TV/TS Group gave a training session to the Lesbian and Gay Switchboard at the Prince Albert pub near King's Cross Station. This talk was attended by volunteers of Switchboard, Lesbian Line and Icebreakers, and was intended to give "a description of their group, with sufficient background information on transsexual (sic) operations for dealing with telephone inquiries."¹ Switchboard's Bob Harris documented this training in his "Report on the talk given by the TV/TS Group", which later became the widely accessible A5 leaflet that formed the basic structure of the 'TV/TS File'. This report frames trans experiences around Dr Harry Benjamin's Sex Orientation Scale, categorising potential trans callers between 'fetish transvestite' and 'surgical transsexual', and going into superfluous detail about gender-confirming surgery.² Harry Benjamin, who had worked in the "eugenicist imaginary" of rejuvenation and standardised a transsexual clinical practice that functioned through the racial "plasticity" of white trans bodies; his Sexual Orientation Scale constructed transsexuality to maintain a eugenic hierarchy of desirable and undesirable trans bodies, not to improve patient outcome.³ Bob Harris's 1978 report formed the basis of Switchboard's trans conceptualisations throughout the 1980s and early 1990s: the same turns of phrase, focus on pathologisation and emphasis on Benjamin's Scale are repeated in the 1984 TV/TS Handout, in the 1985 TV/TS File, and the TV/TS entry of the 1989-1991 Draft Information Sheets.⁴ The 'TV/TS File', created through this TV/TS Group training session, remained until 1995 when it was updated with new identity categories.⁵ The TV/TS Group's influence over Switchboard's policies, through just one training session, can be felt across the decades.

This chapter analyses this relationship between the TV/TS Group and Switchboard to ascertain how the "bleached and medicalised" conception of transsexuality was imported into Switchboard through the TV/TS Group's proximity to Gender Clinics.⁶ Through this, I maintain that historians will be better placed to understand the troubled relationship between

¹ London, BI, SB, 4/6: Letter to London Friend, 25th July 1978.

² London, BI, SB, 6/1/1: 1978 Report on London Friend TV & TS Group talk, p1.

³ B. Velocci, 'Standards of Care', p464.

⁴ London, BI, SB, 6/1/2: 1985 Explanation of TV/TS File and TV/TS Handout, c.1984; London, BI, SB, 6/1/3: Draft Information Sheet, 1988-1991.

⁵ A. Smith & T. Walker, "Needs Reassurance and Support" *The Logbooks Podcast Transcripts* (13 December 2021), <https://www.thelogbooks.org/transcript/s3-e6-needs-support-and-reassurance-transcript> (2 June 2023).

⁶ Gill-Peterson, *HOTTC*, p3.

trans and AIDS: AIDS, as a reactionary symbol of sexual ‘degeneracy’, is oppugnant to a transsexual medical practice built upon eugenics.

Taking its first call on 4th March 1974, the Lesbian & Gay Switchboard began as the London Gay Switchboard and functioned to provide counselling, advice or directions for gay men and lesbians in London. By 1977, Switchboard was taking over 100,000 calls per year, increasing to 175,000 by 1986 with an expanded volunteer team.⁷ Most information for volunteers to deliver were stored in files, on topics from lesbian nightlife to paedophilia, and a dedicated ‘TV/TS’ file after 1978. Through their logbooks, it’s possible to see that they began tracking ‘TV/TS’ callers from October 1978 and used this same categorisation through to 1995. ‘TV/TS’ callers consistently hover between 2-5% of the total calls per year, from 1250 individual calls in 1978/79 to an unprecedented 13.5% increase to 3315 ‘TV/TS’ calls recorded in 1984.⁸

Switchboard allied itself with the Gay Liberation Front and the Third World Gay Revolution, wherein “the struggles of the peoples of the world are our fight as well” - aligning themselves with an international liberationist movement, in ways that could seem clumsy.⁹ This commitment to antiracism is seen through the notoriously strict and slow hiring procedures, often three stages over three months with intense scrutiny on the interviewees’ potential racism, a process which was called into question in the AIDS epidemic. Internally it was labelled “sanctimonious” in the face of the “decay” of civil liberties: “demand is soaring and it is our first duty to meet it... already, the service that most of our callers get is an engaged tone.”¹⁰ This antiracist ideological commitment was overshadowed by the internal makeup of the volunteers: Sunil Gupta’s short film on Switchboard showed how many of the volunteers in 1980 were white men in their twenties - “[Gupta] raised an eyebrow - ‘Oh look, there’s a non-white face!’”.¹¹ Their ideological foundations, if not their working practices, were driven by anti-racism, antifascism and a belief in international liberation.

In 1988, Switchboard received its first openly trans volunteer in Diana James. Diana was

⁷ ‘Switchboard’ *Gay Left* [London], issue 6 (Summer 1978), p28; London, BI, SB, 4/1: 1986 Pink Pound Leaflet.

⁸ London, BI, SB, 5/4/6: Call Statistics 1974-2002.

⁹ ‘Sixteen Point Platform and Program’, <https://pinko.online/pinko-1/third-world-gay-revolution-archive> (2 June 2023).

¹⁰ London, BI, SB, 4/1: A proposal to modify recruitment of volunteers, 1985.

¹¹ G. Davis, ‘The Queer Archive in Fragments: Sunil Gupta’s London Gay Switchboard’ *A Journal of Lesbian and Gay Studies* 27/1 (2021), [doi: 10.1215/10642684-8776904,] p128.

nearly rejected as a volunteer because of “ideological issues” regarding sexuality and gender and recalls that volunteers who were not entirely homosexual or lesbian were subject to accusations that they were not pure enough to work at Switchboard. Through stating her motives as “as a dyke, I wanted to help people”, Diana makes it clear that she joined because she is a lesbian and not because she is trans.¹² In microcosm, this represents Switchboard’s prioritisation of sexuality over gender: trans callers were often signposted to trans-specific helplines with greater specialist knowledge, as they considered their field of expertise *sexuality* rather than *gender*.

From 1978, Switchboard would refer trans callers to the ‘London Friend TV/TS Group’, being labelled the organisation volunteers “will use most often”.¹³ This was the London TV/TS Group, who began operations at London Friend offices before establishing an independent Centre in June 1986.¹⁴ Friend charged low rent to ensure that the London trans community had a space to congregate, as Friend had “concern for sexual minorities who are not understood, and for whom there are few facilities available”.¹⁵ Because of this relationship, the TV/TS Group was one of the only trans groups that welcomed gay and bisexual members: “We [the Group] owe the Gay Community our gratitude for their tolerance, when the ‘normal public’ offered us little.”¹⁶ The TV/TS Group, as well as publishing the Glad Rag Journal, ran a befriending service, helpline, drop-in sessions, annual dinners, a Wives Group, and in 1984 funded the publication of its coordinator’s book *Transvestism in Marriage*. The Group remained autonomous through having separate memberships, rising to 1000 members by 1987 and 1500 by 1991, which made it the largest national trans organisation of its time. It wasn’t just Switchboard who referred callers to the TV/TS Group: in a letter to its Journal in 1986, the Oxford Lesbian & Gaysoc thanked the Oxford Gay Switchboard for referring them to the TV/TS Group to answer their queries after they received a “large increase in calls relating to transvestism”.¹⁷ Throughout the 1980s, it

¹² A. Smith & T. Walker, “Right on Sister!” *The Logbooks Podcast Transcripts* (21 Dec 2020), <https://www.thelogbooks.org/transcript/s2-e6-right-on-sister-transcript>, p9 (2 June 2023); Interview with Diana James, conducted by myself at Worcester College Section 28 Panel, 10 March 2023.

¹³ London, BI, SB, 6/1/2: Oct. 1985 TV/TS File Handout.

¹⁴ London Friend is a counselling and befriending service for lesbians and gay men, obtaining their premises in 1975 and remaining there until the present day. P. Oliver, *London Friend: 50 years of LGBTQ+ Support* (London, 2022).

¹⁵ ‘The Transvestite/Transexual Group meets at London Friend’, <https://50thbirthday.londonfriend.org.uk/timeline/1970s/the-transvestite-transexual-group-meets-at-london-friend/> (2 June 2023).

¹⁶ ‘Yvonne’s Bits’, *The Glad Rag Journal* (24 July 1987), p13.

¹⁷ ‘Oxford & Lesbian Gaysoc Letter to Editor’ *The Glad Rag Journal* 28 (1986), p40.

could be argued that the TV/TS Group positioned itself as experts in training Switchboards in trans issues.

It seemed like the TV/TS Group was a progressive force fighting for transsexual and transvestite recognition. However, when analysing their archival remnants - the *Glad Rag Journal*, and minorly the coordinator's retrospective website from the early 2000s - the progressive veneer begins to slip.¹⁸ This occurs in multiple, intersecting ways - but most importantly, the Group's proximity to Gender Clinics rendered their output as apologia for institutional malpractice and eugenics. The group was afforded an affirmative relationship with Charing Cross *because* their mostly white, middle-class membership was unthreatening, meaning the Group was too closely to the Clinic's eugenicist rhetoric to critique it. This proximity is seen through their 'Evening with Dr Russell Reid' of Charing Cross Hospital in July 1986, and giving a 'Clinician's Corner' section to an anonymous doctor at an NHS Gender Clinic.¹⁹ This proximity imbues the Group with a normativity that rests upon its perceived "plasticity"; the "abstract whiteness" refracted onto the Group's membership justifies their existence as self-defined transvestites or transsexuals.²⁰

This racialised 'plasticity' is demonstrated through the Group's international interactions. In the mid-1980s, at the height of the British Free Nelson Mandela Movement, Issue 31 of *Glad Rag* collaborated with South African TV/TS group the Phoenix Society. Described as a society that "provided a way for (white) men dressed as women to connect with one another"²¹, *Glad Rag* published two of their articles: "[The TV/TS Group] are always pleased to establish links with our sisters from all over the world... maybe we could build up a worldwide sisterhood? We can't possibly make as big a mess of it as the politicians."²² If we situate this "worldwide sisterhood" against the Group's intimate relationship with Gender Clinics, the racialisation of transsexual medicine becomes apparent. To claim 'sisterhood' with an organisation built through racial apartheid made explicit how pathological transsexuality could not make legible trans people of colour. This banner of international white womanhood gestured towards the Group's wider positions on anti-racism. Across

¹⁸ 'Yvonne Sinclair', <https://www.yvonnecinclair.co.uk/> (16 June 2023). Sinclair's website is long-abandoned and serves as a retrospective analysis of the Group's activities from one of the main organizers.

¹⁹ 'An evening with Russell Reid' *The Glad Rag Journal* 35 (1987), p32; 'Clinician's Corner' *The Glad Rag Journal* 50 (1990), pp. 15-16.

²⁰ J. Gill-Peterson, *HOTTC*, p27.

²¹ 'Joy Wellbeloved Collection', <https://searchworks.stanford.edu/view/13724861> (2 June 2023).

²² 'The Phoenix Society' *The Glad Rag Journal* 31 (1986), p32.

Yvonne Sinclair's extensive photo archive of the TV/TS Group's activities, all but one identifiable subject is white.²³ With the wider background of apologia for South Africa, this absence can be viewed in terms of how "Black trans and trans of colour subjects were not welcome within that discourse" - a discourse shaped by racialised medical eugenics.²⁴

Othering and Degeneration: AIDS and the London TV/TS Group

The London TV/TS Group referenced AIDS as something that happened to other people. For Yvonne Sinclair, the Group Coordinator, the AIDS crisis is exclusively mentioned within her critiques of the Beaumont Society's homophobia. In Issue 25, December 1985, Sinclair calls out the Society for expressing concern over the London TV/TS Group hosting events in gay venues during the AIDS epidemic:

"For gays, this is their crisis time; yet we already read in our sister journals attacks on this Group; using AIDS as a cover to undermine others who might be thinking of visiting - by the implication that in doing so they might get AIDS."

The Society, and all transvestites and transsexuals who belittle gay people, are reminded that "the few outlets that exist for us are exclusively Gay yet are we not the first to disown them if we ourselves are thought to be homosexual?"²⁵ Here, AIDS is complexly positioned as something which some trans people perceived as a social and *actual* contagion which bridged towards non-normative sexuality. In Issue 30, Sinclair again criticised the Society for the same reasons - "[the Society] believes that having gays in their midst would undermine them, with the added possibility of AIDS being a threat to their members."²⁶ Sinclair is unable to envision trans people as at-risk of AIDS: she critiqued the Society for not demonstrating solidarity, and failed to realise that she herself was underscoring the separation between 'trans' and 'AIDS'. The AIDS epidemic is "their" crisis time, the "Gay world's" crisis time, and it is the duty of transsexuals and transvestites to stand with gay people during *their* crisis. It is not theorised as something that could directly affect a transsexual or transvestite in the Group, but it is something the community should be sympathetic towards. AIDS is at once welcomed and held back.

²³ 'Porchester Hall Drag Balls, Photo 72' www.yvonesinclair.co.uk/galleries/phddest/images/phd72.jpg (2 June 2023).

²⁴ J. Gill-Peterson, *HOTTC*, p27.

²⁵ 'Yvonne's Bits' *The Glad Rag Journal* 25 (1985), p11.

²⁶ 'Yvonne's Bits' *The Glad Rag Journal* 30 (1986), pp. 15-16.

Beyond Sinclair, other writers at the Glad Rag had opinions on the epidemic. The article ‘Electrolysis for a femme image’ by “Annabel” in March 1986 positioned AIDS as *beneficial* for the trans community in a bizarre argument on how AIDS medical research will speed up drugs used in surgical aftercare:

There is a good chance that the intensive research taking place on AIDS (including the bio-mechanical method of action) will produce a drug which will allow successful and simple transplant of any part of the human body in a much easier way...allowing the total success of operations such as that performed on Lili Elbe. I am not joking but consider this a possibility, a near certainty in the foreseeable future.

Lili Elbe was a Danish trans woman who died after her body rejected a uterus transplant in 1931, under the care of Magnus Hirschfeld’s Institute of Sexology.²⁷ The choice of Elbe as an example exposes a deeply ingrained focus on *normative* femininity, a femininity directly borne from the early decades of eugenic transsexual medicine. Elbe’s posthumous biography *Man into Woman* (1933), writes Kadji Amin, necessarily emphasised Elbe’s racial, sexual and gendered superiority as to do otherwise would mark her as “degenerate” and unworthy of medical transition: “Lili’s portrayal as a biologically fit, youthful, and normatively feminine woman... is required through subscription to the imaginary of eugenic modernity.”²⁸ Her presence here, closing this article about the ‘benefits’ of AIDS, calls the reader to identify with Elbe over people with AIDS; referencing Elbe is Annabel’s own “subscription to the imaginary of eugenic modernity”, the bodies of those who lived and died with AIDS are sites of medical experimentation for the ultimate benefit of transsexual medicine. AIDS here only exists as a stimulus for the development of a transsexual pathology, and again, the trans subject being able to develop AIDS themselves is unthinkable.

‘Annabel’ is not consciously advocating for a eugenics-based transsexual medicine. But in making this connection between Elbe and AIDS, in hinting towards the expandability of AIDS patients for the advancement of transsexual medicine, she revealed how its eugenic parameters do not allow susceptibility to sexual disease. Like Elbe, the writer is forced to contrast herself against “sex degenerates, the disabled and ill” to refute accusations of her own degeneracy.²⁹ The Group’s othering rhetoric is not simply self-protection or survival. It spoke to the effects of a totalising culture of implicitly racialised, purity-based medicine which demands that all its patients perform sanitised white womanhood, to position

²⁷ N. Blumberg, ‘Lili Elbe’ *Britannica* (Edinburgh, Dec 2022), <https://www.britannica.com/biography/Lili-Elbe> (16 June 2023).

²⁸ K. Amin, ‘Glands, Eugenics, and Rejuvenation’, p601.

²⁹ *Ibid.*

themselves against ‘degeneracy’ to secure their own position within the growing panopticon of transsexual medicine.

“Terminate the Call”: the Lesbian & Gay Switchboard

Switchboard’s AIDS policies built upon concurrent British charities through their emphasis on inter-community solidarity, and risk reduction rather than abstinence. But Switchboard, as the most visible gay helpline, played a unique role in the dissemination of AIDS information: “People didn’t know who else to call and they were worried, so who do you call? You called Switchboard, [who became] at the eye of a really nasty thunderstorm.”³⁰ This ‘thunderstorm’ intensified during times of public panic, such as how calls to Switchboard “quadrupled” in the week following the BBC documentary ‘Killer in the Village’ which explained the American AIDS crisis.³¹ Their phone policies hinged upon two principles: to deliver accurate, up-to-date information, and to not inspire panic in any caller regardless of their risk status. Volunteers were required to keep up with the latest developments as an essential counter against callers who get their AIDS knowledge from “malicious, ignorant, morally retarded and dangerous bigots”.³²

Nowhere within the Switchboard AIDS policies is the notion that TV/TS callers, either gay or straight, were at risk. Calls from transvestites and transsexuals were “difficult to deal with,”³³ not only because many of the volunteers were “generalising from hearsay knowledge” but also because of how Switchboard training emphasised the duplicity of TV/TS callers.³⁴ Switchboard’s volunteer training focused near-exclusively on phone roleplaying, going through the various callers that the trainee would likely experience, such as young gay men wanting to find nightlife or closeted married lesbians coming out for the first time. They were specifically designed to see how individuals acted under pressure, how they used the guidance files and, when their AIDS policies were in place, how they introduced the topic of safer sex.

³⁰ A. Smith & T. Walker, “Please Be Gentle” *The Logbooks Podcast Transcripts* (16 Nov 2020), <https://www.thelogbooks.org/transcript/s2-e1-please-be-gentle-transcript>, p5, (2 June 2023).

³¹ London, Bishopsgate, SB/6/1/1, Nov. 1984 Guidelines on AIDS calls for Gay Switchboards.

³² *Ibid.*, pp. 2-5.

³³ First in London, BI, SB, 6/1/1: 1978 Report on London Friend TV & TS Group talk; repeated in London, BI, SB, 6/1/3: Draft Information Sheet.

³⁴ London, BI, SB, 4/6: 20th August 1978 letter to London Friend.

This analysis focuses on the 1988 Pre-Acceptance Training Vollete Pack by ‘Steve’, which gives detailed examples of role-plays for all four, extensive training sessions. In the fourth and final training session, Steve wrote up his ‘TV/TS’ roleplay: a “28-year-old gay man in Morecambe, Lancashire. He is married and is a transvestite. He has no children with his wife.” Steve noted that trainers have various approaches to tackling TV/TS roleplays, but that he creates a “very manipulative caller for whom there can be no real solution, because he doesn’t want one.” He instructed the trainer to “be as manipulative as possible - talk in loving detail about clothes, makeup, how you got away with [passing as a woman] on the bus once”, and to ignore any suggestions that the trainee provides to instead “talk sexy”. The trainee should “show initial interest and a sympathetic approach” and try to understand the main area of interest, namely “his gayness”: “[The trainee should ask] Is he having sex outside his marriage with men? If so, what kind? Is it safer sex? The trainee should preferably *terminate the call* themselves without panicking or losing their patience.”³⁵

The questions that Steve proposes for the closing discussion are entirely unrelated to the roleplay that he puts forward, also unrelated to AIDS: he suggested questions about “TV nightlife” and transsexual surgery - “How do they obtain surgery? What are the requirements? What are the health risks?”³⁶ It can be assumed that his accompanying roleplay is based upon Steve’s own experiences that he is using to define *all* trans callers, including transsexual callers. The ‘heterosexual transvestite’ callers who phoned talk about their clothing is substantiated by the Logbooks Podcast - “you could always tell which caller would steer the topic into a discussion about what they were wearing” - but this was punctuated by sex worker trans callers in situations where they were at risk of AIDS:

““Asian transexual (sic) undertaking gender realignment in London. *Selling sex* and in a relationship with his/her pimp who is totally controlling her life. Suffering physical abuse from boyfriend when he gets drunk. Caller feeling very isolated and unaware of what to do.””³⁷

Steve’s roleplay prepped a new set of trainees, volunteers and trainers to expect trans calls to be “manipulative”, to deliberately evade questions, to be a nuisance that hogs phone-line space. But more than this, the lingering, abstract denial of trans people’s proximity to AIDS is drawn into close focus. The ‘TV’ caller is conceptualised as gay and male, identities which

³⁵ London, BI, SB, 4/2: 1988 Pre-Acceptance Training Pack, ‘TV/TS’.

³⁶ Ibid.

³⁷ A. Smith & T. Walker, ““Needs Reassurance and Support”” *The Logbooks Podcast Transcripts* (13 December 2021), <https://www.thelogbooks.org/transcript/s3-e6-needs-support-and-reassurance-transcript>, p5, (2 June 2023). My italics.

Switchboard understood as vulnerable to AIDS, yet after asking one question about safer sex the trainee “terminate[s] the call”. This command is unique to the TV/TS roleplay; Steve also wrote a roleplay where a 35 year old paedophile confessed to a “consensual relationship” with a 14 year old boy, wherein the trainee should have “concern for the caller” and deliver “non-judgmental advice” - and to not hang up until the caller does.³⁸

‘Steve’ did not intend for this interaction to occur literally: this is a guideline of responses for new trainers to follow, to record the positive or negative gist of a trainee’s performance, and he did not advocate hanging up on trans callers who talk about ‘unsafe’ sex. But there are no other guidelines for trans callers and safer sex: trainees were not told to consider trans-specific sexual health calls, to envision them as an at-risk category even when they self-describe as “gay” and “male”. In the only Switchboard record that acknowledged trans callers could be at risk of sexually transmitted diseases, the build-up towards acknowledging AIDS is punctured by the trainee hanging up. Upon reading “terminate the call”, after hours amidst reams of papers with no reference to trans sexual health, I exited the library in tears. This record is defined by a perception of trans as “manipulative”, as an inherently harmful and difficult caller, and trained volunteers to not conceptualise trans with AIDS - and it is the most revealing Switchboard record on the trans experience of AIDS. It is there, just out of reach. But at the same time, it isn’t, the final conceptual leap between “is it safer sex?” and discussing how to bring up AIDS to a trans caller is never made – because the volunteer hung up. Unlike Jules Gill-Peterson’s “tears of intimacy and relief” in the trans archive, when prior hope for “bad trans objects” becomes shattered through physically seeing their image in archives, this emotion is better understood through Nadia Ellis’s analysis of Black gay oral histories: “What is found still awaits, in essence, to be found.”³⁹

It would be a stretch to argue that ‘Steve’s’ training was malicious and actively perpetuated pathological trans stereotypes. Instead, I argue that the London TV/TS Group taught a conceptualisation of trans identity to Switchboard that was directly influenced by eugenics-based transsexual medicine, which is visible within every Switchboard reference to trans people between 1978-1995. Transsexuals and transvestites were not conceived as at risk of AIDS because of the theoretical proximity of trans people to heterosexuality - a position directly descended from this history of transsexual medicine.

³⁸ Ibid.

³⁹ N. Ellis, ‘Black Migrants, White Queers’, p911.

This analysis of the Lesbian and Gay Switchboard and the London TV/TS Group has had a twofold aim. Firstly, to analyse the environment created by the transmission of transsexual medical knowledge between the two groups, to theorise about the positioning of AIDS as a disease and a signifier of non-normative sexuality, and the underpinning role of eugenics in gatekeeping sexual disease out of transsexuality. But secondarily, I am aware that this is the first attempt to construct a trans history of AIDS in Britain. This chapter, and this whole thesis, aims to prove the viability of this subject and to spark conversation - or even acknowledgement - about the position of trans people throughout the first epidemic. I felt a responsibility to begin this skein of historical inquiry upon terms which upend the pathologised narratives of twentieth century history, to open by confronting head-on how modern trans history has “reinforced the rationality of medicine [and] defined itself by the limiting parameters of transsexuality.”⁴⁰ Through better understanding these parameters of transsexual medicine, the better that historians can grasp the trans relationship with AIDS.

⁴⁰ Gill-Peterson, *HOTTC*, p8.

Conclusion: Towards a Trans Future of AIDS

In Rebecca Havilland's oral testimony, she observed it was very difficult to trust other trans people after her diagnosis:

“Even when I did trust people in London, other trans, I was called an AIDS ridden bitch. So, you very quickly shut up. You think that the heterosexual world is against you anyway, and then the people you think you might have identification with are ridiculing you, you do go into yourself.”¹

This is the real-world effects of transsexual eugenics and speaks to how this topic cannot be isolated from wider histories of trans experience. Havilland speaks of an enforced silencing, a need to “shut up” in order to acquiesce to the demands of transsexual identity – and of the othering she received upon being honest, the removal of her respectable womanhood through the violent accusation “AIDS ridden bitch”. Transsexuality, rooted in eugenicist medicine, could not allow its patients to be anything less than pure. The fear of degeneration and the reaching for (white) perfection is not limited to AIDS. The homophobia of trans groups stemmed from the same impulse, a need to safeguard transsexual identity within the confines of heteronormativity. This command to “shut up” was internalised by Havilland for decades: having written an autobiography in 2010, she states that “there is not one mention of me having HIV, or AIDS, because I still had too much shame.”² The fear of going against the collective narrative worked to silence a potential trans history of AIDS.

The trans history of AIDS cannot be separated from the trans present of AIDS. The grip of the NHS Gender Clinic, now embroiled within a reactionary anti-trans backlash fuelled by the religious right, is still maintained over British trans people. Accessing non-transition related healthcare often leads to the general practitioner still deferring to the authority of the Gender Clinic, still centering the Gender Clinic as the arbiter of the trans patients entire being. Michelle Ross, founder of the trans sexual health service cliniQ in 2011, states that cliniQ was borne out of a noticeable apathy within the trans community regarding their sexual health: “[trans people] weren't going back to the sexual health clinics. They didn't care about their HIV status because no one else seemed to, so why would they?”³ But it is dangerous to isolate this trans experience from everyone's experiences with the NHS. The Local Government Association stated that the 2013 transfer of responsibility from NHS to local

¹ Havilland, 21:33-22:05.

² Havilland, 50:12-50:34.

³ Interview with Michelle Ross, conducted by myself via Teams, 16 March 2023, 36:25-36:36 ; 39:30-39:44.

authorities in the delivery of all local sexual and reproductive care – including HIV/AIDS care – rendered local authorities unable to deliver effective care because of lack of funds. Sexual health, despite how damaging badly funded sexual health services can be, are always one of the first major cuts to be made in times of austerity. David Cameron’s government reduced public health grants for sexual health services by £1 billion (24%) between 2015-2021. In this time, syphilis diagnoses increased from 20,000 per year to 35,000 per year, and new HIV diagnoses remained the same instead of decreasing.⁴ The trans history of AIDS is entangled within this context: trans people are one of *many* demographics within the restructuring of the NHS that was unable to get AIDS-care support.

Having spent nine months on this research, this thesis has changed significantly from where it first began. I entered with the mindset that I was going to recover more individual narratives like Havilland’s, uncover a new skein of testimony that spoke to a hidden trans experience of AIDS. But instead, I found myself in the murky waters of transsexual medicine, the panopticon of NHS Gender Clinics, and the insidious control that diagnosable transsexuality had upon those within its reach. I’ve felt a palpable tension between desiring to find individual subjectivity and not wanting to reify transsexuality as the only manifestation of trans identities. Emotionally, I *want* to find individual narratives to personalise this history, to give it names and faces, as a form of identification with the past. But as Heyam notes, the expectation of individual testimony sets the historical bar much higher than for cisgender people - “when [historians] look at evidence and do not find this testimony, we conclude that we cannot find trans people, because our standard has not been reached.”⁵ I went in wanting to fulfil *my* expectations of testimony, but realised that this would be a sticking plaster over the gaping wounds inflicted by the pathologisation of trans identity. In the face of overwhelming absence, one has to turn to analysing why transsexuality cannot conceive of trans and AIDS in the same breath. A trans history of AIDS in Britain thus cannot be a search for subjectivity, as anything ‘found’ would be an outlier. This history can only be understood through the nuances of its conspicuous absences, because as Spivak discovered, “there is no ‘real Rani’ to be found.”⁶

⁴ Local Government Association, *Breaking Point: Securing the Future of Sexual Health Services* (Nov 2022), <https://www.local.gov.uk/publications/breaking-point-securing-future-sexual-health-services> (16 June 2023).

⁵ Heyam, *Before we were Trans*, p21.

⁶ Spivak, ‘The Rani of Sirmur’, p271.

AIDS AND ELECTROLYSIS — Your questions answered

1. The Government leaflet on AIDS mentions, as skin piercing risks, tattooing, acupuncture and ear-piercing only. Why is this?

In all these procedures the skin is pierced by needles which thus become contaminated with the client's blood. If the same needles are used, without adequate sterilisation, on another patient, this is mixed with the second patient's blood and any infection in the first could be carried to the second. This is called "cross-infection".

Although so far, cross-infection with the AIDS virus by this route is not important, another virus infection, Hepatitis B, is known to be spread in this way. In the medical literature there are several well-authenticated papers describing such cross-infection associated with these procedures, both in the UK and elsewhere. As AIDS becomes more widespread, this will become an important potential route of infection.

2. Why is electrolysis not included?

The very great majority of electrolysis treatment is for the removal of superfluous hair. Here the needle is inserted along the hair shaft into the follicle — the hole from which the hair grows. Unless this is done accurately, the hair is not destroyed and will repeatedly grow again. When done correctly, therefore, the skin is not pierced intentionally although on rare occasions, depending on the skill of the operator, it may be pierced accidentally. The likelihood of cross-infection is therefore very small, even in the absence of adequate needle sterility. The Institute knows of no cases reported in the literature of any Hepatitis B infection related to electrolysis of hair follicles.

3. Is there, therefore, absolutely no risk of becoming infected with AIDS by electrolysis for hair removal?

No-one can claim a complete absence of risk in relation to anything. With a skilled and competent operator, using recommended sterilising techniques, the risk is certainly negligible and to have hair electrolysis in such conditions probably does not increase anyone's risk of AIDS infection.

4. What precautions do electrologists take, further to minimise these risks?

Most Local Authorities have byelaws requiring the registration of premises at which "skin-piercing" operations (including electrolysis) are carried out. Their Environmental Health Officers normally inspect such premises to enforce this and offences carry heavy fines.

The Institute of Electrolysis, through its Honorary Professional Adviser, recommends correct hygiene and sterilisation procedures which are constantly reviewed and updated. In particular it insists that only freshly-sterilised needles are used, a new one for each patient. Where sterilisation is done by the operator, only approved heat-sterilising methods are used. For other items of equipment such as forceps, needle-holders, dishes, etc., suitable sterilisation or disinfection procedures, as appropriate, are specified. Many operators use disposable needles as a routine and those who do not will normally make them available at a small extra cost, on request.

5. Why is the risk minimised when treated by a skilled operator?

Incorrect insertion of the needle, with consequent increased risk of skin-piercing, is minimised with such an operator. A qualified operator understands the problems of cross-infection and sterilisation and takes suitable precautions.

6. Why should I use only a Full-Member (DRE) or an Associate-Member of the Institute?

You can be confident that such a person is adequately trained and highly qualified, both in basic operating techniques and in hygiene procedures. Anyone wishing to join the Institute is required to pass a rigorous practical, written and oral examination and to have had substantial supervised operating experience. Only a small proportion of applicants ultimately qualify. Many are trained by the Institute's own tutor-members and the training and examination, amongst other things, include knowledge of the relevant diseases, hygiene and sterilisation.

7. How does the Institute ensure that its members comply with its recommendations?

- By retaining the highest standards for new entrants.
- By ongoing information and updating of its present members.
- By disciplinary action against any members whose standards are below par.

In all professions, the motivation and integrity of members are the most important element in the maintenance of standards of performance. Anyone can open an electrolysis clinic and register it — there are no legal mandatory requirements relating to competence or knowledge. It follows therefore that anyone who enters "the hard way" by voluntarily taking an expensive and time-consuming training course, followed by an independent examination with high standards, is likely to be thoroughly self-motivated and with a strong sense of responsibility towards her patients.

Figure 2: United Kingdom, HIV/AIDS Design Archive, Other Minority Groups, Professions and Workplaces: Inside of pamphlet from the Institute of Electrolysis, February 1987. © Siân Cook

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