Reimagining Risk: Exploring Understandings of Risk in Sexual Health amongst Gay and Bisexual Men in the North East of England

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Abstract

This ESRC funded qualitative research was initiated in response to a re-emergence of syphilis and continuing increases in HIV rates amongst gay, bisexual and/or men who have sex with men (MSM) in the North East of England. The research was conducted in partnership with local sexual health services from three NHS Primary Care Trusts and a gay and bisexual men's sexual health organisation, with findings intended to inform sexual health services and policy. The aim of this research was to situate understandings and meanings of risk in sexual practice within the everyday lives and experiences of MSM within this particular epidemiological and geographic context. The research asked what MSM understood as a risk in their sexual practice; how they responded to perceived risk in their sexual practice; and what influenced these understandings and responses to risk. In-depth interviews were conducted between March and August 2009 with twenty-three gay and bisexual men, aged 18 – 63, who lived, worked, socialised or accessed sexual health services in the North East of England. In contrast to public health concerns that MSM are not longer practising 'safer sex' in a 'post-crisis' era of HIV, participants described the ways in which they were engaged in a creative and reflexive sexual practice which considered and responded to risk of infection. Findings indicate how respondents drew directly on biomedical knowledge and technologies to inform their understandings and responses to risk. However, these responses were embedded in perceived community norms of sexual practice, which drew on memories of HIV and were based on a harm reduction strategy. Findings from this research are discussed in three chapters in this thesis. The thesis first explores how participants negotiated biomedical and embodied understandings of risk within a community practice that prioritised HIV prevention. The following chapter considers how particular sexual actors were constructed as risky and the implications this had for participants' own understandings of risk and responsibility. The final analysis chapter details the ways in which place and space played an important role in understandings of risk and responsibility, and points to the ways in which regional and national boundaries, as well as changing community sexual practices, impact on the location and management of risk.

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intellectual level, but they also encouraged me to socialise and share in the pleasures of life.

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Finally, I cannot thank the twenty-three participants enough for sharing their intimate and thoughtful stories with me. I hope the following pages come close to doing justice to the amazing histories they willingly shared with me.

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Glossary

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy: Treatment for HIV, usually involving a combination of antiretrovirals
ARV	Antiretrovirals: the medication used to treat HIV and slow or stop progression to AIDS
CD4 count	A CD4 count measures the cells 'targeted' by HIV. A high CD4 count is desirable. A person with a CD4 count that falls below 200 cells/μl is considered to have AIDS. Treatment in the UK with ART is generally started when a CD4 count is between 500 – 350 cells/μL.
Cottaging	Seeking out sexual partners and/or engaging in sexual acts in a public toilet.
Cruising	Seeking out sexual partners and/or engaging in sexual acts in public spaces.
GMT	Gay Men Tyneside, a local community group of gay and bisexual men that meet regularly in Newcastle-upon-Tyne.
HAART	Highly Active Antiretroviral Therapy: Successful treatment of HIV with ARVs became available in 1996. Since then, the effectiveness of what is now known as ART has improved significantly. While not a cure as such for HIV, ART has revolutionised experiences of HIV and resulted in HIV effectively becoming a long-term chronic condition.
HIV	Human Immunodeficiency Syndrome
MESMAC	Gay and Bisexual Men's community development organisation in Newcastle-upon-Tyne.
PCT	Primary Care Trust, currently the main organisation of National Health Service (NHS) primary health services.
Post-exposure Prophylaxis (PEP)	Treatment for potential exposure to HIV, usually involving one month of ART.

Pre-exposure Prophylaxis (PrEP)	The prescribing of ART to people who are HIV negative but deemed to be at high risk of HIV infection. This is currently not widely practised as a health policy, though is being considered by some health policy advocates.
Sexually Transmitted Infections (STI)	This covers a range of infections including: syphilis, Chlamydia, gonorrhoea, herpes, etc
Safer sex	Amongst gay and bisexual men, this is generally understood as condom use for penetrative anal sex. It generally does not include condom use for oral sex, as it was devised to prevent HIV transmission, which is epidemiologically low risk in oral sex.
Syphilis	A bacterial infection, caused by the spirochaete *Treponema pallidum* and treated with antibiotics.
Viral load	One's viral load is the measurement of HIV virus present in the body and the rate at which the HIV virus is replicates. A low viral load means that the virus can be 'undetectable' and therefore, the chances of transmission of HIV are significantly reduced. A viral load test is a standard test for HIV positive people, in combination with a CD4 count which measures the cells 'targeted' by HIV. Ideally, a good result for an HIV positive person would be a high CD4 count, and a low viral load.

Chapter One – Introduction

'Facebook "linked to rise in syphilis"' (*Telegraph* 2010)

'Facebook "sex encounters" link to rise in syphilis' (*Mail Online* 2010)

'Rise of syphilis blamed on social networking sites' (*Daily Star* 2010)

In March 2010, a health story appeared in several UK newspapers and tabloids with titles such as those listed above. Professor Peter Kelly, Executive Director of Public Health for Stockton-on-Tees Primary Care Trust (PCT) was reported to have linked the rise in cases of syphilis in the North East of England with the use of Facebook and other social networking sites. He explained how a number of women diagnosed with syphilis had reportedly found sexual partners through these sites. Professor Kelly commented on the way in which social networking sites appeared to be making it easier for people to meet up for casual sex. He then described how the rise in syphilis was a result of people 'having more sexual partners than 20 years ago and [who] often don't use condoms' (Kelly, as cited in *Mail Online* 2010). The story was criticized by a number of sources for conflating the use of social networking sites and an alleged increase in casual sex, as well as not citing the research sources which would verify these broader claims (Goldacre 2010). The story provides an example of how responses to increasing rates of sexually transmitted infections (STIs) can be linked to presumed 'irresponsible' sexual practice – increasing numbers of sexual partners and lack of condom use – as well as to new technologies and changing social practices relating to these technologies – using social networking sites to find sexual partners.

Michael Brown (2006) explores a similar, although extended, media debate in Seattle when an increase in rates of STIs amongst gay and bisexual men was reported in the early 2000s. Because public health officials used STI rates as a proxy for HIV[1]

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[1] Throughout this thesis, I will generally refer to HIV, the Human Immunodeficiency Virus instead of HIV/AIDS or AIDS. It is important to distinguish between HIV and AIDS. The well used HIV/AIDS conflates two different but related medical phenomena as HIV no longer always progresses to AIDS with the advent of Highly Active Anti-Retroviral Therapy (HAART). Moreover, it is HIV, the virus, and not AIDS, which is contracted (Weait 2007). However, it is also important to acknowledge the historical experience of HIV and AIDS, and the ways in which early experiences were framed and experienced as AIDS or the AIDS crisis/epidemic, especially before the availability of HAART. Therefore, when appropriate, I will also refer to AIDS to signal the understandings, experiences and effects of HIV before treatment was available.

infection, Brown explains, the media correlated the rise in STIs as generally equivalent to HIV. This resulted in a series of articles and opinion pieces which criticised gay and bisexual men for no longer practising safer sex and failing in their responsibilities to prevent HIV. Many articles surmised that this apparent change in behaviour was a result of available treatment for and a normalisation of HIV. Brown outlines how many of these criticisms came not only from public health officials, but also from within the gay community and gay press. These criticisms described the problem not as a 'community-wide' problem, but as a result of a core group of gay men who were irresponsibly engaging in risky behaviour and who were threatening the health and reputation of others in their community. The reaction to increased STI rates in these two examples highlights the way in which increasing rates of STIs elicit more than just concern about the health of those contracting an infection. They point to assumptions about the sexual practice of those who have contracted infections. But perhaps more significantly, they point to the ways in which social and cultural changes underline judgments about individual and collective responsibility to others, and are integral to the ways in which risk in sexual health is framed.

This research seeks to explore understandings of risk in sexual health amongst gay, bisexual and/or men who have sex with men (MSM) in the North East of England. It is important to establish the ways in which key concepts will be used in relation to this research, especially given the relatively contested meanings of 'sexual health' and 'MSM'. Sexual health emerged as a concept in the 1970s and has been employed in a number of ways (Giami 2002; Sandfort and Ehrhardt 2004; Evans 2006). Definitions range from viewing good sexual health as the absence of infection and dysfunction to a broader approach that considers the physical, emotional, mental and social well being of a person in relation to their sexuality. The World Health Organisation (WHO) considers sexual health to be an essential element of sexual rights. Sexual rights for the WHO encompass rights to education and healthcare as well as the rights to bodily integrity, choice of sexual partner and the pursuit of a safe and pleasurable sexual life. The WHO describes the importance of the relationship between sexual rights and sexual health:

> Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO 2004)

Evans (2006) describes how the definition used by the Department of Health in the UK (DOH 2001) is similar to the WHO definition in that both seek a balance between the medical and social approaches. However, where the WHO definition focuses on the rights to pleasurable and safe sexual experiences, Evans points out how the DOH approach to sexual health focuses on safe sex and abstinence, and avoids the term pleasure. This perceived tension between the seeking out of pleasure and the avoidance of infection, observed in the UK DOH sexual health strategy, is an important theme and will be explored throughout this thesis. The term sexual health as a general concept will be used to refer to the physical, emotional, mental and social well-being of participants in relation to their sexual experiences. A distinction will be made, however, between this broad approach to sexual health and sexual health services and practitioners. The approach of sexual health services and organisations across the country – and within the North East of England – can vary widely in relation to the debates above. Therefore, sexual health services and practitioners will be used with reference to the formal services available in the North East and to the range of clinical and community practitioners who make up these services.

Much public health literature uses the term MSM to refer to all men who engage in sex with other men. This is meant to be an inclusive term, which includes not only gay and bisexual men, and also those men who do not identify as gay or bisexual but who have sex with other men. However, it can often result in a reduction of specific and diverse cultures, identities and practices to a particular sexual behaviour (Young and Meyer 2005). Epidemiological monitoring of STI data generally uses the term MSM for a particular category of transmission. In contrast, some publications use categories such as homosexually acquired, rather than MSM. There is no consensus in the literature about which terminology to use. Where Hickson (2011) uses both MSM and gay and bisexual men, Elford (2006) and Kippax and Race (2003) refer only to gay men. This thesis will use the terms gay and bisexual, or 'gay' where appropriate in the analysis chapters, as all of the participants identified as either gay or bisexual, including those men who were married to women. However, the introduction, literature review and methodology chapters will use the term 'MSM' to refer to gay, bisexual and/or men who have sex with men where appropriate, unless specifically referring to gay and bisexual men as a particular social group.

The impetus for this research was an 'outbreak' of syphilis, reported in the North East of England amongst 'MSM', which began in the late 1990s and has continued to persist throughout the 2000s (Simms et al. 2005). NHS and other public health agencies had introduced various surveillance and service coordination mechanisms[2] in response to this outbreak of syphilis. Epidemiologically, this outbreak was significant. Rates of syphilis amongst the general population had remained incredibly low in the UK with the introduction of antibiotics in the 1950s. However, since 1997, the UK had experienced a significant increase in cases of syphilis amongst 'MSM'. This re-emergence of syphilis is part of a general increase in STIs and HIV infection rates amongst 'MSM' in the UK during the same period. In line with national trends, a significant increase in syphilis diagnoses, as well as HIV co-infection, amongst 'MSM' were also experienced in the North East (Simms et al. 2005). The increase in infection rates has been responded to by many public health services and researchers in the UK in similar ways to those outlined by Brown (2006) in Seattle. Many have asked whether the availability of treatment, which has largely transformed the experience of HIV into that of a chronic, manageable illness, has meant that 'MSM' have become complacent about contracting this illness. Moreover, some have questioned whether there is safer sex 'fatigue' amongst 'MSM', who are perceived as no longer practising safer sex (Kippax and Race 2003; Brown 2006; Dowsett 2009). In addition to this 'potential' change in sexual behaviour is the added complication of syphilis. Syphilis is bacterial, which means that sexual acts such as oral sex, considered low risk for HIV transmission, pose a high risk for the transmission of syphilis (Simms et al. 2005; Hickson 2011). The syphilis outbreak in both the North East and the UK signals how the sexual health landscape for 'MSM' has become an increasingly complex field to navigate.

Although STI and HIV rates for the North East continued to be amongst the lowest in the country, the relative jump in syphilis infection and increasing HIV-syphilis co-infection has caused concern amongst local public health authorities. Why had syphilis returned in the North East? What did this increase in syphilis mean for experiences and prevention of HIV in this region? Did this signal a change in the sexual health behaviour of 'MSM'? How should sexual health services deal with this new STI in an

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[2] This included not only enhanced surveillance of syphilis diagnoses from Genito-Urinary Medicine (GUM) clinics, but the creation of a North East Syphilis Outbreak Control Task Force, convened by the Health Protection Agency, and which included participants from all regional PCTs and MESMAC, a local gay and bisexual men's community development agency.

increasingly complex sexual health environment? Public health officials sought to understand why the rates were increasing and, more significantly, what 'MSM' knew and understood about the risk of syphilis, how this factored into their sexual behaviour and how this related to responses to HIV. This study grew out of these concerns. Newcastle University and North Tyneside PCT were successful in securing funding for an Economic and Social Research Council (ESRC) funded CASE (Collaborative Awards in Science and Engineering) Studentship in 2007 which looked specifically at these issues.[3] The aims of this studentship were to develop an in-depth understanding of the attitudes, beliefs and understandings of 'MSM' living and socialising in an area where there has been a recent occurrence or 'outbreak' of cases of acute syphilis.

The epidemiological and behavioural concerns which instigated this research should be situated in a broader UK context. The rates of infection, including HIV, syphilis and other STIs, have remained significantly lower in the North East than most other parts of the UK. These experiences are in stark contrast to those of larger urban centres like London and Manchester, Birmingham and even Brighton, where proportionally high rates of infection have been experienced amongst 'MSM' since the onset of the syphilis outbreak and throughout the history of HIV infection in the UK (HPA 2010a; HPA 2011a; HPA et al. 2011). Although the reasons for these differences are diverse, many who work in sexual health services in the North East attribute these low rates to the relatively low population numbers and the stable nature of the population. In 2009, the population of the North East was approximately 2.6 million people, with 1.1 million people living in Tyne and Wear, making it the least populous region of England. It also has the lowest growth rates. The population of the North East decreased by 3.6 percent between 1981 and 2001 and grew between 2001 and 2009 by only 1.7 per cent in comparison to the population of England, which grew by 4.8 per cent during the same period (Worthy and Gouldson 2010). The relative stability of this population, the limited numbers of people moving into this region from elsewhere, and its geographic location have led many to describe it as socially and culturally distinct from other areas

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[3] CASE Awards are for research students to carry out research projects in collaboration with non-academic organisations. In this case, the partner organisation was North Tyneside PCT. The application was put together by one of my supervisors, Professor Diane Richardson and Dr Vivien Hollyoak, Director of Public Health for North Tyneside PCT. The original title of the studentship was: Reimagining Risk: Developing Patterns of STDs and their Influence on Risk Assessment among Gay Men and MSM. The studentship was advertised in June 2007; I was interviewed in August 2007 and started work in September 2007.

of the UK. For instance, Nayak (2003) outlines how some have characterised it as Pan-Scandinavian or as England's 'foreign' country within, signalling its social isolation from other parts of England as well as its distinctive regional identity. While this demographic make-up and cultural identity does not result in immunity from HIV and STI infection, it is important to consider how the social and cultural context may have a significant impact on the sexual health and the nature of the sexual health interventions in the region. In many ways, an element of this regional distinctiveness and related social isolation can be seen in how national HIV prevention funding and activities for 'MSM' are unevenly applied across the country. In addition to having the lowest regional HIV rates amongst 'MSM' in the country (HPA 2010b), the North East is one of the only English regions that is not formally involved in the national Community HIV and AIDS Prevention Strategy (CHAPS) managed by Terrence Higgins Trust and funded by the Department of Health (Hickson 2011). This does not signal an absence of HIV and other sexual health prevention and treatment work in the region. This work is largely taken up by PCT sexual health services and MESMAC North East (NE), a gay and bisexual men's sexual health community development organisation. However, the absence of this region's 'MSM' community development organisations from formal participation in a national HIV strategy and partnership does suggest a decreased concern at a national level about low prevalence regions. Where government policy and funding specifically targets 'vulnerable' groups, such as 'MSM', the levels of funding and implementation of targeted programmes are also affected by regional population numbers and infection experiences. Given the low numbers of infection of both syphilis and HIV, as well as the exclusion from a national partnership in HIV prevention amongst 'MSM', this study may seem strangely placed. If the numbers are relatively low, why look at such a low prevalence region?

Much of the research on HIV and sexual health amongst 'MSM' in the UK focuses on high prevalence areas, such as London, as approximately half of the HIV positive 'MSM' in the UK live in London (Hickson 2011; HPA 2011b). In recent years, this research has expanded to other larger urban centres in the UK , but has primarily focused on those deemed 'high risk' (Elford 2004; Elford et al. 2005; Elam et al. 2008; MacDonald et al. 2007; Bourne et al. 2009). Little qualitative research has been conducted on the sexual health of gay and bisexual men in the North East of England. Moreover, this research has predominantly focused on experiences of space or identity,

rather than HIV (Lewis 1994; Casey 2007; Coleman-Fountain 2011). There are numerous studies which not only interrogate the experiences of 'MSM' in London, but which also specifically interview HIV positive men, who have been deemed to have engaged in risky sexual behaviour at some point in order to have become HIV positive (Keogh et al. 1999; Bourne et al. 2009). While these studies are very important, the focus on the high risk sexual actor only provides part of the story. In many ways, the absence of research in low prevalence regions or with perceived low risk sexual actors reaffirms the dichotomy between risky and safe. The dichotomy in this case is based on a presumption that because those diagnosed with either HIV or syphilis do not reflect high numbers in certain areas, then most of the population in this area must be doing 'something right'. Built into these approaches is an assumption that low rate means low risk sexual practice. This approach to risk, however, echoes the debates which Brown outlined above that distinguish between responsible, successful – i.e. infection free – and irresponsible, unsuccessful sexual actors. But as Brown (2006:887) explains, 'sex can take multiple forms, and actions,' and the presence or absence of infection should not be used to judge the response to 'risk' in sexual encounters. Furthermore, this highlights the way in which biomedical risk may be an inappropriate concept with which to 'judge' sexual practice. Instead of drawing a strict division between good/bad, or safe/risky sexual actors, Brown argues that the context of the sexual environment needs to be considered when making judgements about the risky nature of the sexual act. Moreover, the context within which sex takes place, including the place, the sexual partner and the broader environment, can have a significant impact not just on the nature of the sexual acts, but also on the understandings of and responses to risk (Kippax and Race 2003). This study aims to situate sexual encounters in a broader context as it considers the ways in which risk is identified, understood and responded to by a community of sexual actors who live in a specific geographic and cultural context, and in a particular biomedical era.

Research questions

Kippax and Race (2003) have argued that biomedical advances in HIV, since the advent of Highly Active Anti-retroviral Treatment (HAART) in the late 1990s, and an emphasis on individual testing and counselling, have resulted in increasingly individualised and medicalised understandings of risk. However, they argue that rather than being complacent about HIV as a result of treatment or suffering from safer sex

fatigue, as has been claimed by some critics, 'MSM' have actively incorporated knowledge based on these biomedical developments into their safer sex practice. If so, what this means is that the ways in which risk is identified and located biomedically, socially and culturally have changed significantly. Moreover, Kippax and Race make a call for social sciences to 'catch up' with the ways in which these understandings and responses to risk are grounded both in the biomedical and the social. This thesis seeks to explore how risk of HIV and syphilis in sexual health is understood amongst gay, bisexual and/or men who have sex with men ('MSM') in the North East of England. In particular, it seeks to explore the social and cultural meanings of risk, and does so by asking three broad questions:

- *How do 'MSM' in the North East of England understand and identify risk in their sexual practice?*
- *How do 'MSM' in the North East of England respond to perceived risk in their sexual practice?*
- *What influences these understandings of and responses to risk?*

In addressing these questions, this research aims to examine the ways in which risk is grounded in both social and biomedical contexts, and to interrogate the ways in which these contexts overlap and possibly contradict notions of, and responses to, risk. The thesis seeks to contribute to knowledge about sexual health practices of 'MSM' and inform sexual health provision in the North East of England in relation to syphilis and HIV. It also aims to contribute more broadly to debates around risk, sexual health and safer sex amongst 'MSM'. Given the significance of the social context of risk, it is important to recognise the ways in which understandings of risk and sexual practices are affected by age, location, space, environment, changes in biotechnologies, health policy and sexual partners. It is also essential to recognise the historical and regionally specific context of this research and the experiences of participants. Consequently, the research will consider the ways in which changes in treatment and responses to HIV over the past 30 years and the re-introduction of syphilis into the sexual health landscape have affected the sexual practice of 'MSM'. Moreover, the thesis will also consider how experiences of men in this study may be affected by their location in the North East of England.

Structure of the Thesis

As will become apparent, these questions will not be answered separately, but will be addressed throughout the three analysis chapters of this thesis. Before responding directly to these questions, the next chapter, *Reframing Risk in Sexual Health,* establishes the broader theoretical, epidemiological and historical contexts of HIV, syphilis and 'MSM' in the North East of England. In particular, it outlines how sexual practice is used in the project as a theoretical approach to risk and sexual encounters, as well as establishing the ways in which risk has been treated in relevant research and how it is employed in this study. The chapter then demonstrates how identity is important in understanding explorations of risk, especially in relation to notions of responsibility and community.

Chapter Three – Methodology details how this research was conducted. It establishes the broad epistemological approach to qualitative research, and details the way in which the research was designed and carried out. In particular, the chapter gives an account of how the research was conducted in partnership with local sexual health services, reflects on how this partnership affected the research, and details the fieldwork and analysis phases of the study. This chapter also highlights some of the ethical concerns which emerged throughout this research and describes the ways in which they were managed.

The first analysis chapter, *Negotiating Biomedical Risk in Sexual Practice*, explores the ways in which biomedical risk in sexual encounters was identified and responded to by participants. In particular, this chapter asks how notions of risk are affected not only by biomedical understandings of HIV and syphilis, but also by the ways in which community and community sexual practice are imagined. The first part of the chapter explores how participants identified risk as embodied, and then asks how participants understood risk of HIV and syphilis. The second part of the chapter outlines how risk was responded to in sexual practice, considering the ways in which risk was negotiated within a framework of harm reduction and pleasure. This chapter considers the ways in which biomedical risks were situated within a framework of community norms and the implications this had for notions of responsible sexual practice.

Chapter Five – *Constructing the Risky Other,* addresses how breaking with the perceived norms of community sexual practice is understood. In particular, this chapter explores the ways in which sexual actors who break these norms are constructed, and the implications this has for the participants' own sexual practice. The first part of the chapter considers the figure of the gay man and asks how epidemiological constructions of risk and community sexual practice contribute to notions of responsibility. The second section explores the notion of promiscuity and the basis on which this label applied to perceived risky sexual actors. The final part of the chapter considers how HIV positive men were understood as a risk, the ways in which these men were responded to in light of community expectations of sexual practice, and how this impacts perceptions of risk by HIV positive men themselves.

Chapter Six – *Mapping Bodies, Risks and Responsibilities*, explores what role place and space have in the identification of and response to risk, but also in the formation of imagined community boundaries. The first part of the chapter looks at the ways in which particular places in the UK are constructed as 'risky' and how this impacts upon sexual practice. The second part explores how notions of risk and illness outside of the UK affect understandings of responsibility in sexual practice for local sexual actors. The last part of the chapter focuses on how certain spaces are considered risky. In particular, this part explores attitudes to public sex and considers the ways in which participants negotiated their own notions of responsible sexual practice in light of changing community norms and broader understandings of risk.

The final chapter to this thesis draws out the main arguments from the analysis chapters. It highlights the ways in which risk has been identified and responded to by participants, and describes how these practices are negotiated within imagined community norms. This chapter considers not only what the findings say about experiences of 'MSM' in the North East of England in relation to risk of HIV and syphilis, but also how the key findings make a contribution to broader understandings of risk, sexual practice and 'MSM'.

Chapter Two – Reframing Risk in Sexual Health

Introduction

Over the last thirty years, a substantial amount of research has been conducted across Europe, North America and Australia on the subject of risk and gay, bisexual and/or men who have sex with men ('MSM').[4] This research has largely focused on experiences of and responses to HIV but is part of a longer history of biological, psychological and social research which has approached homosexuality as pathological and unhealthy (Rosario 1997). Much of this research on risk and 'MSM' has focused on the 'risks' that this group of sexual actors has been judged to have been taking in relation to HIV. However, experiences of risk and HIV have been and need to be situated in broader social and cultural contexts and considerations of how lay knowledge of health risks are embedded in sexual encounters (Kippax and Race 2003). This chapter establishes how this study situates itself within this broader research field, and maps out the main historical, epidemiological and theoretical areas of exploration. In particular, it explores the ways in which identity, community and responsibility matter in understandings of risk. The chapter is divided into four sections. The first section considers the epidemiological context of both HIV and syphilis. It explores the biomedical relationship between these two illnesses for 'MSM', interrogates the ways in which epidemiology has framed illness in sexual health and, driven health policy, and considers the resulting implications for the research questions. The second section reviews the relevant research literature in relation to risk, HIV, syphilis and 'MSM' and sets out the main theoretical approaches in this field. This section then outlines the ways in which risk is conceptualised in this thesis and the implications this has for both the research questions and analysis. The third section of this chapter explores how responses to HIV in policy have changed in the UK over the past thirty years and considers what these changes have meant for policy and personal responses to HIV and in sexual health more broadly. This section then situates these responses in a broader health discourse and traces how developments in biotechnology – along with

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[4] As outlined in the introduction, 'MSM' will be used in the initial three chapters of the thesis as the theoretical, epidemiological and practical context of this research is laid out. However, the term gay and bisexual men will be used when referring to particular collectives or groups of men whose gay or bisexual identity is integral to the discussion.

developing notions of citizenship – have impacted on individual and collective experiences of health. The final section reviews the changing legal and social norms for gay and bisexual men and asks how such developments have affected perceptions of community and community sexual practices. Community as a concept is unpacked and offered as a way of considering both social and biomedical factors in understandings of and responses to risk.

Setting the Epidemiological Scene

As outlined in the previous chapter, the impetus for this research initially came from the reintroduction and significantly increasing rates of syphilis amongst gay, bisexual and/or men who have sex with men ('MSM') in the North East. This epidemiological surveillance and reporting, as I will explore throughout this chapter, has influenced a number of research studies around risk of HIV infection and 'MSM'. This section first establishes the epidemiological context of both syphilis and HIV, including their rates of infection, the history of these infections in the UK and the ways in which biomedical treatment and experiences of these infections have changed. It then moves on to consider the ways in which epidemiological and behavioural approaches to sexual health have been critiqued. In particular, it explores how social and cultural understandings of illness have affected epidemiological approaches to sexual health, especially HIV, and how this influence has framed scientific approaches to risk in sexual health.

Syphilis

Syphilis is a bacterial infection. It is caused by the spirochaete *Treponema pallidum* (Goh 2005; Pattman et al. 2005; Fenton et al. 2008) and has three stages of infection. During the first stage of syphilis sores or chancres, usually painless, will appear where the bacteria entered the body – usually around the mouth, anus or vagina – between nine and ninety days after first contact with the bacteria. These symptoms will last between three to eight weeks. The second stage can occur within six to twelve weeks of infection. Symptoms during this stage are more severe than the first and can include a rash, flu-like illness and patchy hair loss. The second stage can last for many weeks or months and both the first and second stages of syphilis – early syphilis – are highly

infectious. The third stage of syphilis, usually called late or latent syphilis, takes place approximately two years after infection. Symptoms or illness as a result of syphilis during this stage can take between five to thirty years to manifest. This stage of syphilis can result in serious musculo-skeletal, cardiovascular, and neurological problems. Syphilis is transmissible through sexual contact during the 'early' phase – the first and second stages – of infection, but it can also be passed on through pregnancy or blood (FPA 2005; Pattman et al. 2005; Jeffries 2008). In spite of the serious symptoms of the latent stage of syphilis, it is considered to be a treatable sexually transmitted infection (STI) (Simms et al. 2005). Standard treatment in the UK for syphilis is normally a course of antibiotic injections. Patients are considered to still be infectious until the course of the treatment has finished (FPA 2005; Pattman et al. 2005).

In contrast to experiences in Africa, South East Asia and Russia, rates of syphilis were at their lowest in the UK and most European Union (EU) countries throughout the late 1980s and 1990s (Fenton et al. 2008). Syphilis, along with other STIs amongst 'MSM' began to decline during this period to very low levels (Dougan et al. 2007a). However, since the late 1990s, the UK and other EU countries have seen a dramatic increase in the number of syphilis cases (Bellis et al. 2002; Simms et al. 2005; HPA 2009). This increase has also been seen with other STIs (Dougan et al. 2007a). In the UK between 1997 and 2007, rates of syphilis had increased from 301 to 3789 cases reported annually (HPA 2009). While there were significant increases in syphilis reported in heterosexual women and men, rates of reported cases of syphilis had disproportionately increased by 1412% amongst 'MSM' between 1997 and 2002 alone (Simms et al. 2005). The UK Health Protection Agency (HPA) reported that the majority of cases between 1999 and 2008 were amongst 'MSM', representing 73 per cent or 9,590 of 13, 175 cases in total (HPA 2009). Where the 'outbreaks' of syphilis originally appeared in large, urban centres with high populations of 'MSM' like London, and Manchester (Bellis et al. 2002: Simms et al. 2005), reports of syphilis soon began to be reported across the country. Syphilis rates in England at the end of 2009 totalled 2,694 cases, with 1,326 cases diagnosed amongst 'MSM' (HPA2010c). As outlined in the introduction, the patterns of infection in the North East of England have largely followed national trends. Although much smaller in number, cases of syphilis in the North East were disproportionately experienced by 'MSM' who represented 96 per cent of syphilis cases in 2002 (Simms et al. 2005: 222). Rates of syphilis in the North East have continued to

be concentrated amongst this group of men. In 2009, there were 72 cases of syphilis reported in the North East out of a total of 130 cases regionally (HPA 2010c).

This re-emergence of syphilis should be placed in a larger epidemiological and historical context. The previous syphilis outbreak in the UK peaked in the late 1970s (Simms et al. 2005).   However, the 1970s syphilis epidemic was generally limited to 'MSM' (Doherty et al. 2002) and the rates of infection were significantly lower than experiences of syphilis before the advent of antibiotics. The decline in syphilis rates during this period is largely attributed to changing sexual behaviour in response to HIV (Simms et al. 2005). However, levels of syphilis across the entire population significantly fell in the UK and elsewhere in the 1950s when antibiotics were found to be a successful treatment for the infection and became mass-produced (Gilman 1987; Quetel 1992; Hayden 2003). As indicated above, antibiotics have been used consistently to treat syphilis since the 1950s. Records indicate that at the peak of recorded cases of syphilis in the UK in 1946 there were approximately 12, 000 reported cases amongst men and 8, 000 in women. This is contrasted with a radical drop to well under 1,000 cases for men and women by 1956 (Simms et al. 2005: 221). The significance of this reduction – or near eradication – of syphilis due to antibiotics should not be underestimated. Syphilis was an illness that had plagued many countries from the late fifteenth to the mid-twentieth century. Not only was syphilis known to be an illness which lasted for years and affected the skin, heart, brain, eyes, etc, but the treatments for syphilis were equally dangerous, if not more so. For instance, mercury was used to treat syphilis in a number of forms, with the effects of mercury poisoning thought to cause more damage to the individual than syphilis itself (Quetel 1992; Hayden 2003).

Syphilis continued to cause major public health problems and was of prime concern, along with other STIs, for many European and North American governments throughout the first half of the twentieth-century. The illness, at this stage, was not explicitly associated with 'MSM', but with a male heterosexual population perceived to be promiscuous. Major campaigns throughout World War II focused on preventing active (presumed heterosexual) soldiers from contracting syphilis by encouraging them to stay away from 'good time girls' or female prostitutes thought to be carriers of the illness. Gilman (1987) charts how women – generally but not limited to prostitutes –

were established as the source of the infection and most British and American campaigns during this time period focused on preventing men, usually soldiers, from having sex with these presumed sources of syphilis and other venereal diseases. This emphasis on women as the source of infection echoes nineteenth century public health approaches in the UK, and the Contagious Diseases Acts of the 1860s which demanded the compulsory medical examination and registration of working class women who were thought to be prostitutes (Weeks 1989). Although the act was eventually repealed in the 1880s, the approach to syphilis and other venereal diseases during this time highlights the ways in which gender played an important role in the construction of threats to public health. Mort (2000:149-150) describes how the twentieth century saw concerns around syphilis in the UK associated not just with the 'professional prostitute' but also with the 'promiscuous girl who gave sex for free.' While public health concerns around syphilis and other STIs were related to soldiers being physically able to undertake active duty, many were also concerned about the middle class wives who might be infected by their husbands (Weeks 1989; Mort 2000). Significantly, it is during this time period that partner tracing methods were first established by the American army to trace and identify infected persons so as to 'contain' infection. This method is still used in sexual health practice today (Brandt 1987; Quetel 1992). Syphilis has continued to hold significant meaning even after the discovery of treatment. Gilman traces the visual depictions of syphilis throughout its 500 year history, documenting the cultural significance of the illness and its powerful social stigma. He describes how the significant decline in syphilis 'left our culture with a series of images of mortally infected and infecting people suffering a morally repugnant disease – without a sufficiently powerful disease to function as the referent for these images.' (1987:98). Gilman argues that it was not until the appearance of HIV in the 1980s that these images found a new referent.

The connection between syphilis and HIV can be found not only in the visual iconography which Gilman documents, but also in epidemiological connections. Of the UK cases of syphilis reported in 'MSM' by 2009, 34 per cent were co-infections with HIV (HPA 2009). Moreover, the presence of syphilis is considered to increase the chances of HIV transmission (Clark et al. 2001a, 2001b). STI infections, including syphilis, have also been used as a proxy to indicate HIV infection. However, Dougan et al. (2007b) have recently called this method into question and suggest that incidence of

STIs, including syphilis, are not reliable indicators of HIV, despite the prevalence of co-infection. While HIV-syphilis co-infection is a concern for epidemiologists monitoring the epidemics (HPA 2009), the modes of transmission of syphilis and HIV are not exactly the same: HIV is a virus that has to be transmitted via an exchange of bodily fluids, whereas the bacterial nature of syphilis means it has more modes of transmission than HIV. For instance, public health and epidemiological information regarding the transmission of HIV describes unprotected anal sex between men as posing a high risk of HIV transmission, but unprotected oral sex poses much less of a risk of HIV transmission. With syphilis, however, its bacterial nature means that risk of transmission is much higher in unprotected oral sex (Clark et al. 2001a, 2001b). For many years, safer sex messages around HIV prioritised the use of condoms in anal sex but not with oral sex. The re-introduction of syphilis into the sexual health landscape and the difference in modes of transmission between syphilis and HIV has meant a more complicated – and possibly conflicting – set of safer sex messages have begun to emerge in sexual health practice.

HIV

While syphilis was once a culturally significant STI, its relative absence in North America and many European countries since the 1950s had led historians to write of its ultimate demise in the popular imagination (Quetel 1992). As Gilman indicates, however, HIV came to take its place as an illness with powerful cultural and social meaning and stigma. It has been 30 years since the first cases of HIV were diagnosed worldwide,[5] (UNAIDS 2011) and in the UK in 1981 (Berridge 1996). The UK Health Protection Agency (HPA) estimated there to be 86, 500 people living with HIV in the UK as of 2009, with approximately one quarter unaware of their infection (HPA 2010a). In 2008, the UK was amongst the three countries in Europe that reported the highest rates of new HIV infections (van de Laar and Likatavicius 2009). 'MSM' are considered to be disproportionately affected by HIV in comparison to the rest of the UK

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[5] UNAIDS explains that there was a group of gay men who were originally diagnosed with AIDS at this time. This is a change in the public health story of HIV, shifting from the identification of the first patient – patient zero – to a group of gay men. The existence of patient zero – the first patient to be diagnosed with and to allegedly have brought HIV to the US from 'Africa' was highly disputed on both epidemiological and sociological grounds. (Crimp 1988) That this shift still focuses on a group of gay men as the originators or 'vectors' of disease is still highly problematic, as it apportions blame to certain groups of people, and reaffirms social stereotypes.

population, representing 2,760 [6] out of 6,630 new diagnoses in 2009 (HPA 2010) or 3,080 out of 6,750 in 2010 (HPA 2011b). While around 50 per cent of HIV positive 'MSM' live in London, the prevalence of men living outside of London has been proportionally greater for the past few years (Hickson 2011). 'MSM' are considered to be the group at highest risk of HIV infection in the UK, (Dougan et al. 2007c), keeping in line with broader European trends which have continued to see this group as the most affected by HIV throughout the epidemic (van de Laar 2009). The trend of this group being disproportionately affected by HIV across the UK is also seen in HIV experiences in the North East of England. By the end of 2010, the HPA estimates there were 1,884 people living with HIV in the North East, with 745 of those 'MSM'. While the numbers of HIV diagnoses in the North East are amongst the lowest in the UK, higher only than Wales and Northern Ireland, the HPA described how the increase in HIV rates in this region have increased by 150 per cent between 2001 and 2011, making it the highest increase in the country (HPA 2011b; HPA 2011a). Of the 140 new HIV diagnoses in 2010 (HPA 2011a) approximately 42 per cent of those diagnosed contracted HIV through sex with other men, making 'MSM' the largest group to contract HIV in the North East (HPA 2011a).

It is important to note the significant biomedical changes in experiences of HIV over the past thirty years in the UK. Initially, an HIV diagnosis largely meant progression to developing AIDS and to an AIDS-related death (Berridge 1996). The development of anti-retrovirals (ARVs) in the late 1980s did delay the onset of AIDS for some people living with HIV. However, the multiple side-effects of the drugs and the inconsistency in patient response to the treatment meant that the quality of life of those taking ARVs could be very low and treatment was not guaranteed to work (Berridge 1996). It was not until the discovery of a drug regime that was successful in preventing the progression of AIDS that the outlook for people living with HIV began to change (Watney 2000; Flowers 2001; Kippax and Race 2003). The introduction of HAART (Highly Active Anti-Retroviral Therapy) meant that many HIV patients were able to maintain a low viral load and a high CD4 count,[7] significantly delaying the onset of AIDS (Elford

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[6] Hickson estimates this number to be 2, 471 (2011: 14).
[7] An HIV positive patient develops AIDS when their CD4 T cell count falls below 200 cells/μL. Currently British HIV Association guidelines recommend that an HIV positive patient starts HAART when their CD4 count falls below 350 cells/μL for more than three months, although the exact start and the efficacy

2006). The introduction of HAART has essentially revolutionised experiences of HIV and resulted in a significant drop in AIDS-related deaths (Kippax and Race 2003). The number of AIDS-related deaths in UK was 1, 723 in 1995 and 1,480 in 1996. These numbers then dropped to 746 in 1997 and to 515 in 1998 (HPA et al. 2011: 6). Since 1999, the AIDS-related deaths of HIV positive people have remained stable and at significantly lower numbers than before the introduction of HAART (HPA 2010b). Elford explains that pre-HAART, an HIV diagnosis was 'disabling and fatal' but a post-HAART HIV diagnosis is treatable and manageable, meaning that for many HIV positive people, they would 'experience a quality of life unimaginable 10 years ago' (2006:1).

Despite a decrease in HIV diagnoses amongst 'MSM' during the late 1990s, this trend was reversed by the early 2000s. Sullivan et al. (2009) report an increase in HIV diagnoses between 2000 and 2005 amongst 'MSM' in North America, Western Europe and Australia. Consistent with these trends, there has been a constant and significant number of new HIV diagnoses amongst 'MSM' in the UK since 2003 (Hickson et al. 2011). What these numbers mean, however, is up for some discussion. Hickson (2011) outlines how a change in HIV testing policy and practice has resulted in significant increases in HIV diagnoses amongst 'MSM' in the UK. It is important to distinguish between the number of HIV diagnoses - confirmed cases of HIV - and HIV incidence – the number of new HIV infections over a specific time period (Coggon et al. 1997). All HIV figures released by the HPA include an estimation of those people who do not know they are HIV positive. Dougan et al. (2007b) argue that the increase in diagnoses is a result of improved testing rather than an increase in incidence, and that the number of undiagnosed cases is decreasing. Hickson is more cautious, arguing that a lack of direct evidence of an increase in HIV incidence may reflect the inadequacy of the current monitoring system rather than a decrease or stabilisation of HIV incidence (Hickson 2011). While researchers debate what the increase in diagnoses might mean for HIV incidence, the rise in both HIV and STI diagnoses amongst 'MSM' has led many researchers to make claims about the levels of 'risky' sexual behaviour (Kippax and Race 2003). Central to this notion of risky behaviour is unprotected anal intercourse (UAI). UAI is generally seen as posing the highest risk of HIV, with the receptive

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of the treatment is currently being debated and these guidelines advise starting treatment at 500 cells/μL if there are any other health factors (Gazzard 2008).

partner at higher risk than the insertive partner. This epidemiological assertion, however, is made more complicated by the viral load of the HIV positive partner. HIV positive sexual partners currently receiving treatment, and with low or even 'undetectable' viral loads have been shown to pose almost no risk of HIV transmission. However, the still significant presence of HIV positive individuals who do not know their status and/or are not receiving treatment means that UAI is still considered to be a significant risk (see Hickson 2011: 16-30).

Researchers and policy makers have taken the increased rates of HIV and STIs as a sign of increased risky sexual behaviour (Kippax and Race 2003; Brown 2006). Moreover, many have asked if, given the new era of successful HIV treatment, 'MSM' are no longer concerned about contracting HIV. Kippax and Race (2003) have argued that reactions to increasing HIV and STI rates by both research and health professionals often *assumes* that 'MSM' are no longer practising safer sex and that men have become complacent because of available treatment. They also attribute this assumed behaviour to newer generations of 'MSM' who have not 'lived through' the AIDS crisis and might not regard HIV as a major threat. While these assumptions recognise the potential generational differences in understandings of and responses to risk, there has been relatively little exploration of this particular issue (Prestage et al. 2009). Recently, reviews of the literature have made an attempt to address these generational differences. Knussen et al. (2010) reviewed eight surveys conducted in Scotland on sexual behaviour amongst 'MSM' between 1996 and 2008. This review considered two variables in the analysis: UAI with more than two partners and age (younger than 25 and older than 25). Findings from this review showed an increase in UAI with more than two sexual partners during the period 2002 – 2008, compared to 1996 – 2000, although Knussen et al. described the 'risk' activity as stable throughout the later period. This research also found that men under 25 were more likely to report UAI with more than two partners in the previous twelve months. Prestage et al. (2009) have also considered how age influences sexual behaviour in men under 25 in major cities in Australia. This research found that men under 25 were at a slightly increased risk in their sexual practice as a result of UAI, but that they were less sexually active overall. The authors argue that while age is an important factor, findings around risk behaviour on the basis of age need to be situated in broader contextual factors.

In response to the changing sexual health landscape and increasing concerns about changes in safer sex strategies of 'MSM', much of the research in this area has focused primarily on reported sexual behaviour and particular sexual acts. For example, Elford (2006) examined the reasons for risky sexual behaviour amongst 'MSM' in a systematic review of research conducted between 1996 and 2006. Relying on epidemiological constructions of risk, he defined high risk sexual behaviour as 'unprotected anal intercourse (UAI) with a partner of unknown or discordant HIV status' (2006:26). Elford found mixed results, but ultimately concluded that treatment optimism played a very minor role – if any role at all – in a move to risky sexual behaviour. Elford argued that the reasons for UAI were much broader than treatment optimism, including things such as serosorting[8] and strategic positioning[9] (Elford 2006: Hart and Elford 2010). However, he did not question UAI as risky behaviour. This general acceptance of UAI as risky sexual behaviour reflects the ways in which epidemiological understandings of risk have driven much of the public health research in this area and have not always taken into account the ways in which UAI might not always be a risky sexual act.

Critiquing Epidemiological and Behavioural Approaches to Risk

While I do not necessarily question the epidemiological data on rising rates of infection or reported instances of UAI in much of the public health research reported above, I do want to interrogate the ways in which questions are framed and meanings are derived from this approach to HIV and sexual health more generally, and consider the impact this has on understandings of risk. Epidemiology, a sub-discipline of biomedicine, has not always been the dominant approach in HIV research. Patton (2002) has argued that there was a shift to epidemiology from a tropical medicine approach to HIV as the illness emerged in the 1980s. The tropical medicine approach focused on the *proximity* of illness (HIV was seen in particular places) and followed a programme which advocated avoiding particular places, or developing vaccinations which could protect the healthy, non-infected from the dangers in these places. Epidemiology, which took on a more dominant position in scientific research and government policy in the late

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[8] Serosorting is the selection of a sexual partner on the basis of their known or perceived HIV serostatus.
[9] Strategic positioning is the sexual position of each partner based on the biomedical knowledge that the active or insertive sexual partner is at less risk of contracting HIV than the 'passive' or receptive sexual partner in anal intercourse.

1980s, viewed the risk of infection as a possibility based on certain *behaviours*. Rather than identifying particular places as risky, epidemiology argued that all bodies were at risk of illness, with certain bodies functioning as vectors of the illness for the rest of the population. Patton explains:

> Epidemiology defined the boundaries of a disease by constituting an imagined community ("risk group") described through vectors that epidemiology presented as though discovered. Disease may radiate out from a place – an epicentre –but it was rarely proper to that place. Epidemic disease must be confined and policed....Thus, epidemiology seeks eradication of disease, either though spreading cures or through eliminated vectors, that is, through isolating the disease within the vectoral bodies and by separating infected from healthy bodies. (2002: 42-43)

Patton argues that epidemiological thinking had become the dominant biomedical discourse around AIDS by the late 1980s, and directly shaped notions of what – or who - was risky. It was no longer where AIDS was that was important, but in which bodies it potentially resided. The focus on particular bodies as potentially diseased and as potential vectors of the disease became the focus in the 'fight' against AIDS. Patton's exploration of this shift in biomedical approaches to HIV highlights the ways in which HIV as an illness is culturally and socially constructed. For instance, Patton argues that the way HIV has been framed has been determined not only through empirical research, but through power struggles between competing scientists and doctors, as well as pharmaceutical companies and research laboratories. The construction of HIV in epidemiological terms, however, has not only directed HIV research and policy, but had become the basis for individual perceptions of risk.

This epidemiological approach rests on identifying particular 'risk groups' and their epidemiological and social vulnerability to infection as higher or lower than others (Patton 1990; 2002; Watney 2000). The limitations of epidemiology, and a signal of the ways in which the transmission of HIV is culturally constructed, can be seen in who is and is not viewed as high risk. For example, risk groups currently in use by the HPA today include heterosexual men and women, men who have sex with men (MSM), heterosexual men and women born in Africa and heterosexual men and women who are intravenous drug users (HPA 2010a). It is remarkable that the 'group' women who have sex with women are absent from HIV related HPA publications. This absence primarily constructs lesbians as sexual actors who do not engage in risky sexual acts or

as intravenous drug users. Richardson (2000a) has argued that this institutional exclusion has resulted in a false sense of security for such women. The omission of lesbians also demonstrates the ways in which gender is prioritised over sexuality in categorizations of risk. Moreover, the inclusion of the category of intravenous drug users, a 'risk group' which represents an incredibly low HIV infection rate in the UK as a result of strong needle exchange and other harm reduction programmes, (Watney 2000) is also telling. The absence of certain groups and the focus on others highlights the epidemiological focus on certain modes of transmission deemed to be high risk, and certain groups of people perceived to engage in highly risky activity. While epidemiological approaches to health are based on comparing population groups with each other, the reduction of people to a particular 'risk' group problematically excludes multiple risks, conflates sexual acts with identity and assumes no cross-over of categories, raising questions about the reliability of epidemiological categories alone in determining risk.

Social stigma can play an important if subtle role in these categories. Lupton describes how a 'risk group' approach can often lead to a 'stratification of goodness,' (1995:91) where risk is used to assign blame on already stigmatised groups. Kippax and Race also argue that the effects of identifying particular risk groups mean that individuals are entirely determined by an epidemiological approach to risk. 'The epidemiological narrative [is] easy to take for granted and left unchallenged by the mainstream because it is informed by wider cultural narratives about the location of disease and morbidity' (2003:2). That is, epidemiologists – and epidemiological systems of surveillance – are no more immune to the social and cultural perceptions of difference than anyone else, and have embedded social and cultural norms into the ways categories are created, the way questions are asked and the way epidemiological data is interpreted (Richardson 2000a). Kippax and Race go onto argue that the use of the term 'risk group' fails to 'carry any sense of social connectedness and shared meanings: the term was and is simply a marker of an imposed identity category which came to stand for risk' (2003:2). Those individuals who are deemed to be a part of a risk group become synonymous with risk.

Catherine Waldby (1996) further critiques specific epidemiological approaches to HIV transmission and gay men. In her in-depth analysis of biomedical discourse on HIV, Waldby describes biomedicine as a 'cultural practice' and argues, like Kippax and Race, that 'general cultural ideas become implicated in scientific reasoning' (1996:15). She terms this the *biomedical imagination*, demonstrating how biomedicine relies on 'other cultural domains' which 'enables the importation of social narratives into biomedicine's technical narratives' (1996:16). She holds that the biomedical imagination is preoccupied with establishing the 'distinctions between normal and pathological'(1996:6). In establishing the normal – or normative – from the pathological, Waldby argues that biomedicine generally, and epidemiology as a sub-discipline of biomedicine, has created

> new and compelled forms of medicalized sexual 'identity' as the primary means of government of the epidemic. The surveillance practices of AIDS epidemiology have effectively (re)classified the sexual identities of whole national populations, according to its understanding of HIV transmission processes, in its allocation of 'risk categories.' I am referring to epidemiology's utilization of the idea of 'high risk' and 'low risk' groups, where these groups coincide with specified sexualities in the social fabric and to organise its preventative strategies (1996:6).

In particular, Waldby explains how biomedicine has established the heterosexual male body as normative and removed any representation of 'anal receptivity' (1996:14). The heterosexual male body must therefore suppress its 'capacities for passivity and anal and oral receptivity' (1996:14) which are projected onto the bodies of women and gay men. Waldby argues that this 'figuring of body boundaries and their transgression' 1996:14) is central to the ways in which biomedicine 'imagines and sexes the distinction between the normal and the pathological in HIV transmission' (1996:14). A consequence of this according to Waldby, and supported by Patton (1990), is that 'gay masculinity has been so intensely medicalised and so closely associated with the AIDS epidemic that men are effectively treated by much public health discourse *as if they themselves were the virus*, the origins of infection' (1996:13). Richardson (1996) agrees and argues that only certain bodies are understood to contract HIV. Thus, the epidemiological construction of risk groups is neither based in a neutral approach to the 'science' nor does it take into account wider social and cultural considerations outside of the physical – and pathological – sexual acts it describes as 'high risk.'

The epidemiological construction of risk groups is based, in part, on assumed risky sexual *behaviour*. High risk groups are considered to be at increased risk of HIV infection because of the high risk sexual acts they are assumed to engage in. The emphasis on behaviour is not only reflected in the language used by much research on HIV and 'MSM', but in the focus on UAI. As outlined above, UAI is considered risky *behaviour* in spite of the various circumstances or arrangements in which unprotected anal sex might not pose risk of HIV infection. Although health research understands sexuality in terms of behaviour, the notion of behaviour has been heavily critiqued by non-medical researchers of sexuality. Sociologists John Gagnon and William Simon were among the first to critique the biological determinism implicit in the notion of sexual behaviour in the 1970s (Jackson and Scott 2010). Jackson and Scott contend that, although Gagnon and Simon have been understudied, their radical insights form the foundations of the social constructionism of sexuality. Jackson and Scott outline how, in opposition to psychoanalytical and especially Freudian approaches to sexuality, Gagnon and Simon argued that sexuality is not driven by instinct or innate biological drives and that this notion is a major obstacle to understanding human sexuality. Instead, Gagnon and Simon described sexuality as socially constituted. It is not an overwhelming force but part of the everyday. Nor is sexuality developed only in childhood, but is constantly constructed and reconstructed in adolescence and adulthood. They distinguished between gender and sexuality, arguing that there is not necessarily a relationship between femininity/masculinity and heterosexuality. In their 1973 book *Sexual Conduct*, they outlined how instead of considering sexual *behaviour*, a more productive way of exploring sexuality would be through consideration of sexual *conduct*, an approach which recognised the sociality of sexuality. In particular, they argued that bodies and acts become sexual through the application of sexual scripts. These scripts are informed by interaction with others, as well as a reflexive internal dialogue. Jackson and Scott outline how they later added cultural scenarios to the formulation of these scripts, situating this sexual interaction in a wider social and cultural context. These scripts are not static, but are fluid, improvised and part of ongoing processes which adapt to different contexts. Moreover, these scripts and sexual conduct can be guided by non-sexual motives and wider social institutions (Kimmel 2007; Jackson and Scott 2010).

This move away from framing research questions and approaches through explorations of sexual *behaviour* is echoed by Australian researcher Susan Kippax et al. (1993). In their book *Sustaining Safe Sex,* Kippax et al. outlined how the theoretical approach to their research on HIV and gay and bisexual men was not framed through explorations of individual sexual behaviour, but through social *practice*. This approach is based on Gagnon and Simon (2009[1973])'s interactionist understanding of sexuality as socially constructed, situational and culturally specific. This also draws, they explain, on Giddens' (1984) notion that personal practice is not only based on but constitutes social structures. In combining these understandings of sexuality and practice, they moved away from looking at isolated behaviours to look instead at whole patterns of practice. Moreover, the authors maintained that using this approach allowed for exploration of different contexts and relationships, and how these differences affect transactions or negotiations of safer sex in sexual encounters. Kippax et al. explain how their experience with this approach meant that they

> built up a picture of respondents' sexuality, not as a set of individual behaviours, not even as behaviours-in-social-context, but as *social practice* per se, as the mutual constitution of personal and social life....a double object of knowledge appeared: on the one hand the *person* as social actor, on the other hand the *collectivity,* gay community. We were able to characterize the collectivity in certain ways, state some of the cultural dynamics operating in it, and make proposals about directions for collective action by this community (1993:27-28).

Kippax et al. maintained that this focus on practice was illustrative of experiences of both social actors *and* the gay community. The dynamic social practice of study participants was therefore situated in a broader social and cultural context.

Where *Sustaining Safe Sex* was a large, multi-method study with multiple researchers that would allow for a thorough investigation of these elements, the focus on practice is still of relevance to this study. Kippax and Race (2003) return to the notion of practice in an article which reviews the differences between epidemiological and socio-cultural approaches to risk in HIV research. Much like the discussion above, Kippax and Race argue how the notion of sexual practice is a much more productive frame with which to ask questions about risk, HIV and gay men. They argue that the epidemiological approach, which focuses on behaviour, does not take into consideration the specific contextual and practical negotiations around risk reduction in which gay men engage. Sexual behaviour is the act, whereas sexual practice looks at the specificity of the

experience and considers the social and/or community sexual relations and norms which influence and shape this practice. In other words, while men may engage in the same sexual acts, their sexual practice, including their approach or response to risk, might be very different from each other and in different sexual encounters. Each act needs to be understood in the context within which it takes place in order to better understand how men identify and respond to risks. For instance, the practice of UAI between men in which one or both are HIV positive and knowingly have very low viral loads would not be considered the same *practice* as UAI between two men who do not know their HIV status, or viral loads, even though the act – and behaviour – is the same. Moreover, the ways in which the gay men view the role of low viral loads in safer sex strategies would also need to be considered. While the epidemiological perspective would consider these two examples to be the same risky behaviour, it is important to recognise the difference in *practice* where risk reduction is negotiated on the basis on specific circumstances and knowledge, and sits within – or contests – a wider social or community practice. Thus, rather than exploring risky behaviour and the reasons for this behaviour, this study explores how men identified and responded to risk in their sexual *practice*.

This section has sought to establish the ways in which understandings of epidemiology and sexuality will frame this research. Where the section has explored how epidemiology constructs understandings of illness and risky sexual behaviour, it has also attempted to critique this approach and draw attention to broader social and cultural influences. By drawing on Gagnon and Simon, the section then outlined how this study will consider sexuality and sexual acts as *social* and affected by others. Building on this notion of the sexual as social, the section then outlined the reasons why and the ways in which the study of sexual practice can help to contextualise sexual acts and consider the broader social, historical and biomedical context within which these sexual acts take place. Consequently, this study will explore the sexual practice of 'MSM' in the North East of England as it interrogates understandings of and responses to risk. While the research will take into consideration the ways in which 'MSM' are disproportionately affected by HIV and syphilis in the North East of England, as signalled by epidemiological data and historical experience, it will frame how understandings of and responses to risk are situated in 'MSM's' everyday lives through an exploration of sexual practice.

Researching Risk

While I distinguish this research from studies which focus on sexual behaviour, it is important to consider how other research has approached the subject of risk in sexual encounters between men. Indeed, emphasising sexual practice over behaviour does not take away from the relevance of the multitude of studies that have explored risk, 'MSM' and sexual health. Where more sociologically based studies have adopted a social constructionist understanding of sexuality and sexual relations, there are a number of ways in which this area has been approached. This section will briefly consider the relevant research approaches to 'MSM', syphilis, HIV and risk and what this research means for this study. The section will then outline how this research approaches risk and how this will be operationalised in the research and analysis.

Reviewing the Literature

Much of the research in this area has been driven by the epidemiological data, outlined above. The epidemiological research in this area, such as that conducted by the UK Health Protection Agency (HPA), has largely looked at infection rates regionally and nationally and is based on local reporting of infections at Genito-Urinary Medicine (GUM) clinics. It is primarily concerned with particular population groups and the ways in which infection rates of these groups increase or decrease (HPA 2009; HPA 2010A). This research asks how many people were infected and which category population group they fit into, but, as explained above, this nature of research does not explore the context of the infection apart from the presumed mode of transmission, nor the patient's understanding or response to this infection. This research equates risk with risk of infection of HIV and/or sexually transmitted infections (STIs). Other more public health based, largely quantitative research also relies on large samples, but asks broader questions.

Perhaps unsurprisingly, much of the public health research on risk and 'MSM' has been dominated by HIV. There have been few studies with 'MSM' exploring other sexually transmitted infections (STIs). More specifically, there have been few studies that have focused on syphilis and 'MSM' in the UK, although these have begun to increase with the consistent rise in rates of syphilis infection amongst 'MSM'. These studies have

largely focused on: the casual and/or anonymous nature of sexual encounters through which syphilis is presumed to be contracted; the lack of condoms used in oral sex, the main mode of syphilis transmission; the epidemiological connections with HIV, namely that the presence of syphilis and diagnoses of syphilis co-infection raise concerns about the nature of sexual behaviour; and conclude that there needs to be an increase in syphilis education and prevention messages targeted specifically at the 'MSM' (Clark et al. 2001; Bellis et al. 2002; Simms et al. 2005; Imrie et al. 2006). Whereas Simms et al. (2005) reviewed national epidemiological data from syphilis surveillance in GUM clinics, some studies have had a regional focus. Bellis et al. (2002) explored the outbreak of syphilis in Manchester and the North West of England in the early 2000's, where Imrie et al. (2006) looked at the incidence of syphilis on the South-East coast. Both of these studies focused on regional experiences of syphilis and explored *where* syphilis was believed to be contracted, such as saunas, cruising sites[10] and dark rooms, linking the location of sexual encounters to the nature of the sexual encounters. While Imrie et al.'s (2006) study was based on case studies and surveillance data and the methodology left little room for exploration of meanings of syphilis and sexual practice, Clark et al. (2001) conducted interviews with 'MSM' diagnosed with syphilis to assess sexual behaviour, awareness of syphilis and feasibility of prevention campaigns. However, this study focused entirely on the behaviour of those diagnosed with syphilis, and suggested, among other things, that a more 'imaginative approach to marketing condoms' (2001:4) be explored to promote condom use for anal and oral sex. Moreover, in identifying anonymous casual sex as a major 'source' of much of the transmission, one of their recommendations was that 'future development of city centre areas should consider the design and lighting so as not to inadvertently promote areas for anonymous sex' (2001: 4). This conclusion demonstrates little understanding of the sexual practice of the men interviewed in this study as it recommends removing the spaces where transmission was perceived to have taken place. This approach entirely disregards the ways in which anonymous sex may be a social practice that might not be significantly disrupted by the addition of a few additional street lights.

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[10] Cruising is generally understood as looking for sexual partners, usually in a public place, known as a cruising site (Stewart 1995).

In terms of public health research on HIV and 'MSM', a large proportion of this research also focuses on behavioural understandings of sexuality. While some studies do consider the social and cultural contexts of sexuality, many rely on instances of UAI and numbers of sexual partners as determinants of risk. For example, the Gay Men's Sex Survey, otherwise known as Vital Statistics, has been run annually by Sigma Research since 1993 and nationally since 1997. This survey-based study has a series of multiple choice or yes/no questions on age, ethnicity, sexual identity, sexual acts, numbers of sexual partners, payment for sex, drug use, use of websites and experience of GUM clinics and testing. This continues to be one of the most important annual collections of information on 'MSM' sexual behaviour in the UK with a peak in respondents at 20, 000 men in 2002 (Sigma Research 2011). For instance, findings from these surveys have shown how men under 20 are less likely to have visited a GUM clinic or been tested for HIV than men over 20. This research has also highlighted how men under 40 are considered to be over-represented among men contracting HIV (Hickson et al. 2009). In 2010, this survey was conducted in conjunction with a European wide survey of 'MSM' sexual behaviour (EMIS 2011). While these large scale surveys provide important information on national and regional populations and trends in behaviour, they leave little room for exploration of context or practice outside of sexual acts and attendance or non-attendance at GUM clinics. Moreover, these studies tend to consider risk within the relatively narrow parameter of infection and focus on reported use or non-use of condoms and infection results as an indication of risky behaviour.

Public health research that relies on mixed or more qualitative methods, such as short-answer surveys and in-depth interviews can bring a broader appreciation of the contexts to sexual acts, in asking how they are understood as risky. Studies that have employed this methodology, however, continues to ask *why* men engage in risky sexual acts, what the reason are for these acts and what might play a role in changing behaviour (Elford 2004; Elam et al. 2008; MacDonald et al. 2007) . For example, in response to a larger behavioural study which established UAI as the primary risk for HIV infection amongst gay men in England, Elam et al. (2008) conducted a qualitative interview study of forty-eight participants who had engaged in UAI, and explored why they had engaged in this sexual act. Findings highlighted a range of psychosocial reasons for UAI, such as low self-esteem or depression, as well as drug and alcohol use which led to 'risk taking and

loss of control over risk reduction strategies' (2008: 473). Emphasising the emotional needs of 'MSM', this study focused on individual responses to UAI. While it did consider the social and emotional context of the sexual encounter, the study continued to focus on individual participation in UAI, rather than the broader social context, citing emotional reasons for this 'risky' behaviour. In their recent systematic review of research on HIV, risk and 'MSM', Hart and Elford (2010) acknowledge that in addition to condom use, a number of alternative strategies to HIV prevention have emerged in research accounts of sex encounters, such as serosorting and strategic positioning. However, they also point out that it is unclear how 'successful' these techniques have been in relation to the sexual health of both partners apart from HIV transmission. While Hart and Elford acknowledge the possibility that UAI might not always entail risk, they are more concerned with the outcomes of the sexual act, rather than the risk rationale for these alternative strategies.

Much health focused research uses the term UAI to describe anal sex without a condom. However, there has been an increasing focus on the practice of barebacking (Halperin 2007; Dean 2009). While this is UAI, this is not the same as strategic positioning or serosorting. Barebacking is generally accepted as anal sex between men without a condom where these negotiations are assumed not to have been made. In many cases it is constructed as a deliberate act of recklessness, especially with regard to risk of HIV transmission (Dean 2009). Crossley (2002), taking a psychological approach, has considered the reasons for men to engage in bareback sex through analysis of gay male writings. Crossley has suggested that gay and bisexual men in the UK are engaging in bareback sex as an unconscious way of resisting or transgressing heteronormative social norms. Exploring individual beliefs, emotions and rationale within a broader framework, Crossley's approach to risk still seeks answers to why individuals take risks *from* the individual themselves. Like the Elam et al. (2008) study described above, Crossley sees barebacking as a 'deviant' sexual act and concludes that the act must be an individual psychological response to a perceived problem. Both approaches see the practice of UAI, or barebacking as an individual act that deviates from healthy sexual behaviours. However, Race (2007) critiques this approach to UAI, especially its construction of barebacking, and the intentions of the sexual actor. He argues that social science research

is intimately involved in the production of barebacking since it invites sexual subjects to (mis)recognize themselves as purely intentional individuals, either virtuous or deviant. Here we can see how normative discourses of HIV risk and sexuality intersect with neoliberal discourses which stipulate a (tacitly gendered) model of the self that is rational, calculating, independent, in control, and decisional. By concentrating on gay men's moral intentions while ignoring the circumstances of sex, HIV social science invokes and produces a neoliberal sexual actor who finds himself embracing HIV risk. (2007a:101)

Where both health and social sciences construct UAI as a deviant sexual act, Race argues that neither take into account the 'circumstances of sex' and the way in which these circumstances influence and shape understandings and responses to risk. Race argues that research on this topic demands not only a socio-cultural approach that considers the circumstances of sex, but an approach which does not cast 'MSM' as asocial rational risk actors.

Approaching Risk

While epidemiological and quantitative public health research aims to establish or describe the sexual behaviour of gay and bisexual men in relation to risk, and health psychology approaches seek to explain why individuals engage in risky practice, a sociological approach can go some way in situating understandings of risk within a broader social and cultural context. There are a range of sociological approaches to risk, ranging from Beck's 'risk society' (1992) that considers how macro-social processes are related to risk; to Douglas (1985) who focuses on the ways in which notions of risk are used to establish and maintain conceptual boundaries between the self and Other. However, this study does not seek to engage directly with the 'grand theorizing of Beck, Giddens and Douglas...[but to] map the complexities, contradictions and changes in risk understandings' (Lupton 2006: 21). Lupton argues that 'the identification of 'risks' takes place within the specific socio-cultural and historical contexts in which we are located. To call something a risk is to recognise its importance to our subjectivity and wellbeing' (1999:13). That is, to identify something as a risk, or risky, is grounded in a shared social and cultural context. While particular understandings of risk may vary widely, including the understanding of the degree of risk, and the specific reaction to this risk, there is something shared about what a risk is considered to be.

In order to consider the ways in which the social and cultural context play a role in the identification and response to risk, the socially constructed nature of risk needs to be unpacked. This means that risk needs to be viewed not as static, but as constructed by the social, cultural, historical, geographic, spatial and material context within which it is identified (or not) and responded to (Lupton 1999). For example, Race (2001) has demonstrated the ways in which constructions of risk are dependent on both the social and historical context. He explored how the development of the HIV antibody test in the 1980s produced socio-sexual subjects in terms of risk. He argued that risk came to be conceived in terms of the difference between bodies (HIV positive versus HIV negative). This meant that the practice of safer sex shifted from a 'cultural practice' where before the HIV test, everyone was assumed to be positive and safe sex was allegedly a community practice, to a set of techniques practised by individuals. Certain *individuals* came to be viewed as posing a risk of HIV, whereas others who were tested and did not appear to have HIV antibodies were no longer seen as potentially posing a risk. Race argues that this represented not only a change in social practices but a shift in *community* constructions of risk. Similarly, in her exploration of the intersections of biomedical technologies and physical experiences, Rosengarten (2009) outlines how the development of ARVs and understandings of how viral loads affect transmission has changed material understandings of risk and how the virus itself is seen to manifest. Where anyone who was HIV positive was seen to pose a risk of infection to others before the implementation of viral load tests in the mid 1990s, the increasingly sophisticated serological testing which measures viral loads has meant that certain HIV positive individuals, who test below a certain level, are theoretically unlikely to transmit the virus to others. If their viral load is undetectable, they are not considered to pose risk of infection to others. However, experiences of being undetectable are dependent not only on access to viral load testing, but to the availability of treatment. This affects not only those individuals who have not been tested for HIV, but those who will not have access to treatment because of where they live. While being undetectable for many in the UK is a real possibility, the likelihood of an HIV positive individual in a developing country with a poor health infrastructure, or an environment in which accessing HIV testing and treatment is highly stigmatised means that these material understandings of HIV are dependent on place. These approaches to risk demonstrate how individual understandings of risk are grounded in a broader context of social norms and practices, as well as technological and historical factors. They also highlight the ways in which biomedical information, knowledge and technologies play an important role in the

sexual practice of 'MSM.' In this respect, the social and cultural context should not be seen to 'trump' the biomedical knowledge around prevention and transmission of HIV and syphilis, but as integral to understandings of risk in sexual health that draw on biomedical knowledge and technologies.

This study aims to explore the constructed nature of risk, and considers how material, historic, geographic, spatial, social and generational contexts shape how 'MSM' in the North East of England identify and respond to risk in their everyday sexual practice. It recognises how social, biological and legal changes have meant that gay and bisexual men have been exposed to and experienced HIV and syphilis in significantly different ways over the past thirty years. Moreover, it also notes the importance of space and place, and the ways in which they are not only physical entities but socially and historically constructed (Massey 1994). Consequently, this study interrogates the notion that 'MSM' would respond to risk in the same way. Echoing Race's exploration of shifting community practices, this study also seeks to explore the ways in which perceived 'community' norms in sexual practice, including responses to risk, are identified, understood, negotiated, followed or contested and how these norms become more or less important to the sexual actors in question at different times in their life. It is not assumed that these community practices are universally recognised. Instead, this study attempts to understand how participants understood and negotiated their membership in a set of community norms and practices in relation to risk. Finally, this research seeks to maintain a fine balance between lay and expert knowledge in relation to risk. It is not assumed that people are rational or irrational actors who do or do not respond to risk rationally or logically, but actors who negotiate community norms and dynamic understandings of risk in their own sexual practice.

Shifting approaches to health

As already noted, understandings of risk of HIV and syphilis have changed considerably with the advent to new technologies, including diagnostics and treatment. This thesis is concerned with how the individual negotiates the broader social context in response to risk and the ways in which the biomedical has played a role in responses to sexual health. It also considers the ways in which these experiences are situated within broader

experiences of health and illness. Given the priority of HIV in sexual health of 'MSM', this section traces the ways in which risk of HIV has been understood and managed on a policy level by 'MSM' in the UK and how this has changed over the past thirty years. These changes are then situated in a broader health context where, it is argued, notions of citizenship, collectivities and responsibility play an integral role in the management of risk.

Negotiating Community and Individual Responses to HIV

As I have already outlined, 'MSM' have been and continue to be disproportionately affected by HIV in the UK. That public health and social responses to pre-HAART HIV throughout much of the 1980s and 1990s were framed by homophobia, stigma and discrimination has been well documented (Crimp 1988; Patton 1990; Waldby 1996; Watney 2000; 1987; Kitzinger and Peel 2005). Watney explains how the term 'gay plague' (1987:12) was used in the British media throughout the 1980s, ultimately equating HIV – otherwise experiences of AIDS during this time – and the 'gay lifestyle' (Crimp 1988:238). This had a real impact in terms of social discrimination, but also access to health care (Watney1987; Waldby 1996; Treichler 1999). In many cases, social stigma and lack of knowledge about how HIV was transmitted only compounded the isolating and traumatic experiences of people who died from AIDS related illnesses. According to Berridge (1996) the circumstances of the death of Terrence Higgins in 1982 at a hospital in London, especially the use of double-barrier nursing techniques, caused outrage. To improve the care and support for those living with HIV, and to raise funds for HIV research, Higgins' friends established the Terrence Higgins Trust. While this organisation is currently one of the leading non-profit organisations working in HIV prevention and sexual health in the UK, it began as one of many community-initiated projects aimed at raising money for research into HIV, and raising awareness about HIV prevention. In fact, it is now recognised that gay organisations, communities and network structures were integral to HIV education activities and care, well before formal community and professional organisations were formed (Kippax and Race 2003).

Early UK health policy has been characterised as having a delayed response to – or even ignoring – the increasing number of HIV positive 'MSM' who developed and died from AIDS related illnesses (Watney 2000). Berridge characterises this period in the UK (approximately 1981 – 1985) as one of self-help or policy from below (see 1996:13 – 36). Keogh (2008:582) outlines how groups of gay and bisexual men helped reject repressive responses to HIV, such as quarantine and mandatory HIV testing, in favour of more 'communitarian responses.' But more than simply policy from below, Crimp (1988), Patton (1990) and others have described the ways in which cultural practices of safer sex were developed in response to the threat of HIV infection in light of inadequate or inappropriate public health information. Patton argues that it was not medical professionals but gay men who 'invented safe sex', (Patton as cited in Crimp 1988: 252) as they came up with alternatives to strategies of monogamy and abstinence that were eventually advocated by public health officials (King 1993). Public health professionals identified unprotected anal sex as posing a high risk of HIV transmission and characterised multiple sexual partners – or 'promiscuity' – as the main mode of transmission, especially in certain contexts. Bathhouses and other public sex spaces in particular were highly criticised as the 'source' of much HIV infection and many were shut down (Disman 2003). In response to the view that it was the promiscuity that led to high rates of infection, Crimp argued that monogamy and abstinence were not safe alternatives to multiple sexual partners because people did not abstain from sex. Instead, he argued that the gay 'community' was able come up with creative and pleasurable safer sex options because it had 'always known that sex is not, in an epidemic or not, limited to penetrative sex' (1988:253). Patton documents how these safer sex techniques which avoided or reduced penetrative sex were incorporated into official public health policy for gay and bisexual men by the late 1980s (Crimp 1988: 252). Many writers have described the ways in which these safer sex practices became widely practiced throughout the 1980s and into the 1990s by 'MSM' (Watney 2000; Flowers 2001; Race 2001; Dowsett 2009). While Patton, Crimp and Disman refer largely to American experiences of safe(r) sex and therefore, a different experience of HIV to UK gay communities, it is important to recognise the significance of this trans-Atlantic influence during this time and in response to HIV. As well as responding to local experiences, those involved in HIV prevention and care in the UK would have been influenced by and/or sought out advice and/or material from their counterparts in the United States (US), where HIV amongst gay men had first emerged. For instance, Berridge (1996) explains how safer sex material from the US directly informed UK

policy and practice. However, this material, intended for use in UK AIDS campaigns in the late 1980s, had to be smuggled into the UK via diplomatic channels so as to avoid being confiscated at the border as 'obscene' material.

Berridge (1996) and others describe how it was not until the heterosexual and non-intravenous drug using population was feared to be at risk that the UK government intervened on a formal, public health level. The 1987 Don't Die of Ignorance campaign was the first national HIV prevention campaign in the UK. This television campaign was accompanied by the distribution of an HIV information leaflet to every household in the UK (Berridge 1996). The campaign sought to convey how risk of HIV infection was not limited to certain groups of people, such as gay and bisexual men and intravenous drug users, but was a 'risk' for everyone. The campaign, and the broadening out of prevention interventions beyond certain groups on the basis of gender and sexuality (or drug use), represents a shift in public health policy. Flowers (2001) explains how this was a significant moment of change in public health in the UK, as policy shifted from focusing on certain 'groups' to identifying particular sexual 'acts' as posing a high risk of HIV. Consequently, this required a concerted effort to de-link HIV from gay men in the public imagination so that others, men and women, would recognise their potential risk of this illness.

The move to 'de-gay' (Kitzinger and Peel 2005: 177) HIV in public health policy and education was also meant to counter the overt homophobic representations of HIV that were prevalent throughout the 1980s. However, King (1993) argues that they ways in which safer sex was invented and established as a community norm by and amongst 'MSM' in the UK was ignored by health policy as the reason for declining HIV rates amongst 'MSM' in the 1980s. Moreover, the increasing professionalisation of the HIV sector with increased government investment in HIV prevention and education meant 'forgetting' the grassroots work that these gay community specific organisations began. This signalled a move away from a 'strategy of resistance shared by gay men' to providing safer sex information to 'clients' (1993:x). King saw this institutional transformation of responses to HIV as a detrimental move, and describes how this shift represented a de-gaying of the epidemic at a time when 'MSM' continued to be disproportionately affected by HIV. Flowers (2001) describes how this de-gaying,

which went hand in hand with new advances in HIV technology, meant that the construction of HIV risk shifted from group membership to the individual body. With the development and implementation of the HIV antibody test in 1985 (Berridge 1996; Flowers 2001) and the identification of who was HIV positive, the ways in which risk was imagined by biomedicine changed. The epidemiological construction of risky sexual practice before the HIV test had largely been judged on the basis of number of sexual partners/perceived promiscuity – to which Crimp (1988) was responding - and was often equated with the gay 'lifestyle' (Watney 1987). In other words, one only had to be gay to be at risk. However, with the identification of HIV antibodies and increased correlation between reported sexual acts and the presence of HIV in the body, the identification of risk then began to be measured on the basis of specific acts that one did or did not engage in. This can be seen in the way risk began to be measured. For instance, research began to ask about condom use and specific sexual acts, rather than simply number of sexual partners. Flowers explains how it was during this period that the importance of bodily fluids gained significance in how HIV risk was understood, as a hierarchy of risky sexual acts began to be compiled (Flowers 2001). While 'MSM' continued to be affected by high HIV rates, the public health focus moved away from the notion that it was membership in a gay and bisexual community that was the cause of – or response to – HIV infections.

These changes represent a significant shift in understandings of risk and HIV, from an emphasis in health messages and policy that focus on categories of *risk groups based on identity* to a focus on *risk managing individuals*. Critics have argued that the development HIV technologies, such as HAART and the prioritizing of voluntary counselling and testing in the late 1990s has meant a significant shift toward scientific and individual approaches to health in available policy and services. They argue that this signalled a shift away from the collective social approaches to safer sex and harm reduction which marked the pre-HAART response of gay communities to HIV in the 1980s, to a reliance on biomedical surveillance of individual bodies and focus on individual responses to risk of HIV (Flowers 2001; Race 2001; Kippax and Race 2003). Although the scientific developments and application of HIV testing contributed to the de-gaying of HIV and the shift to a focus on the individual, it was also employed by activists in the *re*-gaying of AIDS in the UK. Keogh (2008: 585) argues that the de-gaying of the AIDS epidemic was meant to resist the 'conflation of homosexuality with

promiscuity and disease.' However, the focus of HIV prevention which had been expanded in the late 1980s to focus on the general population did not, according to activists, address the fact that gay and bisexual men were still disproportionately affected by HIV. Keogh describes how activists drew on the 'strategic and political use of epidemiological data' (2008: 585) in their efforts to *re-gay* the epidemic throughout the 1990s in an attempt to channel further resources for and increase the focus on HIV prevention and care for gay and bisexual men in the UK. Keogh outlines how this re-gaying of AIDS on the basis of epidemiological data went hand in hand with the creation of a centrally coordinated partnership of community groups under a national strategy for HIV health promotion, drawing on existing HIV activists and community groups. Moreover, he charts how, since the late 1990s, these activists– now 'Gay Men's Health Promotion Teams' - have become less involved in 'the process of resistance and more in one of active knowledge creation'(2008:585). Moreover, Keogh and others (Adam 2005) have charted the ways in which the re-gaying of AIDS has *not* meant a return to community based approaches. Instead, it signals how health promotion has been governed in a neoliberal understanding of behaviour in its focus on the *individual*. Keogh explains:

> We have moved from a position where homosexual behaviour and identity were constructed as intrinsically pathological or deviant to one where gay identity provides the basis for the promotion of individual health. Health promotion constructs gay men no longer as intrinsically risky individuals, but sees them as having a capacity to *manage* risk. Thus, gay men are instated as custodians of their own health rather than the object of medical discourse. However, they are now also bound to produce and account for their own health status. (2008: 599)

Where early epidemiological approaches saw 'MSM' as risky, epidemiological (and health promotion) approaches now saw 'MSM' as having the potential for health and/or illness. Seen as ultimately being responsible for their own health, they are provided with the correct *information* and encouraged to make the *right* choices. This perspective is readily found in much HIV prevention work.[11]

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[11] For example, the Terrence Higgins Trust website provides information on HIV, STIs and safer sex. The safer sex page includes a note about being aware of the risks when having sex, so that individuals can make informed choices about the sex that they have. It says: 'We all take risks every day - and some of those risks we take in our sex lives. After all no activity can be completely safe and that includes sex. But when you do take risks it's worth being aware of the facts so that you can calculate the risks and make a judgement about whether you want to take them.' This non-judgemental comment describes their website as the provision of information. In doing so, it emphasises how it is up to the individual to make safe and informed choices about risk in their sexual practice. See http://www.tht.org.uk/informationresources/safersex/ [accessed 25 July 2011].

The move in HIV prevention work and sexual health promotion more generally to focusing on individuals and enabling them to make the right choices in their sexual practice plays down the ways in which sexual practice – and safer sex practice – amongst 'MSM' is grounded in social norms and community practices. Dowsett (2009) amongst others is highly critical of this approach and outlines how this has serious repercussions for the sexual health of 'MSM'. He argues that effective safer sex strategies from the 1980s worked because of the ways in which they engaged in the sexual culture of gay and bisexual sex. In contrast, he characterises contemporary health promotion approaches as the mere provision of information rather than a cultural intervention. He argues that behavioural interventions which focus on the individual disestablish sexual practice from identity and depoliticise and de-contextualise risk reduction. In essence, he laments how these health promotion approaches essentially say:

> 'Well, we've done everything we can; now it's all up to each of you'. They fail to take advantage of all that is social in such sex events. They fail to avail themselves of the ethics of the erotic that situate gay men in diverse sexual cultures with purposes in common. They fail to speak to our membership of sexual cultures and our shared values, and thereby fail to reinforce mutual and shared responsibility. In their presumption of dangerous desires, they are antisex. They determine each gay man as an anomic individual rather than as a reflexive gay citizen enmeshed in communal obligations and with issues of comportment to enact. (2009:236)

For Dowsett, this shift to enabling healthy choices is not something that will result in reduced HIV rates. It fails to recognise the ways in which the decrease in HIV rates in the 1980s was brought about through social and cultural – and not behavioural – change. For 'MSM' to take up effective safer sex practices, he argues, it must be done on a cultural level, and one which posits 'MSM' not as 'anomic individuals' but as part of a community with responsibilities to each other, as well as to their own sexual health. This, he argues, is key to any HIV prevention strategy.

Citizenship, Responsibility and the Imperative of Health

So far in this section, I have traced a shift in the management of risk of HIV at a policy and activist level from community to individual. This has been aided by the shift in the location of risk of HIV from certain communities to certain bodies (Flowers 2001; Race 2001). The figure of the HIV positive individual and associated HIV positive identity

(Race 2001) has been enabled through developments in biotechnologies and the ability to locate and monitor the virus in certain bodies. This change in how HIV has been understood and organised, however, is not driven by biotechnology alone, but the ways in which individuals and illness are understood on a social, cultural and political level. Understandings and experiences of HIV and syphilis for 'MSM' needs to be situated in a broader health discourse.

Petersen and Lupton (1996) have described the ways in which the notion of 'healthy citizenship' focuses on the individual. They outline how this has become an important concept in public health policy in Western societies and has been demonstrated through a wide range of empirical and socio-cultural studies since the mid-1980s. In contrast to a public health approach which focuses on the environment, and deals with sanitation and public hygiene and is managed largely through institutional mechanisms, Petersen and Lupton describe how this 'new public health' focuses on the individual, their actions, their duties and responsibilities to improve and maintain their own health. This is achieved through the notion of healthy citizenship and the processes of self-governance. The healthy citizen is not governed by a coercive state but through a moral imperative which demands that they be responsible for their own health and body. It is their civic duty and moral responsibility to optimise their health. This is done through the seeking out and application of health information from experts in established institutions, such as schools, health clinics and other sources of health knowledge. Those failing in their responsibility to optimise their health are not necessarily penalised, but judged as irresponsible, lazy and morally culpable in their poor or ill-health. For instance, given the well-known risks of lung cancer through cigarette smoking, those who continue to smoke knowing the risks are judged to be morally irresponsible citizens (Lupton 1995; Petersen and Lupton 1996). Drawing on Foucauldian notions of governance and a critical exploration of 'the power of knowledge to define and govern subjects' (1996:10), Petersen and Lupton outline how this healthy citizenship is a product of neoliberalism. Neoliberalism 'reinstates liberal principles, including the notion that individuals are atomistic, rational agents whose existence and interests are prior to society' (1996:10). This governance through neoliberal techniques does not impose controls on individuals, but operates through the 'making up of citizens' capable of exercising regulated freedom' (1996:11). Personal autonomy, rather than force, is part of the process as power operates most effectively

when 'subjects actively participate in the process of governance' (1996:11). This focus on individuals, they argue, masks shifting relations in power and knowledge. The language of healthy citizenship also includes an emphasis on participation and community involvement, signalling a shift in responsibility for a healthy population away from state institutions, and towards the 'collective' of citizens themselves. An example of this can be seen in the 'community' responses to HIV by gay and bisexual men in the 1980s and a continuation of these responses through community organisations that continue to function. By invoking citizenship, the boundaries of this community can be national, but can also be constituted through other markers of difference, such as ethnicity, gender or region. This imperative of health (Lupton 1995), therefore, is not merely a question of individual health, but the health of a community of which they are a part. However, the processes outlined above demonstrate how this results in a moral emphasis on individual responsibility for health.

Building on these notions of healthy citizenship and analyses of Foucauldian self-governance, Nikolas Rose (2007) has developed the notion of *biological citizenship*.[12] Responding to research into genetics, and applications in this fields, he argues that these major developments in biotechnology represent a significant shift in the way we understand and govern bodies and their possibilities. Rose calls this the 'molecularization' (2007:5) of life. As life is being shaped and reshaped at the molecular level as a result of new biotechnologies, he argues that the ethical relationship to our bodies has also changed. This 'ethopolitics' (2007:22-27) means that our 'corporality' not just conduct has become subject to Foucault's 'technologies of the self' (Braun 2007; Rose 2007). In other words, the imperative of health is not only to engage in appropriate, healthy activities but to strive to *be* healthy. Where Peterson and Lupton (1996) describe healthy citizenship and the imperative to follow a healthy lifestyle, biological citizenship goes one step further, encouraging citizens to be active and healthy not only through the physical management of bodies through food and exercise, but also through the wide availability biotechnologies for both diagnosis and treatment. For instance, Rose provides the example of genetic testing and the pressure that is placed on people from certain 'high risk' families to find out if they are carriers of a particular hereditary gene that is thought to cause certain cancers. Although they

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[12] Rose explains how he did not coin the term, but borrows it from Adriana Petryna (2002) and develops the notion drawing on a range of critics, including Sarah Franklin, Paul Rabinow and Carlos Novas.

have not presented with signs or symptoms of illness, they are treated as not healthy and as potentially unwell based on an uncertain future and outcome of the test. This testing is relevant not only for the person who is being tested, Rose argues, but also in terms of their responsibility to others, namely, their children and partner, potential or otherwise, as they pose a potential risk in the transfer of 'bad genes' to their children (Rose 2007).

This particular framing of responsibility is largely heteronormative as consideration of these moral imperatives are applied only to producing biological offspring. Although Rose does not explore the specifics of individual relationships of the potential (presumed heterosexual) couples in question, he does not consider how these moral quandaries might not be relevant to or at least responded to differently in a population that does not always follow through traditional heterosexual reproduction and kinship ties.[13] While Rose's evidence regarding responsibilities to others might be limited in this particular example, his argument, especially how the responsibilities and connections to others are embedded in this form of citizenship, is still useful, including in non-genetic cases. For instance, the HIV virus is both detected and monitored in HIV positive individuals through regular measurements of viral loads. As I have already discussed, if these viral loads are suppressed and managed through HAART, the virus can become undetectable and not passed onto a sexual partner (Hickson 2011; Rosengarten 2009). The responsibility in this case lies not only with the HIV positive person to physically use a condom, for instance, to prevent transmission, but to continue to take the medication which suppresses the viral loads and ensure regular testing to monitor levels. The 'benefit' is framed not only for the individual, but to their potential sexual partner and the prevention of future cases of HIV transmission. Although the responsibility in this case is not about reproduction, it is about the responsibility to monitor and manage individual biology so that others are not adversely affected by it.

As Petersen and Lupton (1996) outlined, healthy citizenship is also about membership of a particular community. Similarly, Rose describes how biological citizenship is collectivising. He describes how 'biosocial groupings' (2007:134) or collectivities have

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[13] I am not saying that gay men and lesbian women do not have children, nor that all heterosexual men and women do have or want children. But there is a much wider range of factors and issues that Rose does not explore in terms of moral imperatives and reproduction that need to be considered when the assumed 'heterosexual couples producing biological offspring' formula is not followed.

formed around 'specific biomedical classifications [and] are significant. The forms of citizenship entailed here often involve quite specialised scientific and medical knowledge of one's condition: one might term this 'informational biocitizenship' (2007:134-5). Rose describes the ways in which these collective experiences of citizenship have resulted not only in the increased knowledge and awareness of specialised conditions, but in forms of activism, for example through campaigning for better treatment or ending stigma, as well as to modes of communication, through tools like email lists and websites. For instance, Rose provides the example of early AIDS activists and the ways in which they 'organised themselves into groups, and constituted those who were actual or potential sufferers from the condition as 'communities' – communities *for which* they would speak, and *to which* they were responsible' (2007:144). Rose does not argue that everyone who is part of these biosocial groupings is an active biological citizen campaigning for better treatment. However, what is significant is that collectivities are forming in various ways on the basis of biological identities and that this highlights the ways in which developments in biotechnologies, as well as broader changes in biomedicine, affect people in social and political ways. Rose draws on his ideas for biological citizenship in part from Rabinow's (1996) work on 'biosociality', which describes new forms of collective identification that are emerging as a result of the new genetic era (Rabinow 1996; Rose 2007). Rabinow (2007) explains that the term was meant to help think through how different and new forms of sociality could emerge at a time when understandings of what illness was were changing. Gibbon and Novas (2007) outline how the status of being at risk, for example at genetic risk, can pose significant questions for how individuals identify themselves in relation to illness and how they relate to others, and to similarly affected others. Along with Rabinow (2007), Gibbon and Novas outline how biosociality, which explores the relationship between identity and technology, has its roots in Haraway's cyborg (1991). However, they distinguish this concept from Haraway's by emphasising how biosociality 'attempts to name the kinds of socialities and identities that are forming around new sites of knowledge (genetics, molecular biology, genomics) and power (industrial, academic, medical)' (Gibbon and Novas 2007: 3).

Gibbon and Novas acknowledge that biosociality can be a useful way of exploring forms of illness that are not genetic. Biosociality is about the ways in which collectivities are formed on the basis of shared biological identities and the ways in

which these collectivities interact and respond to change. I would argue that biosociality is a useful concept when considering 'MSM' and their experiences of sexual health. For instance, as outlined earlier in this chapter, public health policy, driven by epidemiological monitoring, considers 'MSM' to be at a very high risk of HIV and other STIs, including syphilis. Moreover, health policy places an onus on regular testing for both HIV and STIs as a means of not only monitoring infection, but maintaining health of this particular population group (HPA 2009). The onus on testing, and the responsibility to test oneself regularly, as determined by public health advice, is strikingly similar to Rose's example of potential carriers of genetic illness from high risk families as not-healthy until they have been tested for the specific cancer gene. Where potential cancer gene carriers generally need only one test to determine their health status, 'MSM' are advised and expected to test regularly. Moreover, they are not considered 'clear' of infection after an HIV test because of the window period in which HIV can emerge, demanding further and regular tests to verify their health status. In this way, biosociality allows us to ask a number of questions of particular groups of people, not just groups connected through genetics. In the case of 'MSM', what are the implications of being treated as a community 'at risk' in public health policy and health promotion interventions in terms of identity? What impact does this potentially collective identity have on responsibility to others in this collective, as well as on an individual level? What does individual responsibility mean if one is not a part of a social collective of other gay and bisexual men in this context? As the earlier discussion of the 1980s responses to HIV highlighted, questions around identity and collectivities are especially relevant to gay and bisexual men given the history and experiences of this group as a social and political 'community,' both separate from and in relation to HIV.

This section has raised a number of issues in relation to collective and individual responses to health which will be explored throughout this research. In particular, this section has charted how biomedical developments in HIV diagnostics and treatment have contributed to a shift from community to individual management of risk, as well as a shift in the location of risk in groups to particular bodies. Moreover, the section has also explored the ways in which individual experiences of health are tied to responsibility, citizenship and collectivities. By drawing on these issues, the research will consider how understandings of and responses to risk amongst 'MSM' are tied not

only to social and cultural formations and manifestations of community, but also to the ways in which the biomedical impacts on upon individual and collective identity and associations. The next section will consider the ways in which social, legal and political experiences of community can be considered together with notions of a biological community.

Shifting Community Norms and Practice

There have been major changes that have taken place in the UK for gay and bisexual men over the past thirty years. These changes have implications not only in terms of legal and social rights, but for understandings of identity, community and sexual practice. This section briefly charts the legal and social changes that have taken place in the UK since the late 1960's and considers the impact these have had on sexual politics for gay and bisexual men. It then explores the notion of community and what community might mean in relation to changing social norms and individual sexual practice. Finally, drawing on the above discussion on citizenship and biosociality, the section explores the ways in which community might play a role in notions of responsibility and risk for the sexual health of gay and bisexual men.

A Changing Gay 'Community'

As with the history of HIV, over the past 30 years there have been many significant legal and social changes for gay and bisexual men in the UK. The *Sexual Offences Act* (1967) partially decriminalised male homosexuality in England and Wales and established the age of consent at 21 for sex between men. This was followed in Scotland in 1980 and Northern Ireland in 1982. The age of consent was further dropped to 18 in 1994, and was eventually changed to 16 (17 in Northern Ireland) at the end of 2000 to bring it in line with the age of consent for sex between a man and woman (Waites 2003). However, in 1988, Margaret Thatcher's Conservative government passed Section 28 (Weeks 2007). This legislation banned the promotion of homosexuality by local authorities and described same-sex families as 'pretend' and inappropriate. Although no one was ever prosecuted under this legislation, it had a serious and detrimental effect on the LGBT equalities work of local authorities and sexual health education more widely (Carabine and Monro 2004). This legislation was eventually

repealed in 2000 in Scotland, and in 2003 by the New Labour Government in the rest of the UK (Weeks 2007). In addition to repealing this legislation, there have been a number of major legal changes that the New Labour Government introduced as law. These include: lifting the ban on gay men and lesbians serving in the UK army in 2000; reducing the age of consent to 16 in 2000; introducing employment equity regulations in 2003; the legalisation of civil partnerships between same-sex couples in 2005; and making discrimination against gay men and lesbians in the provision of goods and services illegal in 2006 (Weeks 2007). These major changes, introduced in a relatively short amount of time, resulted in reversing many of the legal inequalities for gay men and lesbians in the UK.

These policy and legal changes reflect a change in activism and politics that moved away from legal, social and material concerns around HIV, access to health care and decriminalisation of sexual acts in the 1980s and early 1990s (Warner 1999), to a focus on domestic and financial arrangements, including concerns with welfare and care in the family, as well as individual rights. Critics have argued that these changes reflect not only a real change in rights, but a significant political and cultural shift within gay and lesbian politics. For instance, Waites (2003) contends that gay and lesbian movements since the 1990s have adopted a right-oriented assimilationist agenda which focuses on securing individual rights and equality within existing social and legal institutions. For Richardson this highlights the emergence of a new form of sexual politics:

> This is a politics that by invoking – and simultaneously constituting – a 'gay movement' that seeks incorporation into the mainstream, rejects the earlier political language of women's lesbian and gay liberation in favour of a 'lesbian and gay equality' rhetoric. (2005:519)

Furthermore, Bell and Binnie (2000) argue that this focus on equality, rather than liberation, does little to challenge normative assumptions about sexuality and gender and in some ways may reinforce these heteronormative notions. For instance, while Weeks sees the introduction of civil partnerships in the UK in 2005 as a 'symbolic rupture' between marriage and heterosexuality' and therefore the 'de-heterosexualizing of marriage' (2007:15), many others see legalised same-sex partnerships not as anything radical, but as subscribing – or submitting – to a heteronormative institution (Warner 1999; Duggan 2002; Richardson 2004). The marriage debates for many reflect a growing trend in sexual politics. A number of critics have described the ways in which

this new politics moves towards establishing the idea of lesbians and gay men as normal, good citizens who seek integration in mainstream society, rather than anti-social queer activists who seek to disrupt established institutions and practices (Bell and Binnie 2000). Anna Marie Smith (1997) argues that a 'new homophobia' emerged in the 1990s and resulted in the distinction between those homosexuals who demanded to be publicly visible, making claims on the state – 'the dangerous queer' – and those who, ultimately, stayed in the closet with their modest demands for inclusion – 'the good gay.' Thus, the good gay is a deserving citizen who complies with the legal and social regulations of society, and the dangerous queer is the disruptive, irresponsible non-citizen who has not earned their rights to full citizenship because of their lack of compliance with socially demanded responsibilities. Smith describes this response emerging from within a gay and lesbian community as having an increasingly conservative agenda. Although writing about a different context to Smith, Richardson describes a similar shift, and argues how the main focus of lesbian and gay movements to emerge in the UK has been to oppose a 'conservative' and moral right arguments, 'rather than contesting (neo)liberal understandings of (homo)sexuality'(2005:517). Lisa Duggan has named this shift to new neoliberal sexual politics the 'new homonormativity.'

> It is a politics that does not contest dominant heteronormative assumptions and institutions but upholds and sustains them while promising the possibility of a demobilized gay constituency and a privatized depoliticized gay culture anchored in domesticity and consumption. (2002:179)

For Duggan, and many others, while this does not apply to the entire gay and lesbian community, and can vary quite significantly depending on context, it does reflect a growing trend in the political aims and ideals of many gay and lesbian activists and highlights shifting community political norms.

This shift in sexual politics holds implications for what it means to be responsible in sexual practice. For example, understandings of what is risky sexual practice are not disconnected from understandings of social responsibility, which is reinforced by legal and social institutions. In making the link between gay marriage and judgements of illegitimate sexual practice, Judith Butler outlines how institutional legitimacy serves to reinforce certain sexual practices as normative.

The current drive for gay marriage is in some ways a response to AIDS and, in particular, a shamed response, one in which a gay community seeks to disavow its so-called promiscuity, one in which we appear as healthy and normal and capable of sustaining monogamous relations over time. This, of course, brings me back to the question, a question posed poignantly by Michael Warner, of whether the drive to become recognizable within the existing norms of legitimacy requires that we subscribe to a practice that delegitimates those sexual lives structured outside of the bonds of marriage and the presumptions of monogamy. (Butler 2004:115)

In legitimizing marriage, or civil partnerships in the case of the UK, Butler argues that these legally sanctioned relationships serve to *delegitimise* alternate forms of sexual relations. She, and Warner (1999), argue that the disavowal of promiscuity through the legitimising of monogamous domestic partnerships closes down the socially legitimate possibilities of non-monogamous sexual relations. Duggan makes more explicit links between sexual practice and HIV. She argues that the attacks on 'promiscuity' posit 'advocacy of monogamous marriage as a responsible disease-prevention strategy' (2002:182). In other words, the rejection of promiscuity, or multiple sexual partners, in favour of domestic, monogamous partnerships is established within this discourse as a responsible sexual lifestyle for the low risk sexual citizen.

Changes for gay and bisexual men in the UK have not only taken place in relation to legal and social rights, but also in the ways in which certain spaces and places have been used and imagined. It is important, however, to be clear about what space and place are, and how they differ. Massey (1994) argues that space is not merely a physical entity, but is constituted by social relations: space is contingent on the social understandings and relations of the people that use or observe the space in question. Moreover, space is dynamic: meanings and experiences of space are contingent on multiple and changing temporal factors, such as time of day (e.g. day or night) or period of use (e.g. historical or contemporary). Like space, meanings of place are also contingent on social and temporal factors. Massey describes place as a particular articulation or 'envelope' (1994:5) of space-time relations. Place is often defined by geographic or other borders, but is not limited by these borders: it is constructed through the links and interconnections to that which is beyond its borders. These meanings of space and place are fluid and aware of the changing understandings and experiences of particular spaces and places. Kippax et al. (1993) have documented how space and

place play an important role both in the formation of gay communities and how these communities understand and respond to risk. For instance, they describe how place of residence and proximity to an AIDS epicentre, such as Castro Street in San Francisco or Oxford Street in Sydney, has been shown to have a direct impact on perceptions of risk of HIV and sexual practice. Moreover, they also document how a sense of a gay community is 'constituted in practices...and has been transformed over time in gay bars and discos, at gay political meetings and rallies, in 'beats' (places such as parks or public toilets where men may meet other men for sex), in homes and social gatherings' (1993:110). These social spaces and places have played an important role, therefore, in establishing a sense of a gay community, as well as responding to HIV.

Many critics have drawn links between changing sexual politics and space. Duggan observes how gay politics now operates within a 'dramatically shrunken public sphere and a narrow zone of 'responsible' domestic' privacy (2002:182). This narrowed zone has implications for judgements of responsibility, critics argue, in terms of the nature of sexual relationships, but also the spaces in which sex occurs. For instance, Bell and Binnie (2000) contend that the dichotomy of good and bad citizens results in the privatisation, de-radicalisation, de-eroticisation and confinement (spatially and legally) of dissident sexualities. They are especially concerned with the increased legal, social and physical regulation and penalisation of public sex, which includes cruising or sex in public spaces like parks, public toilets and sex on premises venues[14], such as saunas and sex clubs. While these activities have always had a precarious legal status, there is a long history and practice of sex in public spaces amongst 'MSM'. The illegality of homosexuality has meant there have been few public spaces in which 'MSM' could meet, resulting in creative 'alternatives' to traditional, domestic and commercial sexual spaces (Humphreys 1970; Chauncey 1994; David 1995). However, Berlant and Warner (1998) argue that anonymous sex in public rather than private and/or domestic spaces is also a political and erotic practice, and should be seen as an alternative or counter to heteronormative sexual culture. Public sex sites such as cruising spaces and public toilets have become increasingly monitored and/or closed down, and sex on premises venues, such as saunas and sex clubs are under increasing regulation and scrutiny (Delany 1999; Bell and Binnie 2000; Berlant and Warner 2000; Casey 2007). These

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[14] A sex on premises venue is a space where no money of any kind is exchanged for sex, and there is a private space/area allocated for sexual encounters (THT 2008).

critics argue that this legal and social closing down of public spaces is part of a homonormative sexual politics, and has significant implications for how responsible sexual practice is understood by 'MSM'.

While certain public spaces are being closed down, there are now an increasing number of commercial spaces such as bars and clubs that are legally available to men who identify as gay and bisexual to meet and socialise with other men. New spaces have also emerged in the form of virtual spaces and networks, with the flourishing of gay focused websites, chat rooms, and social networking sites. These virtual spaces have transformed the way many men find sexual partners: one can simply go online to find a sexual partner on *Manhunt.net* or *Gaydar.com* in addition to or instead of heading to a local cruising site or gay bar (Race 2010; Davis 2010). Moreover, Race (2010) has argued how online spaces allow for new ways of disclosing HIV status to potential sexual partners, of engaging with a potentially more diverse community of men, and offers new ways of implementing sexual health education interventions. As outlined throughout this section, the legal changes and increasing rights have important implications for what is socially responsible in sexual practice and sexual 'lifestyles.' Not all 'MSM,' including those who took part in this study, may be aware of or involved in these dramatic debates in sexual politics. However, many in the gay 'community' are likely to have been affected by the legal, social and spatial changes as well as the social and cultural responses to these changes. As a result, these factors will be explored in relation to participants understandings of and responses to risk in sexual health.

Imagining Community

As this thesis aims to explore the ways in which sexual practice is embedded in the social in its exploration of risk, it is important to unpack the well-used notion of community in relation to gay and bisexual men. In particular, it is essential to consider what community means, how it has changed and the implications it has for notions of identity, responsibility and responses to risk. Community refers to more than a group and, in the case of a gay community, is often invoked to refer to groups of men who have some attachment or connection to each other, generally on the basis of their sexual

identity as well as on shared values and norms. It is often drawn on by political activists, claiming to represent the interests of a set of sexual citizens (Watney 2000) and by health promoters who plan sexual health interventions in 'the community' or who employ community development approaches (Deverell and Prout 1995). The history of HIV, as outlined earlier in this chapter, has also relied on the notion of a gay community: Kippax and Race (2003) speak about communitarian practices; Patton (1990) describes how the gay 'community' invented safer sex; and Watney (2000) discusses his involvement in gay community activities in response to HIV. However, the meanings of community in relation to gay men are complex and contested. Dowsett (2009:226) explains how the 'gay community has never really been a singular, unified phenomenon; it has always been a point of debate and complaint, pride and mobilization.' Holt (2011) argues that the notion of community has long been problematised, citing evidence of gay men who may be unwilling or unable to identify with a gay community. Moreover, Holt demonstrates the contradictory ways in which gay and bisexual men relate to community. Yet this has not stopped reference to or reliance on notions of community throughout the history of HIV of the 1980s and 1990s or gay liberation of the 1960s and 1970s. Nor has it prevented some gay men, and those working in sexual health, to lament the loss of a 'real gay community' where men once came together to overcome adversity and ill-health (Holt 2011). This nostalgia for a gay community that is lost, or perhaps, that never was, does not mean that the idea or understanding of community is not valid or important. Kippax et al. (1993) have documented the ways in which sexual practice is informed by its social location, and how this can include a sense of community. However, the ways in which individuals relate to and are influenced by a sense of community are not straightforward, nor is this relationship inevitable. For instance, one may identify in a particular way, but may not identify with the referent community. It is important, therefore, to consider how community is – or how communities are – imagined, how this impacts on perceived membership of a particular community as well as what role this imagined community and membership has on sexual practice.

In his study of nationalism, Anderson argues that:

> All communities larger than primordial villages of face-to-face contact (and perhaps even these) are imagined. Communities are to be distinguished, not by their false/genuineness, but by the style in which they are imagined.
> (2006[1983]:6)

It is not necessarily the 'reality' of a physical community that is important, but the ways in which community members imagine the parameters of their own community. In other words, these parameters involve who they believe to belong, who they imagine is excluded, and what practices are shared across this community. Anderson argues that imagined communities are not infinite, but have definitive boundaries and are conceived of as made up of those with shared values and who subscribe to a sort of 'comradeship' (2006:7). For example, Watney (2000) describes how the gay community in the UK has been tied together through shared experiences of loss and homophobia, as well as through community response and resistance during the early AIDS epidemic. According to Anderson, the basis for imagining communities was originally the circulation of books, magazines, journals and newspapers. Through this shared cultural material, the representation of others in the community through culture, practice and ritual, means that the idea of community, of those beyond the 'family' or household and who might never be met, is made understandable and real. The circulation of these materials, according to Anderson, helps to solidify a notion that individuals are a part of a greater community with whom they identify and to which they are committed (Simpson 2000).

While Anderson describes how the cultural exchange and importance of representation is critical to how community is imagined, we also need to consider how the ways in which community is imagined are affected by space, place and mobility. Altman (2000) has argued that notions of sexuality are also affected by reflecting changes brought about by globalisation. In other words globalisation and the international exchange of culture and consumption through increased mobility and new modes of communication has had a significant impact on how and with whom people engage. Binnie (2004) and Puar (2007) have also explored the interconnections between sexuality, globalisation, nation and race. They have both argued that forms of sexual citizenship, and the ways in which sexual communities are imagined, are intricately tied to national values and boundaries. The interaction of this increasingly global network of sexual actors, however, has not necessarily led to a homogenous international gay community, but a shift in the way communities imagine themselves and the way they are identified, responded to and rejected. [15] Moreover, while these critics have highlighted how

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[15] Altman, amongst others, is critical of the global AIDS industry and its importation of 'western' gay identity categories into HIV programmes and funding in the Global South. For instance, see Cohen (2005)

imagined sexual communities are affected by the 'global,' we also need to consider the ways in which the 'local' continues to play an important role in how gay communities are imagined. For instance, the experiences of gay men in the UK over the past thirty years have been dramatically affected by place of residence and varying developments in the local gay scene. Casey (2004, 2007) traces the developments of the gay bars in Newcastle-upon-Tyne in distinction to how the gay 'scene' has developed in larger urban centres such as London and Manchester. The geographic isolation of the gay 'community' in the North East, in addition to a strong regional identity (Nayak 2003) draws attention to the multiple ways in which gay communities within a country can be imagined and experienced.

Where globalisation has led to a broadening of spatial boundaries, and in some cases, a reinforcing of local boundaries, Anderson's notion of an imagined community still relies on perceived boundaries and shared identity. It is important, therefore to consider who lies outside of the boundaries of this imagined community, not only in terms of geographic location, but also in terms of identity. In other words, who is excluded from these communities and on what basis? For instance, in relation to this research, it is important to consider what role identity plays in establishing membership of a gay community as well as who it excludes. As outlined in the introduction, not all men who have sex with men identify as gay and/or bisexual. In some cases, 'MSM' may identify as heterosexual and distance themselves from any association or identification with a gay community. The exclusion of these men – either through their dis-identification with a gay identity or through an active exclusion by other gay men – from an imagined gay community, can have an atomising effect. Kippax et al. (1993) argue that community attachment is complex and have attempted to measure varying modes of attachment by exploring political involvement, social engagement and sexual engagement. They have documented how men who have little attachment to a gay community can often be 'hard to reach:' they tend to have limited capacity to respond to risk of HIV in their sexual practice as a result of minimal exposure to sexual health information as well as to 'community' sexual practices. These atomised figures, isolated already as a result of their potentially socially precarious sexual identity and practice, may be hard to reach in terms of sexual health interventions or may be

on the ways in which western categories of sexuality have been negotiated in HIV and sexuality work in India.

unaware of 'community' sexual practices. While this does not necessarily mean that those men who identify as gay and appear to be active members of a gay community are better able to respond to risk of HIV, research by Kippax et al. has demonstrated how an increased association with a gay community beyond sexual engagement can affect sexual practice and responses to perceived risks.

This sense of imagined community, therefore, is not just important in terms of identity, but also in terms of perceived social norms and community practice. For instance, Dowsett (2009) describes the ways in which the uptake of safer sex practices on a community level in the early days of HIV highlights the importance of an imagined community:

> In the sustaining safe sex period (roughly from 1983 to 1993, I would argue), growing a commonly understood and practised safe sex culture was a social intervention that spoke to gay men's sexual lives collectively. It was about collective obligation and expected comportment as a member of a gay community. All the risk reduction encodings that followed negotiated safety have increasingly been less social, at best interpersonal, for example, strategic positioning, but mostly individualized behavioural formulations, for example, viral load assessment. This process may share characteristics with the concomitant individualisation drive of neo-liberal late modernity; but, so reified, these encodings disestablish the practices of sex from these 'identities and belongings' – from the politics of gay sex – and the social is lost (2009:235-236).

Dowsett argues that the uptake of safer sex was only successful because of its appeal to a sense of community and its demand that community members consider both their responsibilities and actions within this framework. For Dowsett, the importance of community and of the social practices within communities is made clear as the 'success' of community-focused risk-reduction practices begin to break down with the introduction of more individually focused risk reduction strategies. The focus on the individual, although embedded in a broader neo-liberal drive, meant that the politics and the social – both integral to an understanding of a gay community – were lost in sexual health interventions. While Dowsett is highly critical of individual focused risk reduction strategies and argues that the social is critical in HIV reduction amongst gay and bisexual men, he is not arguing for consideration of community which ignores 'complex sexual cultures' (2009:236). Where Holt (2011) points to a documented ambivalence to the concept of a gay community by gay and bisexual men, it is unclear if the shared understanding of community has changed. In other words, when men report

ambivalence with or rejection of the gay community, are they talking about their local community or a broader gay 'community'? Are they talking about a community of the 1980s or of a community situated in the twenty-first century? Is the community which responded to HIV, in fact, the only community that is possible or that can be imagined? Or can there be new forms of community – or new communities – in an era of increasing rights and equalities legislation? What forms do the gay community take now with the above described shifts in sexual and spatial politics? Moreover, how do communities form or change with access to virtual spaces? How do different generations of gay and bisexual men imagine and respond to – or create their own – community norms and practice? What kinds of political and social communities are included or excluded from an imagined gay community?

Dowsett (2009) argues that research and health care need to engage with 'gay men's sexual cultures as ongoing, multiplying, ethical and ever-changing erotic constructions' (2009:235). This means acknowledging and responding to the multiple understandings and experiences of the epidemic which are 'refracted though serostatus, age and generation, race/ethnicity, social inequalities (within countries and internationally),' (2009:235) and which are also situated within real political and social change over the past thirty years. Moreover, he argues, there needs to be an acceptance that multiple standpoints do not point to *a lack of* community anymore than any one standpoint can be taken as a gay community consensus in relation to HIV. Dowsett thinks that, despite the move away from a collective, community approach in health promotion and in sexual politics, researchers need to develop a stronger understanding of social norms and community practices and recognise the multiple ways in which gay communities are imagined and how they can be re-engaged in sexual health interventions. In response to Dowsett's argument, this research acknowledges the importance of community in sexual practice for gay and bisexual men but will not use the term to refer to one homogenous group of gay men. Instead, this research will employ the term community to explore the ways in which participants imagined communities, community sexual practice, the degree to which they felt they were adhering to norms of this sexual practice, and what they thought about the perceived community sexual norms. Moreover, it will consider how these imagined communities and perceived norms of community practice will have been influenced by experiences of age, history, space, place and serostatus.

Imagining a Biosocial Community

This chapter has explored the ways in which the social and biomedical are important factors in understandings of and responses to risk. In particular, this chapter has detailed the ways in which biomedical developments have shaped individual and community responses to risk. However, community responses have also contributed to the ways in which illness has been understood by 'MSM.' In this way, the social and biomedical are not separate factors, competing to influence individual's perceptions of risk, but work together to constitute the ways in which the biomedical is incorporated into the social and vice versa. I have also demonstrated the ways in which identities and communities can play an important role in the sexual practice of 'MSM' as well as in notions of responsibility for ones' – and others' – health. This study will explore the ways in which identity, community, biomedical and social constitute understandings of and responses to risk amongst 'MSM.' With this in mind, I suggest that one way of exploring how 'MSM' negotiate these factors within their sexual practice is through an exploration of an *imagined biosocial community.* We can think about an *imagined biosocial community* as a community *of* gay, bisexual and/or men who have sex with men who are *affected by and at risk of HIV*. That is, this is not about *all* 'MSM' but a community *of* 'MSM'. Rabinow's (1996) concept of the biosocial considers how collective identities are formed, placing its emphasis largely on the biomedical marker of illness or being *at risk* of a particular illness. The medical and social discourse around and the 'community' responses to HIV has reiterated how 'MSM' are perceived to be at high risk of HIV infection. I would suggest that this group of men has been or is living with a heightened sense of being or assumed to be at risk of HIV on an everyday level and which *may* be absorbed and employed in sexual practice. Where the biosocial was originally intended to explore experiences of genetic risk and identity, I have demonstrated the ways in which the experiences of 'MSM' and their relationship with HIV might be considered in a similar way: the ongoing demand to test regularly for HIV; the assignation of an identity to those who test positive for HIV; the ongoing monitoring of viral loads of those HIV positive individuals in an attempt not only to maintain their health but to 'protect' the health of their sexual or other partners. This does not mean that the experiences of 'MSM' are solely determined by HIV, or that every 'MSM' will be concerned with or even affected by HIV. However, I would suggest that this approach might allow us to question and interrogate the relationship this particular group of men has in relation to biomedical risk of illness – including HIV

and syphilis – and the ways in which this relationship is perceived and negotiated. By considering the dynamics of an *imagined biosocial community*, this research can explore how biomedical and sexual negotiations are situated in a broader history of illness, sexual politics and community and unpack the ways in which sexual identity may or may not be important to understandings of risk in sexual practice. While this concept may not be applicable in all instances of the research – indeed Rabinow argued that the biosocial is not an inevitable outcome of genetic identities and groupings – it will be a theme that is explored in this thesis as a way of interrogating the social, biomedical, identity and community issues which emerge in relation to risk.

Conclusion

This chapter has sought to make sense of the broad theoretical and historical areas relevant to this study, and in doing so, provides a broad framework through which the research questions will be addressed. Recalling that the research questions for this study ask what 'MSM' understand as a risk in sexual health, how they respond to these perceived risks and what influences these understandings of and responses to risk, this chapter has outlined how four broad areas will be considered. Firstly, by drawing on critiques of epidemiology and on sociological understandings of sexuality, I have argued that an exploration of sexual practice – rather than sexual behaviour – will provide a more nuanced and productive analysis of risk in sexual health. This approach considers the ways in which the sexual *is* social and therefore views the ways in which risk is understood and responded to are not limited to the individual. Secondly, in reviewing the research on risk and 'MSM' in relation to HIV and syphilis, I have established how risk is not static but is socially constructed and is influenced by historical, spatial, geographic and cultural factors. This study will therefore consider the multiple meanings of risk in relation to the sexual health experiences of 'MSM.' Thirdly, I have traced the ways in which public health responses to HIV in the UK shifted from treating risk as a community-based concern to targeting risk managing individuals. The third section then explored how broader notions of responsibility in relation to individual and community understandings of health are embedded in responses to risk. This thesis will explore the ways in which participants negotiated understandings of responsibility in sexual practice and how this responsibility was framed by notions of identity and community. The last section of this chapter not only

charted the legal and social changes for gay and bisexual men in the UK, but considered how this has made a significant impact on sexual politics and understandings of responsible sexual practice. Given the dramatic ways in which the understandings and experiences of community for gay and bisexual men have changed over the past thirty years, this research will explore how understandings of and responses to risk are affected by perceived and changing community sexual practices and norms. The following chapter outlines the ways in which this approach to the research was practically implemented.

Chapter Three – Methodology

Introduction

Quite early on in the research process, I was asked by a researcher at Newcastle University why I wanted to conduct this study. This colleague explained how she was surprised that a woman had chosen to undertake research on gay and bisexual men's sexual health. She was fascinated by this choice and wondered why I might be interested in doing a study like this, especially as it would involve somewhat intimate conversations about sexual practice with not only strangers but with gay men. Why, she asked, would I want to conduct research on such a personal and potentially 'scary' topic? This brief conversation highlights not only the range of ethical and methodological issues inherent in this research, but also draws attention to the many assumptions around 'who' should do research on 'which' topics and 'how' this research should be done. While the gender of the researcher and participants was seen as a critical issue, what was also striking about this encounter was the reaction to the subject itself: sexual practice was seen as a personal or private topic that people are often afraid or embarrassed to talk about. This, for some people, is made even more 'scary' if the sex is between two men and the person doing the research is *not* a gay man. This encounter was only one of many similar reactions to this research and demonstrates the ways in which heteronormative and gendered assumptions are embedded in the politics of talking about – and researching – sex. These and other issues posed particular challenges to this research and demanded careful consideration throughout the research process. I felt that it was important to address not only the potential sensitivity of the topic area, but also to consider how these concerns and assumptions might play a key role in how researchers, sexual health services and gay, bisexual and/or men ('MSM') might construct ideas around risk. This chapter explores the epistemological, ethical and methodological issues that were dealt with throughout the research process and considers how they shaped the research findings. It will initially focus on the approach to the research, the ways in which the research was conceptualised and how it was practically implemented. It will then describe and comment on how the field work went, including recruitment and in-depth interviewing, and explain how the analysis phase of the research was conducted. The chapter will also comment on the importance and/or difficulties of working with research partners in this study and what this contributed to

the overall research, including analysis and dissemination. Finally, ethical issues are explored in the last section, in addition to being embedded throughout the chapter.

Approaching the Research

Researching in Partnership

I had some concerns with this research project when I applied to be the PhD student researcher. I thought that it would be both challenging and rewarding especially as it was a CASE studentship with non-academic research partners. My initial concerns in this area were two-fold: I was excited about the possibility of working with research partners; and I was also anxious about working within a public health or clinical environment. I was excited to work with research partners because the research would ideally respond to issues faced by sexual health practitioners and it would feed back into local practice and policy. Having research partners meant not only the potential for practical support in recruitment and necessary administrative obligations, but also the possibility to engage in dialogue about the research issues. Ideally, these would be partners who could help facilitate the dissemination and uptake of the findings. I hoped that it would be a mutually beneficial relationship. I was aware of the many problems researchers have encountered in working with non-academic research partners and knew that partnership would involve certain obligations and potential problems, requiring additional resources to manage these relationships.[16] However, I felt that the investment would be worth the return to the research: having research partners meant that the entire research project – including the design, fieldwork, analysis, and dissemination phases – would need to be connected in some way to the practical concerns of the partners and would therefore demand consideration of how the research and its findings could be shared and applied in a sexual health services context.

While the formal non-academic partner was one Primary Care Trust (PCT), the total number of partners included three PCTs who had financially contributed to this research and with whom I had a formal relationship. In addition, I worked with a number of organisations who did not contribute financially but who did cooperate with and

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[16] This was made clear in a training session at Newcastle University, run by the Faculty of Humanities and Social Sciences in Autumn 2007. This session included two CASE studentship holders, who spoke about their experiences with research partners, funding and balancing the research/work relationship.

contribute to this study. The research therefore required the cooperation and collaboration of multiple formal and informal research partners.[17] The range of partners involved in this research and the requirements of these partnerships meant that it was important to establish formal mechanisms to include them in the research process. This primarily took the form of an advisory group that would meet regularly throughout the study.[18] While the advisory group was established early on in the PhD, it was important to begin building up a picture of local sexual health concerns, especially as they related to this research. I spent January to April 2008 meeting individually with advisory group members and other key contacts to find out more about what they did in their daily work, what their concerns were in relation to the research topic and what they wanted to see come out of this research. These conversations were illuminating in terms of local health politics between the PCTs, specific sexual health concerns around 'MSM' who have syphilis and HIV and, more practically, in terms of the sexual health interventions, practices and policies that were relevant to the study. However, these meetings also signalled the beginning of the important individual relationships with advisory group members and partners. They allowed for questions relating specifically to the research issues as they were seen locally, but also enabled partners to learn more about me, my background, my research experience and my motivation for taking part in the research. While many members explained that they were involved in the research because it was being carried out in the North East, these individual meetings also helped to cement my credibility and commitment to the research and garnered considerable support, trust and access throughout the research process.

It was important for advisory group members and partners to be invested in the research, not simply because it would help with the research on a practical level, but

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[17] North Tyneside Primary Care Trust was the formal partner on the ESRC CASE agreement. However, two additional Primary Care Trusts – Newcastle and Gateshead – financially contributed to this research and were involved throughout the research. Finally, MESMAC NE did not contribute financially to this scheme, but were critical partners as the main gay and bisexual men's outreach organisation in the North East. Moreover, each of these organisations were involved in the HPA chaired Syphilis Outbreak Control Task Force, a group which met bi-annually to share information on syphilis prevention and treatment activities. This group was an important stakeholder in the research.

[18] The membership of this group varied throughout the research as NHS staff retired or changed positions. Advisory group membership included: Professor Vivien Hollyoak, (North Tyneside PCT) who retired in December 2008; Dr. Helen McIlveen, (North Tyneside PCT); Nikki Jeffries and Kathryn Kain (Newcastle PCT); John Lawson (MESMAC North East); Sheron Robson (Gateshead PCT/Strategic Health Authority); Alice Wiseman (Gateshead PCT/NE Government Office) who joined the advisory group in 2008 replacing Vivien Hollyoak; and Mark Oddy and Steve Paske (Gateshead PCT) who joined the group in 2009 when Sheron Robson moved to the Strategic Health Authority.

also because this research project was intended to feed back into sexual health service practice and policy: this was also one of the overall aims of the CASE studentship and a motivating factor for my participation in the research. Initial meetings and ongoing discussions with partners established their concerns, but also provided insight into how the research could be practically undertaken and the ways in which the research findings might be received by sexual health services in the region. Consequently, both formal and informal research partners were considered important in the study and consulted throughout the research process. It was within this context that the research was designed. In addition to exploring what others had researched in this area, and considering the various theoretical and methodological approaches to the topic, the specific issues and concerns expressed by partners played a significant role in the aims, design and implementation of the research. For instance, after discussions with colleagues at MESMAC, it was agreed that recruitment should not just take place in sexual health clinics, but should be much broader, to include public sex environments, community workshops and commercial spaces. The potential tensions between the academic demands of a PhD study and the practical concerns of sexual health services might have thrown up considerable barriers to conducting this research. However, despite a few difficulties in access and research approach,[19] I found that managing a research project which sat between these two 'organisations' provided an exciting and productive space where I could both learn from and push the boundaries of each 'institutional' approach.

While the research was developed within this partnership framework, it was also designed with a sociologically critical approach to sexual health and the epistemological approach that might be expected of the research by partners. The research could have quite easily adopted an epidemiological approach to sexual health, one which has driven many sexual health policies in the UK. That 'MSM' are seen to have higher than average rates of HIV infection has, until now, meant that additional resources, interventions and services have been targeted at this particular population group

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[19] I will explore some of these later in the chapter, but examples include: difficulties in getting 'permission' to recruit in clinics from some health professionals who were not entirely supportive of the benefits of qualitative research; limited access and time given to recruitment by health staff in clinics; and criticism around the limitations of qualitative sampling and the impact this had on findings.

(Hickson 2011).[20] While 'MSM' do continue to have the highest prevalence of HIV in the UK, as outlined in the previous chapter, epidemiological approaches to sexual health do not take the social and cultural context of sexual encounters into consideration and frame health 'problems' in terms of risky behaviour. Although the range of partners, including clinical staff, community development workers and broader health management, meant that they did not share exactly the same ideas, most were largely concerned with the reduction of perceived risky sexual behaviour, rather than an exploration of sexual practice. While this study was concerned with the research interests of partners, it was also designed to consider how risk could mean much more than how it was defined by public health. Instead, it was designed to explore how risk was defined and identified by the men themselves and how it fitted into their everyday sexual practice, not in an attempt to better educate or correct their ideas, but to explore more widely what risk in sex was and what it meant.

Exploring Sexual Practice

Given the aims of the research, the study needed to be designed in a way that would explore personal and intimate facets of men's lives. This did not necessarily mean that men would not be willing to share some of their experiences, but that the methodology needed to be sensitive to the ways in which information was collected. In addition, it was important to acknowledge and accept that this research would not be able to 'know' everything about these men's sexual experiences. Denzin and Lincoln (2011:4) outline how qualitative research relies on a wide range of methodologies and 'interconnected interpretive practices, hoping always to get a better understanding of the world. It is understood, however, that each practice makes the world visible in a different way.' In other words, any methodology would always only provide a partial version of sexual practice. For instance, during a conversation with a member of faculty, he suggested a research design that would involve men keeping diaries and engaging in multiple interviews over the period of a year, which would aim to 'capture' particular experiences or times where they identified risk, responded to risk, or which changed their minds or influenced their perceptions of risk in sexual encounters. However, this approach was based upon a concept of empirical research that aimed to measure how

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[20] This information was reiterated in conversation with Sheron Robson, then Sexual Health Lead, Gateshead Primary Care Trust, who was a member of the research advisory group.

certain encounters might impact on sexual practice. Moreover, this research was not about 'capturing' actual experiences, but exploring the meanings of experiences and emotions in sexual encounters and sexual practice *with* research participants. Accepting the partiality of gaining 'knowledge' was an important element in establishing the relationship between myself and the research participants. As Judith Butler comments:

> As we ask to know the other, or ask that the other say, finally or definitively, who he or she is, it will be important not to expect an answer that will ever satisfy. By not pursuing satisfaction and by letting the question remain open, even enduring, we let the other live, since life might be understood as precisely that which exceeds any account we may try to give of it. If letting the other live is part of any ethical definition of recognition, then this version of recognition will be based less on knowledge than on an apprehension of epistemic limits (2005:42-43).

In accepting that one can never truly 'know' the other, it was important to engage with what participants might share *with* me. This meant that the research process would be one that both I and the research participants shaped. In taking this approach, the research could ask critical questions around sexual encounters in a way that was non-judgemental of sexual practice and was accepting of what people wanted to and could share.

The research 'problem' was broadly framed and the qualitative research methods established in the project proposal. But there was still scope within which the qualitative methods could be shaped and conducted. Jennifer Mason explains that many researchers 'assume that their study will involve qualitative interviews' but the choice must have an epistemological, ontological, methodological and/or political basis (2002:63-64). In-depth, semi-structured interviews were established as the primary methodology of the research for two broad reasons. Firstly, the aims of the study and the research questions clearly played a critical role. The research was exploring experiences of risk amongst 'MSM,' a sensitive topic. Semi-structured interviews have proven to be a very effective means of getting people to talk about 'sensitive' research themes such as sexual beliefs and practices (Plummer 1994). Given the research would involve discussing topics such as sexual practice, identity and health, this type of interview would allow the creation of a 'safe space' to talk about these issues. Semi-structured interviews using a general set of questions or interview guide would enable exploration of key research themes and provide the flexibility of responding to stories,

following up on particular issues and seeking clarification of meaning and understanding. This open approach to the interview, however, would be balanced by guidance or structure from the interview questions. For instance, issues of illness, death, loss and trauma had the potential to emerge in these interviews. The semi-structured approach could provide a sensitive way of closing down painful feelings and moving onto other questions when appropriate. Not only would the structure of these interviews permit individual adaptation to each participant's needs and comfort levels, it could also be used to develop a personal rapport with each participant. I assumed that the subject of the interviews would not necessarily be a topic that was normally talked about and that I would need to engage in this topic slowly, working up in the interview to perhaps more emotional or personal issues. The flexibility of this methodology provided the opportunity to judge when and when not to explore particularly sensitive, emotional or upsetting issues. Embedded in this approach is the notion of a reflexive interview, and the recognition that the interview is a joint product and a shared experience (Bornat 1989; Thomson 1998). It is created by both the participant and the interviewer, whose positions, aims, responses, and relationship play an important role in the finished interview. An interview that was active and reflexive (Holstein and Grubium 1995; Mason 2002) would help create a safe space within which sensitive issues could be explored.

Secondly, while the research aims guided the selection of semi-structured interviews, particular ethical and theoretical concerns also played an important part in this selection. I wanted to conduct research that did not view participants as *objects* of study, but as *subjects* of study. While there is sometimes a fine line between the two approaches, I was concerned that the men's experiences and perspective not be reduced to '7 of 10 men said X' even if they were one of a larger number of participants. Other qualitative studies that relied on interviews but worked with only short answers did not explore personal, situational and changing meanings of sexual encounters in as much depth as required for this study (for example Clark 2001; Bellis 2002; Elford et al.; 2004; Hickson et al. 2007). In addition, these types of studies which try to describe the broad sexual behaviour or large groups of people by relying on short answers are unable to unpack the underlying meanings of terms, phrases and practices and often rely on the above described public health definitions. It was important that the research critically question these very definitions and consider how risk was understood in a range of

sexual encounters. It was decided that this would best be achieved through the more in-depth and hopefully meaningful engagement with study participants.

Research Design

Ethical Approval

Anyone conducting research within the NHS is required to seek formal ethical approval from one of the NHS Local Research Ethics Committees (LRECs) (NPSA 2011). Given this research involved working with NHS service providers, with part of the recruitment taking place in sexual health clinics, the research required ethical approval from an LREC. The extensive application required a complete overview of the project including methodology, recruitment methods and details on how the research would address any ethical issues. The completion of this application was aided by advice from research partners, supervisors and other colleagues, an NHS-run training course and a postgraduate workshop on research ethics at Newcastle University. The application was submitted to the Sunderland Local Research Ethics Committee and I attended the committee meeting with my supervisors and a member of my advisory group on 28th July.[21] The committee asked only a few questions about the study and raised no significant ethical issues with which they were concerned. The research received formal approval from this committee in August, and approval from the North of Tyne NHS Research and Development office in September 2008. Although this application process took a considerable amount of time in developing the exact research protocol, materials and established responses to potential ethical issues that might arise, the application process and discussions with colleagues proved useful in that it meant I felt prepared to deal with both practical and ethical issues which could emerge in the research.

Interview Guide and Rehearsal Interviews

Although semi-structured interviews were decided upon as a well established way of talking about sensitive issues, I was concerned that discussions around syphilis might be difficult. Syphilis is not a new infection, but the relative silence in recent sexual health discourse around syphilis meant that men might not know anything about it, or more

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[21] Professor Diane Richardson and Dr. Janice McLaughlin and Sheron Robson, Gateshead Sexual Health Services accompanied me to the meeting.

importantly, not have anything to say about it. Many of the research partners spoke about the lack of awareness or knowledge of syphilis which they perceived amongst the men who would be participating in the research. Moreover, I was concerned that the interviews would largely focus on HIV and that this obviously significant topic might take away from or drown out discussions around syphilis. Due to this potential discursive barrier a number of strategies were explored to facilitate discussion in the interviews around an apparently 'forgotten' or 'unknown' topic. Drawing on work in participatory methodologies (Cornwall 1992; Shannon et al. 2007; Emmel 2008) and after discussions with others who had experience of using these methods, I explored using a brief mapping exercise which might engage the participant. This involved the participant writing down anything they could think of on the subject of syphilis in two minutes, either in the form of a list or a mind-map; this was meant to stimulate ideas and draw connections from one idea to the other. Once they had written their words, ideas, and associations about syphilis, they repeated the process for HIV. Having a few minutes to write down anything that came to their minds on this particular subject could have potentially worked as a starting point for the interview as well as serving as a reference throughout the interview. The aim of this initial 'brainstorming' exercise was to stimulate thoughts on a topic that was little discussed. Asking participants to write on syphilis first, and then HIV, could have helped them focus on this 'forgotten' illness, rather than be overwhelmed by the still very much present (I assumed) HIV. Moreover, having the interviewee establish a set of ideas or references to follow up on, rather than me asking about particular illnesses, might also reduce any anxieties around being asked 'scary' or overly 'personal' questions. If the participant could identify a story or association with either syphilis or HIV from their own experiences, it was thought that it might facilitate a more relaxed and familiar discussion.

Before attempting this activity with participants, I tested it out with two friends on separate occasions. On both occasions, each friend struggled to come up with ideas about syphilis, but eventually did write something on the sheet of paper, although both had no problems writing down ideas about HIV. Both were concerned to about writing down the 'right things', despite my instructions that it did not matter what they wrote. When I asked about the particular words or phrases they had written, the discussion was very stilted. In some cases, the person was defensive or anxious that they had written the wrong thing or did not really know much about what they had written. What they

wrote was not a personal experience and they felt they could not say very much about it. But perhaps the most important discovery in these exercises was that I did not know how to respond to what they had written. I was surprised about some of the things that were raised, and in some cases did not understand how what was written was related to the topic in question. Fearing that they had written the wrong thing, and seeing my hesitancy in asking questions or understanding what was on the piece of paper, meant that the flow I had hoped might be provided by this initial exercise not only did not take place, but also made a potentially awkward topic even more awkward. While my initial idea had been in part inspired by brainstorming exercises that had taken place in some workshops, which helped stimulate ideas and discussion, my inexperience with this activity and the potentially further awkwardness that this could bring to the interview meant that it should not be included. Moreover, it made me aware that the ways in which I think and am prompted to talk about certain topics is not the same for everyone and that this exercise might be too broad for some participants. It was important, therefore, not to impose my own way of thinking on the structure of the interview.

Having decided on semi-structured interviews, I developed an interview guide that focused on key areas of exploration, but which also allowed for flexibility (See Appendix A). Establishing the main areas to explore, a draft interview schedule went through multiple revisions in consultation with supervisors from March to November 2008. I tried to establish a broad framework for the interview, identifying key questions or areas of exploration, with subsequent or follow-up questions. I found it very difficult to 'narrow' down the questions to only a few per theme, out of fear of shutting down or missing any potential avenues of exploration. The interview schedule, however, was not a script to be strictly followed, but a guide that provided prepared questions and reminders of the areas to explore. At the same time, it allowed for new questions in direct response to participants' answers and stories (Mason 2002). Still wary of the sensitivity of the subject and concerned not to 'jump' into highly personal questions, the interview and each main thematic area were started with questions to participants about what other gay and bisexual men thought about the topic. It was suggested that asking men about what others thought or did would allow respondents to talk about others and themselves in relation to others. In this way, the men could be asked more generally about the sexual practice and attitudes to risk of the men that they knew, with follow up questions about their own perspective. This approach enabled participants to be

reflexive about their own practice while at the same time describing their sense of and relationship with community norms.[22]

After multiple drafts of the guide, I conducted two rehearsal interviews. A pilot interview was not conducted at this stage for a number of reasons. Firstly, I was unsure of the interview schedule and wanted to try out the questions with others to get direct feedback on how clear the questions were and what sort of response they might elicit. Secondly, I wanted to practically try out interviewing people around their sexual practice. While I had conducted interviews before on HIV prevention and sexual rights, I had little experience talking to people about their personal sexual encounters. It was important to ensure that my interview technique was not only effective in questioning and listening, but also that I was able to 'handle' the intimacy of the topic. My approach to the research topic was that sexual practice in general was nothing to be embarrassed about. However, it was important to make sure that this was the case in practice. The rehearsal interviews were conducted with people who would not be part of the research sample because of access issues, as well as the limited sample from which participants in this study would be drawn. The first rehearsal interview was conducted with a colleague who 'performed' the role of a gay man from the North East. This early experience did not go well. I was surprised by some of the responses and thought the tone of the interview was not quite right. The experience highlighted how some questions could easily be interpreted as stereotypical or judging and that I needed to be sensitive to particular issues when discussing sexual encounters. For instance, my colleague responded defensively about the number of sexual partners he had had in the past and expressed how he was embarrassed about this fact. Although the question was not meant to imply any judgement when asking about previous sexual experiences, the respondent had interpreted (or projected) an element of judgement in how I asked about past experiences. This pilot interview also drew attention to particular technical issues with the recording equipment that could arise. However, this experience and the reflexive conversation I had with this colleague after the interview was helpful in identifying what I needed to further work on. Subsequent to this initial interview, the

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[22] This approach worked to a certain extent. Quite a few men relayed stories about men they knew and then explained how they felt and/or acted differently. However, a small number of men responded with 'I don't know what other men think' or 'I don't know other gay men.' While this allowed me to ask them questions about themselves, or they responded about their own perspective, some of the men found it strange that I would ask about other men, and not them, thus highlighting the ways in which I would have to adapt or modify the interview schedule according to each interview situation.

schedule was revised, largely clarifying or simplifying questions. A second rehearsal interview was then conducted with a gay friend who lived outside of the North East. This interview was better, and further helped me to develop my interview questions and technique. Both interviews were transcribed, which allowed further study, in consultation with supervisors, around interview questions and technique.

Sampling

The original ESRC CASE studentship proposal described interviewing gay men and men who have sex with men (MSM). As outlined in the introduction, the term 'MSM' has the effect of masking diverse identities and cultural practices. However, it was also important not to exclude or alienate participants with the use of gay men alone. Interviewing men who identify as only gay and bisexual men seemed to miss an important group of men who had sex with other men. I decided to use the phrase gay, bisexual and/or men who have sex with other men but tried to minimise the use of the awkward and problematic acronym 'MSM' as much as possible when communicating with potential participants.[23] Where the phrase men who have sex with men was used, it was employed as a description of practice, rather than an identity or category. In contrast, the term 'gay and bisexual' was used when speaking to men in the interview context where appropriate. I decided 'gay and bisexual' might capture the majority of experiences of the men who were interviewed and that using labels that people were more familiar and comfortable with would be less likely to alienate potential participants. In fact, one study participant raised the use of the term 'MSM' in his interview and described how it was a term that nurses and doctors use when they were too embarrassed to say gay or bisexual. This experience confirmed the recognition and rejection of 'MSM' in everyday use. Although there were two men who participated in this study who were married to women at the time of the interview, both identified as gay and/or bisexual to me before the interview started.[24] Discretion was used in each

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[23] One of my advisory group members suggested using the headline 'Men Wanted' on my posters and brochure to capture the attention of potential recruits and to not be limited by identity labels. He suggested that I then ask: 'are you a man who has sex with other men' as way of further clarifying who I wanted to include. He suggested that men who did identify as gay and/or bisexual might find this question amusing, whereas those who did not publicly identify as gay might still recognise themselves in the recruitment criteria. See Appendices C, D, E & G for recruitment brochures, posters, and other advertising material where I used this terminology.

[24] Interestingly, the two 'married men' and one bisexual man who took part in the study all felt it important to identify themselves as not straightforwardly gay at the very beginning of our research relationship, either in person at the start of the interview, or on the phone when they introduced

interview situation, following the lead of the participant and their use of gay, bisexual or other terms.

The initial sample target was between twenty-five and thirty participants. It was hoped that this number of participants – each participating in one to two hour interviews – would provide enough diversity and range of experience that could be dealt with within this study. Participant criteria included 'MSM' from the North East of England who lived, worked, socialised or used health services in the region. The recruitment area was purposefully made broad because of the nature of the North East and the ways in which 'MSM' used the space. Most commercial 'MSM' spaces, including bars, saunas and businesses, were located in Newcastle-upon-Tyne. Moreover, the highest rates of syphilis and/or HIV were recorded in Newcastle and Gateshead PCT areas (HPA 2011a). However, 'MSM' who access these commercial venues and/or health services lived across the region. It was important not to limit participation only to those men who happened to live in these three PCT partner areas (Newcastle, Gateshead, North Tyneside) as this would limit the participation to those who chose to or could afford to live in these particular areas. While the recruitment material included a broad geographic area, practical issues regarding breadth of recruitment activities focused on partner PCT catchment areas. As explained above, although not all men lived in these areas, there was high participation in economic, social, cultural and health activities in these areas by a wider range of people. Thus the decision to focus on these areas in terms of recruitment, but to widen the geographical boundaries in the participation criteria, was based on these factors. Although home addresses were not requested, participants in this study described themselves as largely from Newcastle, Gateshead and North Tyneside PCT areas, as well as from County Durham.[25] While many were originally from the North East, participants included men who had lived outside the North East for a number of years and men who had moved to the North East from elsewhere.

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themselves to me. I felt this highlighted their assumptions – and mine – about who might take part in a study of this nature.

[25] It should be noted that these four areas represent a small geographic area in a geographically extensive region.

It was hoped that seeking a diversity of participants from within this geographic area would provide a rich data-set to explore the research questions. In particular, this study sought the participation of 'MSM' with a range of experiences in order to examine: changing perceptions of illness, especially given the availability of HIV treatment and subsequent changing health advice; variation in relationships with gay communities in terms of identity, but also changing relationships with and meanings of community over time; and changing and different experiences of and attitudes towards the physical, social and emotional context of sexual encounters and relationships. As a result, the study prioritised recruitment methods, detailed in the following section, which targeted a range of men in terms of social and sexual context, varying engagement with community, experiences across different time periods and experience of different kinds of relationships. Moreover, the study aimed to include a range of men in terms of age, class, ethnicity and disability. However, preliminary discussions with research partners highlighted a lack of specifically targeted recruitment options, such as groups or organisations that were both gay (or MSM) *and* people of colour or class-specific (i.e. working-class clubs). Moreover, certain spaces might be seen as unsafe to be recognised as gay (Bell and Valentine 1995). Given the need to recruit 'MSM', the study prioritised recruitment activities which focused on gay specific and/or health venues, as these were considered the most likely to result in 'MSM' respondents. Inclusive language[26]was used within these targeted recruitment activities in an attempt to be more inclusive. Participants' experiences of their own racialised and classed positions emerged throughout the interviews and will be commented on throughout the thesis. While class was not explicitly explored as a variable, participants' own racialised positions – or 'whiteness' – is briefly addressed in relation to regional identity and place, in Chapter Six.

No specific quota of HIV positive men or those with infections of syphilis as participants was established because the research questions demanded a much broader exploration of experiences with and without infection. It was important to include men with a range of experiences with infection in the study, but disclosure of HIV status and/or syphilis infection is an incredibly stigmatised and sensitive issue; it was agreed

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[26] The material on the website and the recruitment brochure (See Appendix C) included the phrase: would welcome responses from men of all backgrounds, regardless of age, disability, race, religion, belief or class.

that demanding disclosure of HIV and/or syphilis infection was not ethically or practically conducive to recruiting participants or conducting interviews. In addition, I undertook a multi-pronged recruitment strategy that included recruitment through sexual health clinics as well as through commercial gay venues, which I hoped would result in a wide range of participants. Two participants – both over the age of 40 – disclosed their HIV status to me in the interviews. Five participants reported they had contracted and had been treated for syphilis; four had contracted syphilis in the last ten years; one had contracted syphilis in the 1970s; two of the four men who had recently contracted syphilis, discovered they had syphilis at the time of their HIV diagnosis. All other participants described themselves as HIV negative, although one participant explained that he had never been tested for either HIV or syphilis.

The original research proposal included a sample of men aged 20 – 45. This was largely due to the high levels of syphilis and/or HIV amongst this group of men. Research partners were eager to point out, however, that men outside this age group were of equal concern to them, as these men had lower rates of attendance at GUM clinics and it would be of wider interest to explore how men of varying ages identified and responded to risk. Moreover, given the social constructions of HIV, as detailed in the previous chapter, a wider age range would allow for explorations of experiences across different time periods. It was therefore decided to widen the age group of potential participants to men 18 years of age and older. The exclusion of participation of men under 18 in this study was for two reasons. Firstly, the experiences of men under and over 18 were viewed as very different and beyond the scope of this study. This research aimed to explore the perspectives of adult men and including men under the age of 18 would have required a different approach in terms of recruitment and interview focus. Secondly, a colleague in the same department had begun conducting research with gay and lesbian youth and was recruiting participants from the same geographic area. Although the age group of our participants overlapped slightly, it was decided good practice to try and draw a boundary between the two research projects, especially in an attempt to minimise the participation of respondents from an already well-researched demographic group.

Based on the changing and significant experiences of HIV over the past thirty years in the UK, it was considered important to try and capture the generational differences and changes in attitudes and understandings of risk. Recruitment targets were established which sought a similar number of men from three age cohorts. These cohorts were: 18 – 29 years old; 30 – 44 years old; and 45 and older. While acknowledging that wherever they were during these times – the North East or elsewhere – would have had an influence on how they would have 'lived' through these eras, the rationale for this division of ages is based on when these men had been introduced to *some* element of gay social and cultural life.[27] The time period and assumed specific social, legal and health context is outlined below.

- **18 – 29 years old:**
    - introduced to gay social and cultural life between 1997 to present;
    - HIV is a manageable chronic infection with access to ART ('successful' ART regimes began around 1997);
    - people are not (or at least not nearly as many) dying of AIDS-related illnesses because few people are developing AIDS[28];
    - criminal prosecutions of 'reckless' transmission of HIV have begun to be pursued (Weait 2007);
    - Section 28 has been repealed (Weeks 2007);
    - and syphilis has re-emerged as a sexual health concern.
- **30 – 44 years old:**
    - introduced to gay social and cultural life between 1983 and 1996;
    - HIV is untreatable and people continue to die of AIDS-related illnesses;
    - experience of what some have called 'the protease moment' (Race 2001) where the development of successful ART means that HIV becomes manageable and the development of AIDS significantly slowed down;
    - potentially part of a gay community that developed safer sex practices (Berridge 1996; Patton 2002; Weeks 2007);
    - sees the introduction of Section 28 which led local authorities to be wary of 'promoting' or teaching material about homosexuality (Carabine and Monro 2004);
    - and syphilis is not a wide public health concern.

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[27] This rationale is based on the notion that these men, who would have turned 18 at some point during each of the specified time periods would have been considering their own sexuality at this time. It does not assume that participants will have come out at the age of 18 – as many had not - but that this was an age when sexual identities, preferences and practices would have been emerging.

[28] While this is generally the case, the number of late diagnoses – a person diagnosed with HIV with a CD4 count below 350, the point at which they are considered to have AIDS – has increased considerably. For instance, in 2009, 39 per cent of all MSM diagnosed with HIV were considered late diagnoses (HPA 2010a).

- **45 and older:**
  - introduced to gay social and cultural life before 1983;
  - HIV and AIDS had not yet emerged as a major public health concern;
  - part of the sexual liberation era, where gay sex is de-criminalised in 1967 (Waites 2003);
  - potential experience with previous outbreaks of syphilis in the 1970s;
  - and they may also have been a part of a gay community that helped develop safer sex practices in response to HIV when it appeared.

The age range of the final 23 participants was well balanced, with participants ranging in age from 18 to 63 years old. The three age groupings had a fairly balanced number of men from each, with a slightly higher number of men over the age of 45 (See Table 1).

Table 1: Breakdown of Study Participants by Three Age Cohorts

Age	18 – 29	30 – 44	45 & older
# of participants	7	7	9

As well as there being relatively even numbers of participants across the three broad age cohorts, participation from men across all ages was also fairly well balanced (See Table 2).

Table 2: Breakdown of Study Participants by Age Group

Age	18 – 20	21 – 29	30 – 39	40 – 49	50 – 59	60 & older
# of participants	2	5	5	5	4	2

Fieldwork

Access and Recruitment

It was expected that recruitment for this research would be difficult for a number of reasons. Firstly, as described above, the interviews focused on potentially sensitive issues that some men might find embarrassing and difficult to speak about. Secondly, it was felt that my position as a woman might deter men from coming forward to discuss their sexual practice. Thirdly, this category of men represented potentially an over-researched target group with multiple research projects on gay and lesbian experiences being conducted in the North East region, which might result in research 'fatigue' (Kippax and Race 2003). In anticipation of the potential difficulties in recruitment, I looked to the research advisory group and partners for support and ideas, and as

gatekeepers who could signal my legitimacy as a researcher to potential participants throughout the recruitment process. In addition to discussions and suggestions made by members in regular advisory group meetings, I consulted individually with them as well as with other staff in partner organisations, such as MESMAC NE and Gateshead sexual health services. Participants were reimbursed any travel costs, but it was made clear from the outset that a monetary voucher of thanks to encourage people to take part as other studies have done would not be provided. Most men did not take up this offer of reimbursement and described their motivation for participation as related to the fact that the interviews were part of an 'educational' project (i.e. my PhD) and/or that they were concerned about the sexual health of gay and bisexual men in the North East and wanted to contribute in some way to improving the sexual health of the 'community.'

A multi-pronged recruitment strategy was employed in order to maximise exposure to the target audience (See Appendix B). The first access route was direct advertising, which included hardcopy and online advertisements, posters and brochures. The second access route was via sexual health services and relied on the assistance of sexual health staff to actively recruit potential participants. The third access route was comprised of presentations at relevant meetings, workshops and events. Men also contacted the study through a 'snowball' method, as a result of their contact with existing participants. Participants were encouraged to tell their friends about the study at the end of the interview. In addition, some participants volunteered to help recruit for the study: some men asked in the interview if they could ask their friends, while others advertised the study in work, school and social locations, and encouraged colleagues and friends to also take part. A total of 28 men made contact with the project, with 23 men interviewed for this research between March and August 2009.[29] The decision to stop recruitment in September 2009 was taken due to the number of high quality interviews and good coverage of participants from across the age groups. It was felt that the data collected through interviews was a sufficient range and depth to examine the project research questions.

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[29] Five of the 28 men who contacted the project were not interviewed. These men had made contact with the project and initially expressed interest in participating, but did not respond to telephone calls or email messages when I tried to arrange an interview.

Table 3: Breakdown of Total Participants by Recruitment Route

	Route 1 Advertising	Route 2 GUM clinics	Route 3 Presentations	Snowball	Total
18 – 29	1	1	4	1	7
30 – 44	4	2	1	0	7
45 & over	4	0	3	2	9
Total	9	3	8	3	23

In the sections below, I discuss each of these methods in detail, including any barriers encountered and reflections on how they were overcome.

- Access Route 1: Direct Advertising

Following well-established recruitment techniques of direct advertising, a research brochure (See Appendix C) and poster (See Appendix D) were designed for wide distribution. These materials were made available from early October 2008 in MESMAC offices, gay bars, saunas, one gay business, and cruising sites. In large part, these materials were distributed and posted by MESMAC staff who offered to help with the research. The distribution of research material is one example where the research partnership worked extremely well. MESMAC staff were able and willing to distribute project material during their regular outreach work in places that I was either unfamiliar with or unable to access as a woman. For instance, MESMAC colleagues displayed recruitment posters in saunas and at cruising sites, which did result in respondents making contact with me (See Table 4). Moreover, MESMAC staff had an established relationship with local gay business owners and were easily able to leave material in three gay bars, two saunas and one gay shop. I was in regular email contact and met regularly with MESMAC staff to see what had been done, if more material was needed and if a change or rethinking of the recruitment strategy was needed. For instance, in June 2009, new recruitment postcards were designed (See Appendix E) to specifically target men under 30, who at that point were underrepresented in the research. MESMAC staff suggested the use of postcards, rather than brochures. They made these new postcards available in their offices, distributed them to relevant gay venues and made them available on their stall at Newcastle Pride in July 2009. Finally, short announcements were included in local LBGT publications suggested by MESMAC and other partners (See Appendix F).

Table 4: Breakdown of Men Who Made Contact with the Research via Direct Advertising

	Flyer in Bar/Sauna	*Flyer in MESMAC*	*Poster in Cruising site*	*MESMAC Website*	*Gaydar*	*Total Volunteers*
18 – 30			1		1	2
30 – 44		1		2		3
45 & older	1				2	3
Total Volunteers	1	1	1	2	3	8

In addition to paper-based advertising, online advertising was also employed, with the creation of a project website with reciprocal links to research partner sites. All recruitment material directed potential recruits to the project website, which included information on the research, participant information sheets and means of contacting me by email or telephone. After discussions with research partners, additional funding was secured from one of the PCTs to fund an advertisement on GAYDAR, an online website for men who have sex with other men (See Appendix G). It was felt that this website was well used by men who have sex with men and would provide a way of targeting men who did not regularly access more public gay spaces, such as bars or clubs or health clinics. The animated banner appeared as an advertisement to men who were registered as being in the North East and was seen for approximately 6 weeks from the end of January to early March 2009. While only three men came through as a direct result of this method, one participant described how he had seen my project advertised in other places, but it was the banner on Gaydar which prompted him to get in touch with me, reflecting the need for multiple recruitment approaches.

- Access Route 2: Sexual Health Clinics

Given the formal partnership arrangements with sexual health services, recruitment through sexual health clinics was established as an important part of the strategy. Recruitment through the sexual health clinics in the three partner PCTs was one of the primary reasons for seeking NHS ethics approval. In addition to leaving project brochures in the waiting area for people to read, this access route asked sexual heath staff to recruit potential participants from the clinic. Advisory group members facilitated contact with key staff members in each of these clinics and provided 'approval' for this collaborative recruitment route. Given the sensitivity of the research, the need for anonymity and confidentiality, and the specificity of the research criteria, I visited clinics on a number of occasions between September 2008 and January 2009 to not only

provide an introductory briefing to staff members, but also to talk to them about how it might fit into their work, to identify any potential barriers and answer any questions they had. At these meetings, I provided staff with printed material about the project, including detailed recruitment criteria and talked through these briefing materials with staff so that they did not 'cherry pick' potential recruits. Health workers were asked to approach patients who fitted the recruitment criteria, outlined in the talks and in the material I provided, as part of their regular work routine. They were asked to tell potential participants about the research and give them a brochure with my contact details. If the men were interested, health workers were able to pass on the contact details of the potential recruit to me, so that I could make direct contact[30] (See Appendix B for diagram of the recruitment process). I followed up with meetings when possible and phone conversations with key contacts to establish progress and review what might be improved. This method resulted in the least number of participants of the three access routes, with only 3 participants making direct contact with me as a result of discussions with GUM staff, and a fourth participant learning about the study at the GUM clinic, but contacting via a different method.

Table 5: Breakdown of Men Who Made Contact with the Research via Health Clinics

	Newcastle	Gateshead	North Tyneside	Total Volunteers
18 – 30	1			1
30 – 44	1*	1	1	3
45 & older	0(1)**			0
Total Volunteers	2	1	1	4

*This volunteer did not say which clinic he went to, although Newcastle seemed to be indicated**Volunteer came through Gaydar, although had seen/been told about study at Newcastle GUM Clinic

The low recruitment numbers from this route were disappointing, especially given the excellent relationship with advisory group members. There were a number of barriers to not only recruiting in clinics but also to working with health staff on a qualitative research project. Firstly, although clinic managers had approved my recruitment strategy in advance of my NHS ethics application, one GUM clinic demanded that I present my research plan to a small group of doctors to get approval to recruit from their clinic. This clinic treated the highest numbers of 'MSM' in the region and it was essential that it be included in the research. Although I was granted research access, the research was criticised for conducting a very small – and apparently insignificant –

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[30] This process of passing on recruitment contact details was approved by the LREC ethics committee and discussed in detail with the advisory group and key clinic contacts. A system of passing on details was worked out with each clinic. However, no contact details were ever passed on to me through this method.

qualitative research study. They also did not agree with staff collecting the contact details of potential participants, despite the approval of my advisory group member who arranged my research activities in the clinic. Although my key contact did supervise a number of sexual health nurses and assistants, she and other senior sexual health advisors with whom I worked were still responsible to the doctors at the senior level of management and hampered by the organisational and bureaucratic systems of this particular clinic.[31] In many cases, she was unable to respond to my requests for meetings with staff despite repeated attempts. Our many conversations would often involve her telling me apologetically that staff were too busy to focus on recruitment and that she felt she could not ask them to do any more as they were already overworked. The difficulties of working with this particular clinic continued as the apparent endemic organisational problems were further compounded by a change of premises mid-way through my recruitment phase, effectively ending what little recruitment this clinic was providing for this study. Towards the end of the recruitment phase, I attempted to spend some time in this clinic, hoping that my presence might remind staff of the research and to provide a face to the research leaflet for potential participants. This was originally suggested at the start of the recruitment phase but rejected by most staff at clinics who described it as a 'waste of my time.' Advisory group members were supportive of the idea, but I was unable to follow through with this due to conflicting schedules, the need for me to seek further approval from doctors and attend a very busy staff meeting, and ultimately, due to illness of the person organising these activities.[32] The problems of working with clinical staff were not limited to this one particular clinic. Staff at all three clinics, despite agreeing to help with the recruitment, were often too busy to include a brief talk about the research with patients or would simply forget about the research. One contact from a clinic admitted to forgetting about the research and suggested that I call her on a weekly basis to remind her about it. This same contact also felt that it was not appropriate to leave the research brochures in the waiting room because the clinic also worked in family planning and young families might be offended by the research focus. Finally, contact with any of the staff at clinics was made difficult by poor channels of communication as clinical staff did not regularly respond to emails, telephone calls or telephone messages.

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[31] Other sexual health clinics that were not doctor led proved less problematic in terms of getting approval and in speaking to staff.
[32] I had also, by this point, recruited sufficient numbers of participants through other recruitment activities.

- Access Route 3: Presentations

This recruitment method involved making short presentations about the research to men at relevant meetings, workshops and events and providing them with research brochures. Presentations would generally take no longer than 5 – 10 minutes, although in some cases I would stay afterwards to allow men to speak to me about the research on an individual basis. Examples of meetings and events that I attended included an HIV positive men's group, a young men's sexual health group, a gay and bisexual men's community group, sexual health training workshops and a stall at Newcastle Pride. Unlike the problems described above, my participation in meetings and workshops were well facilitated by non-clinical sexual health staff and MESMAC employees. Working with these key staff members proved an invaluable experience, as they suggested activities they were involved in, helped coordinate my presentations with event schedules and actively supported me throughout the meetings. This route proved a useful method of recruiting men. In some cases, the men who came forward at these presentations were already aware of the research and said they had 'been meaning to get in touch with me.' My presence at these meetings provided the incentive and/or opportunity for these men to participate.

Table 6: Breakdown of Men Who Made Contact with the Research via Presentations

	Community Events	Presentations at MESMAC	Presentations in NHS Community Services	Total Volunteers
18 – 30	1	2		3
30 – 44		1	1	2
45 & older		1	2	3
Total Volunteers	1	4	3	8

Interviews

Men were able to contact me by email or telephone.[33] I spoke to each participant by telephone, even if they had contacted me by email, in order to have a conversation about the research, how they found out about the study and to give details such as giving them the Participant Information Sheet (See Appendix H) and the interview logistics. I also wanted to reassure them that the interviews would be confidential and take place in a 'safe' space. It was important to conduct the interviews in a space that was both safe and convenient for participants but also safe for myself, as a woman interviewing men (Lee 1997, Arendell 1997). The issue of safety is not just limited to gender difference,

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[33] I used a project specific mobile phone number and email address as the only point of contact to ensure confidentiality and safety for both participants and myself.

but is an important issue to consider for any lone researcher meeting with a research participant. Moreover, it was important that the participant feel the interview would be held in a confidential and professional location. Participants were offered a choice of four interview locations:

- Newcastle University [34]and MESMAC NE offices were located in the centre of Newcastle-upon-Tyne and easily accessed by public transport;
- Gateshead Sexual Health Services at Walker Terrace was also located close to buses and metros;
- and the North Tyneside One to One Centre[35] was located further outside the city centre, but was more convenient for those who did not work or live close to town.

All of these locations offered a private room, in a reasonably public but relatively anonymous space. Interviews at the University generally took place during office hours which meant there were always other people in neighbouring offices should I need any assistance. The remaining three locations were accessed only during business hours and all three had well-established safety procedures. Most men opted for Newcastle University, although a number of men chose MESMAC offices because they were either familiar with this space, it was closer to the centre of town and/or they wanted to access MESMAC services before or after their interview with me.[36]

In addition to exchanging information in the initial telephone conversation, it was important to start building up a relationship with the participant before we met so that I would be somewhat familiar to them by the time I met them for the interview. As participants would only be interviewed once, it was important to make the entire interview process as comfortable and friendly as possible in order to establish a good rapport quickly and early on. At the start of each interview, I ascertained if the participant had read the Participant Information Sheet (which had been previously provided via email or post), gave them the opportunity to read it again, as well as reading and signing the consent form (Appendix I) and answered any questions they had. The interviews, conducted between March and August 2009, lasted around 1.5

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[34] Free visitor parking on university premises was offered for those who opted for Newcastle University, which was generally greatly appreciated by drivers.

[35] This centre offered sexual health, family and reproductive health services, in contrast to the other two clinics used in this study which provided sexual health services only.

[36] Each of the interview spaces in sexual health services premises were conducted in a private room that was regularly used as a consultation or counselling space, with access to an alarm system if needed. In all three cases, I met the interviewee at the entrance and brought them into the room privately, bypassing the need to involve reception or other staff and ensuring that the participant's identity remained anonymous.

hours and were all digitally recorded. They were transcribed throughout the fieldwork period and transcription was finished by November 2009. Participants were assured that the recordings would be listened to and transcribed only by me. Participants were offered the opportunity to receive copies of their transcripts via email (as encrypted files), which only a few men took up. I explained that due to ethical restrictions (which I explore in the final section of this chapter), no contact details or information on participants would be kept once the interview had been transcribed and seen by the participant if desired. While I would not be able to send them the final report, any research related publications would be made available on the research website and through research partners such as MESMAC.[37] I was concerned that, even though no contact would be maintained with participants after the interview process, their involvement with the research would provide some degree of trust in me as a professional and ethical researcher, with whom they were sharing intimate details about their lives.

As mentioned earlier, I was aware that my position as a woman might impact on the interviews and my relationship with male participants. While the field of sexual health is dominated by women and participants might have had at least some experience in talking about their sexual health with these health professionals, I was not a sexual health professional and this was a different encounter. Moreover, I felt that, despite the prevalence of women in the sexual health field, the gender dynamics of a female interviewer and male participant would be an issue that required critical attention in any context. Researchers have written, to a certain degree, on the gender dynamics of women interviewing men. Exploring the vulnerability of female interviewers, Lee (1997) and Arendell (1997) both describe fairly harrowing experiences of inappropriate behaviour, feeling unsafe or at risk from overly dominant men in their studies on sexual harassment and divorced fathers. Grenz (2005) and Perrone (2010) described becoming objects of sexual desire for the men in their studies on clients of sex workers and drug use in dance clubs. Pini (2005) details how the men she interviewed asserted their masculine identity and reproduced the gendered hierarchies of their organisations in interviews. Some of these researchers did construct men as one homogenous group. Where Schwalbe and Wolkomir (2001) describe how men 'perform' their masculinity

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[37] The final research report was made available on the project website in March 2011, and featured on the home page of the MESMAC NE website, which linked directly to the report.

in the interview, Oliffe and Mroz (2005) set out a list of typically male characteristics that they advise interviewers to prepare for, such as short answers or avoiding emotional topics. Moreover, many assumed that men and women are fundamentally different in how they act and think and that interviewers need to be aware of this in the first place (Oliffe and Mroz 2005). I would argue that this hyper-awareness of difference perhaps serves to introduce this to the interview, or at least, ensure that it is always present. This literature also tends to deal with heterosexual men as the subject of research and heterosexual women as the interviewers. It therefore makes certain assumptions about the relation between these men and women. The literature paid little attention to the gender complexities of the interview relationship especially in relation to non-heteronormative gender dynamics. Consequently, many of the descriptions of men as subjects of female interviewers simply did not match my experiences of interviewing 23 gay or bisexual men.

Gender differences did play an important role in the interviews I conducted. Some men sought permission to say things they might not normally say to women. While these questions could have been prompted by the formal interview setting and my position as a researcher attached to the university, I had the impression that they did not want to offend me as a woman. For instance, a few men asked if it was okay to swear in the interview. Others were concerned not with swearing but with being more explicit about their sexual practice and checked that it was 'okay' to be blunt. However, not all men asked these questions and some assumed that it would be acceptable to swear and speak bluntly given the nature of the interview topic. This seemed to be because this was also how they spoke about sexual health matters with others, including sexual health professionals, and this was reflected in some of the non-NHS sexual health literature.[38] For the men who did ask permission, it seemed that they were testing me out to see what was appropriate in terms of the language they used and the sorts of things they spoke about. The men seemed to be negotiating how to speak to me and censoring or at least thinking about censoring how they might normally speak about sex with other men and/or gay men. While some of the men would ask before they said something if it was okay, other men would check afterwards that I was not offended. One man apologised for speaking in a way that might have been inappropriate but indicated that I would

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[38] MESMAC NE pamphlets used everyday terminology, such as 'fucking', and 'cum.' In contrast NHS material generally used terminology such as sexual intercourse and semen (HPA 2005; MESMAC 2011)

have to get used to hearing things like this. When I said it was 'okay' to speak in this way and that it was the nature of the research, he said that he thought I would have to be fairly 'shock proof' to do this research. Even though it seems I was perceived as 'shock proof' by some men and that seemed to be okay to listen to participants describe their sexual practice and preferences, many men were still aware that I was not their normal audience for this sort of discussion. However, I do not think this awareness hampered the interview discussions, an observation supported by comments men made at the end of interviews. Once the men had asked or decided that I was able to 'handle' the swearing, bluntness or the graphic nature of their descriptions, the flow of the conversation improved: I had 'passed the test' as they appeared to be less concerned with saying 'inappropriate' things to me.

In addition to the impact the gender dynamics appeared to have on language, my presence in the interview went some way to shaping how men described reasons for 'risky' sexual practice. A small number of participants spoke to me about what men – as a group – were really like when it came to making decisions around risk. One man said: '*you know what men are like once they get excited'* (Joe 50s). Another said '*you know, blokes get an overriding urge and things, you'll know this, you don't need me to tell you'* (Rick 50s). These and other participants relied on stereotypical or essentialist ideas about men in that they described men as not thinking rationally when they have sex, that they are driven by these urges and only think about risk after the fact. These examples also referred to me and my position as a woman, explaining that I would know about this. I was unsure if these comments were made in relation to the research I was doing, or if it was because I was a woman and would know that men were different. I do think that having an audience of a woman might have invited this description of what men were like, which was perhaps an easy way for participants to explain things and also perhaps a way of stopping any sort of further questioning from me: I would have to accept that men were like this because I would not know any differently because I was not a man. Although these points were not raised very often in the interviews, they demonstrate the role that gender had in not only shaping the language used, but in

creating particularly gendered opportunities to shut down discussions or in creating 'excuses' for sexual practice.[39]

In addition to gender, my own sexual identity played an important role in the interview dynamics. Where the recruitment material was explicit that interviews would be conducted by a woman, it was not explicitly mentioned that I was a lesbian. I was open with research partners who helped with recruitment about my sexuality. I did not actively 'out' myself before or during the interview, however, neither did I deny that I was a lesbian. I did not think it was necessary or appropriate to announce my sexuality in advance of meeting participants and decided that I would respond honestly if I were specifically asked. Although I cannot be certain, many of the interviewees identified me as a lesbian without me verbally disclosing this to them. No one asked about my sexuality, but it seemed as though some men identified me right away. For instance, some of the men in the interviews referred to '*those straight people*' or '*heterosexual women*' and I believe purposefully excluded me from that category. One man, at the end of the interview, told me that his niece had just come out as a lesbian, which I took to be a sign that he had identified me as a lesbian as well. The reason I raise the issue of my sexuality, is that I think it makes me an 'outsider of sorts' in the interview experience. I am a woman, and therefore an outsider to gay and bisexual men's experiences, as outlined above. But I also identify as a lesbian which perhaps makes me a 'queer insider,' as someone who 'might' be able to identify with the non-heteronormative life styles of the interviewees. I do not assume, however, that a non-heterosexual lifestyle and/or identity will result in a shared understanding of the world. Indeed, this study demonstrates how a shared 'homosexual' label masks a range of differences. The awareness of my sexuality in the interviews highlights two issues. Firstly, the gendered dynamics of the interviews was made more complex by the sexual identity of both participants. Secondly, I felt my 'insider of sorts' position allowed me to quickly establish a good rapport with many participants. Some of the men commented on this at the end of the interview, saying that they had told me much more than they thought they were going to, or that they were very nervous but that I had made them feel very

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[39] These comments did shut down discussions, to a certain degree. In some cases, I was unsure of how to respond to these comments. Although I did ask for clarification, and in some cases asked if all men where like this, or if they felt this way about themselves, it presented itself as a small obstacle in the discussion. Most of the interviewees did not rely on this essentialist narrative, however, and I was able to move beyond gendered stereotypes and talk about participants' personal experiences.

comfortable. Although I had gone to great effort to make participants feel comfortable within the interview, I perceived the rapport established with many of them was aided significantly by my own queer position.

Analysis

The analysis phase of the research began before interview transcription was completed and continued throughout the writing process. This 'thinking through' of the interviews took place via notes written after interviews, in supervisions where we discussed emerging issues, and throughout the transcription process as I relistened to and relived the interview experience again. A preliminary analysis was conducted with the first seven interviews. Annotated transcripts with my comments, observations and thoughts were discussed with supervisors. This analysis helped to identify emerging themes and issues. Once transcription was completed, I read through the transcripts making thorough notes and comments. Although key themes to explore were identified in the early stages of the research, the close and multiple reading of transcripts allowed for a number of new themes and issues to emerge, such as the importance of place and notions of responsibility. After reading each transcript thoroughly, key ideas and issues that seemed significant for each interview were mapped out. This mapping allowed me to pull out a huge range of key issues and themes and to begin to draw connections across the interviews: the maps of key issues further allowed me to see connecting themes across participants. For instance, one of the HIV positive participants spoke about the desire to be undetectable (have a low viral load in his blood stream) and how he felt this was the desire of most people in the HIV positive community. This sentiment of undetectability was one that was shared across the transcripts regardless of the serostatus of the interviewee. The desire not to be seen or recognised as HIV positive extended to concerns around HIV not being 'seen' or recognised in society at all. In thinking about HIV in this way, I was able to draw out connecting thoughts and concerns around stigma, silence and identity from the transcripts.

Throughout the process of working through the transcripts, patterns emerged which structured the findings. In the identification and response to risks, participants not only established biomedical risks such as syphilis or HIV as important, but they also

identified particular people and places as risks with which they were concerned with. Slowly, a pattern emerged that led to a framework through which organised the findings: what is a risk, who is a risk and where is a risk. The organisation of the interview material in this way then helped to establish how the interviews responded to the study research questions. This overarching structure emerged as I was preparing to present my findings to the advisory group meeting in January 2010. In seeking to find a way of translating the mapped findings of the transcripts to sexual health practitioners, I was able to clearly look at the themes across the interviews through this broad categorisation of risks. By placing these risks into certain categories, I was then able to see how the men in the study identified similar risks, but responded to them in very different ways. For instance, while one participant identified cruising sites as dangerous places, full of risk of STIs and violence, another participant described these sites as friendly, social, familiar and even safe.

It was at this point that I began using NVivo8 to code the transcripts for specific themes. In discussions with others who had used this software, many had suggested that the 'thinking through' of the transcripts and ideas needed to be done before coding the data. However, they advised that the software would help me better manage the findings once the thematic and analytical framework had been established. Having set out the general areas of exploration, on the basis of this broader mapping, I began coding the transcripts for relevant themes using NVivo8. However, I found this process unsatisfactory. While NVivo8 allowed for extraction of quotations from the transcripts and compiling collections of these 'findings', I was unhappy with how these extractions were taken out of the context of the interview and was unsure what 'to do' with them. I thought it was important to analyse the issues and themes within the context of the entire interview. Using NVivo8 to pull out extracts resulted in hindering my ability to visualise the connections and meanings, as I kept having to go back to the entire transcript to understand the meaning of the individual quotations. In addition to this, the coding resulted in an incredibly long list of collections of themes, which made it difficult to write about. Instead, it was more useful to reread transcripts to highlight examples of certain themes within the context of each interview, using a more hands on and visually stimulating approach through mapping and tables. These allowed for a more flexible and visual way of collecting and organising themes and examples. Even though the broad framework was relatively simple, inserting examples or evidence within this

framework required a much more intuitive approach: analysis was more of an iterative process than simply a cut and paste one. While this process of analysis did result in word files of quotes relating to particular themes and issues, it did not result in the use of NVivo8 in the main coding process.

While NVivo8 was not used to code the transcripts, the software provided an excellent means of searching for words or phrases across the transcripts. It enabled efficient searching for particular sections of interviews that I wanted to write about, and allowed me to easily pull up sections of interviews that made reference to certain ideas. For instance, to build upon my knowledge that men had referred to 'London', 'Africa' and 'the North East', NVivo8 was used to search for references to these words when working through the importance of place. The search function provided quick access to every word reference as well as to the broad context of how these words or ideas were discussed. While the search for particular words did not 'cover' all the discussions of the concept, this function provided an excellent starting place in each of the transcripts to explore how certain themes were spoken about. In addition, this function also provided insight into how significant these references were. For instance, five of the participants specifically described the transmission of bodily fluids as a significant and perhaps the most significant risk in sexual health. These numbers were discovered through an NVivo8 search for the term 'bodily fluid'. This search brought up 10 interviews, where 5 were specifically referring to the transmission of bodily fluids. The search, then, allowed for an exploration of certain concepts throughout the interviews, as well as establishing the frequency and significance of them.

Finally, the analysis of the findings did not take place in isolation. Advice was sought out from colleagues and supervisors about their approaches to and experiences of analysis.[40] During this period, I also presented early findings at a number of conferences and conducted feedback sessions to research partners. These more formal presentations allowed me not only to talk about my research, but also to engage with other people's questions and feedback about the research. For instance, I gave a presentation at

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[40] As well as having discussions with various members of staff on how they approached analysis, I organised and participated in a peer sharing session on analysis with other PhD and postdoctoral researchers in December 2008.

CHAPS in March 2010, an annual national conference for HIV prevention for gay and bisexual men. The second speaker on the panel dropped out at the last minute, leaving the entire session dedicated to my research. This resulted in an excellent interactive discussion with the audience about not only my research, but also about how the issues raised in my presentation were experienced across the country. This experience, of being able to get direct feedback from others, as well as understanding it in a national context, was incredibly useful. In June 2010, I ran a feedback session for research partners from MESMAC and Gateshead sexual health services. This morning-long session not only provided feedback to partners about the findings, but also provided a space to discuss partner reactions to and thoughts on the findings. These discussions fed into the writing of the final research report for partners (Young 2011). They also helped me to think about how these findings and my approach fitted into practitioner experiences and the local context. I was able to 'check' how the findings I presented resonated with people who work with 'MSM' on an everyday basis. These experiences also allowed me to talk about examples from the interviews, further consolidating my ideas and understandings of the findings and what they meant.

Ethical considerations

There were a number of ethical issues which emerged throughout the research process, many of which have been discussed throughout this chapter. For instance, issues around the sensitivity of language resulted in strategically using 'MSM' or gay and bisexual in recruitment material and interviews. Concerns around data security were addressed by encrypting transcripts and storing them on the Newcastle University network. The safety and comfort of the interviewee and myself was addressed through choosing discrete but public interview locations as well as conducting interviews during the day. Given the nature of the topic, the choice of semi-structured interviews reflected the possibility of traumatic issues surfacing in the interviews, as well as a way to deal with these issues. All project material provided information on sexual health services, and brochures about services, syphilis and other sexual health concerns were made available in the interview for those requiring or requesting further information. Project results and findings were made available to participants via the project website and feedback sessions in order to ensure that participants saw the outcome of their participation in the research.

In the rest of this section, I will focus on one issue in particular and its implications for the study as it reflects the changing understandings of HIV and the ways in which these understandings have practical implications for HIV-related research. In the UK, someone can be prosecuted for either 'reckless' transmission of HIV or intentional cause of harm through HIV infection (Weait 2008, Dodds et al. 2009). At the moment, in England and Wales, there are five conditions required to charge someone for the reckless transmission of HIV: scientific evidence is required to demonstrate the defendant infected the complainant; the defendant must have known their HIV status when transmission took place; they must have known they were infectious to others; they must not have taken precautions to reduce the risk of infection; and transmission of HIV must have taken place (THT 2007). Scottish law has a slightly different set of conditions, and Dodds et al. (2009) explain how it is possible to be prosecuted in cases where there has been no transmission of HIV (this has not yet happened). The issue is particularly significant for this research because of the implications of maintaining confidentiality of research participants in light of one of the cases of 'successful' prosecutions for the reckless transmission of HIV which took place in Scotland. Although the specifics of the legal systems are different in Scotland and England, both legal contexts have implications for access to research material and instances of reckless transmission. In the Scottish case, the defendant had voluntarily participated in a research project while he was in Glenochil prison. The results from this research were seized by the police and used as evidence in the case against the defendant (Bird and Leigh Brown 2001; Dodds et al. 2005; Weait 2008). Dodds et al. explain how this case 'raises the questions of researchers' capacity to assure confidentiality for research participants when potentially incriminating evidence can be demanded for use in the courts' (2005: 30). The implications of this experience meant that many researchers in the UK who work with HIV positive research participants would theoretically be required to release confidential research material to the Crown Prosecution Service (CPS) were charges made against one of their participants. Although this has not yet happened, many researchers in this position have taken the decision to destroy any contact details of participants, in order to ensure confidentiality of participation in research.[41]

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[41] This practice was discussed at the CHAPS 11 conference in Nottingham, 4 – 5 March 2008, during a session that discussed the issues around criminalisation of HIV.

In response to this legal and ethical situation in HIV research, I needed to establish what my ethical and legal obligations were and how I should proceed with the research. For instance, should a participant disclose potentially incriminating information, what would I be ethically and legally required to do? Moreover, would the threat of potential CPS seizure of interview transcripts and recordings deter potential research participants who were HIV positive? After discussions with other researchers and with further investigation, two courses of action were decided. Firstly, it was important to reassure participants that their involvement would be anonymous and confidential and would result in no harm to them. It was therefore agreed to follow what other researchers were practising and not keep names and contact details of participants. Participants were told that they did not have to give me their real or full name and that any identifying information, including phone numbers and email addresses would be destroyed once their participation in the research had finished. This, in combination with using pseudonyms in the transcripts and in any written work, meant the research record would provide no links between the transcript and the interviewee's name or contact details. Secondly, should anyone disclose information in the interview that could potentially be incriminating, I would alert them to this and suggest we change the conversation. This was explained at the beginning of all interviews. Although there was no legal obligation to report evidence of reckless transmission, I thought it was critical that participants be aware of what they were saying and that they should seek advice from sexual health workers. These measures appeared to address the potential threat to confidentiality, while at the same time contributing to creating a safe and confidential space within which participants could share their experiences. This seemed to adequately deal with the potential threat to confidentiality, while at the same time ensuring that participants were able to feel that interviews were a safe and confidential space within which to share their experiences.

However, not keeping participant details meant that I would not be able to maintain a relationship with participants after the interview process. Was this approach an ethical treatment of research participants? Given the 'shared experience' (Bornat 1989: 191) of the interview, I thought it was somewhat unethical to simply stop all contact and communication with participants. They had given up their time to be interviewed and shared intimate details about themselves. It seemed only fair to give something back to them, even if it was by demonstrating how their participation in the study was useful

through the production of research outputs. As a compromise, participants were informed that research outputs would be available on the project website and through research partners, for instance by leaving reports available at MESMAC NE. They were encouraged to look for these outputs if they were interested in the study outcomes. But my concerns about not 'giving something back' to participants, in hindsight, underestimated the potentially positive experiences that participants had in the interview itself. Like Bornat (1989) who was reminded that the interview was a shared experience when research participants thanked *her* for asking them questions (Bornat 1989: 191), I experienced the same sentiment when many of the participants thanked *me* for the interview. A number of participants explained that not only did I put them at ease and that it was less painful than they thought it might be, but that they enjoyed the interview experience very much. It allowed them, they explained, to think about people and experiences from their past. In some cases, participants described how they never spoke to others about what they discussed in the interview and found it a cathartic experience. In other cases, they described the interview as a space in which they could talk about their thoughts and emotions with someone who they felt would not judge them. While I cannot be certain that all participants 'enjoyed' the experience, and I was still somewhat dissatisfied with the lack of follow up, it seemed that these experiences went some way to addressing the ethical or socially responsible need for reciprocity in the interview experience.

Conclusion

This chapter has described the methodological choices and research process, explored the ethical and epistemological issues that were faced, and demonstrated how these issues, challenges and concerns shaped the final research outcomes and analysis. In contrast to early concerns that this was a 'scary' topic or that I would have difficulty getting men to speak to me about their sexual practice, the design, recruitment and interview phase went incredibly well. The relationships that were established with research partners played an integral part in designing and undertaking this study and it would have been a very different project if the partners had not been involved. While the relationships with all partners were not perfect, the benefits of partnership were well worth the additional time and resources they required. In addition, the anticipated problems of recruitment did not materialise as a diverse and significant number of men, in terms of varying age, experiences with illness, relationship to the gay community and

experiences of relationship types, came forward to be interviewed. These men not only shared intimate details of their lives with me, but many volunteered to help the project further, resulting in offers to distribute research brochures to friends and colleagues and the appearance of new volunteers who had been referred to me by project participants. The interviews themselves were thoroughly challenging, emotional, upsetting, rewarding, and sometimes, incredibly funny. The confidence and trust that was placed in me and the investment I made in each interview, I believe, contributed to a fascinating set of stories and research findings. Although I found the analysis phase of the research a very difficult and slow process, the involvement of multiple audiences, including sexual health practitioners and academics, helped to critically examine the interviews from a wide range of perspectives. Finally, the ethical issues faced throughout the research process contributed to a reflexive engagement with not only the findings, but also with the participants, partners and the process itself. It is hoped that this ongoing engagement will be reflected in the interpretation of the interviews presented in the following three chapters.

Chapter Four – Negotiating Biomedical Risk in Sexual Practice

Introduction

The importance of biomedical understandings of risk cannot be underestimated in sexual health. Definitions of illness, modes of transmission and methods of prevention are all dependent on biomedical technologies that can identify, detect and treat illness and biomedical knowledge and research that can guide advice for prevention and care in sexual practice. However, sexual health is also constituted by the social and cultural practices of sexual actors as communities, seen in the early responses to the HIV epidemic in the UK (Patton 1990; Watney 2000; Weeks 2007). Biomedical, social and cultural understandings of sexual health, therefore, cannot be considered in isolation. This chapter asks how biomedical understandings of risk of HIV and syphilis are negotiated in sexual practices that are framed by 'community'. This chapter does not aim to define what a gay community is or dis/prove its existence. Instead, it explores the ways in which communities were imagined and how the perceived norms of sexual practice and responsibility within these imagined communities were negotiated in individual sexual practice. The chapter asks what role biomedical knowledge played in the identification and response to risk. It also considers how memories of the AIDS crisis and understandings of responsibility in relation to community play a role in sexual practice and the management of risk in sexual health. To this end, this chapter addresses the ways in which imagined communities and their histories establish biomedical risk as a cultural and social concern.

This chapter is divided into two sections. The first section explores what participants identified as a risk. It considers the ways in which biomedical knowledge contributed to embodied understandings of risk. It then gives an account of how experiences and memories of HIV play a role in shaping contemporary concerns around the illness. This section also considers how syphilis as an illness was understood and situated in a cultural, sexual and historical context. The second section of this chapter addresses the ways in which these social and biomedical understandings of risk were reflected in sexual practice. This section focuses specifically on the ways in which anal sex and oral sex were associated with particular risks, how these risks were overcome or negotiated and the ways in which participants described their concerns around harm, responsibility and community in their own sexual practice.

Identifying Biomedical Risk

Lupton (1995) has described the differences between expert and lay knowledge in health, where the non-medically trained individual develops their own understandings of biomedical knowledge. However, Rose (2007) argues that individuals are increasingly developing an expertise of highly technical biomedical information in relation to their own health concerns. This section asks how risk, or more specifically, how HIV and syphilis were identified and understood biomedically and what impact these understandings had on the management of bodies. These biomedical understandings of risk cannot be disentangled from a broader social and historical understanding of illness, culture and 'community' (Sontag 1989). In particular, this section explores: how respondents relied on corporeal markings of illness; the ways in which memories of early HIV experiences were understood socially and culturally and marked contemporary understandings of community; and how syphilis was incorporated into this complex management of sexual health knowledge.

Imagining Risk on and in Bodies

Quite a number of men in this study described their understandings of risk of infection as tied specifically to the body and to the management of bodies in encounters with others. Five participants explicitly mentioned the transmission of bodily fluids as a significant, and perhaps the most significant, risk in sexual health. Using phrases such as '*avoiding transmission of those bodily fluids' (*Jeremy, 40s)*, and *'they will catch it through the exchange of bodily fluids'* (Edward, 60s)*, the men described biomedical understandings of how the transmission of HIV and STIs takes place between bodies. Andrew (30s) referred specifically to biological processes when he described how people make judgements around risk in sex.

> *So I think that they probably, you know, have enough basic biology from school to know that, well, it's still bodily fluids and it's still getting into my system and blood circulates at every point of my body and things like that.*

Andrew's description of how transmission works, that it is necessary for something to enter the blood system, reflects a basic epidemiological understanding of how the transmission of HIV and other viruses takes place. That is, the virus must physically enter the blood system of another body, either through blood or semen, and that this can happen through the transmission of bodily fluids in sex (Flowers 2001). Andrew and many of the men in this study were not only familiar with this idea, but also suggested that it was basic knowledge that most gay and bisexual men would have about sexual

health. Interestingly, however, this assumption of basic knowledge did not apply to bacterial infections such as syphilis. Whereas the men were well versed in the epidemiological nature of HIV, the specific biomedical nature of syphilis was not so well known. I will explore this in greater detail below in the sub-section on syphilis.

The reliance on biomedical understandings of risk by men in this study extends beyond the explicit use of medical terminology. The need to protect one's body against the transmission of bodily fluids can be seen in how some of the men spoke about risk and bodies more generally. Some of the men in the study spoke about needing or using a *barrier* between themselves and other men, usually in the form of a condom. One man referred to the condom as both a '*preventative barrier*' and a '*protective barrier*' (Max, 30s). Jeff (30s) relayed how '*it wasn't a barrier against everything*' when he contracted syphilis despite using a condom for penetrative anal sex. The idea that the risk of infection is something you can physically avoid was reinforced through the terminology men used when speaking about practices of safer sex. For these men, it was about creating a protective, physical barrier between themselves and a virus that was potentially present in someone else's bodily fluids.

Unlike Andrew's assertion that basic biology education from school would inform these understandings of risk of infection, two men mentioned only recently learning about the specificity of transmission via bodily fluids. Jack (20s) described initially being afraid of meeting someone he knew to be HIV positive because of his uncertainty about how HIV was passed on. He explained:

> *R: ...my initial reaction was oh, if I touch him I'll catch it.*
> *I: Really?*
> *R: Yeah. When I went to his house, I didn't want to use the toilet. I know, it's silly.*
> *I: But a lot of people think that.*
> *R: Yeah. But I don't think that now. And uh, I know you can't catch it if you, like, kiss someone, or share the same fork for example. Or even a bottle of water. You can't catch it that way. Obviously it's just through sexual intercourse. Or blood transfusion.*

Jack's initial fear of transmission through touch and not an exchange of intimate bodily fluids was something that Rick (50s) also described being concerned about before his own diagnosis with HIV. Previous to his diagnosis, Rick described not wanting to work

with someone who was HIV positive because of fear of transmission. It was only once he had been diagnosed with HIV and learned more about the illness, he explained, that he became aware of the need for blood or semen to be passed on to someone else for the transmission of HIV, something that was unlikely to happen in a workplace environment. '*Well, I know that unless you're gonna inject somebody with your blood, it's very difficult to catch it off somebody. You know, semen.*' Both Jack and Rick learned about the specificities of transmission through direct encounters with HIV in other people or through having the virus. Both spoke about this information and these recent encounters as though they were a revelation. Moreover, their descriptions of modes of HIV transmission were the most detailed of all study participants. The way in which both spoke about the specific means of transmission suggests that this information had only recently been incorporated into their sexual practice and that these encounters, with people or the with illness itself, had a potentially significant effect on how they understood their own bodies and the bodies of others. While their self-reported lack of knowledge around HIV transmission was exceptional amongst study participants, their reaction to this new, epidemiological information reflects the ways in which many of the study participants described embodied understandings of risk.

The importance of bodily fluids in understandings of risk echoes other studies. For example, Richters et al. (2003) conducted research in Sydney, Australia with men who were diagnosed with HIV. The study explored when and how these men believed they had contracted HIV. Their findings highlight the cultural importance of bodily fluids in identifying risk amongst gay and bisexual men. Respondents described how sexual acts perceived to result in the exchange of bodily fluids, such as anal intercourse, were identified as risky and seen as the most likely point of transmission. In the same the way that Richters et al. (2003) identified a reported hierarchy of risky sexual practices on the basis of the exchange of bodily fluids, the participants in this study described similar perspectives in relation to risk, bodily fluids, and sexual practice.

In line with these understandings of risk, a significant majority of participants described stopping or reducing the transmission of bodily fluids in sexual encounters as a priority in the prevention of HIV and other STI transmission. This meant managing their own

bodies as well as the bodies of others. One man explained how he avoided brushing his teeth before going out, because there would be risk in having oral sex with someone if there were small cuts, even '*if there is a little blood*' (Frank, 20s). Frank, however, was the only person to explicitly refer to this preventative practice for oral sex. Most men reported how preventing the transmission of bodily fluids was most effectively achieved by either using a condom when having penetrative anal sex with another man or abstaining from sex with anyone else. As one of the participants stated: '*I would suggest the only safe sex is no sex at all, or sex with yourself*' (Joe, 50s). Joe felt that there was always a risk of transmission of bodily fluids in any sexual act with someone else and, therefore, would not identify sex with anyone else as entirely safe. He went on to explain '*...I don't believe anything is safe if it involves somebody else. But some things are riskier than others, and some things aren't as risky.*' While Joe described sex with anyone else as risky, he also considered certain sexual acts to be much more risky than others, relying on a perceived hierarchy of risky sexual acts on the basis of level of bodily contact and the potential for passing on bodily fluids. This suggests how the management or control of bodies – and more specifically, the control of bodily fluids – in sexual encounters was seen as an integral feature in the identification and prevention of risk of infection by participants.

In addition to being concerned with the exchange of bodily fluids, some of the men described how physical signs of infection present *in* the body could be visible *on* the body: an infection that was present in the blood and/or semen could show up as something physically visible on the body, meaning that the external body could be 'read' for a sign or marks of illness. In keeping with the management of bodies described above, over half of the men in this study spoke about looking for visible signs of infection on the body such as a rash, lesion or wart, whether in relation to themselves or on the bodies of their potential sexual partners. For example, David (40s) described keeping an eye on the body of your sexual partner, and staying clear if you '*see something obviously glaring like a genital wart.*' Nigel (40s) also explained how he developed a routine of looking for signs, both in his younger days in response to HIV and syphilis, and again, more recently, when he had been told that syphilis had re-emerged.

...the first thing I used to do is...to look around for evidence of um, you know, lesions, or shankars, because that was the visible demonstration of somebody who was infected with HIV, with syphilis, rather. And so you used to look for things like that. Um, whereas I think ever since the syphilis thing has crept back in, you know, before I started seeing [my current partner], you know on the comparatively few sexual encounters, casual sexual encounters I had, I found myself doing that again. That I would look for visible signs, and you know, if there were any sort of marks in the genital area that I didn't like the look of...

Both David and Nigel described looking for signs on the bodies of people they did not know or who might be '*casual*' partners. Nigel's direct reference to his current partner distinguished the practice of looking for physical signs on the bodies of men he did not know that well from his risk-identification practice with a regular sexual partner. This is an important distinction to make. Most of the men in this study described using different methods of assessing or identifying risk according to the sexual and/or social situation they were in. Moreover, where both Nigel and David relied on physical signs to indicate potential risk of illness, their practice of this method of risk identification differed over time. David described having looked for signs of illness in a 'casual' sexual partner throughout his sexual history. Nigel, however, explained how he resumed this practice in response to learning about the rise in rates of syphilis, incorporating this new epidemiological information into his risk assessment strategies.

As indicated by Nigel and David's practice of identifying risk over a period of many years, looking for signs of illness on the body is not new: there is a long history of seeking corporeal signifiers of illness (Brandt 1986; Gilman 1988; Mort 2000). This is especially true in the history of HIV where physical signs such as lesions from Kaposi's sarcoma – a well known AIDS-related illness – were often used to represent AIDS in the media throughout the 1980s and 1990s (Watney 2000; Hallas 2009). This classic and culturally significant sign of AIDS shows the perceived embodied reality of the illness with the presence of the virus in the blood made visible on the skin. For many gay and bisexual men during this time, the physical markings were both a sign of a risk of infection in potential sexual partners, and a physical reminder of the ongoing social stigma of HIV. Furthermore, there was much effort focused on treating and/or hiding the lesions as a way of managing not only the physical signs of AIDS, but also the social and cultural stigma that came with it (Weitz 1990; Crimp 1992; Couser 1997). Since the advent of successful HIV treatment and its success in preventing the

development of AIDS, cases of AIDS-related Kaposi's sarcoma have almost entirely disappeared (Russell 2007). HIV is now, generally, not visible on the skin. However, the cultural and historical significance of these early physical signs of HIV, as well as the longer history of sexually transmitted infections being marked on the body (Brandt 1985; Gilman 1987, 1988, 1995), highlights the ways in which corporeal markings of illness have and can play an important role in how illness is imagined, identified and managed.

Looking for signs of infection was not limited to other bodies. In a concern for their own health, some men relied on an absence of signs on their own bodies to reassure them that they were fine or 'healthy'. For instance, Simon (30s) explained how his medically trained partner assured him during an HIV scare that he did not have HIV because of a *lack* of physical signs of infection.

> *...he says you haven't got that and um, he says you know I wouldn't have that because he works in the medical profession, he would know these sort of thing. He said no you haven't got that. You'd be able to tell straight away if you had Anti-Immune Deficiency Syndrome, you'd be able to tell straight away, because of things like your blood goes anaemic and this sort of thing. You'd be having other big problems as well. So uh, like your gums wouldn't be healing up rapidly and this sort of stuff. Um, so he says you haven't got that man.*

Simon was reassured by his partner's insistence – and medical training – that he would be able to tell if there was a problem. Other men and especially those who had some professional experience in health were convinced that they would be able to see the signs of infection on their own bodies. Andrew (30) explained that despite the fact he did not know the specific signs for syphilis, he would be able to tell if something was wrong.

> *I probably have no awareness of its individual symptoms, if any, as it were. I just know what virulent symptoms look like, what bacterial symptoms look like, as it were. And generally I don't appear to have viral, I haven't gone through periods of flu-like symptoms.*

Andrew's insistence that he knew the symptoms to look for suggests a medical approach to infection. While he explained throughout the interview the steps he took to avoid coming into contact with infection, such as regular condom use and largely avoiding anal intercourse, he described how he also relied on the physical symptoms

that he would expect to see if he were to contract an STI. Quite a few of the men spoke of symptoms, of flu-like illnesses or sore throats, which they identified in hindsight as signs of infection, demonstrating a collective understanding of warning signs in relation to sexual health. Jeff (30s) explained how he made the connection between syphilis and a time when he was unwell only after he was diagnosed with the infection:

> *I think when I was sick, I was poorly. And I never thought for one minute that I would have had an STD. You know and I was really poorly at one point.*

While some men actively looked or were even on guard for symptoms of illness, others such as Jeff either did not recognise the symptoms they had or used the experience of symptoms as an explanation for illness in hindsight. This need to connect illness with symptoms was quite important for a significant number of the men in the study. Symptoms were seen as a sign that something was wrong and the absence of symptoms was understood generally as sign of good health or absence of infection. This perspective confirms how illness or lack thereof was perceived to be visible on the body. Moreover, the visibility of illness provided a way of managing one's own body, as well as others'.

As well as looking for signs of infection, some men described *imagining* where potential or actual risk was located on the body. In contrast to Andrew, who described how infection once in the bloodstream was present at every point of one's body, Max (30s) identified the specific location on the body where infection might have been present.

> *I've had syphilis, I got it through somebody – he had it at the back of his throat. He might not have been aware of it. Um, he might have had a bit of a sore throat...*

Max's description suggests the way he feels that it was it was only by coming into contact with that particular body part that resulted in his infection. Rick (50s), echoing Frank's concerns around oral health, also described a specific place on his own body where he felt that he contracted HIV: '*I've had bad gums as well, you see, in me mouth. And I think that's where it's happened, I think.*' For both Max and Rick, identifying the particular place on the body of transmission suggests an embodied understanding of risk of infection: they both identified specific parts of their body where they were potentially exposed to this infection. They both identified points of vulnerability where they had

come into contact with someone else and had contracted an infection. This was significant in terms of how the men view their own bodies as being *at risk* of infection: it was not simply the contact of bodies that poses a risk, but the contact of specific body parts where this transmission can take place.

This reliance on physical signs as an indication of illness, whether on or in yourself or others, was not held by everyone. Some men were insistent that lack of symptoms was not the same as good health or lack of infection. For instance, Oscar (50s) described how he was scared of contracting syphilis, given its prevalence and the fact that '*there's no symptoms*'. Other men asserted that you cannot tell by looking at someone if they are HIV-positive or have STIs. David (40s) stressed that '*somebody could look the figure of health and then could have HIV, you would never know until they told you.*' Alan (40s) explained that '*with HIV and syphilis, you carry those infections for many years without showing any physical signs for the damage it's causing to you.*' There certainly was no overall agreement amongst the men I spoke with regarding which infections would result in signs on the body, if any, and which ones would not. While not all men felt there were signs to indicate infection, the reliance on a particular understanding of science and biology to understand risks, either looking for observable signs, or understanding that an infection may be asymptomatic, and therefore not visible to the eye, demonstrates how corporeal understandings and management of infections were informed by biomedical discourse.

Negotiating Community, Memory and HIV

Having established the ways in which most study participants held embodied understandings of biomedical risks in sexual practice, this section considers how HIV in particular was imagined. All of the men in this study described HIV as the most significant risk for themselves, as well as for gay and bisexual men more generally. However, as outlined in Chapter Two, community responses have significantly marked experiences of HIV over the past thirty years. This section explores the ways in which memories of AIDS and notions of community have played a role in understandings of HIV and how these understandings are shaped by generational experiences. The men in this study over the age of 45 all described personal experiences of AIDS from the 1980s

that have stayed with them over the past thirty years. They not only described how these experiences had a significant influence on their own understanding of and response to HIV, but also how these experiences were *shared* with other gay and bisexual men. One of the most significant experiences described to me was that of losing friends. Matt (50s) explained how: '*men of my age have lived through the same nightmare as I've lived through, when it comes to losing friends'*. Most of the men could remember the approximate number of friends who died. Matt recounted how '*8 of [his] close friends died'* and Oscar (50s) described how he '*lost about 20 friends'*. Both men explained how these deaths had a lasting impact on their understanding of what became known as HIV. As a result, HIV was formulated as a painful and real risk in their lives.[42] For instance, Oscar, in describing a particular friend who died, explained how the extreme physical deterioration was a very upsetting experience.

> *I mean I knew somebody, same kind of build as I am, I'm not that, I'm only a 32 [inch] waist, but I, I mean I'm not, well, he was into weightlifting and things like that. But when he died, he went down to that [indicates his finger]. Just like a, just like that, you know. And that destroyed, that disturbed me, you know? But I can't, I can't get it out of me mind, you know?*

Oscar explained how this intimate experience remained with him. This image, along with his powerful description, serves constantly to remind him of the impact and devastation that AIDS had on his many friends and partners. It was not simply the number of men or their physical deterioration, but also the circumstances in which these deaths took place. Edward (60s) described a particularly upsetting experience of how a friend who eventually died was treated in hospital:

> *The first friend of mine who died, because of AIDS, not that anybody knew it was AIDS, he got a kind of flu symptom, in 6 weeks he was dead. And he died naked, on a metal trolley, in a hospital corridor, and no one would touch him. We washed him. We dressed him. The undertakers came and they all wore gloves. No one would take the funeral. It was, nobody in the hospital would touch him. They would have nothing to do with him. They wouldn't go near him. Once they realised that it was the dreaded whatever it was, or rather, there was that particular kind of pneumonia and the skin cancer. Once they saw that, they wouldn't go anywhere near him...This was '84 and in a teaching hospital...*

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[42] Both men, in describing the loss of their friends, were visibly upset when talking about these experiences. During the interview, as they were explaining this to me, both had tears well up in their eyes and stopped, momentarily, focusing on the interview. Matt quickly changed the subject and moved onto another related topic. Oscar, who spoke at length about a particular friend and partner who had died, eventually asked to take a break, although insisted on resuming the interview despite my suggestions that we stop.

Edward went on to explain the intense fear, stigma and discrimination that was experienced in the 1980s, where medical staff would refuse to touch patients believed to have AIDS, where churches refused to conduct funerals for those men who died of AIDS and where coffins were even lined '*in case anything leaked*'. This harrowing experience echoes Berridge's (1996) descriptions of the upsetting and undignified experiences of AIDS-related deaths in the early 1980s and which Watney (2000:223) characterised as 'isolated, inexplicable, shocking, [and] surrounded by mystery'. What is striking in Edward's upsetting description is how he described sharing this experience with other friends, and how they all worked together to take care of their friend after the hospital and mortuary staff abandoned him. He did not see this shared experience of washing, dressing and caring for their friend, when others would not, as unique: he and other men all experienced and responded to both loss and the need to care for others on a community level. Edward's story is not unusual; indeed, community responses to these experiences are well documented. Watney argues that it was the circumstances surrounding AIDS related deaths during this period that 'motivated many into HIV/AIDS-related work in the voluntary sector in the early and mid-1980s' (2000:223).

Along with Edward, men over 45 all described how these traumatic experiences had a profound and long-term effect on them and therefore how HIV continued to be a real concern for their own sexual health and that of others. How they articulated these experiences and their continued concern with this infection reflected intense feelings of sadness, fear and frustration. For the men who lost friends, they described how they could forget neither the '*nightmare*' they and all gay men of their generation lived through nor the continued risk of HIV. For those men who did not specifically mention losing friends or partners, they also described how they were aware of and lived through the history of HIV in the UK. Many cited the 1987 UK Government public health campaign *Don't Die of Ignorance* as making a direct impact on them and their sexual practice. Nigel explained:

> *I'm of an age where I remember the tombstone adverts and things um of the 80s, sort of 85- 86 time, the 'Don't Die of Ignorance' type thing. And that had a profound effect on me, because I mean at that sort of time you know, I was uh, I was quite sexually active. And um, it really sort of, beforehand, I did do things which were, you know before HIV was heard of, you didn't think about using condoms, because condoms were just to stop women getting pregnant. You know, you didn't think about it, and um, and then that sort of campaign came*

along and it sort of stopped me dead in my tracks and I said well actually, I can have fun, but I don't have to put myself at risk. And that sort of um stayed with me.

Nigel described how those advertisements were important influences on his sexual practice, and made him aware not only of the risks of HIV, but also of the ways in which it could be prevented. For instance, his early associations of condoms with birth control changed; the *Don't Die of Ignorance* campaign made him aware that condoms could also be used to prevent HIV in sex between men, and he could '*have fun*' without putting himself at risk. He described how this notion of not putting yourself at risk was something that stayed with him throughout his sexual practice since the early campaign. Nigel's description was not unusual amongst study participants in his age group. All the men in the study over 45 made some reference to this UK government health campaign and the way it directly impacted or marked their lives. The consistent reference to this campaign highlights it as an important moment in both their individual lives, and in the collective history of gay and bisexual men in the UK.

Almost none of the participants under 45 described personally knowing men in the 1980s who died of AIDS-related illnesses.[43] However, some of these men referred to stories of loss which were passed onto them by older men. For instance, Andrew (30s) explained how his early visits to gay bars in Newcastle in the 1990s would often involve older men relating their own experiences of HIV and of safer sex to younger men. He described this as a form of cross-generational sharing of experience and information at a time when he felt other educational figures, outside of the bars, were not doing so. Andrew's reference to a lack of educational figures recalls the debates around the de-gaying of AIDS (King 1993; Watney 2000; Flowers 2001) explored in Chapter Two, where HIV interventions and funding from the late 1980s and throughout much of the 1990s shifted from focusing on gay and bisexual men to a heterosexual population. This shift resulted in a significant decrease in targeted HIV prevention work with those gay and bisexual men who had not experienced the early epidemic or prevention work (Weeks 2007). Andrew described his experiences:

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[43] One younger man, Frank (20s), described an uncle who had died of AIDS-related illnesses. However, Frank's personal experience of loss was unique amongst most of the men under 45 in this study.

[older men] would come across [to us]. But for every one that came across and maybe said something inappropriate, the next one along came up and went, you alright lads and blah, blah, blah and you know, you do know there's condoms on the bar, or whatever it might be. Have yous been here before, do yous need showing around. And yes, we made fun and we said some terrible things back and what have you, but there were messages in it, there were messages in it.... Historically, younger gay men, the only adults that knew they were gay were these older men at the bars and things because their parents didn't, their teachers didn't uh, because of stigma and all those sorts of things, certainly in the early days of coming out. So I think there is something about these, these older men do play something of a sort of teacher.

Andrew framed his encounters with these older men in bars within a broader historical context of gay 'community' development, where older men helped to educate younger men about gay social practices and spaces, including HIV prevention. Within this context, Andrew described how he took messages about HIV prevention on board because they had '*so much power from those men because of what they were involved in in the 80s'*. Andrew clearly privileged the lived experience of older 'community' members as an important source of knowledge. Alan (40s) echoed Andrew's sentiments when he described his experience of talking to older gay men in San Francisco in the late 1990s and in early 2000:

you'd speak to somebody and there might be a guy say in his early 50s, standing outside a bar having a cigarette, or something, you were just passing. And you'd get talking to him and he'd say back in the early 80s, um, I lived in this community and pretty much everybody I knew died. Um, like street by street. And then I think you come down to my group, where people were getting the medicine. So you know, I'm very aware of the deaths and that.

Alan explained how his discussions with older gay and bisexual men made him aware of not only the deaths of many men, but also the changes in experiences of HIV. Alan was HIV- positive, and recognised the significant differences between his experiences of living with HIV and the early generation of men who did not have access to Highly Active Antiretroviral Therapy (HAART). For him, these stories played an important role in his understanding of how gay and bisexual men's history was affected by HIV. But they also indicated the changing experiences of HIV within this community, of which he knew first hand. For Alan and for Andrew discussions with men who had experienced the impact of the early AIDS epidemic first hand made them acutely aware of the history of HIV for gay and bisexual men. This intergenerational sharing of memories and loss, for both men, also helped to establish *them* within a community of shared experiences and pasts.

Other men under the age of 45, who did not describe this cross-generational sharing of experience and memories, explained how their exposure to HIV was often through media representations of HIV, either through newspapers, television or film. For instance, the film *Philadelphia* (Demme 1993) was referenced by three men in the study. Jeff (30s) described how his concerns around HIV were marked not just by the advertisements described above but also by the images – real or fictional – of people experiencing AIDS.

> *you know, because you'd seen the adverts, you'd seen people who, had you know, gone from being a well paid lawyer to somebody who's just sitting in a chair who looked terrible.*

The film, which featured a lawyer (Tom Hanks) dying of AIDS, was one of the first mainstream Hollywood films to focus on experiences of AIDS, including homophobia and discrimination (Sturken 1997). A number of younger men, under the age of 30, also referred to media representations as making a significant impact on their early awareness of HIV. In addition to mentioning the film *Philadelphia* as an early memory of HIV, Jack (20s) described being made aware of HIV at a very young age through a newspaper article.

> *I just remember the paper. And um, it was my dad's mother, my Nana. She said uh, oh gay men are evil. They've all got HIV. And then she showed me the newspaper at the time. And that sort of stuck in my… I mean, I was only like 4 or 5 but that stuck in my mind.*

Although Jack was very young, he described how his first introduction to HIV was linked to homophobia and his grandmother's very angry reaction. The impact of the article, and his grandmother's subsequent reaction, are evident in Jack's description and his stress on how this memory had stayed with him over 20 years later. Very early memories of gay men and HIV were not specific to Jack. Colin (20s) explained how he remembered public health advertisements from when he was very young.

> *You know I think in the '80s and the early '90s when I was much younger. You know, I remember those ads with the big tombstone and it was like people kind of dying left, right and centre.*

As described above, the *Don't Die of Ignorance* campaign aired in 1987. This would have made Colin around the age of six when the campaign first began, and signals his young age in relation to his first memories of HIV. Will (20s) also described an early exposure to HIV through the UK television series *Eastenders*, when one of the

characters, Mark Fowler, was diagnosed with HIV in 1991 (Geraghty 1993).[44] Although Fowler was heterosexual, the introduction of HIV into a mainstream television programme marked Will's early memories and understandings of the illness. Will explained how he '*remember[ed] growing up with that story*', and explained that he '*would have been, you know, 8,9, maybe 10, beginning of my sort of adolescence. And I could start understanding that sort of thing*'. Will would have been around six when the story line first appeared, but he seemed to remember the story as it progressed into his adolescence, when he explained that he could '*start to understand that sort of thing*'. These media representations clearly made a strong impression on several of the men in this study, as demonstrated through their personal memories of iconic AIDS events at a very young age. These references to media representations highlight how certain events are remembered collectively and how they become a part of a shared or 'community' history. For instance, in Alessandro Portelli's (1991) *The Death of Luigi Trastulli and Other Stories: Form and Meaning in Oral History*, he explores how a post-World War II community in northern Italy collectively 'misremembered' the date of death of a factory worker when they were interviewed over twenty years after the fact.[45] Portelli argues that this factual inaccuracy should not be taken as a mistake or a sign of the fallacy of memory, but as a way of highlighting the importance of collective memories in forming community histories and creating community meanings around events. In this way, the younger men in this study, regardless of whether or not they do remember these experiences from such a young age, signal their belonging to a particular community of gay and bisexual men, which was significantly affected by the AIDS crisis of the 1980s and 1990s, by affirming their memories of these events. Moreover, this 'crisis' played an important role in their personal and collective histories as gay and bisexual men.

Although participants described understandings of and encounters with HIV that were shaped by generational differences, they all described being aware of the history of loss, community responses, homophobic stigma and discrimination through direct

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[44] Mark Fowler was a heterosexual character on this show. Mark remained on the show as an HIV-positive character for many years (Quilliam 2006).
[45] Individuals interviewed from the community all remembered the death of the factory worker as instigating a significant strike against factory owners in the small town. In actual fact, according to records, Luigi Trastulli died three years before the strike took place. See. Portelli 1991, especially Chapter 1.

experience, intergenerational community building and iconic 'memories' of AIDS. Moreover, they reported how their own personal histories and contemporary experiences as gay or bisexual men were affected by these memories. The incorporation of a shared history of illness and loss into the personal memories and experiences of participants points to the ways in which a community of gay and bisexual men was imagined. In other words, the shared memories of AIDS played an integral role in how they imagined a community of gay and bisexual men to be affected by HIV and the ways in which they were a part of this community. This is not to say that all participants imagined the same community, but that many described a community which held these elements in common, and one within which they felt they were negotiating their own sexual practice. The ways in which the men saw HIV as posing a risk to themselves, however, depended very much on the risk management strategies that were a part of their sexual practice, and which I will explore in the second section of this chapter.

Re/introducing Syphilis

In contrast to the cultural and community significance of HIV, which can be seen in the vivid memories reported by participants above, syphilis has only recently re-emerged epidemiologically as a risk for gay and bisexual men in the UK. Given this relative absence from sexual health policy and interventions, this sub-section explores what participants knew about syphilis, if and how they had encountered it, and what associations they had with this infection. This sub-section considers the cultural and social significance of syphilis for gay and bisexual men, and asks how risk of this infection was imagined. While most men reported having heard of syphilis, only a small but significant minority of participants described any sort of experience with or knowledge of this infection, including modes of transmission. A small number of men, who were over the age of fifty, spoke about syphilis specifically in relation to their own, particular health concerns.[46] Rick (50s) was highly concerned with contracting STIs including syphilis; he had been told that because he was HIV positive, contracting syphilis would further complicate his health. Oscar (50s) was worried about syphilis because of the potential damage it could do to further complicate an existing serious

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[46] Interestingly, men under 50 rarely mentioned existing health conditions, or spoke about other peers with health conditions. This may be largely down to the characteristics of the older demographic, where men over 50 may be more likely to have health concerns. However, I cannot know if the younger participants were free of health concerns, or simply did not disclose this information in the interview.

health condition. Both men described how they were highly concerned about the state of their own health and how they had made a point of finding out more about syphilis because of the risk it posed to their health. Both explained how they had been told that syphilis was contracted via unprotected oral sex and that only condoms would prevent the transmission. Apart from personal health anxieties, three participants who worked in health care described being aware of syphilis, the main mode of transmission and the treatment options available. Joe (50s) and Will (20s) focused on the availability of treatment for syphilis, as though it was a regular part of the health routine. They demonstrated this awareness by discussing the nature of the medication and how it was administered via injections, suggesting that this information was a part of either their current employment or training. Andrew (30s) was less specific in relation to treatment options, but discussed how he had attended a conference where syphilis and other STIs were the main focus. While he admitted knowing very little about syphilis before this conference, his exposure to information on syphilis took place in a professional environment. The ways in which these five men described their knowledge about syphilis, as a direct result of their experiences through health care, suggest that syphilis for these men held largely biomedical associations or connotations.

The most salient reason given for knowing anything at all about syphilis was previous experience with the infection. Five men in this study disclosed having been diagnosed with syphilis. Men who had contracted syphilis as part of this most recent outbreak, such as Max (30s), generally knew more about it than most of the men in the study who had not experienced the infection. This included both how it was contracted and treated. Jeff (30s) explained that he made a point of learning everything he could about syphilis, once he had been diagnosed. He explained that he would ask pharmacists and call the doctor to find out more when he was dissatisfied with the information he was given: *'I made it my business to find out what these things were'*. While he knew very little, if anything, about it until his diagnosis, he insisted that his partner was more aware of syphilis because of previous experiences.

> *Alex knew, because his [ex-]partner had been through it. And again, I believe that's the only reason he'd know because his partner, for all he's been to the clinic, um, never had, you know, he never caught it off his partner, and his partner had it. And he had to go through injections and everything just the same. And the only reason Alex would know about it in detail is because his partner, his ex-partner went through it.*

Jeff described how he felt syphilis, unlike HIV, was not an infection that most gay and bisexual men knew about and that one would only know about it because of a direct or personal experience with the infection. Jeff saw his partner's knowledge of syphilis as exceptional, as it was only through his ex-partner's experience – rather than a general awareness amongst gay and bisexual men – that he became aware of the illness. Both Jeff and Max described how they felt isolated in their experiences of syphilis, and felt as though they were the only ones who had contracted these infections and knew anything about them. Like the men who were concerned about syphilis for health reasons, or who had encountered syphilis through their professional health work, Jeff and Max's experiences of syphilis were not situated in an understanding of a gay community like HIV, but as something that they experienced individually through a health-related encounter. These atomised experiences suggest how syphilis did not play a significant role in community understandings of illness amongst gay and bisexual men and was not something that could be learned about from or perhaps discussed with peers.

Familiarity with syphilis was not limited, however, to experience with the recent re-emergence. As explained in Chapter Two, in spite of the dominant narrative around syphilis which insists that it had all but disappeared shortly after the introduction of antibiotics in the 1950s (Quetel 1992, Clark et al. 2001, Bellis et al. 2002), there was a small outbreak of syphilis in the 1970s amongst homosexually active men in the UK. This epidemiological 'anomaly' was reflected in the experiences of older participants: for the men in this study who were over 60, and to some degree those in their 50s, syphilis was something they had experienced as sexually active gay men in the 1970s and early 1980s, before the onset of HIV and HIV prevention messages.[47] Charles (60s) explained that he contracted syphilis in the 1970s which was '*cleared by um, by thank you, National Health Service*'. Matt (50s) described how when he was younger, in the days before HIV, the attitude towards syphilis was '*oh take some pills, it just means to say you can't go drinking for a week or two. So that's the way that people think about it*'. For men who were sexually active before the onset of HIV, STIs, including syphilis, were something easily treated by antibiotics. Many of the men over 50 spoke about STIs in this way. For example, Edward (60s) explained how he felt that STIs, including syphilis, were just a part of being a gay man, '*an occupational hazard. Yes of course*

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[47] As explained in Chapter Two, STIs generally decreased in the 1980s with the onset of HIV, largely relating to the uptake of safer sex practice (Dougan et al. 2007).

you could get a dose of something, but Brenda at the Clap clinic would smile at you and say: Are you here again? Uh, and that was it.' Edward's humorous comments about getting treatment at the sexual health clinic signals how for him, and for many men over 50 in this study, syphilis was a part of the many minor and manageable risks that one encountered in the days before HIV.

Unlike Edward and Charles's awareness of syphilis from past experiences in the 1970s, the experiences and associations with syphilis for men under the age of 50 were very different. Five men associated syphilis with the much more distant past. Omar (30s) explained that he knew very little about syphilis, but that he had learned from a television program that '*King Henry 8th had syphilis'.* Omar's association of syphilis with famous historical figures acts to distance syphilis from the realities of the present as he constructed it as an illness of the 'past'. It is not only the links to the distant past that makes syphilis, for some men, seem a part of another reality. Relatively contemporary representations of syphilis, which allude to the horrific experiences of the past, also act to create these associations. For example, when Colin (20s) was told about the re-emergence of syphilis in a sexual health clinic, he described how he was reminded of the John Greyson film *Zero Patience* (1993) amongst other references and the way syphilis was represented. He explained:

> *One of the characters has syphilis in it, and it was back in the '80s when HIV was new, and they had, they had all these terrible things, because you went mad and children were born deformed, and it just sounded like this horrendous, awful thing and you hear about [syphilis] in historical costume dramas and these stories about men who had to carry around steel rods they had to shove down their penis, and yeah. So I suppose there was a lot of baggage with it that I thought was fairly scary, so um, that's what she told me, she didn't tell me that about syphilis, but when she told me that there was a problem with syphilis, all of that stuff was sort of dredged up.*

The representation of syphilis as '*this horrendous thing'*, linked with pre-HAART experiences of AIDS in the Greyson film made Colin think of historical experiences of syphilis which were linked to dated and painful sexual health procedures. While he acknowledged that these associations were not contemporary, it is significant that these were the primary associations he had with syphilis. The historic connections described by participants suggest that the long history of syphilis had not been wiped from the collective memory, but still held a particular cultural significance, but one that was associated with the past.

In contrast to these historical representations, none of the participants described any sort of contemporary associations with syphilis outside of a medical context. In many cases, very little, if anything, was reportedly known about syphilis. Furthermore, around half of the men in this study described their lack of specific knowledge about syphilis as the norm amongst the gay and bisexual men they knew. Most of the men explained that there was actually very little discussion of syphilis amongst their friends and partners. This lack of discussion played an important role in terms of how men thought about syphilis, and in some cases, its perceived prevalence. Peter (teens) explained that syphilis might come up in conversation in relation to what you can potentially 'catch', but not in relation to actual experiences of people contracting syphilis.

> *...I would view it like it was exotic. Not exotic, you know, but it's so out there, you never hear of it much. You hear all the time, but don't hear it in that situation. Like, or you can catch stuff like syphilis or HIV and stuff, but you don't really hear like this person has syphilis, is suffering from syphilis. Like I don't really hear friends who say I have caught syphilis or I have syphilis or anything like that.*

While Peter had heard of syphilis as one of those things that you can '*catch*,' he did not know anyone who had contracted syphilis, nor had he heard any of his friends talk about it. He had also not heard of anyone '*suffering*' from it, as though it were a serious illness that one would suffer with. In contrast, he explained, his friends would talk about contracting other STIs such as chlamydia or gonorrhoea. Syphilis was something that he had not heard mentioned by his friends as something to be concerned about in sexual health. This silence made him think it was *'exotic'* or rare and suggests how experiences of syphilis are individualised. When syphilis was spoken about in a social context, it was often raised by people who had had direct experience of it. For instance, Max (30s) explained the response when he told his friends he had contracted syphilis.

> *I remember speaking to one person when I had contracted it...and the person said well I thought it was just sailors who had syphilis. Like, I don't really know anything about what I've got now! [laughter] And, so I think it's just a, a disease that is very... people really don't know anything about it, they don't know what the symptoms are, they don't know what the risks are.*

Max explained that this association with certain groups of people, such as '*sailors*', considered to be 'promiscuous' and transient, led him to question what it was that he had contracted, and prompted him to think that people were generally quite unaware of syphilis. While one of the men mentioned the primary, secondary and tertiary stages of syphilis, and the nature of the symptoms of each of these stages, most men in this study

explained that they did not know what the specific symptoms were. This lack of awareness of syphilis may not be specific to gay and bisexual men and may in fact reflect the absence of syphilis in the popular imagination of the general population, given the low rates of the illness in the UK since the 1950s. However, Max's reference to sailors above suggests how gay and bisexual men *may read* syphilis differently to a general population, given the well-established cultural and historical associations of sailors and homosexuality (Baker and Stanley 2003).

Whether the lack of contemporary awareness of syphilis was related to it simply having 'disappeared' as a result of effective treatment, syphilis was seen today as different from the painful and physically damaging experiences of syphilis in the past. The contemporary availability of treatment means that most cases of syphilis do not progress onto the secondary and tertiary phases that result in more visible, physical symptoms (Simms et al. 2005). Much like the experiences of HIV, the advent of treatment for HIV meant that highly visible signs of infection like Kaposi's sarcoma are now no longer seen. And while there are similarities in the symptomatic suppression of both illnesses with the advent of treatment, I would suggest that the cultural significance of the illnesses were imagined as very different amongst participants. As outlined in the previous section, HIV for many men was rooted in a recent history that was tied to a notion of community and identity. In contrast, associations with syphilis were linked to either a specific medical concern or a distant historic time, suggesting that syphilis did not seem to be considered something that specifically concerned gay and bisexual men. While neither HIV nor syphilis might be highly publicly visible in relation to their everyday lives, these experiences suggest that syphilis did not hold a particular cultural significance for these gay and bisexual men. Where HIV was understood as an illness that affected imagined communities of gay and bisexual men, syphilis was not specifically associated with community experiences of illness. Although men over the age of 50 had previous experiences of syphilis, no one spoke of the need to pass on information about syphilis to younger generations of men. Moreover, syphilis was described as an individual experience that could be readily rectified by a trip to the '*clap clinic*'. This suggests that study participants imagined a community of gay and bisexual men in which syphilis did not hold any cultural or even biological significance. Syphilis was not 'gayed' in the same way that HIV had been, and was not understood as a

particular concern for gay and bisexual men. Where communities are imagined through shared identities and experiences, and the previous sub-section describes how HIV was an important factor in the ways in which gay communities were imagined by participants, syphilis has not played the same role. I explore the ways in which this might influence the response to perceived risks in the sexual practice of study participants in the next section of this chapter.

Responding to Biomedical Risk in Sexual Practice

The first section of this chapter explored the ways in which biomedical risks were understood by participants as embodied and in relation to imagined communities of gay and bisexual men. This section addresses how study participants responded to these understandings of risk in their sexual practice. In particular, this section considers how the biomedical, social and cultural understandings of risk were incorporated into norms of imagined community sexual practice. The section gives an account of the ways in which community sexual practice and responses to risk were perceived, the ways in which the men described their individual sexual practice, and the degree to which they saw themselves as a part of a shared sexual practice.

Practising Harm Reduction

Echoing dominant messages in sexual health advice of the past thirty years, all of the men in this study described a hierarchy of risky sexual acts in relation to contracting infections, with certain sexual acts posing more of a risk of infection than others. Public health messages targeting 'MSM' describe anal intercourse as the riskiest form of sex between men because epidemiologically it poses the highest risk of HIV transmission (Kippax and Race 2003, Hickson 2011). Unprotected oral sex, according to epidemiologists and public health practitioners, poses less of a risk of transmission of HIV (Hickson 2011). It is not, however, 'risk' free as it is currently the primary mode of transmission of syphilis in the UK between men, in addition to posing a small risk of HIV transmission. Generally speaking, however, unprotected oral sex is seen as less risky than unprotected anal sex (Hickson 2011). As outlined in Chapter Two, this hierarchy of sexual practices in relation to risk is the result not only of epidemiological research, but also of a 'community' developed response to HIV that focused on harm

reduction, as opposed to harm *elimination* (Watney 2000). This harm reduction approach, however, is not universally advocated. For instance, Watney highlights how the use of 'safer sex' in the UK differs from American usage of 'safe sex', which emphasises the total elimination of risk. Watney contrasts this (contested) American public health approach to sex between men with the harm reduction approach practised in Britain, Canada and Australia. Echoing Crimp (1988), Watney (2000), Weeks (2007) and Patton (1990, 2000) all argue that the creativity in sexual practice between men has resulted in forms of sexual practice that can reduce the risk of HIV transmission, is diverse, and allows for sexual enjoyment. That is, there are alternatives to abstinence, monogamy and, in some cases, penetrative sexual acts, in sexual practice which can result in a reduced risk of HIV transmission. This approach to HIV prevention, developed in the 1980s, continues to hold a dominant place in sexual health literature and interventions today,[48] as well as in popular understandings of HIV and STI prevention amongst all of the men in this study.[49]

The development of safer sex advice in the UK was largely aimed at HIV prevention, but has been taken on board by many in sexual health services to prevent a number of (but not all) STIs. Safer sex messages in the 1980s were generally targeted towards HIV prevention, largely due to decreasing rates of STIs (Dougan et al. 2007a). While public health messages have become more complex in response to increasing HIV and STI rates, there continues to be an emphasis on the higher degree of seriousness of HIV in comparison to other STIs (DOH 2001).[50] For instance, an example of this can be found on the sexual health section of MESMAC North East's current website. The section describing the risk involved in oral sex states: 'Of course there are STIs other than HIV, but luckily most of them aren't anywhere near as serious' (MESMAC NE 2011). It is unsurprising that sexual health organisations and literature reinforce this hierarchical notion of disease. Most STIs, including syphilis, are treatable. While traces of syphilis remain in the system even after treatment, the ill-health effects of the infection have

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[48] This is apparent accross the range of sexual health websites aimed at all men who have sex with men, which advocate this hierarchy of sexual practices, including MESMAC North East http://www.mesmacnortheast.com/ and the range of sites run by Terrence Higgins Trust. http://www.tht.org.uk/.
[49] While none of the men spoke about their role in developing these practices, a number of men described being involved in early AIDS prevention and counselling work throughout the 1980s.
[50] This approach generally excludes Hepatitis C, which is not technically an STI, but which has been transmitted through sex between men.

become largely manageable with antibiotics. However, as outlined in Chapter Two, STIs have attracted increased concern over the past decade due in part to the ways in which they complicate and increase the probability of HIV transmission in certain circumstances, and have been used as a proxy to measure HIV rates (Bonell et al. 2000, Røttingen et al. 2001, Dougan et al. 2007b). Thus, while sexual health messages have increased in complexity, focusing more specifically on STIs such as syphilis and gonorrhoea, the overall message from many sexual health organisations and services has continued to prioritise the prevention of HIV.

It is within this historical, social and epidemiological context that the men in this study developed their own approaches to sexual health: all of the men in this study described how the hierarchy of both infections and sexual acts formed an integral part of their understandings of safer sex and, they argued, their everyday sexual practice. For the men with whom I spoke, safer sex was not about abstaining from sex, but about weighing up the risks in a particular situation and responding to them through their sexual practice. For instance, as explained earlier in the chapter, all the men in this study described unprotected anal sex[51] as the biggest risk in sex between men. Such a view is largely due to the fact that they believed anal intercourse to be the primary mode of transmission of HIV.[52] Almost all the men described their sexual practice as largely avoiding unprotected anal sex (that is, anal sex without a condom). In some cases, this practice of avoiding unprotected anal sex continued with both casual and long term partners. Andrew (30s) explained that he used condoms '*99.5 percent of the time*' when having sex with casual partners, and continued to use condoms with regular partners, for fear of breaking the habit:

> *I don't necessarily want to break the behaviour, in the sort of theoretical chance that this relationship isn't going to last forever, then it is a relatively ingrained behaviour, which rarely ceases, and that's helpful in all sorts of things. So I'm sort of keeping the practice up, as it were. Staying on the condom wagon...*

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[51] All of the men in the study spoke about anal sex in relation to penetration with a penis. None of the participants explicitly mentioned fisting (penetration of the anus with the hand and part of the arm). Only one participant mentioned the use of sex toys as an alternative to penetration with a penis. Thus, for the purposes of this chapter, anal sex and/or intercourse will refer exclusively to penetration with a penis.
[52] As outlined in Chapter Two, both partners are not at equal risk of HIV transmission in this particular sexual act. The receptive partner is generally seen to have a higher chance of contracting HIV than the insertive partner (Hickson 2011).

Joking that he was staying on the '*condom wagon*', Andrew alluded to the idea that this was what he thought most gay and bisexual men practised. Gerry (20s) also described using condoms for anal sex regularly with his partner and explained that it was something that they practised without much discussion, regardless of the regular precautions they take with their sexual health:

> *I've been in a stable relationship for about three years now. Um, we use them anyway, so, even though we both have been tested regularly, um, we still use condoms as a, it's just a matter of course.*

Gerry explained how condom use was a part of his regular or normal sexual practice. As a sign of this practice, both Andrew and Gerry described always having condoms with them for sex, regardless of when or where the sex took place. Gerry explained that he has been and would always be prepared: *'I'd never not have one, um, not have a condom on me.'* For others, condoms continued to be used, even in circumstances which might be seen to influence allegedly 'responsible' decision making, such as the consumption of alcohol. Frank (20s) explained that '*even when I'm drunk I use [a] condom*', indicating that for him, condom use was something he felt was non-negotiable. These statements and sentiments reflect the ways in which the vast majority of men in this study considered condom use in anal sex a normal and/or integral part of their sexual practices.

Those men who were perceived *not* to use a condom every time were described in highly negative ways. About one-third of the men specifically used the term bareback or barebacking to describe the practice of anal sex without a condom. Will (20s) explained how '*bareback sex is um, either penetrating another person anally or receiving another person, you know, anally, um, without a condom.*' While Will's definition was technically neutral, the practice of barebacking is generally regarded by many in sexual health circles as blatant disregard for HIV. It has become a particularly heated debate topic in sexual health conferences and meetings, indicating tensions within community norms of sexual practice.[53] Moreover, these debates often relate this issue to the ways in

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[53] A very heated debate was had at a CHAPS conference I attended in Brighton in 2009, where the sexual health practitioners argued that bareback sex was no longer simply anal sex without a condom, but had taken on a more symbolic, cultural meaning as it related to HIV transmission (see Halperin 2007, Dean 2009). While opinion at the CHAPS debate was somewhat divided, the general attitude to barebacking and bareback pornography amongst sexual health staff in the North East was always negative and judgemental. At a number of sexual health meetings I attended, sexual health practitioners regularly

which gay pornography represents unprotected anal sex as sexy and more enjoyable than sex with a condom (Dean 2009). Most of the men in this study who use the term were fairly critical of bareback as a sexual practice. For instance, David (40s) explained how barebacking was something that he and his friends all agreed was not acceptable.

> *Well, most of the people I discuss this with are obviously close friends. Um, and we share a common, a common view that um, you know you have to be responsible for your own, your own safe sex... for example, no barebacking, under any circumstances.*

The term and practice were often referred to with disdain. All participants claimed it was something that they themselves did not practice; none of the men in this study described themselves as barebackers, even when they described having anal sex without a condom. Barebacking was usually mentioned in relation to what *other* men did. Moreover, it was something that not only HIV negative men were concerned with. For example, Rick (50s) who was HIV positive described his disappointment with men on an HIV positive men's chatroom.

> *If you go on an HIV website, they wanna have bareback sex. And I don't know why, because I don't think they realise or they just don't care, because as you're probably aware, the infections you can pick up in the strains of HIV which could render your drugs useless.*

Rick's complaints highlight how bareback sex for some men was not simply about the transmission of HIV, but also about the potential harm it posed to others. Rick described how he was concerned with picking up a different '*strain*' of HIV and felt that the men should know, or were ignoring the fact that their practice of anal sex without a condom put them and their sexual partners at greater risk of harm. Rick's concerns about acquiring a different strain of HIV reflect current biomedical messages around sexual practice between two HIV positive sexual partners. This discourse focuses on two risks in UAI between two HIV positive sexual partners: superinfection – when an HIV positive individual acquires a strain of HIV that is different from their existing strain of HIV; and resistance – when the resistance to certain combinations of HIV treatment in one partner is 'passed onto' the other partner. While there is ambiguous evidence around the development of drug resistance, the occurrence of superinfection has been demonstrated in a number of studies (Bourne et al. 2011). Furthermore, Rick's concerns

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complained about the presence of 'bareback porn' and the negative influence they felt it must be having on gay and bisexual men. One practitioner described it as 'evil' and immoral as she felt it could only contribute to sex without condoms amongst gay and bisexual men, resulting in an inevitable HIV infection.

around acquiring a different strain of HIV are not unique to him. Bourne et al. (2011) have shown how superinfection and drug resistance are a concern for recently diagnosed HIV positive men in the UK, and perceived to be integral to their everyday health management, signalling the incorporation of recent biomedical research into sexual practice.

Although Rick perceived that there were men who barebacked, many in the study felt that the practice of bareback sex was rare and limited to a small minority of men who did not adhere to what participants perceived to be a widely established community norm around anal intercourse. In a discussion around safer sex and how men represent themselves as practising safer sex on online dating websites, such as Gaydar, Andrew (30s) explained:

> *I think if men want ... or [are] very determined to have unprotected sex then they promote that almost. So their ad will say, looking for, you know, bareback sex. Um, and if you take it, or whatever, you know. I want a guy who will, or something like that. And I think that, I think, again, possibly, because there is so much pressure on them that it's not the done thing, then they almost assert it more, that they do it.*

Andrew explained how he felt bareback sex was seen as 'wrong' and potentially irresponsible. His description implied that it would be difficult to find a partner with whom to have bareback sex because of the community norms he perceived to be in practice, and the consequent moral judgement of the sexual actor who breaks these norms. While Andrew conceded that men do engage in this sexual practice, he felt that it was, at least in his experience, not a frequent occurrence.

Despite a perception of non-bareback sex as an established community practice by Andrew and other participants, some participants were concerned that bareback sex *could become* widespread amongst certain groups of men. Nigel (40s) discussed how younger men might be more vulnerable to 'unsafe' influences, such as bareback pornography.

> *What I am sort of conscious of, particularly, and I think it's, and I think the impact of pornography must influence people. This great, um, desire for bareback porn. And you know the number of younger people you see in these, you know, videos and films and things and they're having bareback sex and I think that must influence younger people. Which I think is like, that's a real*

concern for me because I think there are younger people, you know, completely different generation who weren't exposed to that government campaign, the hard-hitting government campaign. Or actually seeing situations, you know, where people are actively, not recommending but they're not sort of highlighting the risks about um unprotected sex.

Nigel's concern around younger men's lack of exposure and/or experience with the emergence of the AIDS epidemic of the 1980s and early 1990s highlights the connection he made between the perceived community norms of sexual practice amongst gay and bisexual men, and the way this practice may be affected by generational experiences (Plummer 2010). He was especially concerned for younger men – those not a part of the generation intimately or directly affected by HIV – who might not adhere to community norms of safer sex, established and adhered to by older gay and bisexual men. He described how their increased vulnerability was due to this lack of direct exposure to early experiences of HIV, which he felt he and other men around his age had experienced. The sense of belonging he attributed to this age group suggests that he made a strong connection between the earlier collective experience of the AIDS crisis and the response to risk in sexual practice today. He distinguished between different generations of men not only on the basis of age, but also on the assumed experiences they would have had in relation to HIV and their adherence to an imagined community sexual practice. That is, he expressed anxieties around the potential harm that representations of barebacking could have on these younger men, signalling a concern not only with the individual practice of gay men who chose to (or depict) bareback(ing), but the potential harm that it could pose to other members of the gay and bisexual 'community.' For Nigel and for many of the men in this study, sexual practice was not something that took place in isolation, but had the potential to affect others. This meant that sexual actors were linked in terms of biomedical risk and, therefore, in their responsibility to others within this 'community'. Nigel's concern, however, points to the ways in which this imagined community sexual practice and sense of responsibility to others was significantly affected by generational experiences.

In many ways, these anxieties suggests how participants imagined *multiple* communities of sexual practice which were formed and influenced by generational experiences and practices: Rick imagined a community of HIV positive gay and bisexual men who sought out and/or engaged in bareback sex and with whom he did not wish to associate; Andrew perceived barebacking to be practiced by a very small number of men who

were largely excluded from dominant community sexual practice of safer sex; and Nigel was concerned with how the age and experience of younger gay and bisexual men could lead to different and more risky sexual practices amongst this group of sexual actors. Where earlier in this chapter, participants were described as imagining themselves as part of a community of gay and bisexual men with a shared history of AIDS, the perceived diverse sexual practices of men within this community reflects a fragmentation of this imagined community.

While the imperative to use a condom for anal sex was considered to be strong amongst most of the men in this study, a minority of participants described exceptions to this *'use a condom every time'* adage, which they explained were different from the practice of barebacking. Moreover, these exceptions to anal sex with a condom took place in a particular context and can be described as what Kippax and others have called 'negotiated safety' (Kippax and Race 2003:3). This term has been used by number of researchers since the late 1990s to describe a form of harm reduction in sexual practice amongst gay men throughout the UK, Australia and many other countries.

> The practice of negotiated safety is a prevention strategy that allows for the relatively safe practice of discarding with condoms within seronegative regular relationships, as long as safe sex agreements are negotiated to cover sexual behaviour outside these regular relationships. (Kippax and Race 2003:3)

This practice, widely recognised as a form of harm reduction, considers the risk of harm to both partners. A number of men, like Frank (20s), Joe (50s) and Jeff (30s), described using this strategy. Jeff explained why he made the decision to stop using condoms with his partner.

> *Because we'd been checked out, I think, we'd both been to the clinic and we'd both been checked out. Um, we had practised safe sex for the first 3, 3 ½ months of our relationship and neither of us had been with anybody else. And I dare say never would... we reached a point in our relationship where, you know, we thought then, deemed acceptable. And I know, you know, we both know what people would say and that you should constantly practice safe sex, but then we've come to our decisions. I think it's different for each individual, everyone has, we trust each other. I think if there were a lack of trust, then we'd still be using condoms, we trust each other and the fact that we've both been given the all clear now means we're happy. You know, that, we're, we're, we're pretty safe and as long as we stick to what we did and we don't go playing about, we'll be fine.*

Jeff described relying on two essential elements for this strategy to work. Firstly, he described how he and his partner were both tested at the sexual health clinic, and were given the '*all clear*'. These biomedical markers signalled, for him, that both he and his partner were without infection and, therefore, would not pose harm to the other if they did not use a condom for anal sex. Secondly, Jeff described how he and his partner trusted each other to not go '*playing about,*' and therefore, to not pose harm to the other. Jeff described two forms of trust: emotional and biomedical. In addition to the *emotional* trust he described having in his partner to remain faithful and thus not pose any harm to their relationship, Jeff trusted his partner to not cheat on him, since cheating would potentially expose him to a physical harm of STIs and/or HIV. Jeff believed his decision not to use condoms would be judged negatively by others, including sexual health practitioners, and perhaps other gay and bisexual men as well suggesting his perception that non-condom use would break with community norms of sexual practice. He justified his decision on the basis that he thought it was different for everyone and that the trust he had in his partner was enough to establish the safety in their decision to stop using condoms. Jeff's response also seemed to be trying to convince me that this decision was reasoned and logical, indicating a perceived strong community norm amongst gay and bisexual men where condom use was seen as essential for anal sex. While men like Andrew and Gerry explained how they continued to use condoms throughout their relationships, Jeff relied on the trust he had in his partner, and which he believed to be mutual. Trust, for Jeff, meant that neither man would do harm, emotional or physical, to the other.

Negotiated safety in regular partnerships was not limited to 'traditional' monogamous arrangements. Participants spoke about engaging in a range of sexual arrangements, reflecting what Heaphy et al. (2008) have described as creative and reflexive management of sexual relationships. For example, Joe (50s) described being in an 'open' relationship with his long-term partner, which meant that they had agreed each could have sex with other men. He described how they held a tacit agreement around condom use in anal sex with other sexual partners. Joe explained how sexual activity outside of their relationship had normally meant casual sexual encounters. However, he reported that there were two occasions when these extra-'marital' encounters developed into more serious and long-term relationships. It was because of this, he explained, that

he went for sexual health check-ups with these partners to make sure that neither partner had any STIs or HIV. Joe described seeking the biomedical confirmation which Jeff and his partner had sought out because of the nature of the relationship, even though he had negotiated a very different 'monogamous' relationship to Jeff. Much like Jeff, however, Joe described not using a condom with these two long term partners because he considered them to be regular partners and because they had both been given the all-clear. Joe's polyamorous/monogamous relationship, and the ways in which he described managing his sexual health in these circumstances, captures the complex ways in which men negotiate both the use and non-use of condoms in a number of relationships.

While Kippax describes this negotiated safety within the context of 'regular' partnerships, some of the men elaborated on how they employed a similar strategy with non-'regular' sexual partners. For example, Matt (50s) spoke of how he had multiple sexual partners and regularly used condoms for anal sex with these partners. However, he also explained how he practised anal sex without a condom with one partner in particular: *'there's a guy who I see very regularly...and he doesn't like being fucked with a condom. So therefore, he doesn't have many sexual partners....'*. Matt described how this was not a decision he made lightly, and was taken only in the belief that his partner had few other sexual partners, and after he had tried to introduce condoms to the sexual relationship: *'I say, look Luke, I'm happy to wear a condom. You know because I've got some sensitive ones, you know, that sort of heterosexual men use'*. Matt explained how he was the insertive partner, who was technically at less risk of HIV than Luke. He was also concerned, however, about the risk he potentially posed to Luke. Emphasising the steps he took to reduce risk to both himself and his partner, Matt explained how he lost a number of friends to AIDS in the 1980s, and that he was very concerned with the possibility of contracting HIV. Consequently, throughout his description of his experiences with Luke, he tried to make it clear that anal sex without condoms with casual partners was an exception to his regular sexual practice with other men.

> *R: I tend not to take risks you know when it comes to condom use, unless it's the circumstances that I've just discussed with you, with a particular partner. But even then, I'm thinking to myself, well I know I've been tested and I haven't had penetrative sex with anyone else, other than you, Luke, since I was tested last without using a condom. But I have taken other risks....*

I: But you said that, um, the men that you'd had sex without a condom with, you, you've almost not vetted, but you know him and you make a sort of risk assessment.

R: Yes, that's right. Mm hmm. It doesn't happen very often Ingrid. You know, I'm not constantly going out and having sex with other men without using a condom. (Matt, 50s)

Matt's need to reassure me that this was not his regular practice suggests he felt that the practice of not using condoms for anal sex was generally unacceptable amongst most gay and bisexual men. He reported how his sexual practice outside of this relationship conformed to perceived community norms. His 'regular' practice involved being consistently tested for HIV and STIs, using condoms for anal sex with other men, and having unprotected anal sex with only one person, whom he knew and trusted to have few sexual encounters with others. This last element, of trusting that this partner would not have other sexual partners, was based not on an individual trust that Jeff described above, but on a perceived community practice of men regularly using condoms for anal sex with their sexual partners. Despite the fact that he described making an exception in his sexual practice, he felt the need to contextualise this practice in the interview. This was in order to demonstrate how he had assessed the risk to himself and to his partner in the situation, and concluded that risk of HIV to both was low enough to proceed.

The men who described practising 'negotiated safety' did not, by their own admittance, try to eliminate all risks, but sought to minimise or reduce the risk of infection and the harm to both themselves and to their sexual partners. Once they felt the risk was sufficiently reduced, they engaged in sexual practices that prioritised pleasure. That is, when the risk was reduced below a level they judged acceptable, pleasure and intimacy became more important than the remaining risk factors. Joe, Jeff and Matt all described to me how the total elimination of risk was not possible in sexual encounters with others, but that they attempted to reduce the potential harm to themselves and to others within a manageable and enjoyable form of sexual practice. These men described negotiating the risks in their sexual practice, as well as specific sexual arrangements within a perceived community norm of practice that prioritised HIV prevention and rejected UAI. In this context, negotiated safety was seen as an extension of community sexual practices. Rather than being an exception to the rule, these instances demonstrate the ways in which the men adapt to sexual and emotional situations while still adhering

to the prevention of harm based on a biomedical framework. This practice also takes into consideration the potential harm that might be done to each other, as seen through the negotiations with sexual partners that took place in each encounter. Their concern with conforming to community practice highlights the ways in which they felt a responsibility to reduce harm in relation to HIV prevention. This responsibility was not only in relation to not contracting HIV themselves, but also in relation to preventing their sexual partners from potentially being put at risk of HIV. This demonstrates how the prevention of HIV transmission was understood as both an individual and collective responsibility for most men in this study, echoing to some degree the notions of responsibility in discussions of healthy (Petersen and Lupton 1996) and biological (Rose 2007) citizenship. The following sub-section will consider how other biomedical risks factor into perceived community norms, individual sexual practice and notions of responsibility.

Negotiating non-HIV risks

Although oral sex[54] is the main mode of syphilis transmission due to its bacterial nature (Clark et al. 2001), most men in this study expressed not being very concerned by the risks they associated with unprotected oral sex. In fact, this kind of sexual practice was described as significantly less risky than anal sex by all the men in this study. However, the men did not specify if unprotected oral sex was more or less risky than protected anal sex. In many ways, oral and anal sex seemed to be described as if they were in two completely separate categories of sexual risk, regardless of the use of condoms for either act. Moreover, there was very little discussion of oral sex apart from fellatio. Only one man spoke about rimming[55] and considered it to be in the same category as oral sex in terms of risk. He did acknowledge the risk of Hepatitis, but described how he had been vaccinated for both Hepatitis A and B, and therefore felt that he was not at risk. It is unclear whether he was aware of Hepatitis C as a potential risk, which is normally associated with 'rough' anal sex, such as fisting, where there is the potential for bleeding (Aidsmap 2011).

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[54] Most men described fellatio as oral sex. Unless otherwise indicated, I will continue to use the term oral sex for fellatio, in keeping with the terminology of participants.
[55] Otherwise known as analingus, rimming is the practice of licking or sucking the anus of your sexual partner.

In general, most men described unprotected oral sex as low risk in relation to the risk of HIV transmission, which was the main concern for most men in this study. For instance, Colin (20s) explained:

> *...you can get [HIV] from having oral sex, but, it's a very very low risk, unless you know you've got wounds on your penis or your mouth, which could be a route of transmission, you know.*

While Colin's comments highlight an awareness of the *possibility* of risk of HIV transmission through this act, he and others saw the *actual* risk of transmission as incredibly low. His reference to wounds on the penis or in the mouth draws us back to the earlier discussion in this chapter on risk in and on bodies and the awareness of many men to be 'on guard' for potential physical avenues of transmission. Colin's comments are typical of the way that the majority of participants described risk relating to unprotected oral sex. Similarly, Paul (30s) explained how he had experiential evidence that there was a very small risk of HIV transmission in unprotected oral sex. This risk was even further minimised by elimination (or reduction) of the transmission of blood.

> *I've had oral sex with a guy who was HIV. I knew he was HIV and I thought well the risk was minimal. I've got no cuts, got no blood, this that and the other. So, but obviously it's still more of a risk than somebody who isn't. But yet, how many HIV tests have I had all my life? Quite a few.*

Paul's practice of getting regular HIV tests, all he assured me with negative results, reassured him that this practice was low risk. His knowledge of having an HIV positive sexual partner further supported this notion: if he could have unprotected oral sex with someone who was knowingly HIV positive, and not contract HIV, then unprotected oral sex would pose relatively little risk to him in terms of HIV transmission. While Paul relied on biomedical knowledge to know that having cuts and blood in the mouth would increase risk of transmission of HIV in this encounter, he also demonstrated the ways he relied on knowledge gained from past experiences, where he had not contracted HIV in spite of having an HIV positive partner.

A few men spoke about the risks of contracting other STIs, including syphilis, through unprotected oral sex. Matt (50s) described how he was aware that unprotected oral sex posed some risks, not just of HIV, but of other STIs:

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you can still be exposed to the virus through oral sex. HIV/AIDS, syphilis, gonorrhoea. All of it. And, the risk for HIV/AIDS for oral sex is not as pronounced as it is for anal sex, but it's still a risk.

As outlined earlier in this chapter, some men were aware that oral sex was the main mode of transmission of syphilis. Most men, however, were less sure about the bacterial nature of syphilis and, therefore, the difference between syphilis and other STIs in terms of mode of transmission. Moreover, most men assumed that syphilis, like other STIs, was contracted primarily through unprotected anal sex. Yet when they were made aware of how syphilis was contracted, either through sexual health clinics, advertising, in conversations with other men, or even within the interview itself,[56] they tended to group it together as a risk with other STIs. For example, Jeremy (40s) explained that for him syphilis was:

just another STD that I don't want. It's in that bucket of STDs there. It's no better or worse than any of the others that are all equally bad for me.

The majority of the men in this study expressed similar feelings about syphilis. They described how syphilis was something they did not know very much about, but assumed it was an STI that they did not want and therefore identified it as a risk in sexual health. Having very little to say about syphilis specifically, the men often resorted to talking about STIs in general whenever the topic was raised. Relying on their existing knowledge about STIs, most men treated syphilis as no different from chlamydia or gonorrhoea in terms of the harms it posed to them. For instance, in contrast to HIV, Joe (50s) explained that most gay men he knows, including himself, think of syphilis as just one of many STIs.

I think they do think of them separately. The other STIs syphilis, gonorrhoea, chlamydia, I think they consider them all to be the same prevalence, the same problematic, the same treatment, curable, whatever.

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[56] In a number of interviews, I introduced this information to the discussion. I made this decision for two reasons. Firstly, as outlined above, it was clear that many of the men did not know that syphilis was bacterial and not viral, and that the main mode of transmission was through oral sex. As the provision of sexual health information was one of the benefits offered to participants, it seemed important to provide this information, both verbally in the interview and through the provision of an information leaflet. Secondly, I also took the decision to introduce this information as the men, on the whole, found it quite difficult to talk about something they knew so little about. Consequently, it meant that when men did speak about the possibility of contracting syphilis specifically, it potentially drew on this 'new' information that I had introduced to the interview.

The way Joe included syphilis in a list with other STIs such as gonorrhoea and chlamydia was based largely on the assumption that it was a treatable infection, unlike HIV. This played an important role for participants. While most admitted to not wanting to contract an infection, many described the possibility of treatment easing their concerns. Thus, the availability of treatment for STIs, including syphilis, meant that the men in this study saw syphilis as a very different infection from HIV. It was perceived as something that was perhaps unpleasant, but relatively manageable.

It was within this context that most men described the practice of unprotected oral sex as widespread among the gay and bisexual men that they knew. Almost all the men in the study described not using a condom for this practice and perceived this as a community norm. Edward (60s) exemplifies how most men spoke about oral sex: '*I can't remember the last time I saw anybody having protected oral sex.*' Just over half of the men said explicitly that not only was this their regular practice, but that they could not imagine ever using a condom for this sexual act. For instance, Will (20s) explained how he '*never practise[d] sex, well, oral sex with a condom*' and Peter (teens) described how he did not '*use protection for oral sex*'. For those men who had contracted syphilis,[57] none of them described changing their practice of unprotected oral sex. Not only did the men, of all ages, describe this as their own regular sexual practice, but most considered that this was the norm in the sexual practice of others. For instance, Paul (30s) surmised that '*out of a hundred men, maybe one…gay man would use a condom especially for oral sex*'. Reiterating Edward's comments and Peter and Will's practice, the use of condoms in oral sex was seen as relatively rare, in spite of the potential risks of contracting STIs. In many ways, this reflects how men in this study perceived a community sexual practice that prioritised HIV prevention, and was less concerned with the prevention of STIs, including syphilis, transmissible through unprotected oral sex. It also suggests the way in which new sexual health information, which may be at odds with community sexual practice, may not be taken up and/or incorporated when people are simply told about the risks of infection.

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[57] This does not include participants who were diagnosed with syphilis at the time of their HIV diagnosis.

There were, however, some rare exceptions to this norm. A few of the men said they had begun to practice oral sex with condoms *after* they were specifically made aware of the risks involved in unprotected oral sex, although these risks were not always in relation to syphilis. Oscar (50s) explained that he was scared of contracting syphilis because of the effects it could have on the brain. Jack (20s) began practising oral sex with a condom once he learned that HIV could be contracted this way. Rick (50s), after his HIV diagnosis, claimed that he would no longer engage in oral sex without a condom because the risk of contracting something like syphilis would cause too many problems for his already complicated health status. Jeremy (40s) described always using a condom for oral sex because he wanted to entirely avoid having to go to a GUM clinic after an early, traumatic experience. For Jeremy, Oscar and Jack, finding partners who were willing to engage in protected oral sex was difficult.[58] Jack explained the problems involved in negotiating condom use for oral sex with partners:

> *R: ...when you say that you want to use a condom for oral sex, they just think why? That's the look they give you, why would you want to use that? And not, a lot of men aren't very comfortable with using a condom for oral sex. And I've stopped going, I was about to have sex with somebody, I say can you use a condom for oral sex and he refused, so I asked him to leave.*
>
> *I: And how did he respond?*
>
> *R: He didn't like it. But I thought, it's not my problem, I'd rather be safe than sorry.*

Jack's stance – '*I'd rather be safe than sorry*' – represents a strong conviction in the face of widespread social practice when it comes to prevention. While most of the men in the study would take this stance in relation to anal sex, Jack was most definitely in the minority when it came to the practice of oral sex. In contrast to judgements made around barebacking, explored in the previous section, most participants did not negatively judge those men who did not take all available precautions to prevent STI transmission. Instead, the widespread social acceptability of this potentially risky sexual practice signals how the prevention of HIV was a shared goal for most gay and bisexual men, whereas the prevention of STIs, including syphilis, as a community practice was much less unified.

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[58] Rick described himself as not currently sexually active, but described how he planned to use condoms for oral sex in future sexual practice.

This reported community practice of unprotected oral sex, I would argue, is not merely a result of men who just want to have a good time, but grounded in a safer sex ethic based primarily on HIV prevention. While many described being concerned with contracting an infection, others described themselves as part of a community of sexual actors who affected each other. Thus, it is not simply the shared goal of preventing HIV that influenced many men's sexual health strategies, but a concern for others. Reflecting the rationale of many men in this study, Andrew (30s) described how he weighed up the risks of HIV, STIs and his sexual practice as it affected both his sexual health and the sexual health of his partners.

> *I perceive that my risk of contracting HIV through oral sex is very low, not even relatively ... you know, 4, 5 percent isn't bad odds, as it were. So, that, that's risk I am willing to take. And I took that in a very conscious way for the last, I've been having oral sex with men for the last 13, 14 years. So I took that as a very conscious choice through all of those years. With syphilis it isn't so much of a conscious... with STIs it isn't so much of a conscious choice, other than with most of the other STIs I perceive that they are, um, relatively low risk as a disease to me and in terms of transmission, because I'm not going to be transmitting them through anal sex in the majority, because the vast majority of my anal sex is protected, and the risk of my transmitting an STI through oral sex where I am sort of the person providing the oral sex as it were, is relative low as well and it's very very rare that I receive oral sex as it were, which is a choice of mine. Um, whereas, so yes, so my perception is that god forbid I was to contract, through oral sex, gonorrhoea, as an example, then that would be alright. I could live with that. That is a risk I'm willing to take. I perceive it to be a relatively low risk disease.*

In this extract, Andrew touched on a number of sexual health, biomedical and intimate issues in a nuanced and thoughtful way. What is important to point out here is the way in which he sought to reduce the harm posed to both himself and to his sexual partners. In relation to HIV, Andrew explained how he has consciously considered the risk of HIV to himself through this practice and decided that it was very low. Moreover, his many years of experience of this sexual practice reassured him that he had made the right choices in relation to HIV prevention and that unprotected oral sex was relatively safe in this regard. As a result, Andrew felt that the risk he posed to others was minimal, as it was unlikely that he would be in a position to transmit HIV to sexual partners. His sexual practice, apart from oral sex, was protected, and the risk of HIV transmission to other men was therefore minimal. This conscious decision highlights the ways in which Andrew had adopted what he perceived to be a shared community goal in HIV prevention, a responsibility he had as a member of an imagined community of gay and

bisexual men who shared this goal. In relation to STIs, Andrew explained how he was less aware of an overt rationale to prevent STIs, but that given his knowledge he felt that he was relatively protected. Moreover, he described how he felt contracting an STI would not be the worst thing that could to happen to him and would be a manageable outcome of his sexual practice. That he had not contracted an STI in the previous 14 years reaffirmed for him the salience or success of his safer sex strategy: his experience of not contracting an STI or HIV convinced him that his sexual practice was low risk, demonstrating a temporal process of risk evaluation. Finally, however, I would like to consider Andrew's comments in relation to the risk he posed to others. While he described largely being concerned with the transmission of HIV, he also spoke of the possibility of transmitting other STIs to other men. For Andrew, his safer sex strategy was not merely about preventing *him* from contracting an infection, but also about reducing the risk he posed to his sexual partners. He felt that the nature of his sexual practice was such that it would significantly reduce, if not eliminate, the chances of passing on an infection to a sexual partner. This concern demonstrates a practice based in a sense of responsibility not just to the self, but to others in his 'community,' again, echoing Rose (2007) and Petersen and Lupton's (1996) discussions of responsibility and citizenship.

The second part of this chapter has shown the ways in which study participants' responses to risk in sexual practice were based on particular biomedical understandings of risk which were negotiated with perceived community norms and priorities. The majority of men spoke about the priority of preventing HIV transmission, and this appeared to play an important role in their sense of community and their responsibilities to this community. While this priority was enacted through imagined community norms of sexual practice – i.e. the prioritisation of protected anal sex – the men also expressed concerns about the harms that breaking with these norms could pose, especially to younger men. Some men described anxieties around how these norms were passed on, and, therefore, the ways in which the boundaries of this community were formed and maintained. Moreover, the re-introduction of syphilis and the potential challenge it poses to sexual health strategies highlights the ways in which community norms of sexual practice, and the related ways in which communities are imagined, can experience change and fragmentation.

Conclusion

This chapter has shown how the identification of and responses to risk in sexual health by participants drew on biomedical and social knowledge and were embedded in community sexual practices. These practices were not those of *a* community of gay and bisexual men, but those of multiple imagined communities (barebackers, young gay men, regular condom users, men directly affected by HIV, etc). However, participants also described a particular imagined community of gay and bisexual men affected by and responding to HIV. In other words, they described a group of sexual actors whose social *and* biomedical histories in relation to HIV contributed to both a sense of community and understandings of community sexual practice in response to risk. These community responses to risk have been shaped by biomedical and social factors. I would therefore suggest that these biomedical, historical and social factors demonstrate a form of biosociality (Rabinow 1996) within this imagined community of gay and bisexual men affected by HIV. In Chapter Two, I outlined how biosociality was based on the notion of clusters of sociality that form around sites of knowledge and power in relation to particular illnesses. These sites of knowledge and power include biomedical knowledge and institutions, but also social knowledge and practice, and shared experiences of illness and activism. Biosociality emerges from and affects how individual actors relate to others who are similarly affected by these sites of knowledge and power. This chapter has demonstrated the ways in which forms of biosociality have emerged and been embedded through community sexual practices in response to HIV. For instance, we have seen how corporeal understandings and management of bodies, drawing on particular biomedical understandings of risk, were integral to notions of risk of HIV in sexual encounters. This chapter has also explored how participants imagined a particular 'community' history in relation to HIV and how this 'shared' biomedical history has affected contemporary notions of HIV as an ongoing risk. In contrast, experiences of syphilis have highlighted how an absence of community can be a significant factor in the awareness and/or responses to illness. Participants described how perceived norms of community sexual practice were based in a harm reduction approach that prioritised HIV prevention. These norms included a combination of biomedical and social HIV prevention methods such as condom use, negotiations with sexual partners and HIV testing. In addition, this practice highlights how participants were concerned not only with their own sexual health, but also with the sexual health of other men and therefore felt a sense of responsibility to prevent harm to others.

I would suggest that participants drew on the notion of an imagined biosocial community in how they negotiated their own sexual practices, that is, an imagined community of gay and bisexual men who are collectively affected by (and concerned with) HIV. Much like the elusive 'gay community', an imagined biosocial community in this instance is not a uniform or static set of actors defined by a particular illness. It is an imagined community within which participants attempted to negotiate a responsible sexual practice in relation to others. Anxieties expressed by participants around practices which did not adhere to perceived community norms, however, highlight the ways in which this imagined biosocial community can be shaped and affected by factors such as age, generation and serostatus. By exploring the notion of an imagined biosocial community, we can see the ways in which biomedical, social and community factors worked together to inform understandings of and responses to risk. In other words, it is not just that particular forms of biomedical knowledge and experience contribute to participants' responses to risk, but that both work in combination to form an understanding of risk within an imagined community of sexual actors. In offering the notion of a biosocial community, I am not suggesting that this is the only or dominant framework within which participants negotiated their own sexual practice. However, it does provide a useful lens through which to explore how the biomedical and social work together within a community framework and I will therefore continue to explore this throughout the thesis. The following chapters will not only focus on the issue of biosociality. On the contrary, they will also explore how sexual practice is affected by multiple factors and will therefore seek to further interrogate if, how and where biosociality emerged. While HIV prevention was a reported priority for all men in this study, individual responses to risk reflected the ways in which multiple communities and norms of sexual practice were imagined and adhered to by participants. The next chapter will further examine the ways in which generational differences, as well as the changing political and social norms of imagined communities, impact on understandings of and responses to risk.

Chapter Five – Constructing the Risky Other

Introduction

This chapter explores how individual actors within imagined communities of gay and bisexual men were understood as breaking with or adhering to community norms of sexual practice. It asks *who* is seen as the risky sexual actor and why? What role do experiences of illness play in understanding responsibility and risk? Moreover, what does it mean to be a responsible sexual actor and how might this have changed over the last thirty years? The chapter explores how participants constructed both risky and responsible sexual actors and how these constructions were framed by their perception community norms. It also examines how generational experiences have shaped how men decide what is risky and incorporate these decisions into their sexual practice. In other words, how has 'responsibility' for risk reduction in individual sexual practice been negotiated within the changing sexual and social norms of imagined communities? This chapter is divided into three sections. The first section explores how participants perceived gay men to be depicted and treated in terms of risk on the basis of biomedical, social and experiential knowledge. Furthermore, it addresses how this depiction and treatment influenced how gay men, as a social category of sexual actors, were understood in relation to risk by participants themselves and how these understandings were affected by generational and social experiences. The second section considers the idea of 'promiscuity' and the ways in which particular men were categorised as promiscuous and potentially risky. This analysis takes into account how the construction of 'risky characters' was framed by changing community sexual practices, as well as the notion of harm to others. The final section explores the ways in which HIV positive gay men were viewed in terms of risk. It also considers the experiences of HIV positive participants, and the ways in which they sought to manage risk in their sexual practice and within perceived community norms.

Gay Men

Much has been written on the negative and homophobic representations of gay men and HIV over the past thirty years. Gay men have been constructed as risky sexual actors by the media, as well as in policy and culture. These constructions have often been rooted in a discourse based on prejudice, misinformation and stereotype (Sanderson 1995). For

instance, Watney (1987, 2000) has documented the inaccuracies and homophobic language used in media representations of gay men and HIV throughout the 1980s and 1990s. Waldby (1996) and Patton (1990, 2002) have demonstrated how biomedicine discourse and health policy have also unfairly treated gay men as risky. Homophobic constructions of gay men have become more subdued and less common in recent years, especially with the introduction of equalities legislation (Carabine and Monro 2004) and increasing social acceptance of homosexuality (EHRC 2009; Mitchell et al.2009).[59] However, some men in this study reported feeling that such negative depictions of gay men have continued to persist. The first section of this chapter examines the ways in which participants perceived gay men to be represented and treated as risky within a biomedical and social context and explores how participants responded to this construction of gay men. Very few participants referred to bisexual men in their descriptions found in this section. Thus, although I refer to gay and bisexual men in relation to community norms and practices, this section considers the image of 'gay' men in contrast to other forms of identity, and to the practices of men who have sex with other men.

Interpreting Epidemiological Difference

A number of participants described how gay men were represented as either being at or posing a greater risk of infection than the general and/or heterosexual population. This construction was based largely on health-related sources or experiences. One-quarter of the participants quoted specific health statistics which described gay men as riskier sexual partners due to the higher than average rates of HIV and sexually transmitted infections (STIs). In addition, over half of the men explained how they collected information on safer sex and the risks facing gay and bisexual men from various websites, health literature and gay and bisexual men's group meetings.[60] These sources of information, many of which highlighted the risks of HIV and STIs specifically for gay men and which supplied many of the participants with the most recent statistics relating to infections amongst gay men, served to make men aware of the risks for gay men and to reinforce the already existing idea that gay men were at higher risk of

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[59] Although these reports outline the ongoing stigma, discrimination and inequality experienced by the LGBT population in the UK, they also concede that there has been a major shift in public attitudes towards an increasing acceptability of homosexuality.

[60] Meetings and groups where people accessed this particular information included Gay Men Tyneside (GMT) which met at MESMAC, MESMAC's young men's group and STAG (Gateshead and South Tyneside Gay and Bisexual Men's Project), which runs out of Gateshead Sexual Health Services.

infection than men in the heterosexual population. None of the participants described websites, pamphlets or training sessions that challenged the depiction of gay men as being at high risk of infection. By contrast, Hickson (2009) argues that much public health literature depicts young heterosexual men and women as being at greatest risk of HIV in the UK. He further suggests that such representations are untrue and describes this literature as homophobic because it does not reflect the epidemiological evidence. The evidence, he argues, demonstrates that gay, bisexual and/or men who have sex with men ('MSM') continue to be at the highest risk of infection in the UK. It is significant that Hickson's observation regarding representations of gay men in relation to risk of HIV infection is not reflected in the observations and experiences of study participants. Much like the debates around the de-gaying and re-gaying of HIV in the 1990s, discussed in Chapter Two, these contrasting interpretations demonstrate how the representation *and* interpretation of epidemiological data is influenced, in complicated ways, by social and cultural factors (Kippax and Race 2003). It also highlights how the subtle yet important differences between depicting gay men *as risky* and as being *at risk* of infection. Participants struggled to make sense of these differences and in some cases, conflated the two. For some men, the high rates of infections amongst the gay male population meant that gay men must be engaging in risky sexual practice. For other men, the high rates of infection meant that gay men were more vulnerable and at more of a risk because of the existing rates of infection and not solely because of their sexual practice. While no clear stance was apparent amongst participants on whether the increased STI and HIV rates were caused by risky sexual practice or were contributing to increased vulnerability of sexually active gay men, what was clear for most of the men in the study was that rates of both STIs and HIV were perceived to be disproportionately higher amongst gay men in comparison to the general population.

The interpretation of HIV and STI data by clinical sexual health staff and the perceived unequal treatment of gay men in clinics on the basis of this data was reported by some men in this study. A small but significant number of participants described how, for them, personal experiences with health staff in sexual health clinics reinforced the notion that gay men were, or were considered to be, more risky than men in the heterosexual population. For instance, Paul (30s) described how he felt gay men were seen more quickly in sexual health clinics because they were perceived as more likely to have HIV and/or STIs.

But I used to get special treatment there as well. Sometimes I used to walk in and there'd be fifteen people in the queue. And all of a sudden me name would come up and I'd think, well, hang on, is it because I'm gay that they want to pounce? Hang on, he's gay, is he gonna have syphilis? Is he gonna have gonorrhoea or what? You know, and never mind these straight people, yawn, boring...

Paul felt that his special treatment at the sexual health clinic was directly related to being gay and the purportedly higher chance of him contracting an STI. Similarly, Jeff (30s) felt that he had been treated differently to other patients at a sexual health clinic. He explained how a health advisor had suggested he use a condom for oral sex with his partner, and he felt this advice was given to him because he was gay and not because of his sexual practice. However, unlike Paul, Jeff felt this treatment was unfair and inaccurate.

but then, as I says to [the health advisor], what do you expect a heterosexual couple to wear a condom whenever they engage? You know, like how do people get pregnant? You know and she just laughed and she said, oh it's just standard. And I said well it's wrong for yous to expect a gay couple, you know, just cause we're the same sex, to have to wear a condom all the time, even when it comes to oral sex. Cause again, no doctor will ever say to a heterosexual couple well you've gotta wear a condom for oral sex. I just find it... but then of course comes the risks of, you know, in a gay relationship, are obviously high risk. You know, I don't understand why we're a high risk, because one of me mates who shags about like nothing else, he's at a far higher risk than I'll ever be, you know, in my opinion.

Jeff perceived his own sexual practice to be more responsible than his friend's, mainly because Jeff did not '*shag about'*. To this extent, Jeff claimed that the categories of risk on the basis of sexual identity used by clinic staff were both inaccurate and unfair. Moreover, he described how angry he felt by the fact that his relationship was not considered in the same way as the relationship of heterosexual couples. Jeff described how his relationship was monogamous, both partners had been checked out as being infection-free and both men were planning to come regularly to the clinic to get tested. Jeff argued that the health advice given to him was based only on his identity as a gay man, not on his sexual practice, and therefore his treatment in the clinic was unjust. While we cannot know how clinic staff dealt with heterosexual patients from this excerpt, other research (Wilton 1997) has shown how health promotion material and advice has not been neutral in terms of sexuality and gender, but has made assumptions about the nature of sex people engage in on the basis of their perceived identities and the associated levels of risk. Wilton argues that these biases have led to the creation of material that treats gay

men as different from heterosexual men and women.[61] Jeff felt he was treated differently to heterosexual patients, and as being more risky than them. Given his perception of the diverse sexual practices within the general population, he characterised this treatment as unfair.

Colin (20s) described a similar experience when he went to a sexual health clinic for the first time. He explained how the experience was not only overwhelming but reinforced what he had read about gay men – as a community – and the way in which biomedical discourse played a significant role in constructions of this community.

> *everything that I've read about gay men as a community, in this country, tends to suggest that there's always a higher risk than maybe the general population. But I don't know whether, or how true that is, but that's the impression I get. And also the first time I ever went to get tested, um, before me and my partner were thinking about having, having penetrative sex, um, the first, I thought well you know, before I start doing that I better get tested, just to make sure? And just the way I was treated when I went in. They were great, but they were like, right, you know, we'll give you this Hepatitis B jab because you've not had that and do you know there's loads of syphilis going around so we'll give you a syphilis test and do you want to talk to a counsellor about HIV? And I was just thinking, wow, you know, I'd no idea that um, that they would pay so much attention to me. And the impression I got was that I was getting my jabs before I went on holiday to like India or something...like they have to load you up with all these defences against all the things that you might catch, just if you're having, just if you're having a relationship, or trying to meet someone. And I just, yeah, that was the impression I got. You know, because I just think that gay men are kind of seen as this, this community that's somehow defined by disease in some ways.*

Colin's session with the sexual health advisor introduced him to the range of STIs, tests and vaccinations targeted specifically at gay and bisexual men. While he felt he was just '*mak[ing] sure*' that he was okay to have penetrative sex with his partner – something he felt was responsible and normal sexual practice – the experience also reaffirmed his belief that gay men were only seen by sexual health services in relation to the potential '*diseases*' that they could contract. Whereas Paul and Jeff perceived that they were treated differently to a heterosexual patient, Colin felt that he and other gay men were constructed *primarily* in relation to the infections and illnesses they were deemed to be at a higher risk of contracting. Moreover, Colin's comparison of his sexual health check-up to getting his

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[61] In his reflections on HIV prevention programmes and approaches to gay men in the late 1990s and 2000s in both the US and the UK, Rofes (2007:43) reiterates this point, and argues that the many programmes and interventions established to support and care for gay men use 'as foundational building blocks a pathology-focused understanding of gay men.'

'*jabs*' before he went to somewhere like India did more than highlight the difference between gay men and heterosexual patients; it suggested to Colin that gay sex was a high risk practice, and that gay men were necessarily at a higher risk of infection because of this risky (and potentially exotic) practice. Both Jeff and Colin voiced concern that this 'special' treatment of gay men as a high risk population did not take into consideration their individual sexual practice and the way in which they might be at less risk of infection than other sexual actors.

This sub-section has demonstrated an awareness amongst participants of the higher than average rates of STI and HIV infection amongst gay men than the general population. It also described how direct experiences in sexual health clinics for some participants reinforced the construction of gay men as highly risky sexual actors. Where Chapter One detailed the ways in which biomedical discourse was embedded in participants' risk management strategies in sexual encounters, these examples highlight how particular sources of biomedical information are also integral to the ways in which communities of sexual actors are constructed. The following sub-section will consider how participants responded to these perceived constructions of gay men as risky sexual actors.

Responding to 'Risky' Categorisation

As outlined above, most of the men in this study recognised the higher risks of HIV and STI infections for gay men in comparison to the heterosexual population. However, the differences between being *at risk* and *being risk*y could be easily conflated, thereby resulting in this entire category of men being imagined as highly risky sexual actors. That is, many men in this study worried that sexual health information and treatment in clinics (described above), as well as media representations and public attitudes in general, could lead to gay men being constructed as risky sexual actors. Moreover, this portrayal was premised on an assumption of highly risky sexual practice such as having multiple sexual partners and/or engaging in unprotected anal intercourse (UAI), and would be confirmed by the continuing high rates of infection. Almost half of the men in this study expressed concern about popular images and perceptions of gay men as risky and felt it reflected badly on them. Both Jeff (30s) and Colin (20s) described their shock and upset at being treated as risky sexual actors on the basis of their identity in sexual health clinics, rather than their individual sexual practice. Furthermore, the men in this study who expressed concern felt that this image of gay men as risky sexual actors

would make others think that *all* gay men behaved in this stereotypically – and irresponsible – way.

Simon (30s) described how he felt media representations of gay men were stereotypical and not representative of him and many other gay men he knew. He was therefore upset with a gay colleague who he perceived to be reinforcing media representations of gay men because he was acting in a sexually risky manner. Moreover, Simon explained how he was highly concerned that his heterosexual colleagues would think that all gay men were like this.

> *He used to go on the bloody internet all the time and go onto things like um, fitlads UK and all this sort of thing. And what got me was, he had actually a long-term partner and they actually lived in the house together! And yet both of them were quite happy to go and have a bloody one-nighter! And I used to say to all my other mates, because he was very open about it, and they knew I was gay because they knew I had a civil partner, but you know, I often used to say, will that bugger give over! Say to everybody else at work, it used to ashame me, I mean, because he was the type, he was what the media would view as a media stereotype, gay bloke, in the sense that they're all promiscuous, they all go around shagging everything that'll move and all the rest of it and they're, they're not in it for the love, they're in it for the sex and all this. And sometimes when he used to go on about all these relationships, because his mobile was forever bloody going, an, I was going to say, I almost felt ashamed! ... Do you know what I mean? Um, and I used to say, we're not all like that you know!*

Simon expressed his upset not only at this man's sexual practice, but also at the public openness of this practice. Furthermore, he was disapproving of his colleague's one night stands, especially as his colleague was in a long-term relationship. Simon's concern with this sexual practice was the way his colleague appeared to be "*shagging everything that'll move,*" and therefore reinforcing the dominant media stereotype of gay men. In addition, Simon described how this sexual practice was irresponsible and distasteful to him. He contrasted his colleague's sexual activities with his own monogamous relationship and civil partnership, demonstrating the ways in which he felt he was in a much more sexually responsible relationship. However, he was concerned that this man's sexual practice would be understood by his work colleagues as what all gay men did and therefore that he would be read in the same way as his colleague simply because he was gay. In spite of increasing legal rights for, and social acceptance of, gay men in the UK, Simon's concerns around the construction of gay men as highly sexually active and risky demonstrate how gay as a label can still be perceived to reflect a homogenous and stigmatising category.

Simon's views, that gay men's sexual practice is much more diverse and more responsible than the media representations implied, were prevalent *largely but not exclusively* amongst men in this study in their late 30s and older. That is, many of the participants of this broad age group rejected the stereotypical media images of gay men as sexually irresponsible for a number of reasons. Some of these men described how they felt gay men were involved in a wide range of low-risk sexual partnership arrangements. Like Simon's emphasis on monogamy and civil partnerships, these relationships included monogamy, love and commitment. For example, Jeff (30s) described how he was '*getting married*' next year, whereas Nigel (50s) described how monogamous, long-term partnerships were more emotionally and sexually fulfilling than one night stands. These men drew on their own sexual practices to explain how they felt that gay men's sexual relationship could be much more diverse than media representations and the sexual experiences of Simon's colleague.

However, responsible sexual practice for this group of participants was not limited to monogamous relationships and/or reduced numbers of sexual partners. Participants in their late 30s, and older – but especially those over the age of 40 – not only rejected depictions of gay men as risky, but actively argued that gay men were considerably *more* responsible than the heterosexual population because of established community practices of safer sex. For example, Joe (50s) explained how he felt that older gay men were more responsible than their heterosexual equivalents because of condom use.

> *R: I think certainly older people, and I've read things about, is it now people in their 50s and 60s are actually, uh, straight people, are picking up a lot more sexually transmitted infections because they're having more sex. You know, they're splitting up from relationships later on in life, meeting new partners, still sexually active. And I think almost, they've got to the point in thinking because of their age, they're not going to pick up these infections. So I think that uh, within the straight community, I think they are probably taking risks much more than… I still think gay people, and certainly older gay people [sigh] are more responsible. But I couldn't tell you why I think that. I couldn't say it's because of conversations or research I've seen or anything. I just think it is.*
>
> *I: And how do you, what do you mean by the fact that they are more responsible?*
>
> *R: Um, that they will, they will use condoms.*

The responsibility that Joe described was not based on the number of partners men had, but on the nature of their sexual practice and established condom use. As outlined in Chapter Four, condom use for anal sex amongst gay men, as well as regular testing for

HIV and STIs, was seen as an established community norm amongst gay and bisexual men by most participants. For this group of participants, then, the depiction of gay men as risky, and therefore irresponsible, was inaccurate because it failed to recognise long-term community practices of safer sex.

Some participants felt that evidence of this established community practice of safer sex was reflected in the provision of condoms, lube and the safer sex information by social services, voluntary and third sector agencies, as well as through the collection of these materials by gay men. Nigel (40s) explained.

> *And certainly, you know, the gay people that that um, that I see in in the pubs that I go to will very often pick up a handful of condoms and lube. People at Gay Men Tyneside and MESMAC very often on their way out, very often they're getting their sort of supplies in and I think that's a really responsible thing. The straight scene doesn't have anything comparable. Um, and you know, I mean, I I still think it is that new HIV infections are greater, the number is greater through heterosexual transmission in this country. So I think that, um, that lack of, the lack of condoms on the commercial scene could possibly influence that. And also the fact that it's still perceived to be, HIV is perceived by some to be a gay plague and therefore, some young heterosexual person is like well I'm not gay, so I can't get it, so I've nothing to lose really.*

Nigel described observing gay men actively seeking out and using condoms in their sexual practice, in contrast to the ways in which they were depicted as risky. For Nigel, this was not simply a question of individuals seeking out condoms, but about a broader community norm: the perceived promotion of condom use on the commercial gay scene, as well as in MESMAC and other community organisations/groups, demonstrated how gay men as a community had responded to, and continued to respond to, risks of HIV and STI infection. For Nigel and Joe, the availability of condoms, and that gay men actively sought them out, was an established community norm which highlighted that gay men were responsible in their sexual practice, especially in comparison to the heterosexual population. Their descriptions of the sexual practice of this imagined community of gay men sought to contest the public health informed images of gay men as risky. Moreover, Nigel's reference to the rates of HIV transmission amongst a heterosexual population also highlights how he viewed the sexual practice of gay men as responsible. Like Jeff who felt his straight friend was at a higher risk than him, Nigel relied on perceived epidemiological surveillance data to demonstrate how gay men – in contrast to a heterosexual population – were not as risky because of the lower rate of infection. In this example, Nigel makes a distinction

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between being at risk (higher levels of HIV) and being risky (number of new HIV infections in a low HIV prevalence population). While Nigel spoke at length about the risks in sexual health which gay and bisexual men face, he also perceived a community practice which responded to these risks. In contrast, the way he evoked the higher rates of infection amongst a heterosexual population in combination with the emphasis on a lack of socially established responses to HIV and STIs highlights the way in which he constructed the heterosexual population as risky.

While the above comparisons to a heterosexual population did not always specify the gender of these risky sexual actors, it is important to reflect on the role of gender within the broader history of HIV to gain a more nuanced understanding of how the concepts of being *at risk* and being *risky* have been, and continue to be, employed. Historically, along with the construction of gay men as risky sexual actors, specific groups of heterosexual women (i.e. sex workers) have been described and/or understood as risky in terms of HIV and as posing a risk *to* heterosexual men. Such constructions present heterosexual women as *risky* and reinforce (non-drug using) heterosexual men as *at risk*. In such a framework, we see that the blame or responsibility for infection is placed on the supposed *risky* sexual partner (Richardson 1996; Waldby 1996). This idea, which emerged from much of the public health discourse of the 1980s and 1990s, has been strongly criticised (Patton 1990; Richardson 1996)[62] because it indicates a problematic understanding of HIV. The dichotomy of either being at risk or posing a risk to others reproduces social prejudice (e.g. racism and/or, sexism) and demands increased responsibility in terms of HIV, and to a lesser extent STI, prevention only from *certain* people. The above statements from participants actively sought to challenge this assumption that only some people are risky whereas others are simply at risk on the basis of sexual *identity*. By drawing on comparisons with a non-gay population, the men sought to show how they perceived the degree of risk to be based on particular sexual practices, and therefore not reducible to particular identities. To this extent, I would

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[62] The epidemiological evidence has shown how, within heterosexual sexual transmission, women are perceived to be at a higher physiological risk of HIV infection than men (Global Campaign for Microbicides 2011). However, this perspective is also highly gendered, especially in terms of representations of the African heterosexual HIV epidemic where women are often only seen as victims of male violence, power and unequal 'traditional' gender relations. While these factors are very important, the risk of HIV transmission is based on much more than the gender or sexuality of the people involved, but the nature of specific sexual acts, viral loads, existing health conditions of each person and access to reproductive and sexual health services.

argue that the depictions of gay men as risky, which were criticised by participants, are similar to the assumptions of the role of gender in representations of women as risky amongst the heterosexual population. For Nigel and Joe, as well as for many other participants generally over the age of 40, their comparison with a heterosexual population sought to challenge the creation of a hierarchy of groups of people on the basis of sexual identity who are seen and understood simply in terms of risk.

While participants in their late thirties and older challenged and rejected constructions of gay men as risky, men in their mid-thirties and younger responded differently. That is, where these older men described how the representations and treatment of gay men as irresponsible and risky was unfair and inaccurate, many younger participants described their belief that many gay men *were* engaging in potentially risky sexual practice. Although this was not the case for all participants of this age group, a significant majority of these younger participants felt that the dominant sexual practice of gay men *was* to have multiple partners and to engage in one-off sexual encounters. For example, Andrew (30s) explained how he did not trust men not to cheat on their partners in relationships. While this did not signal to Andrew that gay men were *too risky* to have as sexual partners, it did encourage him to use condoms in all of his monogamous relationships. Outside of monogamous relationships, Max (30s) and Paul (30s) both described how gay men, including themselves, had multiple partners and regularly engaged in one-off sexual encounters. Peter (teens) and Steve (teens) each described how many of their friends regularly had one-night stands with other gay men, and how they also had engaged in similar sexual relationships. All of these men identified increased risk in sexual relations with other gay men because of forms of sexual practice that were perceived to be the community norm. While having multiple sexual partners is not in and of itself risky, the ways in which these men spoke about these forms of sexual encounters echoed a biomedical discourse that links multiple sexual partners to increased risks of infection (Clark et al. 2001; HPA 2007). As I will explore below, these men made the links between this sexual practice of having multiple partners and being risky and responded in various ways.

For some participants in this age younger group, it was not only the presumption of having multiple sexual partners that made gay men risky, but also the *increased opportunities* to have sex, and their inability to 'control' themselves. For example, Jack (20s) described how he felt gay men, including himself, struggled to maintain long-term relationships because of the temptation of other men.

> *But gay men find it hard to maintain a relationship. I mean myself, I find it hard to maintain a relationship. It's a lot, they're like, it's like going into a sweetshop. There's like so much variety. Oh I'll have this and this one and this one. So you just don't know what to pick and it just doesn't last.*

Jack's perception that gay men are unable to maintain a monogamous relationship chimed with the stereotype of gay men as highly risky. Moreover, some men felt that gay men posed a much greater risk of infection than other 'MSM'. For example, Paul (30s) explained how he felt gay men posed a very high risk in terms of STIs and/or HIV, especially in comparison to the bi-curious men[63] with whom he normally had sex. He explained how he felt gay men had access to, and therefore had sex with, more sexual partners than those men who did not identify as gay.

> *...The gay man I'd probably think, ah, you've had loads of cock, you! You know, especially if you're young and good lookin', you're on the gay scene, you'll have it left, right and centre. So I probably would think I was gonna have more risk off a gay man, than off the straight....because if it's obviously a gay man, it's gonna be easier for him to have loads of sex. Especially if he's young and good lookin'.*

While Paul did not think that his non-gay identifying partners were risk-free, he felt they posed considerably less risk of infection than gay men. Relying on the perception – and gender stereotype – that men in general have uncontrollable sexual urges and are sexually voracious, Paul distinguished between gay men and other men in terms of their *opportunities* to have sex. Paul felt gay men, and especially younger gay men, had more opportunity for sex than bi-curious men in straight relationships. Because of these increased possibilities of sex, Paul felt that gay men posed more of a risk of infection than other sexual partners.

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[63] Paul described a number of his sexual partners as bi-curious, as men who identified as straight but who would have sex with other men, or at least with him. For Paul, these men were not gay because they did not identify as gay.

The perception of highly sexually active gay men as risky because they have sex with multiple partners was something that many of the men in this age group negotiated in relation to their own sexual practice. In Paul's case, this had practical implications for his choice of sexual partner. He explained how he had difficulties maintaining an erection with a condom and therefore preferred to have sex without one. As a result, he chose sexual partners who he felt were less risky than gay men as a way of reducing his own risk in sex. Reflecting on his own sexual practice, Max (30s) described how he felt he had *'slept with too many people and... put [himself] at unnecessary risk'*. He explained how he associated multiple sexual partners with higher risk of infection, but that he felt his sexual practice was in line with that of other gay men. In spite of this perceived community norm, he was concerned that this sexual practice was too risky. Where both Peter and described having one-night stands in the past, they also explained how they now wanted to find long-term partners. Such a change in terms of sexual practice and relationship status shows how they both sought to distance themselves from what they perceived risky sexual practice. In relation to his past experience, Steve (teens) explained: *'I'm ready to settle down now, but at the time, I was just doing things I shouldn't have done, just for the thrill, but I didn't really enjoy'*. Steve spoke about his desire to settle down with a long-term sexual partner, and how this relationship would allow him to move away from what he perceived as the dominant sexual practice amongst gay men. Moreover, he explained how he did not really enjoy the one-night stands he had and how he was looking for a more enjoyable, longer-term sexual arrangement. Indeed, he described his depression as the reason for his one-night stands. Linking depression to sexual activity, Steve explained that this sexual practice was detrimental to his psychological well-being. I would suggest that Steve's connection between improved mental health and reduced sexual partners, as well as Max's self-criticism for perceived risky sexual practice, is linked to broader debates around responsible sexual citizenship for gay men. The focus on monogamy and long-term relationships as a 'healthy' sexual practice reflects Duggan (2002) and Butler's (2004) arguments, explored in Chapter Two, which posit a rejection of multiple sexual partners as acceptable sexual practice in an era of legalised same-sex partnerships.

Where the men above described reflecting on their own past sexual practice as gay men and moving away from perceived community norms of sexual practice, other men commented on how they felt these sexual norms were directly connected to their own

identity as gay men. As outlined above, Jack (20s) described not maintaining long-term relationships very easily. He went further, however, when he spoke about how he did not follow what he saw as established community sexual practice in terms of having multiple sexual partners:

> *this is probably where I don't make a very good gay man, I guess. A lot of them don't seem to care, but I'm very, I guess I'm a bit prudish or picky, who I go for.*

That Jack describes himself as not making a very good gay man points to his understanding or perception of most other gay men as highly sexually active and not 'caring' about what their sexual partners were like. He actively distanced himself from depictions of gay men as 'risky' but also from his idea of that which is fundamental to being gay. Colin (20s) also distanced himself from a perceived community practice of sex with strangers and expressed his concern and upset about what appeared to him to be a broad acceptance of this highly sexually active practice. Colin explained how he avoided public toilets if he could, mainly because he would always encounter sexual health advertising aimed at men who cottage.[64]

> *And you can't go into a cubicle without there being MESMAC stickers up, saying you know, are you a gay man, do you want to talk to someone. It's great that people are concerned about, I'm not saying that there's any problem in the work that people are doing because I think it's admirable and important. But I guess I'm frustrated about the way that we don't seem to be able to move beyond that, you know.*

Colin expressed concerns that gay men as a community are generally not '*able'* to move beyond cottaging and was upset that he was constantly faced with reminders of this 'community' practice through sexual health intervention posters and stickers in public toilets. For both Colin and Jack, the depictions of gay men as *overly* sexually active was not reflected in their own personal experiences; it was an association from which they sought to distance their own sexual practice and, ultimately, their identity as gay men.

This section has been concerned with how gay men have been represented as a community of risky sexual actors. It has explored the ways in which participants described and responded to biomedical, media and social constructions of gay men as risky sexual actors and considered the varying ways in which responsibility in sexual

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[64] Cottaging is understood as cruising for sex in a public toilet (Stewart 1995).

practice was defined. Participants in their late thirties and older rejected representations of gay men as risky by highlighting a perceived community norm of condom use, and arguing how this reflected a responsible sexual practice. In contrast, participants in their mid-thirties and younger described how images of gay men as highly sexually active accurately reflected community norms of sexual practice. Moreover, these men felt these norms *were* highly risky and some sought to distance themselves from these practices. This younger group of men defined responsibility, therefore, not in relation to condom use, but on the basis of monogamy and long-term relationships. Although both definitions of responsibility employed by participants drew, to a certain extent, on biomedical discourse, they were also highly influenced by a changing sexual politics. I would suggest that these differing notions of responsibility reflect the ways in which multiple communities were imagined by participants, pointing to the shifts in discourse around sexual citizenship and the ways in which community norms of sexual practice are formed. The following section will consider the ways in which individuals within these communities are judged to be risky sexual actors in relation to perceived community norms.

'Promiscuity' and responsibility

The previous section considered the ways in which imagined communities of gay men were constructed as risky, and how participants responded to these categorisations of risk. This section looks more closely at perceived sexual practice within these imagined communities and explores the ways in which judgements of risk and categorisations of risky sexual practice were made. As outlined in Chapter Two, the last thirty years have witnessed extensive changes in the social and political landscape for gay and bisexual men. In particular, the introduction of civil partnerships, equality legislation and legislation guaranteeing reproductive and adoption rights for gay and bisexual men and lesbians has opened up new possibilities for same-sex relationships and families (Weeks 2007). These changes have had a significant impact on the social norms and expectations of younger gay men and lesbians. Where a number of the older men in this study experienced legal and social constraints in their sexual practices and social relations, many of these restrictions have been lifted, creating a considerably different environment in which to come out as gay or bisexual. Recent research in the North East has shown how many gay and lesbian youth expect to form domestic, monogamous

partnerships and create families of their own with their same-sex civil partners (Coleman-Fountain 2011). This section considers how these changing social norms and expectations are reflected in understandings of responsibility and risk in relation to sexual practice and sexual relations with others, across different generations of gay and bisexual men and within different imagined communities. In particular, this section considers the notion of 'promiscuity' and how it has been contextualised. It asks: how have certain gay and bisexual men been categorised as risky and; what role does harm play in these categorisations of risk?

Quantifying 'Promiscuity'

Most men in this study evoked the image of a gay or bisexual man who was an irresponsible sexual actor. For example, at least one-third of the men in this study, across all ages, specifically used the term 'promiscuous' to describe certain men who they knew personally, or on the basis of their reputation amongst gay and bisexual men in the North East of England. The label of promiscuity was applied to those men who were seen as risky in terms of HIV and STIs and as generally people who *should* be avoided as sexual partners because of the risk they posed. Moreover, some men in this study explicitly aligned promiscuous sexual practice with risky sexual practice. For instance, when talking about sexual partners whose sexual history was unknown, Gerry (20s) explained: '*you don't know how promiscuous or risky they've been in the past.*' But understanding what was meant by the term promiscuous, and therefore, *who* was promiscuous for the men in this study was dependent on a number of elements and was not always based on a definition shared by all of the men.

In many cases, promiscuity was *linked* to having multiple sexual partners and many sexual encounters. Simon (30s) explained how he associated promiscuous sexual practice with '*having relationships and flings all the time and this sort of thing.*' Jeremy (40s), when describing someone he knew as risky, explained that this friend was very promiscuous because of the number of people with whom he had had sex. In addition, the environment within which sex took place was significant to Jeremy's understanding of promiscuity.

> *I'm thinking about a guy in particular who will happily cruise gay clubs, toilets, cruising grounds, um, saunas, you know, he's very, very promiscuous. And I*

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would say, to my knowledge, doesn't use protection very often, has multiple partners.

The combination of multiple sexual partners, sex in what he perceived as less than respectable venues and/or not using condoms helped form Jeremy's generally negative description of this person. For Jeremy, this individual demonstrated the riskiest sexual practice, and was someone he was eager to distance himself from. For a number of men in the study, this imagined promiscuous figure embodied risky sexual practice; promiscuity was therefore associated with men who had very high numbers of sexual partners, who may have engaged in sex in public – non-normative sexual spaces for sex – and who generally did not use condoms. Thus, it was not simply the practice of having multiple partners that led to certain men being defined as promiscuous, but also an array of other factors. By describing some men as promiscuous, study participants actively linked personal sexual practice to broader sexual responsibility. Sexual practice was not merely an individual action, but was linked to community norms and responsibilities and was therefore subject to judgement by others. However, as outlined earlier in this chapter, the ways in which communities of gay men were imagined, and the perceived norms of these imagined communities varied greatly amongst participants.

Given these variations in perceived community norms and practices, it is important to unpack the ways in which promiscuity was judged. We can do this by considering the different elements that were involved in labelling individuals as promiscuous. For instance, there was a general sense amongst most participants that having multiple sexual partners *could* become a risky sexual practice. But establishing how many sexual partners were *too many*, and in what context this might or might not be the case, was not uniform amongst study participants. The men in this study described how the number and frequency of their sexual encounters changed considerably over time. Indeed, the number of men with whom the participants had sex and the locations within which this took place differed significantly between participants. Moreover, judging one's own sexual practice, including the number of partners and the nature of these encounters, and determining whether it was responsible sexual practice was not so straightforward. Many study participants appeared to negotiate these factors in relation to a perceived community practice. In other words, promiscuity, or being promiscuous, was measured in relation to the perceived norms of a gay and bisexual community. For some men, this

was made more difficult if they did not have a strong connection to other gay and bisexual men. For instance, Nigel (40s) described a discussion around promiscuity with a doctor in the mid-1980s when he went to get his first HIV test. The following excerpt highlights how comparisons with others, both inside and outside of communities of gay and bisexual men, were critical to situating his own sexual activities.

> *The doctor said to me, are you promiscuous and I said, yes. And he said how many sexual partners have you had in the last week, and I said none. And he said well how many in the last month and I said one. He had a pen and he threw his pen down and he said how many sexual partners have you had in a year. And I says, oh I don't know, about ten. And he said, he says you clearly have a very narrow perspective of what being promiscuous is. He says I'll see people here who will have 50 partners in a week. But of course, because I, although I was sexually active, I wasn't really part of the main gay community because I wasn't out. So I sort of lived in this kind of, where my only sort of sexual outlet was down at the gardens.[65]. And I was always that nervous about being seen down there. I wouldn't talk to people or, I used to go cottaging and invariably, you're still not part of the community. You're part of the activity, but not part of the activity. So you don't, you're not aware of, or so if somebody says are you promiscuous, you just think well, there's my mum and dad married for twenty-five years or whatever, so by their standards, yes, I suppose I am.*

Nigel's experience demonstrates the ways in which he judged his own sexual practice as promiscuous in relation to perceived social norms. However, he did not rely on an imagined gay community as an indicator of these norms; Nigel drew on his heterosexual parents as markers or indicators of 'responsible' or 'normal' sexual practice. That he used a heteronormative social norm – his parents' long-term and presumed monogamous marriage – is significant. Although Nigel described not being a part of a gay community at that time, his participation in cruising and cottaging *did* provide an alternative perspective on 'normal' sexual encounters. While he might not have known how many sexual partners other gay and bisexual men had, he did witness and participate in sexual encounters with multiple men. But for Nigel, just engaging in sex with multiple men, without a social connection, was not an acceptable *social* norm for him. His self-reported isolation from a perceived gay community meant that he judged his own sexual practice as promiscuous in relation to the only social norms to which he felt connected. While Nigel's isolation from a community he perceived to exist contributed to his own self-judgement around his sexual practice, his story highlights the ways in which community norms and connections to that community play an important role in terms of how sexual responsibility is judged.

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[65] The gardens was a well known cruising area for gay men in Newcastle. It is no longer a cruising site.

Nigel's understanding of promiscuity in the above experience also highlights the way in which community sexual practice may be viewed in different ways, not only by those who are 'outside' of this community, but those who form a part of a community of sexual actors. For instance, having multiple sexual partners was explicitly described as negative and as central to their understandings of promiscuity by at least one-third of participants. In contrast, however, a number of men described having multiple partners as part of the norm of being gay and described how this sexual practice should not, in and of itself, be considered promiscuous. For instance, Matt (50s) explained how he had a lot of sexual partners from a very young age.

> *I was very sexually, um, what's the word, begins with a p, not promiscuous, preten, well, I started having sex fairly early as a result of the assaults that I suffered. And that sexualised me far earlier than I think any boys would be sexualised.*

Matt drew on his childhood experience of abuse to explain why he was sexually active with a wide range of partners, but separated this practice from promiscuity. He explained how the sexual assaults he experienced as a young boy were the reason for his highly active sexual lifestyle, distinguishing himself from other boys as being sexualised much earlier. Thus, despite his multiple sexual partners, Matt did not see himself as promiscuous. Furthermore, Matt spoke about his sexual practice as generally responsible. He explained how he regularly used condoms in sex with other men and that going to the sexual health clinic was a *normal* part of his life. For Matt, responsible sexual practice was not based on how many men he might have sex with, but on the nature of this practice and the degree to which he and his partners adhered to a safer sex practice. A significant number of men in this study agreed with Matt's stance. Many men described having multiple sexual partners when they went to saunas or cruising sites, for instance, as simply engaging in '*an element of [gay] culture.*' (Andrew, 30s), something they considered to be the social norm for gay and bisexual men. Nearly half of the participants reported having multiple sexual partners, either now or in the past. Four men explained how they were in open relationships, where they had a regular partner but also had sex with other people. Some participants described actively refusing to have one regular partner, preferring to have one-off sexual encounters with strangers or casual sexual partners. For many of these men, this was not perceived as promiscuity, as Matt explained, but rather as non-monogamous sexual practice.

The above discussion, regarding what constitutes promiscuity and what the community norms surrounding sexual practice with multiple partners are, echoes debates from the 1980s and 1990s which linked gay men to promiscuity. Douglas Crimp's (1988) argument – that having multiple sexual partners allowed gay and bisexual men to imagine and put into practice creative and sustainable safer sex responses to HIV – was written in response to gay writers, such as Larry Kramer and Randy Shilts and to media and public health criticisms of gay men's 'promiscuity.' These writers posited that gay men were too promiscuous and that as a result of this over-sexualised lifestyle HIV continued to 'afflict' the gay community. Crimp and many others disagreed and argued that such attitudes sought to blame the spread of HIV on those most affected by the illness and thereby diverted attention away from the mis-information around HIV for gay and bisexual men. For Crimp, promiscuity – or multiple sexual partners – was not the problem, but the solution.[66] The 1990s saw similar debates around gay men and 'sexual lifestyle' but subtly shifting towards gay men integrating into 'normal' heteronormative culture (Warner 1999, Duggan 2002). For instance, Andrew Sullivan's (1995) *Virtually Normal: An Argument About Homosexuality* was one of many texts that sought to move the gay movement away from a radical liberation politics towards equality and integration into 'mainstream' society. This integrationist framework meant distancing 'respectable' gay men from the so-called promiscuous gay men, as well as distancing (the idealised) sex at home from public sexual practice. The move to a more privatised approach to sexuality and sexual practice has been critiqued by many critics, including Duggan (2002), Warner (1999) and Berlant (2000). In particular, Warner argued that this move to a more mainstream and individualist notion of gay identity and practice desexualised the lesbian and gay movement and depoliticised queer sex in the 1990s. As outlined in Chapter Two, evidence of these shifts in discourse in the UK can be seen in the many legal changes which emerged throughout the 2000s, such as civil partnership and inheritance legislation. While these changes reflect an important reversal of discriminatory legislation for gay men, many critics such as Butler (2004) have suggested that 'rights' to institutions such as marriage (or civil partnerships) can

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[66] As outlined in Chapter Two, criticisms of promiscuity were also rooted in the inability to test for HIV and the assumption that multiple partners resulted in infection, rather than how certain acts were more likely than others to be the cause. See p 36 of this thesis.

also serve to delegitimise sexual relations that fall outside of these presumed monogamous relationships.

The shifts in discourse outlined above were negotiated by men in this study and were reflected in the way some participants spoke about civil partnerships. For some of these men, civil partnerships were used to describe monogamous sexual relations with a single partner that have been legitimised and recognised by the state. While not all participants aspired to these state-recognised unions, some, such as Simon, used their own experiences of civil partnerships as a way of demonstrating how they were different to gay men who had multiple sexual partners. Along with highlighting the participants' concern with the number of one's sexual partners, this focus on civil partnerships also signifies a *privatisation* of sexual practice. Jeff (30s) for instance, described how his upcoming 'wedding' ceremony would not include any 'intimate' moments.

> *R: There'll be no physical contact between the two of us at the ceremony. And we've both agreed on that. More for the fact that we've both got aunties, parents, grandparents, the older generation. And we're like no, we won't.*
>
> *I: Not even a kiss?*
>
> *R: No, we won't kiss, there'll be nothing. We'll be very reserved in what we do. But once we're hammered, and we're on the dance floor [laughter] well get our piece!*

For Jeff, this ceremony was not to provide an overt display of his sexuality, but to demonstrate the way in which he and his partner were making a commitment to live a monogamous and responsible life with each other. He described how they '*wouldn't make anyone feel uncomfortable,*' highlighting the way in which he was concerned with how others would accept his lifestyle 'choice.' By intentionally removing any physically intimate moments from the official ceremony Jeff sought to distinguish himself from more sexualised images of gay men. This negotiation of his sexuality in public, by not kissing his partner during their 'wedding' ceremony, suggests an adherence not only to a heteronormative notion of responsibility in having one, legally recognised partner, but to a particular image of a non-sexualised gay man.

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This sub-section has considered how promiscuity is judged in relation to number of sexual partners and how establishing a responsible number of sexual partners was understood in relation to the norms of imagined communities. Matt and Andrew imagined a gay community within which having multiple sexual partners was not promiscuous, but a normal part of gay culture and could be part of responsible sexual practice. In contrast, Jeff adhered to an imagined community practice in which responsible public displays of sexuality were limited to particular settings and conformed only to certain practices. While number of sexual partners played an important role in how promiscuity – and responsible sexual practice – was understood, the following section considers how the perception of harm in sexual relations is also tied to judgements of promiscuity and personal negotiations with responsibility.

Measuring Harm

While having multiple partners was not seen by all men as risky or irresponsible, the idea that someone *could* have too many partners was prevalent amongst participants Most of the men who made negative judgements about numbers of sexual partners linked this sexual practice to the potential harm or risk of infection it posed to others. These men suggested that to be promiscuous was to pose a risk of infection to others not just because of a highly active sexual practice, but also because of a perceived lack of concern for others. Moreover, a key factor in labelling someone as promiscuous was the perception that they were unconcerned about others, demonstrated by the potential risk that they posed to others. Consequently, there was a general understanding amongst most men in this study that someone was promiscuous if he had multiple sexual partners *and* did not take precautions, including either condom use and/or regular sexual-health check-ups. For example, Oscar (50s) made a direct link between men he felt were promiscuous and their concern with sexual health.

> the group that go to the Eagle, and they, they're very promiscuous, so, see the thing is, right, at the end of the day, they might not go for an MOT, GUM check.

According to Oscar, the Eagle was a bar for older men in Newcastle which had a specific room in which men could have sex with each other. Oscar described the men he knew or saw use this space as having sex with a lot of sexual partners and questioned whether they took care of their own sexual health. While Oscar described his own

sexual practice as engaging with multiple partners in this same place, he distinguished himself from those men he labelled as promiscuous. Oscar's disassociation from these men points to his concern not just with their individual sexual health, but more generally with the risks posed by men who do not get regular sexual health check-ups. Oscar felt that individual sexual health checks were essential to the overall sexual health of all gay men and that this was why his sexual practice was responsible. In contrast, men he described as promiscuous were irresponsible in what he perceived as failing to undergo regular sexual health check-ups. Similarly, Steve (teens) made the link between multiple sexual partners and failing to undergo testing when describing someone he felt was risky. He explained how his ex-partner was risky because he '*used to sleep around and he obviously wasn't, didn't get himself tested.*' The assumptions made about those men deemed to be promiscuous were that they would not get the regular sexual health check-ups that were perceived as necessary.

Increasing the uptake of testing for HIV and STIs is considered a priority for sexual health providers. Furthermore, regular testing for all gay and bisexual men is advocated by NHS and sexual health organisations across the UK. MESMAC North East suggests that regular sexual heath checks at least every six months are recommended as not all STIs will have demonstrable symptoms which might prompt a check (MESMAC 2011). Moreover, the UK Health Protection Agency (2007) makes a direct link between the uptake of testing and the reduction of transmission of STIs and HIV. Echoing this discourse around the importance of knowing your health status, the majority of men in this study saw regular testing as an essential part of being responsible sexual actors. It was seen as critically important for the sake of their own sexual health but also for the sexual health of other gay men. Paul (30s) for instance, was so concerned about the fact that some of his friends and sexual partners did not go to the GUM clinic that he was considering offering one of them money to go if they could not be persuaded otherwise:

> *I'm gonna go and see him now and try to convince him. If I offered him money, he probably would... I'm gonna try and persuade him without money, see what he says.*

The emphasis on testing as a part of sexual health practice, referred to not only by Oscar, Steve and Paul, but also by a number of other men in the study, indicated how public health discourse, specifically epidemiological ideas around identifying, isolating

and treating the source of infection, was prevalent in understandings of promiscuity and harm to others.

Epidemiology emphasises the need to know one's status in order to protect others from further infection through uptake of treatment (HPA 2007). Most men in this study assumed a link between getting tested and taking up treatment for a potential infection. According to this logic, any diagnosis would require further trips back to the GUM clinic to continue checking for possible infections, as well as abstaining from sex until the infection had cleared. Such logic assumes that knowledge prevents harm. In other words, if a person knows they are, for example, HIV positive or have contracted syphilis, they should seek out treatment to reduce or minimise the potential harm to others.[67] Although many men based their judgements around testing on an assumption that treatment would be pursued, there was little evidence from this research to say whether seeking out treatment in response to diagnosis was actually the practice. One of the HIV positive participants spoke about learning of his diagnosis, but also expressed how he did not return for treatment until he was very ill, at least one year later. He explained how he did not want to undergo treatment earlier because he was unable to face what his diagnosis meant. Another man mentioned a sexual encounter with someone who, prior to having sex, explained he had an STI and that he was still infectious. The participant agreed to have sex with him after being given this information, explaining how he went to the sexual health clinic the next day to deal with the infection he assumed he had contracted. These experiences do not reflect the opinions of the majority of participants who described a different sense of responsibility with regard to sexual health. It remains unclear whether knowledge of an infection changes one's sexual practice. However, the men's emphasis on knowing one's status points to how epidemiological discourse appeared to play an important role in not only one's own sexual health responsibilities but also in the expectations of others men's sexual health practice.

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[67] I will explore this perspective in more detail in the final section of this chapter, where I consider the social attitudes towards HIV positive men and the expectations around prevention that are placed on them.

The link between promiscuity, not testing and presumed poor sexual health practice meant that men who were labelled as promiscuous and/or as having a bad reputation were sometimes, somewhat conveniently, thought to be the *source* of infection. Max (30s) explained how he contracted syphilis and how he was convinced he knew from whom he had contracted it simply because of this person's reputation.

> *I'm not even certain who it was. But I've got an idea of the guy who it was because he had a, according to a couple of people I knew at the time, he had a bit of a bad name about himself, where he would sleep around with people, he'd have threesomes with his boyfriend and I was in a sauna and I had a sort of a threesome and I remember getting it within a window period after that.*

In this example, Max placed responsibility for so-called healthy sexual practice solely in the hands of the other person. Max felt that this man must have been the source of his syphilis infection. He articulated this through an emphasis on the man's reputation and the nature of the sexual acts. The link between someone having a *bad name* and *being* the source of infection reiterates the perception that this sort of person would not take responsibility for their sexual health, and consequently, would be the most likely candidate to pass on infection. Even when there was no STI transmitted, men who were seen to be promiscuous were seen as posing a considerably higher degree of risk. Matt (50s) explained how he confronted a young man about risk after he recounted having unprotected sex:

> *...who did you have it with? Tom. Well Tom's a trollop! You know, he's a tart of the first order. You're gonna have sex with him? So anyway, the penny sort of dropped. But it was only then, when the penny dropped...when I confronted him about the risk.*

Matt was not only concerned that his friend had had unprotected sex, but also that he had had sex with someone perceived to be '*a trollop*' and therefore as a potential risk, and convinced his friend to go to the GUM clinic to get tested on the basis of this perceived exposure to a risky sexual partner. Matt's knowledge of Tom and his reputation was the motivating factor for his friend, he explained, to get tested.

In some cases, the reputation alone was enough to link source of infection with particular sexual partners. Jack (20s) explained how he had heard that a particular drag queen, allegedly known to use cruising areas, was thought to have HIV.

there's like a drag queen – I don't know how true it is – it's just rumours who has HIV, cause he's contracted it from the gardens. And yeah, a lot of people stay away from him. So he's quite renowned, so people just like back away from him. So I guess in that sense, people are aware of it and they know like they can catch it off him, so they stay away from him.

For Jack, the spaces within which this 'flamboyant' figure moved consolidated the image of him as having HIV. While not all the men thought the use of cruising areas was risky, Jack felt that this factor reinforced the idea that this person had engaged in risky sexual practice and had as a result contracted HIV. Although Jack described how certain men who contracted HIV *might not* be at fault it seems that this person's reputation of having HIV, of engaging in sex in a public space, of apparently having a bad reputation on the gay scene, and of being a flamboyant drag queen contributed to a believable story of the correlation between reputation and disease. Interestingly, '*the gardens'* do not exist anymore as a cruising site (Casey 2007). Many of the participants spoke about using '*the gardens,'* although some men, like Jack, described never having used cruising sites. Jack and a few other men referred to '*the gardens'* in their interviews as though it was a contemporary space still in use. This iconic image of a specific cruising site perhaps goes some way to making the story Jack heard and repeated more believable.[68] While most of the men in the study described regular testing and protected anal sex as an essential component of safer sex, the level of concern around the possibility of infection increased considerably for many men when particular sexual partners were involved. While these particular partners may not have had, or passed on, an infection, they were often spoken of and treated as being much higher risk than the 'average' sexual partner. Specific knowledge or gossip about a particular sexual partner's sexual practice or status could be a motivating factor that prompted men to get tested or become concerned about their sexual health.

Although many participants felt that promiscuous men were highly likely to have an STI and be the 'source' of infection, they did not necessarily equate contracting STIs with irresponsibility and promiscuous sexual practice. In other words, the presence of

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[68] This story also highlights the fact that a lot of the gay men in this study described how having sex with someone who was known to be HIV positive was too much of a risk for them, even if precautions were taken. I will explore this opinion and the discrepancy between potential and *known* risk in the section on HIV positive men in the next section of this chapter.

an infection did not automatically mean that someone was deemed to be or have been promiscuous and, *therefore*, risky. Men who were perceived as innocently contracting STIs and/or HIV were presented through the lens of victimhood, described as being 'victims' of irresponsible promiscuous men who passed on the infections. Jack (20s) explained that some people who contract HIV, for instance, might not be promiscuous or have knowingly engaged in 'risky sexual practice'. Instead, they might unknowingly be infected by their partner who had been, or was still, cheating on them. He described how a friend of his became HIV-positive in this way: '*he caught it through his ex-partner who was cheating on him, so it was through no fault of his own, in a sense*'. The perception of some men as victims and others as perpetrators was generally linked to their presumed sexual practice: they were either promiscuous and guilty or not promiscuous and innocent. Men seen to be in the wrong, either promiscuous or cheating on their sexual partners, were described as the source of infection. They were seen as irresponsible and unconcerned about the sexual health of others.

Despite the prevalence of this innocent or guilty approach to infection, there were some cases where participants struggled to place people into the strict categories of victim or guilty partner. As outlined above, Max (30s) described having identified the source of his syphilis infection in a particular sexual partner. However, he questioned his own responsibility when it came to potentially passing the infection onto someone else. At a particularly emotional point in the interview, Max described how he felt he was too promiscuous and felt very guilty about having potentially passed syphilis onto someone else. Max imagined this person as not like himself, but as someone who was the innocent victim of Max's irresponsible sexual conduct.

> *I might be the only person they've been with that month. I'm thinking, and that person has thought, oh, I've been with him, oh he was a carrier of X, and he gave me it. And I just think, oh god, that would be horrible to think that. That would be horrible to think that that person has categorised me as being somebody, well he gave me the clap! Or he gave me X.*

Max struggled to understand his own position as a victim of the person he identified as the source of his infection, but also as a potential perpetrator for another sexual partner. He set himself up as different from this imaginary sexual partner, establishing his own regular, promiscuous behaviour as worse – and more irresponsible – than someone who might have engaged in a one-off risky sexual encounter. That Max imagined his

'victim' to not be promiscuous, as he described himself to be, illustrates how this discourse contributes to a stigmatised experience of infection. Max's own experience of syphilis was forgotten as he concentrates on the imagined victim he potentially infected and the harm he did to this sexual partner as a result of his so-called promiscuity.

The figure of the 'innocent victim,' either the HIV positive man whose partner cheated on him described by Jack or the imagined man who potentially contracted syphilis from Max, reinforces the notion of the irresponsible, harmful other. The act of distinguishing between the 'victim' and the 'perpetrator' recalls early debates around HIV infection of children and haemophiliacs versus gay men and sex workers (Richardson 1987). It further invokes current debates around the criminalisation of HIV transmission (see p. 90-91). What is relevant here is that unless someone who is knowingly HIV positive is considered to have made a serious attempt to prevent the transmission of HIV, they can be held criminally liable, thus placing the legal (and social) responsibility of prevention on the HIV positive person. While I do not wish to conflate the criminalisation of HIV transmission with the move in the LGBT movement towards increased rights and equality, I do want to focus on how both debates can invoke a dichotomy of 'good gays' and 'bad boyz' (Bell and Binnie, as cited in Brown 2006: 877). This binary opposition of good and bad serves to reinforce and demonise those men who are perceived as failing to be responsible in preventing infection. Although Chapter Four described how participants perceived community sexual practices which prioritised the prevention of HIV over other infections, the construction of the risky sexual actor in this case considers the potential transmission of *both* HIV and STIs as harmful to others. That is, while a harm reduction approach to sexual practice meant a responsibility to prevent HIV, participants described how an *additional* responsibility for gay and bisexual men was to prevent doing harm to others. This meant that responsible sexual practice demanded consideration of others' sexual health, as well as one's own. Thus, those men who are seen to engage in risky sexual practice – in this case, cheating on your partner in a non-open relationship – fall on the side of the promiscuous, irresponsible individual who is the source of infection and has therefore failed in their responsibilities to others.

Study participants made a distinction between two types of gay men: responsible, risk-averse sexual actors who considered how their actions impacted upon others and engaged in 'responsible' sexual practice; and those who were promiscuous, irresponsible and unconcerned with their impact on other gay men. Participants therefore described promiscuity in terms of number of sexual partners *and* in terms of potential harm posed to others. While the image of the 'good gay', for the men in this study, was not strictly limited to monogamous sexual practice, this figure embodies contemporary public health ideas about what is responsible. This highlights the ways in which biomedical engagement was an essential component of responsible sexual practice within an imagined biosocial community. In other words, responsible sexual practice necessarily involves regular testing, as seen in the discussion with Paul, Oscar and Steve. Furthermore, if someone has a high number of sexual partners, they have an increased responsibility to test regularly for HIV and STIs. The men in this study therefore viewed men who they deemed not to be complying with this socially responsible sexual norm as risky others. They were the promiscuous homosexual who should be avoided, signalling a desire to both not be like this person and avoid this person as a sexual partner. This idea was reinforced by reputation or community applied label, and by the presence or idea of the innocent victim who has been infected by the uncaring and dangerous gay man.

HIV positive men

The previous two sections have described the ways participants judged themselves and other gay and bisexual men to be risky sexual actors and how these judgements and categorisations were understood in terms of community, responsibility and harm. Where the previous two sections addressed constructions of sexual actors with an STI, including syphilis, and/or HIV, this section specifically examines the ways in which the biomedically determined other – the HIV positive man – was understood in terms of risk. As I argued in the previous chapter, the priority of the imagined biosocial community was the prevention of HIV transmission. This section asks what impact this imagined shared priority had on the construction and experiences of HIV positive men as sexual actors and what has this meant for serodiscordant relations? The first part explores the ways in which men negotiated community norms of sexual practice in relation to HIV positive sexual partners and how they perceived HIV related stigma.

The second part considers the experiences of two HIV positive participants, looking in particular at the ways in which social norms of disclosure and biomedical understandings of risk were negotiated within a framework of stigma. Moreover, this section considers how the notion of innocent/guilty sexual partner, explored above, influenced these understandings.

Embodied risk

As discussed in the previous chapter, many participants felt a strong sense of responsibility to prevent HIV transmission. However, in many cases this meant that HIV positive men were seen as risky individuals. Not only were they seen to contain the potentially 'deadly' HIV virus within their bodies, but, as sexual partners, they were also understood as posing a risk of transmitting the virus – and therefore harm – to others. Participants' descriptions of their sexual practice and approach to safer sex suggested that they were trying to avoid the HIV *virus,* but were also avoiding HIV positive *men*. How HIV positive individuals might pose a risk to others in terms of infection is highly dependent on a wide range of biomedical factors. For instance, HIV positive individuals who have not yet been diagnosed with HIV, such as those who recently acquired the infection, often have a higher viral load and are therefore more likely to transmit the virus to a sexual partner if safer sex is not adhered to. In contrast, those diagnosed with HIV generally tend to have lower viral loads; they may also be on medication which can further reduce viral loads and the risk of transmission to a sexual partner. However, most HIV negative men in this study were unaware of the importance of viral loads in transmission and the increased chance of transmission with someone who has recently acquired HIV[69] (Hickson 2011). The identification of HIV positive men as risky was attributed to the mere presence of HIV in their bodies. As a result, whereas condom use with sexual partners whose HIV status was unknown seemed to be an acceptable sexual practice for most participants, the situation changed dramatically when the HIV status of the partner was known. In other words, those perceived to be HIV negative, because they did not disclose a positive status, were seen as considerably less risky sexual partners than HIV positive men. While this was not the case for all participants, those who did engage with, or consider, HIV positive men as sexual partners were in the minority.

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[69] See the glossary of this thesis, which explains how viral loads are significant to the risks of transmission of HIV.

While the majority of participants described how they never knowingly had an HIV positive sexual partner, at least one-third of participants said they would not engage in sex with someone they knew to be HIV positive.[70] For instance, Joe (50s) explained: '*if I knew somebody was HIV, I wouldn't want to have sex with them. That would prevent me having any sort of sex with them.*' Joe explained how knowing someone's HIV status made a real difference to his perceptions of risk in a sexual encounter. He described how protected anal sex meant that there was reduced risk of HIV transmission. Yet, this practice was seen as not good enough to reduce risk with an HIV positive partner. Joe explained how he was

> *ashamed to say that, I really am. Because I think, possibly we should all be having sex as if everybody did have HIV and then you would, you know, there wouldn't be the issues in the pot. But it's not as simple or straightforward as that, I realise.*

Significantly, Joe explained how men '*should*' be acting as though everyone had HIV, in an attempt to eliminate the '*issues*' he described of having to distinguish between partners on the basis of their serostatus. However, that Joe lamented this fact indicates that he felt that he and other gay and bisexual men were *not* acting as though everyone was potentially HIV positive. These comments highlight how Joe was living though changing community norms in terms of HIV prevention. The safer sex response among gay and bisexual men, in the very early days of HIV by gay and bisexual men was to assume and act as though *everyone or anyone* could have HIV *because* of the inability to test for the virus (Patton 1990; Flowers 2001; Race 2001). The advent of the HIV antibody test in 1985[71] resulted in a significant change in the way HIV was understood, and this test contributed to the creation of an HIV identity on the basis of new biotechnologies (Race 2001). Race (2001) has argued that the introduction of this test contributed to the individualisation of experiences and responses to HIV. Joe's comments echo this claim, suggesting a change in sexual practice in terms of HIV

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[70] This was not a question explicitly asked of all participants. In many cases, study participants volunteered this information as a part of our conversation. In some cases, I asked how men would react if someone disclosed their HIV status to them, or if anyone ever had done this and what had happened. I felt that explicitly asking if someone would have sex with an HIV positive partner would be too much of a leading question, and would be perhaps ethically unsound. However, I have included the comments volunteered by men in this section of the chapter because of how they powerfully express the stigma relating to being HIV positive and how this impacts attitudes in sexual practice and safer sex.

[71] Berridge (1996) describes how the HIV antibody test became widely available in October 1985 in the UK, despite its development in 1984.

prevention amongst gay and bisexual men; what he perceived as the existing social norm amongst gay and bisexual men was a desire to differentiate sexual partners on the basis of their serostatus. This process of individual differentiation highlights a shift from earlier experiences of HIV prevention based on a 'community' response described above. Moreover, that he described himself as being '*ashamed*' to admit that he would reject a sexual partner who disclosed his HIV status also shows how he was negotiating his own sexual practice in light of these perceived social changes.

Other study participants echoed Joe's concerns around the ways in which community norms influence how potential HIV positive sexual partners are treated. However, instead of focusing on the ways in which all gay and bisexual men as a 'community' should act towards HIV positive men, as Joe had indicated, a number of the younger men focused on the HIV positive *individual*. This was especially the case for men under the age of thirty. For example, Peter (teens) explained how he would not knowingly have sex with an HIV positive sexual partner.

> *I wouldn't even put myself in that situation. I would feel bad about it because it would not have been his fault that he contracted HIV. It could have been doing safe sex all the time but one situation, he could have been, could have been contracted through needles, he could have been stabbed. Or he could have, you know rape, rape could be involved. So he didn't know about anything could have happened.*

Peter felt that whatever the circumstances of his relationship with this person, they would pose too much of a risk for him. Like Joe, who expressed guilt in rejecting HIV positive partners, Peter also described '*feel[ing] bad*' as though he should not admit to this discrimination. But Peter's comments suggest that his reasons for feeling guilty were not based on a sense that the community had let down this person as Joe had described. He did not mention a gay community at all. Instead, Peter focused entirely on the HIV positive individual and the other person who may have '*raped*' or '*stabbed*' this imaginary person. Peter qualified his statement by suggesting that not all HIV positive men contracted HIV because of irresponsible safer sex practice but through a whole range of possibilities, many of which cast the individual as a victim. Much like the discussions in the previous section of this chapter, where men distinguished between the innocent victim and the guilty perpetrator, Peter did not want to be seen as rejecting all HIV positive men outright, because they *may* not have failed to practice safer sex or make attempts to prevent HIV. However, while some HIV positive men might be seen

by participants as having innocently contracted HIV, they were still viewed as posing a risk to others, namely those who are presumed to be seronegative. Thus, while the mode of infection played a role in how the HIV positive man was read as a responsible or irresponsible sexual actor, anyone who was HIV positive was generally seen to be a very risky figure, and one who must be treated with extra caution, which usually meant rejecting them as a potential sexual partner.

While Joe and Peter typify the views of a significant number of study participants in terms of the stigmatising of HIV positive partners, they reflect slightly different perspectives on how *community* norms and practices were understood or rationalised in relation to the construction of HIV positive men as risky. Joe felt that community norms should be different to what they were, but that he acted like other gay and bisexual men. Peter's comments focus more on the individual and considered how the individual acted and whether he was 'irresponsible.' Peter's rationale clearly contrasts with Joe's concern about community responsibilities to this individual. Where Joe felt the community had – perhaps irresponsibly – let down HIV positive men through its different treatment of serodiscordant men, Peter felt that these HIV positive men were in this position not because of how the community constructed risk, but either through their own 'irresponsible' sexual practice or that of their partners. This difference in emphasis points to a tension between the participants understanding of HIV prevention as either community or an individual responsibility. While the rhetoric of abstinence from sex with HIV positive men was dominant in both their interviews, the way in which they understood their own responsibility and that of the community differed significantly. The difference between Joe's (and other older men's) responses and Peter's (and younger men's) responses to HIV positive men highlights how understandings of community may be influenced by generational factors.[72] Furthermore, it also suggests how HIV positive men may be viewed as having different or increased responsibility to prevent HIV within an imagined biosocial community.

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[72] It is very difficult to establish a cut-off point for this observation on the basis of age. In general, men under thirty responded like Peter, while men over 40 spoke about HIV positive individuals as Joe did. However, there were a number of exceptions in each case, and this differentiation on the basis of age is only meant to be indicative. This does, however, suggest a number of fascinating research questions that could be explored in future research.

Although HIV positive men were generally seen as a significant risk for most men in the study, there were some exceptions. Four men in the study, across the age groups, described having had a relationship with men who they knew to be HIV positive. Three of these men described how they considered there to be little chance of HIV transmission because of the nature of their sexual practice and their regular testing for HIV. Paul (30s) and Oscar (50s) both described sexual encounters with HIV positive men and explained how the use of condoms and/or the nature of their sexual encounters satisfactorily addressed and reduced the risk of transmission. Will (20s) explained how he had had a number of HIV positive sexual partners.

> *I've had, you know, quite a number of sexual partners with HIV. Um, some of which have actually been of my age. And you know, because we've had that awareness of the fact that HIV was there, you know, we were aware of the sexual health, protection measure that we have to take to reduce the risk of me contracting it, or of him contracting anything from me that could complicate his condition. I think that goes, it's nice, I think that's quite nice to think about because there wasn't that barrier of you have HIV, I'm not going to touch you. It's a variety, you've got that, we've both got knowledge, we're educated. We know what HIV is about and how best to treat it and reduce the risk of you transmitting that to somebody else.*

Will talked about how both he and his sexual partners actively discussed and explored sex that reduced not only possible HIV transmission to him, but also the risks that Will potentially posed to his HIV positive partner. In fact, apart from the two HIV positive men who took part in this study, Will was the only participant to identify risks of infection that an HIV negative sexual partner might pose to someone who is HIV positive. Moreover, Will felt that their extra precautions added more to the relationship as he described how this shared knowledge brought about a further level of intimacy to the experience.

Andrew (30s), the fourth man to discuss his experience with an HIV positive sexual partner, expressed some concerns about the risk of HIV transmission. He described how the exclusion of certain sexual acts – primarily anal sex – helped relieve many of the anxieties he and his partner had around the risk of transmission. However, he explained how their sexual relationship differed from his other sexual relationships insofar as they excluded protected anal sex. He described how they decided that anal sex '*wasn't the be all and end all for either of us. And we were managing perfectly well without having it, so why have nervous sex I guess'.* Andrew's reference to potentially having 'nervous

sex' – anal sex with his partner – highlighted the additional anxieties he felt they both had around their serodiscordant sexual encounters. While Andrew felt that protected anal sex would theoretically reduce risk of HIV transmission, in this case it did not appear to reduce the risk enough for both him and his partner to feel at ease. All four men stressed that they had reduced or attempted to reduce the risks of transmission of HIV by negotiating safer sex practice with their partner on the basis of their biomedical understanding of how HIV transmission takes place. While they all identified the risk of HIV transmission in these encounters, they also felt that this risk was minimal or significantly reduced. For them, having an HIV positive partner was not, in and of itself, risky. The priority of HIV prevention was the responsibility of *both* sexual partners. This opinion of a shared sense of responsibility, however, was not held by the majority of men in the study as indicated in the previous section.

That many men in this study described HIV positive men as overly risky sexual partners, because of the increased risk they posed to their presumed HIV negative partners, highlights the continuing high levels of HIV stigma present amongst gay and bisexual men. A number of men made comments not only about how HIV was stigmatised amongst gay and bisexual men, but also about how these ideas were common amongst the general population. Nigel (40s), for example, explained how he believed HIV stigma was widespread.

> *I think people would say if you're HIV positive, you must be promiscuous, you must have lots and lots of sex. That's somehow, you know, that you're dirty, uh, you know all sorts of negative connotations put on things like HIV and that's why you see, if you look on teletext and things like that, people will say well we shouldn't be wasting NHS resources in providing treatment for people with HIV because they've brought it on themselves. But you know these, and you don't have to scratch very deeply beneath the surface for these attitudes to come out.*

Nigel's observation is redolent of Peter's comments on the ways in which HIV was contracted and the division of innocent and guilty HIV positive men. Nigel described how he felt that the vast majority of the population, including gay and bisexual men, would think that most HIV positive people were irresponsible and had brought this infection on themselves. Nigel expressed anger towards these views – as did most participants over 45 years old – and actively sought to distance himself from these opinions. While he thought that gay and bisexual men *should* be less discriminatory than others because of their past experiences with HIV, he still felt that there was considerable stigma amongst gay and bisexual men which resulted in discrimination against HIV positive gay men.

HIV stigma amongst gay and bisexual men in the UK has been widely explored (see for example Dodds et al. 2004). It is well established that stigma has a significant impact on the lives of HIV positive people in the UK (NAT 2008). While a number of men in this study, for example Nigel, spoke openly about their disdain for this stigma, and Joe and Peter expressed guilt or shame about their sexual discrimination against HIV positive sexual partners, some of the men in this study were more concerned about how this HIV-related stigma might affect *them* personally, because the prevalence of stigmatising attitudes. Such sentiments suggest that HIV positive men were seen as sexually risky partners because of risk of infection – a risk to bodies – but also as potentially risky by association – a risk to identity. For example, Jack (20s) explained how he did not want to be mistakenly identified as HIV positive because of what he perceived to be widespread social stigma:

> R: *...my friend Lawrence who has HIV, he's got a t-shirt, he wears it a lot of the time. He says I'm positive about being positive. So I mean, I know there was a march this year for gay men who have HIV, through town. I don't know if you heard of it?*
>
> I: *Was that in December, for World AIDS Day?*
>
> R: *Yes, I think so. They had a march through town. And, yeah, they were quite comfortable with the march itself. But it's strange because I didn't want to go on the march. I was going to but I didn't want people to think I had HIV. If they'd seen me. I don't know whether that's a, it's probably a silly thing to think, but…*
>
> I: *But do you think then that people ….*
>
> R: *I think people seeing me, or seeing somebody else who was on the march, for example, would think, uh, they've got HIV, stay away from them.*

While Jack saw his friend's *acceptance* of his HIV positive identity, and was impressed by how *'comfortable'* his friend was with the march, he actively distanced himself from participating in the march for fear that he would be mistaken for a HIV positive gay man. He felt that people would automatically assume he was HIV positive and that they would then distance themselves from him because of his perceived HIV status. Jack's anxiety around his association with HIV positive people suggests not only a recognition of HIV-related stigma in the gay and bisexual community, (Dodds et al. 2004, 2009) but also an acknowledgement of how he and other men perpetuated this stigma by their disassociation with HIV positive men. Where Jack's example of stigma and rejection is

in a public, social context, the rejection of many HIV positive men in a sexual context, as risky sexual partners, can be seen to mirror the social experiences of stigma. The following section will consider the ways in which HIV positive men understood and responded to this stigma.

Being the Risky Other

A significant number of the men in this study described how and why they actively distanced themselves from HIV positive men, both as sexual partners and in social settings. While this was by no means a universal sentiment, this response was understood as dominant amongst gay and bisexual men by many participants. Such a consensus amongst participants suggests the potential for community-based discrimination – both perceived and experienced[73] – against HIV positive men. The discrimination of sexual partners on the basis of HIV status, in addition to the widespread social stigma, was powerfully understood by the two HIV positive men who took part in this study. Both Alan (40s) and Rick (50s) described an awareness of negative social attitudes to HIV positive people. The following short profiles explain how they understood their HIV diagnosis, and the stigma and rejection which they faced. It is important to note that the stigma they experienced, and perceived, in a social context directly influenced the ways in which they navigated their sexual lives and identities.

Alan was diagnosed with HIV and syphilis a number of years ago. He was devastated by the diagnosis of HIV and felt that it totally changed his life. He had to leave his job in another country and move back to the North East. Syphilis, he explained, was the least of his concerns, especially as it was easily cleared up by antibiotics. Alan reluctantly told his family about his HIV diagnosis, some of whom no longer speak to him. Alan felt that he had been raised with the notion that homosexuality was wrong and that his being gay *and* contracting HIV was too much of a taboo for some of his family to understand and accept. Alan felt he could not tell anyone that he had HIV. He

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[73] Much research on HIV-related stigma distinguishes between experienced stigma and perceived stigma (Dodds et al. 2004; NAT 2008). That is, experienced stigma is what people have had happen to them; whereas perceived stigma is what people expect to happen to them once they disclose their status or are found to be HIV positive. In many ways, this perception of stigma results in self-censorship or restrictions to avoid potential discriminatory responses and can be just as violent or distressing as actual experiences of discrimination (Goffman 1986[1963]).

was advised to lie on job applications about his health status by medical professionals and social workers. They suggested he might experience discrimination should he disclose his serostatus, but Alan felt uneasy about this. In terms of disclosing his status to others, Alan felt he could not tell sexual partners about his HIV status. Moreover, he explained that no one asked him about his serostatus despite the available education about HIV. He believed that men should ask. He explained that he felt inhibited when having sex with men who he presumed to be HIV negative, and how, as a result, he only allowed certain sexual acts to take place in order to minimise HIV transmission. Alan felt he was '*the risk*' to other gay and bisexual men. Relying on biomedical understandings of how HIV worked in his body, he described how he hoped that it would become *undetectable* so he would potentially pose less of a risk to a serodiscordant partner.

> *the hope is that the virus becomes undetectable. And um, and obviously there are lots of studies which do indicate, but won't put their names to it, but if you're undetectable, it's very difficult to pass it on. However, I think even now [in] the HIV positive community, to become that undetectable status is something that is desired. Because you feel, because it's awful to think you're a risk to other people's health, you know.*

While Alan hoped to reduce his HIV viral load, which would mean he was less risky to other serodiscordant men, he eventually hoped to find an HIV positive sexual partner '*because they'll have the understanding, they'll have to come to terms with the acceptance of this*'. Recognising the sexual health risk he posed, Alan wanted to find other men who had similar experiences – sexually and socially – with whom he could share his own experiences of living with HIV.

In this short profile, we can see how Alan described the way he felt he embodied the risk of HIV: he felt that he was '*a risk*'. Drawing on his biomedical knowledge of HIV, he hoped that his viral loads would become low enough so that he would no longer pose a risk to others. That is, he hoped he would be able to 'pass' as an HIV-negative gay man in a sexual context, but also biologically: despite the presence of HIV in his body, and his related biomedical identity, he wanted to physically pass as HIV negative so that he did not pose a risk of infection to a sexual partner. However, even if his viral loads did get to an undetectable level, he felt he would always be HIV positive – he would always retain this identity – and therefore described how he sought an HIV positive partner who would understand his situation. This desire suggests that Alan understood himself as biomedically and socially separate from an imagined biosocial community of

gay and bisexual men whose priority was to prevent the transmission of HIV. In contrast to the discussion in the first chapter which discussed the ways in which imagined community sexual practices were perceived to reduce the risk of HIV transmission, Alan's perceptions and experiences suggest that the priority of HIV prevention was enacted by many men through the sexual rejection of HIV positive men. As a result, Alan responded to this perceived rejection of HIV positive men by not disclosing his HIV status, but by: limiting or modifying his sexual practice with presumed HIV negative men; hoping his body would become less risky with reduced viral loads and ongoing treatment; and by seeking out other HIV positive men as sexual partners with whom he could be open about his status. Alan described a number of ways in which he recognised the HIV-related stigma amongst gay and bisexual men. He also spoke of how he was a part of this group before his diagnosis and had participated in this HIV-related discrimination. Consequently, he felt unable to disclose his HIV status to partners, friends and work colleagues and took it upon himself to prevent HIV in sexual encounters with others. Alan's experiences highlight the way in which he felt the social norms around disclosure constrained his ability to talk about and share his HIV experiences.

Rick was recently diagnosed with HIV and syphilis. Like Alan, Rick was less concerned with his syphilis diagnosis because it was cleared up with medication and because he was overwhelmed by his HIV diagnosis: '*if HIV is a bolt of lightning, syphilis is like a small needle*'. Rick was married to a woman, and described how he had kept his sexual encounters with men – and now his HIV status – completely separate from his life with his family and friends. He was unable, he felt, to tell anyone about his diagnosis. When asked if he would tell other men about his HIV, he explained:

> *if I went in a room full of HIV people who are HIV, I've got no problem tellin' them. But if I go in a room where I don't know anybody's diagnosis, I won't, I wouldn't want anybody to know.*

He felt that the stigma of HIV was too strong and that if he told other people he would '*get blanked*' or '*they might run a mile*'. This meant that he was unsure about disclosing his HIV status to potential sexual partners and that he felt such behaviour was what other HIV positive men did as well.[74] However, he was also concerned about his legal

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[74] Although recently diagnosed, Rick described using an HIV positive organisation in the North East, where he spoke to other gay HIV positive men about their experiences of living with the illness.

obligations as an HIV positive individual. He described how he was not sure if he would have sex with someone without disclosing his status: '*that's why I'm not having sex at the moment*'. He explained:

> *I was never sure of the law. And I'm still not one hundred percent sure on the law. So, to clear me, with the law, it would be better if I did tell them that I was HIV. Rather than just takin' the precautions. But I don't know, I'm still playin' about with that in me head, and tryin' to, will I go to the sauna and have anonymous sex and I don't have to tell anybody and just make sure there's condoms being used, you know? ...I'm still playin' around with it because I think it's very deceitful like, but, I think it's still a risk in somebody, I mean, if a condom was to split, anything like that. You'd have to tell him then, you know? So I, I'd feel more comfortable with somebody who was HIV positive anyway, with the same strain.*

Rick's concerns around what he should do in relation to the criminalisation of HIV highlight a tension between social practices and the law. Both HIV positive men described not disclosing their serostatus to sexual partners, while at the same time presumed HIV negative men were not asking sexual partners about their status, and were rejecting HIV positive men as sexual partners. Thus, although Dodds et al. (2009) outline how over half the men in a recent national survey agree with the current criminalisation of HIV transmission, the social practices of gay and bisexual men create an environment which makes disclosure very difficult.

Like Alan, Rick identified himself as '*the risk*' and was aware of not only the social stigma of HIV if he disclosed his status – fearing men would '*run a mile*' – but also his legal obligations to inform potential sexual partners of his status and/or take '*precautions*'. Rick was unsure of what he should do, as he felt he was unable to disclose his status but did not want to be '*deceitful*'. As we have seen, Rick's self-conception as someone who only posed a risk to others and his anxiety about being socially and sexually rejected by non-HIV positive men were common responses among the HIV-positive participants. Rick reported not feeling like a part of a community of gay and bisexual men who are HIV negative. Such exclusions signal a change from his previous sexual encounters with other men. Although he did not see himself as part of a gay and bisexual community as a married man, he *did* feel able to engage in anonymous sexual encounters with other gay and bisexual men. Since his HIV diagnosis, he felt he had to restrict his sexual practice, prioritising the prevention of HIV for other men. For

Rick, this has meant abstaining from sex with other men[75], rather than disclosing his status and negotiating a safer sex practice with potential partners.

Alan and Rick described feelings of isolation from an imagined HIV negative community of gay and bisexual men once they were diagnosed with HIV. Both described not being active political members of a gay and bisexual community before their diagnosis. Alan explained how he was not the sort of person that would be '*marching for equality and everything, blankets, all that, you know[76]*'; while Rick talked about only engaging with men in saunas, and via the internet. That is, neither *identified* with a community on the basis of sexuality, but sexually participated in a community of men presumed to be HIV negative.[77] Once diagnosed with HIV, both men spoke not only about how their sexual practice significantly changed, but how they felt they were now 'restricted' to finding sexual partners from a different community of gay and bisexual men. Alan and Rick both felt that they could only seek out sexual partners who were HIV positive, signalling their perceived isolation from an imagined *biosocial* community assumed to be comprised of men who were HIV negative. Moreover, while both men recognised their isolation they nevertheless expressed a sense of responsibility for preventing HIV transmission to others in a community of which they felt they were no longer a part. That Alan and Rick struggled with their responsibility for HIV prevention and their sexual relations with others highlighted the ways in which they were negotiating their position and sexual practice within perceived community norms: the imagined sexual practice of this biosocial community meant that HIV positive men had to abstain from sex to be responsible sexual actors or have seroconcordant sexual partners. Moreover, HIV positive men negotiated this practice tacitly, without disclosing their status to their sexual partners and without their sexual partners asking their status. As a result, community practice around disclosure meant that spaces to talk

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[75] Rick explained how he had stopped having sex with his wife when he started having sex with other men. Thus, although he told me he was married, he described himself as a gay men in terms of sexual practice.

[76] Alan's mention of blankets refers to activism and responses to HIV by activists to remember those who had died of HIV. The image of the AIDS quilt was fairly iconic in the 1980s and 1990s. It was part of the NAMES Project AIDS Memorial Quilt and each quilt patch represents someone who has died of AIDS related illnesses. (See Sturken 1997, especially 183-219) In this quote, Alan seeks to distance himself from a politically active gay and bisexual community that advocated for rights and HIV prevention.

[77] One could argue that their social exclusion from a political gay community served to reinforce their perception of HIV-related stigma. However, this was not explored in the interviews and will not be explored here.

about HIV were being closed down, creating a biomedical and social division between serodiscordant men.

Conclusion

By exploring the figure of the risky sexual actor, this chapter explored how participants drew a distinction between responsible and irresponsible sexual actors and how this was negotiated in relation to established and changing imagined community norms. In many ways, this distinction was based on a biomedical set of criteria. For instance, the importance of testing for HIV and STIs generally was seen as an essential element of sexual practice. While the awareness of viral loads was low amongst HIV negative participants, HIV positive participants relied on regular serological testing as a measurement of the risk they posed to others. Moreover, this dichotomy of risky/non-risky actors was based on a sense of sexual citizenship and the ways in which community was related to this experience of citizenship. Where older gay participants were adamant about the responsibility of the gay community in terms of HIV prevention and lamented the community wide-HIV stigma, younger participants based their judgements of risk and responsibility on individual practices. The division of sexual actors within an imagined biosocial community on the basis of their perceived responsibilities, therefore, was not based merely on biomedical markers or identification with a sexual community, but on a combination of these factors. Furthermore, these elements were interpreted in dramatically different ways by different segments of actors, signalling how changes in experiences of community affect understandings of risk. However, the negotiations of changing community norms were more complex than generational differences, pointing also to increasing 'homonormativity' (Duggan 2002) in debates around responsible sexual conduct and relationships. The men in this study demonstrated the ways in which community practices worked in combination with various forms of biomedical knowledge to make judgements about *who* was risky. The next chapter will continue to explore how biomedical knowledge and community norms were employed in understandings of and responses to risky places and spaces.

Chapter Six – Mapping Bodies, Risks and Responsibilities

Introduction

This thesis has so far explored the ways in which participants identified sexual practices and sexual actors as risky. This chapter examines the relationship between risk, space and place. One of the reasons for examining space and place is the way in which spatialised understandings of risk have played an important role in the history of the AIDS epidemic. In the United States (US) during the AIDS epidemic of the early 1980s, gay bathhouses[78] were seen by public health officials and some gay men as risky spaces in which most HIV transmission took place. The most publicised debates took place in San Francisco and New York. Many were closed down as a result of this perceived high HIV transmission, despite being where the most HIV information and testing was available to gay and bisexual men (Woods and Binson 2003). This example highlights how particular *spaces* were attacked as contributing to the transmission of HIV, as well as particular communities. In other words, it was not only gay men who were constructed as risky, but gay men who had sex *in certain spaces*. Although the example of the bathhouse closures is situated in a different historical and national context to this study, it demonstrates the way in which space is integral to the understanding of risk in sexual health, as well as how it is an important factor in the processes of stigmatisation in relation to sexual health. In other words, the bathhouse debates of the 1980s demonstrate how space and place are integral to sexual identities, practices and notions of risk. This chapter will therefore explore a set of spaces important to participants in terms of risk, and consider how these spaces were further influenced by time and place. This chapter is divided into three sections. The first section explores the ways in which place was used to construct risk. It asks how understandings of particular places and particular communities played a role in the identification of and responses to risk within the North East and beyond. The second section considers the relationship between risk and experiences of illness beyond UK borders. As Massey (1994) indicates, understandings of place are dependent not only on what lies within particular boundaries, but also what is understood to lie beyond them. This second section explores how representations and meanings of ill health outside of

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[78] Bathhouses are referred to generally as a sauna in the UK (Stewart 1995).

the UK impacts upon participants' understandings of and responses to risk within these national borders. The final section of the chapter looks at the links between risk, sex and public space. This section addresses what participants thought about sex in public, how it was linked to risk and how concerns with risk in public sex may have changed for participants over time.

Constructing Risky Places

Certain places may be described as risky and are often seen in this way because of both the risky *spaces* that are contained within their borders, but also the risky *people* who are seen to reside within these spaces. That is, constructions of both risky spaces and risky people can contribute to labelling particular geographical places as risky. This section explores the way in which certain places in the UK were understood in relation to risk of infection. Where the previous chapters have focused on sexual practice and perceptions of risky sexual actors, this section asks how participants understood these elements of risk as they negotiated their sexual encounters in the North East, as well as in other parts of the country. In particular, this section considers how biomedical knowledge and understandings of 'community' factor into both spatial and temporal understandings of risk.

Mapping Risky Cities

Over one-third of the participants identified particular places in the UK as risky. In many cases these places were large cities such as London and, in some cases, Manchester. Moreover, these larger urban centres were often contrasted with perceptions about risk in Newcastle and the North East in general. These larger cities were seen as riskier for a number of reasons. For some participants, the assessment of risk was based on public health statistics: over a quarter of the men in the study described how they were aware of the statistics of HIV and/or STI infection on a regional basis, or at least in terms of how the North East compared with other larger urban centres such as Manchester and London. As outlined in the introduction to this thesis, the North East rates of HIV are the second lowest in the country. London HIV rates, in contrast, are the highest per capita in the UK, with over half of all HIV positive

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gay men living there (HPA 2010a).[79] Participants not only highlighted the disparity of HIV rates amongst gay men across the country, but also outlined how these statistics played a subtle yet important role in their identification of the risk of infection. For example, Andrew (30s) explained how he was very much aware that rates of HIV were higher in London than they were in the North East. He described how he felt his chances of encountering an HIV positive gay man as a sexual partner were much lower in the North East than they were in London.

> *I know to have unprotected sex in London, where one in four gay men have HIV, would be a very very foolish thing to do. But to have unprotected sex in, um, the North East, where one in, I'm not quite sure, a lot, one in 15, 20 gay men have HIV is sort of the chances are, are that much lower, that I, I can get into very foolish[thinking].*

Drawing on these public health statistics, Andrew described how he used this information to map out areas where there were more HIV positive individuals. The concentration of HIV positive gay men in London, for Andrew, meant that he was more likely to encounter an HIV positive sexual partner there. He then explained how it was '*foolish thinking*' to rely on these specific statistics because there were HIV positive men who lived, worked and/or travelled outside of London. Although he acknowledged how reliance on statistics alone was not enough to assess risk, his comments show how statistics played a role in his perception of risk. While he described how he could theoretically contract HIV anywhere, with any partner, he also spoke about relying on scientifically vetted knowledge to make him feel *slightly* safer in certain places. Andrew's comments highlight the ways in which he and other men in the study reported an awareness of the non-uniform geographic distribution of HIV positive individuals across the country and how this made some participants feel as though there were different degrees of risk in particular places.

For some participants HIV statistics signalled more than just risk of HIV infection. Nigel (40s) explained how his awareness of HIV rates in London led him to believe that sexually transmitted infections (STIs) would also be equally prevalent.

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[79] The 2010 report demonstrates the continued trend of low rates in the North East compared to London.

Statistically the level or the incidence of HIV infection is greater in London. But then I think to myself well there's a reason for that. Um, in my head, I think well is the reason because people are more liberal because of their approach to safer sex? And if that's true, then um, potentially then there will be a greater level of incidence towards syphilis, gonorrhoea and all the other, all the other things.

Nigel read the HIV statistics as not only relating to chances of encountering someone with HIV or STIs but also as indicating the nature of their sexual practice. Nigel's concerns that there were more '*liberal*' approaches to safer sex in London, as indicated by the statistics, meant that he thought safer sex was not, or at least not regularly, practised. Nigel felt that the high HIV and presumed STI rates also indicated possible risky sexual practice. Similar to discussions in the previous chapter around promiscuous men as the source of infection, Nigel felt that the men in London who had infections contracted them through regular unsafe or risky sexual practice. His comments reflect a perception that high infection rates indicate not only statistically higher chances of encountering someone with an infection, but also increased chances of people not being responsible members of an imagined biosocial community who engage in regular safer sex practice. Public health statistics were used by Nigel, and a number of other men in the study, to identify *where* there were high numbers of risky *people.* In other words, places that were viewed as risky, such as London, were risky because of the people there; they were people who were perceived to be acting irresponsibly and, therefore, who potentially posed harm to others. To this extent, constructions of place, using public health statistics, were shown to influence the ways in which risk was assessed and/or rationalised.

What is significant about the use of statistics in this way is that it demonstrates how the identification of risk was tied to certain places, especially for those men who spoke about travelling around the country. As outlined in the introduction, the population of the North East has been described as static in comparison to other parts of the UK. The North East is perceived as being comprised of a relatively stable population (Nayak 2003; Worthy and Gouldson 2010). However, nearly two-thirds of the participants spoke about moving across the country because of education, work and leisure. Andrew and Nigel reported regularly travelling to other parts of the country as part of their work. Yet, for both men, their own experiences of travelling did not always factor into their assessments of risk *in others*. That is, they did not always consider the possibility that those deemed risky people by public health statistics might also travel to other parts of

the country, outside of these high prevalence locations. The ways in which participants viewed their own travel experiences in contrast to the perceived stability or non-travel of risky individuals *from* elsewhere suggests how place was important in identifying risk in certain people; it suggests that where people are seen as being *from* played a role in identifying *who* was risky and locating *where* risk was.

The regional mapping of risky places for the men in this study was not solely based on public health statistics. Other men, who could not quote Health Protection Agency (HPA) statistics about HIV positive gay men or provide the numerical chances of meeting someone who was HIV positive in Newcastle compared to Manchester, explained how they also believed the regional distribution of HIV positive gay men and risk was not uniform. These men described how large gay *spaces* and associated gay communities in major urban centres were indications of risk. Max (30s) explained how he felt that high numbers of gay men, signalled by these well-established gay spaces, was directly linked to risk:

> *I would think I was more at risk in contracting HIV/AIDS, um, in Manchester and in London. I think if I have, of course they're bigger cities, higher concentration of gay people. Um, so I think that yes, there is a lesser risk in Newcastle. But it's a bit irrational to think that, because what evidence do I have to back that up? How do I not know that a percentage of the population and the amount of people who have been contracted with HIV in Newcastle? It might be a higher percentage compared to people in Birmingham, Manchester, London, Edinburgh even, um, I don't know the figures, so it's a bit irrational for me to think that.*

Max was hesitant to say with certainty that London and Manchester were riskier than Newcastle in terms of HIV because he did not have the statistical evidence to support this claim. That Max identified higher concentrations of gay men in *particular places* as risky recalls the ways in which some participants framed gay men as risky in the previous chapter and points to the ways in which participants confused or even equated being *at risk* with being *risky*. For Max, the more gay and bisexual men there were in one place, the higher the risk of contracting HIV. According to this logic, if gay men were considered highly risky sexual actors, then the larger the concentration of these men – signalled by visible gay spaces – in a geographic place means that it was risky. Much like Andrew and Nigel, Max based the construction of risky places on the perception that there were higher numbers of risky people in these places and did not

take into account the ways in which people, including himself, might travel in and out of these allegedly risky places.

The construction of London as a risky city was framed through an historical lens. A small but significant number of participants described how London has always been riskier than Newcastle in terms of infection because of the significantly higher numbers of gay men in London, the perceived high numbers of gay spaces (consumer and otherwise) and, therefore, the assumed level of opportunity to engage in sex. Much like the arguments used to close down bathhouses in the early AIDS epidemic, some of the men made direct links between the increased opportunities to have sex and increased risk. Most of the men in this study aged over 45 described stories of friends moving to London in the 1980s (or earlier), who went on to contract HIV. They contrasted these stories with their own experiences of staying in the North East and remaining HIV negative. These divergent experiences contributed to the ways in which they made judgements around risk. For example, Charles (60s) explained how he thought that gay and bisexual men were able to find many more sexual partners in London throughout the 1960s, 1970s and 1980s, in comparison with the much smaller, more rural areas of the North,[80] where sex between men was a much more private or low key encounter. He felt this difference in environment was the reason so many men he knew contracted HIV in the early days of the epidemic.

> So I think it's people taking their own habits that they'd had at home, in rural areas, where they knew, fairly small number people, going to London, particularly, mixing and a lot of people getting multiple partners and things.

Charles described his impression of a lack of public spaces in the North where gay men could meet in the 1960s, 1970s and 1980s. In response to the lack of suitable public spaces, he organised a regular gay evening at a pub for a period of time. However, he reported being concerned with the visibility of some of the men who came to this pub. He criticised one man for wearing women's clothes, who, he explained, did not look suitably 'feminine' and drew the 'wrong' sort of attention to himself and the group. Charles felt there was a need to be private and discrete because of the social disapproval

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[80] Charles described moving between the North East and other parts of the North of England during the past 40 years. This is in contrast to most other participants, who largely remained in the North East of England.

and discrimination they feared and experienced.[81] Apart from meeting in this pub event, Charles described how the sexual practice of gay men who lived in semi-rural spaces or villages, himself included, was often arranged in private homes or at private parties. Sex was not as readily accessible on such a large scale in these areas as he imagined it was or experienced it to be in London. Consequently, Charles felt that the men from outside of London were not well-equipped to deal with the risks of a larger city, where the increased opportunities for sexual partners led in many cases to them contracting HIV. To this extent, the sexual habits established *outside* of London translated into riskier practices for his friends *in* London. Moreover, the visibly public gay and bisexual culture of London was contrasted with his Northern experiences, where he perceived there to be fewer gay and bisexual men to meet and/or with whom to have sex.

Where Charles attributed increased risk to an increase in sexual opportunities and a need for a different type of sexual practice, other men felt that it was the sheer number of gay and bisexual men in London that increased the risk of HIV in the early epidemic. In some cases, study participants blamed the AIDS-related deaths of their friends directly on their physical presence in London, rather than on the need to change sexual practice. Matt (50s) described how a number of his friends contracted HIV in the 1980s '*because*' they were in London. He felt he was alive today (and HIV negative) because he remained in the North East:

> *I think I'm alive because I live in the North East of England and didn't move to London at the time that they did... because there were so many more opportunities there to have sex in London....more opportunities. More people to have sex with. Uh, and also the population is so closely packed.*

Matt did not see the higher numbers of gay men as a close knit community, but equated multiple sexual encounters at this time with increased risk of contracting HIV and/or STIs. For him, the sexual opportunities were far greater in London than in the North East and this was the reason why his friends contracted HIV. He explained how he thought the sexual acts in which he engaged in the North East were not different to what his friends practised in London. What mattered, therefore, was *where* and with whom the sexual acts took place. In this case the much higher numbers of gay and bisexual

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[81]Charles provided an example of this discrimination: he explained how the murder of Lesley Moleseed, which took place in the mid-1970s, resulted in the police harassing a number of people for alibis and targeting a number of gay men. Charles explained how there was one man in particular who had his life '*destroyed*' because his alibi turned out to be his boyfriend, who was sixteen and, thus, underage.

men in London, in comparison with the North East meant encountering an increased number of HIV positive men as sexual partners.

Despite social and legal changes since the 1980s, and an increase[82] in public gay commercial spaces in the North East, such as bars, clubs and saunas, many of the participants continued to see cities like London as riskier than Newcastle *because* of the increased opportunities for sex. For example, Matt's painting of the North East as a safer – or less risky – place than London was not limited to the 1980s and historical experiences with AIDS. He went on to explain how he felt the opportunities to have sex with lots of people, available in the 1980s in London were still very much available today.

> *My mates down in London who are as equally testosterone driven, they seem to be having sex all over the place with all sorts of people. You know, go down old Compton street in London, and I did the other, you know, a few months ago, and you know, people were cruising all over the place.*

Matt described the availability of sex in a well-established gay area of London as very high, as was the desire for him and his friends to find sex. This image of London full of highly sexually active gay men framed his understanding of the city as much riskier than the North East in two ways. Firstly, he described how men '*were cruising all over the place*', suggesting high numbers of gay and bisexual men. Secondly, he noted how this cruising was done by '*all sorts of people*,' suggesting that the range of people cruising in London stood in contrast to the smaller, perhaps more homogenous and familiar group of gay and bisexual men in the North East. This construction of different types of communities, in both number and types of people, played an important role in Matt's judgement of risk and contributed to his perception of community sexual practices in London as strikingly different to his perception of community sexual practices in the North East.

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[82] While Charles spoke about the lack of public spaces for gay and bisexual men to meet in the 1960s and 1970s, other participants did describe various gay spaces. Edward (60s) in particular spoke about a number of bars in the North East where gay men could go to socialise and find sexual partners throughout the 1960s and 1970s, albeit with the need to keep their location and/or existence hidden. However, he also commented on the limited numbers of these spaces, citing only one gay bar in Newcastle in the 1960s. This does not include public spaces for sex, such as cruising areas and cottages. I will specifically explore this issue in the final section of this chapter.

For a few of the men in the study, it was not simply the higher numbers of gay men in London that made it a riskier place, but the *type* of gay men who were there. Some of the participants thought that the diversity of people in London made it riskier, in contrast to the perceived make-up of the population in the North East[83]. In addition to Matt's description above of '*all sorts of people*' cruising in London, Simon (30s) described how he felt that London generally was a more '*transient*' place, attracting people from all over, who might be tourists, business men, or simply wanting to 'try out' the London gay scene.

> *I think here in the North East, the gay community is not as transient, do you understand the meaning of that? If you went to somewhere like London, and you go to somewhere like Manchester, you will find people who are travelling the world who are just visiting there, they may be a sales rep, there may be the situation where I'm stopping over one night on a flight from one part of the world to another part of the world and maybe just visiting London as an overnight stay. But maybe this person may want to sample the gay community?*

Simon thought that London and Manchester, and more specifically the '*gay community*' in these cities, was transient because it was made up of people from all over the world, including not only long-term residents but also tourists and people passing through. This image was in direct contrast to his perception of the North East and its gay community. Simon's comment emphasises the importance of long-term residency or the stability of a gay community to the assessment and perception of risk. While he used '*community*' to describe gay and bisexual men in both London and the North East, he felt that the nature of these gay communities in each place was different because they were shaped by space and place. His experience of this community in the North East, and his perception of its stability and static (or familiar) membership were, therefore, important factors in his description of London and its gay community as risky.

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[83] As outlined in the introduction, the North East of England is perceived to be a fairly homogenous – and largely white – population, with very few visible ethnic minorities. However, Nayak (2003:43) argues how 'the public presence of ethnic minorities may appear at first glance barely visible but in actuality this presence is carefully negotiated across temporal and spatial dimensions...the segregation of ethnic minority communities within discrete urban quarters encourages the region to appear superficially more white than it actually is.' He explains how the concentration of visible ethnic minority communities in particular areas of the city goes some way to challenge descriptions of the North East as a 'bastion of English whiteness' (2003: 37). Participants did not explicitly mention race in relation to the diversity of London and Manchester. However, an emphasis on the diversity of people from 'all over the world' as contributing to a gay 'community' in these places and in contrast to the less transient gay community of the North East suggests the ways in which the perceived 'whiteness' of the region *may* have been a factor in constructions of the gay community in the North East. While the methodological priority in this thesis has focused on age and sexual practice, rather than race, the next section in this chapter does interrogate notions of nationality and risk.

In contrast to the constructions of risky London, the North East was depicted as a much safer place in terms of risks of infection. Without always using the word safe, the men often described the North East in comparison to larger urban centres such as London and Manchester, demonstrating how they felt geographic difference was significant to the assessment of the risk of infection. This came up in a number of ways. In contrast to London and Manchester, the participants described the gay community – the presence of out gay and bisexual men who live, work and socialise in the region – in the North East as being fairly small. Colin (20s) explained his impressions of Newcastle when he first moved there.

> *I moved here after I finished university so there wasn't a period as there was for many of my friends who live in Manchester or London, um, where they were going out to new places a lot and meeting a lot of new people in various sort of big, metropolitan environment. I mean, Newcastle is obviously a city but it's quite a bit smaller and certainly, in terms of being a gay person, [opportunities] here are really quite limited.*

In contrast to the larger urban centres, Newcastle provided a much smaller space within which to socialise with other men, giving the impression to some participants that opportunities to meet other gay and bisexual men were limited. Matt (50s), who had lived in the North East for his entire life, went further than Colin. Matt equated community with high numbers of gay and bisexual men. He explained that '*there is not [a gay] community in Newcastle*' in contrast to London, where he felt there was ample opportunity for sex. In comparison to London, he felt that Newcastle did not have anything that resembled a gay community. When asked if this made the North East a safer place, he explained:

> *the North East is a fair... appears, has the impression of being, whether it is or not is another matter. But it appears to be somewhat safer because of the reduced population numbers. That's the only thing that I would put it down to.*

Matt described how the reduced numbers of people – meaning the reduced numbers of gay and bisexual men – meant that the opportunity for sex in the North East for sex was significantly lower. As explored earlier in this chapter, Matt felt that fewer opportunities for sex were directly linked to reduced risk of infection. He thus described how the North East seemed somewhat safer because of this reduced number of potential sexual partners. Matt's use of the word community is significant. Unlike his description of perceived community norms in sexual practice and condom use detailed in Chapter

Four, Matt's understanding of the gay community in this case was one that *did not* provide safety from risk of infection. That is, the gay community in relation to place for Matt captured the number of men and, therefore, the amount of sex available. This distinction in the definitions of community highlights the varying perceptions and understandings of this term held by the participants. In Chapter Four, Matt described very powerful shared memories of a community of gay and bisexual men affected by and at risk of HIV – which I have argued has helped to create an imagined biosocial community. However, this imagined biosocial community seems to be different from the gay community he described in London. Consequently, in this context, Matt's association with a gay community is with risk, rather than with a shared history or shared responsibilities in preventing HIV. Such a stark distinction highlights how geographic boundaries affect his imagined sense of community.

Apart from the relatively small size of the gay population in the North East described above, this area was described as less risky because of the stability of the population of gay and bisexual men who lived, worked and socialised there. As outlined in the introduction to this thesis, the sense of a distinctive regional identity is strong in the North East (Nayak 2003) and this was reflected in the interviews. The North East was where the majority of men in this study had lived for most of and sometimes all their lives. Some had never left and others had returned to the North East after time away for education or work. Those who were not from the North East had moved there to establish a career and/or had largely settled there, living with partners, working or retired. Simon (30s) explained how he felt the gay community in the North East was not '*transient*,' that it was not made up of people from around the world who stopped in to '*sample'* the gay scene as was the case in London and Manchester. In contrast to Matt, Simon felt that the gay community in the North East was more about long-term membership than about numbers, and he described it as quite stable, with regular and familiar faces. This sentiment was supported by a number of men in the study, who described a desire to maintain a long-term and cohesive gay community in the North East[84]. This desire for a sense of cohesiveness was expressed in a number of ways. Some spoke of efforts to establish an LGBT community centre in Newcastle and about ongoing work with the police on LGBT issues. Quite a few men spoke about their long-

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[84] This was the case for men across all age groups, with the exception of men in their teens and very early twenties.

term participation in social and community groups such as Gay Men Tyneside[85], MESMAC Young Men's Group or the Metropolitan Community Church in Newcastle.[86] Other men spoke about previous experiences of working 'in the community' in the North East during the 1980s and 1990s, especially in relation to HIV counselling and prevention work. And many spoke about regularly going to gay bars, which felt familiar and like 'home' and which had become part of their regular routine. Moreover, most participants described feeling familiar with or recognising other men they perceived to be a part of the gay community in the North East. This strong sense of place and attachment to a particular community was not necessarily unique to the North East. However, what is important here is how this sense of place in the North East was used to contrast safety and risk with other places and cities, such as London and Manchester.

Some men made a direct link between the familiarity of the place and the level of risk. This was especially the case when they identified people from *outside* the region coming *to* Newcastle. One participant in particular was concerned about the increase in people coming to Newcastle and going to gay bars and saunas during events such as Northern Pride. Oscar (50s) described people from elsewhere as riskier than people from the North East. When asked why this was the case, he explained:

> *I don't mean cause they're coming from London or Glasgow, I'm not saying they have got infections. I'm not saying that. I'm not trying to condemn them. But you just don't know who they've been with.*

Oscar was concerned that he did not know who these people had been with and, therefore, could not know their sexual history and/or practice. Oscar's comments suggest that this was an important factor for him in managing sexual risk. He explained that this did not mean people he knew were risk-free. However, Oscar felt it was important to know – or be familiar with – prospective sexual partners because one would be able to find out more about them. 'Strangers' coming to the city for a brief period of time, according to Oscar, were riskier because there was no way of accessing their sexual history and, therefore, assessing the level of risk that they could pose. Moreover, many of the men in the study described relying on this shared community

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[85] This group is self-described as the North East's Longest Serving Gay and Bi Men's group, which meets weekly at MESMAC NE premises. http://www.gay-men-tyneside.org.uk/ [Accessed 26 September 2011].
[86] http://www.mccnewcastle.org.uk/index.html [Accessed 26 September 2011].

knowledge of men's sexual histories as measures of risk and safety; a number of men described talking to their friends about potential sexual partners in order to find out more about their sexual history. Some described how these discussions often took place in bars, although this practice was not exclusive to these venues. This sharing of knowledge allowed a local gay community to easily identify and label certain men as risky because of their perceived sexual practice and/or HIV status. This meant that those labelled as risky were more identifiable for the larger local gay community.[87] That this knowledge was perceived as more accessible in a smaller gay setting – or with a smaller population – meant that the North East, for some participants, felt safer than bigger and unfamiliar places.[88]

Furthermore, participants specifically described how they felt HIV was not *visible* in the North East, thus giving the impression that it was a safer environment. In addition to the knowledge of statistics and reputation of London and Manchester as having a higher HIV positive population, the perception that the North East did not have a significantly visible HIV positive population worked to further distinguish the North East as a safe environment. The lack of visibility of HIV in the North East was described in a number of ways. For instance, some of the men spoke specifically about the lack of visibly HIV positive men. Paul (30s) asked:

> *How many people on the Newcastle gay scene are openly HIV positive. How many is there? Don't know... 2, 3, 4, 5? Out of thousands.*

He explained how there were very few HIV positive men who were open about their status even in a large gay community. While Paul did not believe that there were only five HIV positive gay men in the North East, he described how this lack of visibly open HIV positive men gave the impression that HIV was not present in this region.

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[87] We have seen evidence of this in the previous chapter where Jack identified a drag queen perceived to be HIV positive, and Matt described the sexual partner of a friend as a trollop. See pages 160-161 of this thesis.

[88] This chapter until now has largely discussed North East as a distinctive place, in comparison to larger, urban centres, and in relation to risk of infection. However, participants made a distinction in terms of perceived risk and experiences in various spaces within the North East. Not only was there a perceived distinction between the safety of gay friendly urban spaces versus more rural or peri-urban spaces, but participants also commented on certain areas *within* Newcastle where they felt at risk. Participants like Peter (teens) and Steve (teens) both described incidents of homophobic attacks in Cramlington and South Shields – urban spaces that were far away from the city centre. While this thesis focuses largely on experiences of risk of infection, perceived risks of infection were not always inseparable from other risks for participants, and in some cases, were significantly affected by constructions and/or experiences of different spaces.

Although Paul was concerned about HIV in the North East for himself, he felt unable to gauge the level of risk of HIV based on identifying HIV positive residents. Moreover, Paul spoke about a number of venues in London specifically designed for HIV positive gay men, something an HIV positive friend had told him about. The perception of the lack of visibility *and* services in the North East specifically targeted at HIV positive gay and bisexual men suggested to participants the presence of a small HIV positive population in the region. This was further compounded by the perception of a lack of specialised services. Jack (20s) described how an HIV positive friend of his had to go to London regularly for his health care needs.

> *The only place [is] in London who does it. I'm not sure what they do. They just test his blood and report back to him, oh yeah, everything's fine. Or we need to up your medication... Mm hhmm. A lot of people from England, I mean he's up here so he has to go down to London. It's the only HIV centre, apparently. I mean, I'm not clued up on it altogether, it's just what he's told me.*

Although Jack was unsure of what services or treatment his friend received, the latter's apparently necessary journeys to London contributed to Jack's impression that HIV specific services were only available in larger urban centres. In other words, services were available because there were more HIV positive people to use them. The perception that the North East had a very small HIV positive population was reinforced for these men by the fact that their friends had to leave the North East to find specific services. Participants' personal connections to HIV positive men and subsequent experiences *outside* of the North East reinforced the lack of *visibility* of HIV *in* the North East.

Gerry (20s) described how, in his opinion, all of the issues raised above, especially the lack of visibility of HIV positive gay men, led people to believe that HIV was not present in the North East.

> *I think that HIV is just not seen in Newcastle at all. Um, I just don't think that anybody, I think people are aware of its existence, um, but I don't think anybody in Newcastle thinks about it unless they're sort of confronted with it.*

Concerns around the lack of visibility of HIV in the North East, in combination with the smaller and more familiar gay environment, helped to consolidate the idea that the North East was a safer place. Much like the anxieties explored in Chapter Four, where study participants believed that *other* men, unlike themselves, might not be concerned

with risks of HIV and STIs, notions that the North East was a less risky place than a much larger city worked in the same way. The men described how they were concerned that *other* men did not think there were risks in the North East, whereas they *did* continue to look for signs of risk at home, as well as outside this region. However, they still maintained a perception that the risk of infection was reduced in the North East. What they looked for, the degree of anxiety with which they looked and how they responded to risk in the North East compared to larger, more urban centres, were as not the same.

Some participants recognised contradictions in their constructions of the North East as a 'safer' place. For example, some of these men recognised their own travel in and out of the North East, and to a certain degree, the potential travel of other gay and bisexual men as increasing risk. Recognising the role mobility might play in increasing the risk of HIV and STIs, a number of study participants relied on the public health indicators of risk relating to certain places as a guide for their own responses to risk. Recalling his fear of infection in cities like London explained earlier in this chapter, Nigel (40s) explained how this incorporation of public health information into his sexual practice was perhaps irrational:

> *the thing is, that people who go to London, they're not immobile. They go to Leeds, they go to York, they come to Newcastle! And just because you know just because... I could go out on the scene tonight and meet somebody and you now, that person could have had sex with a dozen people in London two days ago. You don't know that. So to me it's completely irrational. But it is a real issue for me.*

Nigel's dilemma demonstrates how risk assessment strategies for many participants relied on a range of sometimes conflicting information. His own experience of travel caused him to question the identification of London as risky. However, he explained that this did not ultimately change his mind about the risks in London. While he acknowledged that people from London travel even, he notes, *'to Newcastle!',* his sense of risk was still very much tied to a sense of place in the North East and his constructions of a local gay community. The following section considers how study participants implemented ideas about risk based on place into their sexual practice.

Responding to Risky Places

As mentioned earlier in this chapter, around one-third of the study participants actively identified London and/or Manchester as riskier than the North East. However, the men responded to this risk in varying ways. Some men responded to high rates of infection in certain places by abstaining from all sexual activities. Nigel (40s) was concerned with HIV and STI statistics. The high rates of HIV and STIs and the accompanying promiscuity he perceived amongst gay and bisexual men in London meant that he avoided any sort of casual sexual encounter while visiting places he felt were too risky.

> *Geographical location um, plays a big part in my perception of risk too. I'd be less inclined, and I work in London quite extensively, and you know when I was single, if I was in I don't know, Leeds, or York or something like that, I'd probably be more inclined to engage in a casual sexual encounter than I would be in London...and I think definitely, there are um, occasions, there have been times when I've, that I should ever turn down an offer of sex. But there have been times that I have and I've just gone back to my hotel and thought no, because um, I'll just be screwed up with um concern or something like that. And I just think no go home or go to the theatre or something.*

Nigel described being too anxious to have any sort of sexual relationship in London because he perceived the risk to be too great. He contrasted his sexual practice in places such as York or Leeds to that in London, where he thought there would be less risk of HIV or STI infection. Nigel felt the risks were simply too high to consider anything but abstaining from sex in London. Simon described similar feelings in a London sauna that he visited with his partner. He explained how he and his partner agreed that they would not engage in oral sex with other men because the sauna was in London.

> *And when me and my partner went there, we both made a, a decision, don't do any oral stuff[89] with anybody, um, because you don't know where they're from in that part of the world and he fully understood that.*

Simon's concern that he did not know where people were from suggests that he wanted to distinguish between the risks involved in this sexual practice in London and those in the North East. His emphasis on people's origins, and his earlier description of a transient gay population in London, indicate how he felt engaging in sex with men in this particular space in London was too risky.

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[89] In his interview, Simon described how his sexual practice explicitly did not include anal sex. He, like a number of other men in this study, avoided the practice of anal sex as a form of risk reduction, but also because of their own sexual preferences. Consequently, Simon's comment that he and his partner would not 'do any oral stuff' signalled within the context of the interview that he would not have sex with anyone.

While Nigel and Simon claimed to have abstained from sex in London, other men modified their sexual practice; in other words, they changed their sexual practices when they moved from the North East to places they perceived as risky. Matt (50s) explained how he would not make any exceptions to his condom use when he was in London, because of the perceived high HIV and/or STI rates.

> *I would always wear a condom for fucking. Um, yeah, I'd always wear a condom for fucking or being fucked for that matter.*

While Matt was adamant throughout the interview that he very regularly used condoms for anal sex, the assertion that he would '*always*' use a condom was a subtle but important distinction from his reported regular practice in the North East. The modification of his sexual practice was not limited to using condoms more regularly. Matt described how risk of infection was only one of his concerns when he was outside the North East as he also took into account the public spaces in which he would cruise for sex. He explained that he enjoyed cruising in London and found that it was much easier to find sex there than in the North East. However, his lack of familiarity and his perception that the risk of attack would be higher in certain spaces meant that he modified where and how he cruised for men.

> *I only go cruising in places that there are other gay men. Uh, the risks that I run here are because I know the geography. I know the history.*

In his interview, Matt described cruising outside of established cruising areas in the North East. He felt comfortable doing this, he explained, because he felt he would be able to identify any potential risks and know how to leave the area or already had an exit strategy if needed. However, he was not familiar with non-gay spaces in London, and therefore felt that to manage his risks he should stay in well-established cruising areas. Where Matt had described the increased numbers of gay and bisexual men in London as an increased risk for infection, he saw this same high numbers of gay and bisexual men as a sign of reduced risk of violence, for example, in certain spaces within London. For Matt, the increased risk in London was, therefore, not only the risk of HIV and STIs, but also the lack of familiarity with certain spaces.

Max (30s) did not specifically describe his sexual practice outside of the North East, but described how visiting other, higher prevalence areas played a role in his response to risk. Max explained how he would normally go to the sexual health clinic if he

suspected something was wrong with his health. He would not only rely on physical symptoms, but would also factor in the potential risks of the places he had visited and the people with whom he had had contact.

> *And when I've been to the GUM clinic in the past, I've thought about oh well, have I been to London or Manchester in that time? And I would think, was it one of the people I was with, or a person I was with? Um, and I would begin to think back, and I would think there was a greater risk and I would think, that person might have been more promiscuous, uh, in the city that they live in.*

Having established that these cities posed a higher risk, Max included the idea of places as risky in his assessment of potential exposure to STIs and/or HIV before a visit to the clinic. Redolent of the ways in which Max identified certain men as the source of infection in the previous chapter, this correlation between place and risk shows how his assessment of risk is premised in part on contact with potentially risky sexual actors in London or Manchester. Max established going to the GUM clinic as a regular part of his safer sexual practice but flagged up the importance of perceived risky places as potentially increasing the urgency with which he felt he needed to visit a GUM clinic. Most of the men who identified certain places as riskier than others did not, in general, avoid particular places but would modify their sexual practice either while in these places, or by responding to the increased potential exposure to risk once they had returned home. Whether through abstinence, regular condom use, or regular check-ups at GUM clinics, these men described a heightened awareness of the risks associated with particular places and the need to respond accordingly.

Rejecting RiskyPlaces

That London and Manchester were seen as riskier cites than Newcastle was not a perspective shared by all study participants. In contrast to the opinions and practices described above, an additional one-third of the respondents reported how places with higher rates of infection were not riskier than other places. They therefore rejected the idea that certain places were riskier than others in terms of HIV and STI transmission. In keeping with the safer sex practice described by men as a community norm in Chapter Four, these participants felt that risk was linked to the nature and not location of the sexual practice. For example, the lower rates of HIV in certain areas did not mean that the risk was eliminated or entirely absent. Alan (40s) felt that the public health

statistics which identified HIV as high in London masked or downplayed the real risk of HIV in the North East.

> *I mean obviously people sometimes talk about maybe HIV is not as prevalent in the North East as it is in London. But I think there's a significant number of cases here, and in any major city.*

Alan described how low statistics did not equal absence of risk. Moreover, he was highly concerned that men in the North East might think HIV was not a risk for them because of its alleged low prevalence in the region. He argued that there were significant numbers of HIV positive individuals living in any major city in the UK, and, as a result, people needed to be aware of and respond to this risk regardless of the city in which they resided. His comments indicate how he felt that the possible presence of someone living with HIV in a particular place meant that there was always the potential risk of infection.

For other men, place or comparisons to other places were not important in the identification of risk in sexual health. Gerry (20s) described how the spaces in which sex took place, whether in the North East or in London, made no difference to the risk of infection in a sexual encounter. David (40s) explained how he had never considered the fact that London might be riskier than the North East.

> *I don't think [about] it regionally. I mean really the only one area I'm particularly conscious of is this one here, because it's where I live. Um, and on the rare occasions I visit London or Manchester or places like that, then you know, I would take the same precautions as I would take here. But, more because I take those precautions than oh well it's a bigger place, high population is probably gonna be more instance of HIV.... And I think it would be a particularly stupid thing to do, you know. If I had a choice between somebody local and somebody from London to shag, um, well, would I not take the Londoner just because, um. And honestly,no. That's not really something that I have in my consciousness.*

In contrast to participants described earlier in this section, David was very much aware of the statistics of HIV and STIs in the North East but did not concern himself with rates outside of the place in which he lived. When I suggested to him that other men in the study felt that higher rates in London played a role in their concerns about risk, he explained how he had never considered using this information in this way and that it was '*stupid*' to reject someone as too risky because of where they were from. Unlike

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Nigel, David felt that the possibility of travel erased the regional differences visible in public health statistics, and therefore, he did not use these statistics to assess risk in sexual encounters.[90] Similarly, Jack (20s) also rejected the notion that being in a certain place would reduce or increase his chances of infection because people can easily move around.

> *I: Does location or does geography play a role in where you think…*
>
> *R: No. No. I mean, because I mean, if I was to contract HIV, I mean I could go to Scotland and so, it just depends on the person. For me, like, I say you don't know who has HIV.*

Jack argued that one could not make assumptions about a person's HIV status based on location or where the person was from. While HIV rates are much higher in London than in Scotland, for instance, Jack did not think that these rates or these measurements were enough evidence to establish a direct correlation between place and risk. Moreover, Jack described how he felt that HIV positive people were *not* identifiable by looking at them. Consequently, anyone could be HIV positive anywhere in the country.

While HIV and STI rates of infection were higher in other parts of the country, this group of men were adamant that statistics would not alter their safer sex practice, nor would it encourage them to act differently: their sexual practice would remain the same wherever they were in the country. These men cited the possibility of travel as a key factor in this decision, acknowledging both their travel around the country as well as the travel of men from the alleged risky places. Ultimately, they argued that one could not rely on regional statistics to determine who had an infection and, therefore, who posed a risk as a sexual partner. The best form of protection against HIV and STIs, they felt, was to follow through with their established safer sex practice, which treated everyone – whose sexual history and/or serostatus was unknown – as a potential risky sexual partner. This is not to say, however, that place was not important for these men. David spoke about his concerns regarding where he lived and the increasing rates of syphilis and other STIs. Alan expressed concerns about the risks he perceived other people to take in the North East on the basis of a perceived lower rate of HIV infection. In this way, place did play an important role in how these men saw themselves and others. The

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[90] David did rely on statistics in terms of which infections he should be concerned with and how gay and bisexual men are affected by these infections.

North East was seen as distinct from other parts of the country in that it was geographically and culturally different from larger urban centres. Many study participants described strong ties to the region and were proud about their North Eastern identity. This included those men who rejected the notion that risk of sexual infection was higher in other parts of the country. And while place played an important role in their assessment of risk, they were primarily concerned with the place *where* they lived, rather than the places to which they might travel.

This section has explored the significance of place in constructions of risk of infection. One-third of the participants drew on understandings of risky sexual actors based on health statistics, the prominence and/or visibility of gay spaces, and different meanings of community to establish London and Manchester as risky places. By linking certain places to increased risk of infection, these men constructed the North East as a stable and safer place for sexual encounters. Moreover, they described how they modified their safer sexual practice in relation to where they were in the country. In contrast, a further one-third of the participants rejected this hierarchy of risky places within the UK. Taking the importance of regional location and mobility of sexual actors into consideration, these men were more concerned with their immediate surroundings and potential risky encounters with people who could be from anywhere. This section has highlighted the creative and varied management of risk on the basis of biomedical information, and how this has been influenced by understandings of regions or places within the UK. The following section considers how global understandings of place have played a role in the identification and management of risk in sexual health.

Understanding Global Risks

Patton (1990, 2002) Treichler (1999) and others have written extensively on how understandings of HIV in the 1980s and 1990s were associated not only with particular *people* (gay men, intravenous drug users, sex workers) but also with particular *places* (first Haiti, then countries in Africa). The perception that one was not at risk of HIV if one was not a member of these risky groups of people or *from* a risky place was widespread. Moreover, such an understanding fed into media representations of HIV, epidemiological research, and public health policy and practice for many years.

Although the bulk of infections continue to be recorded in the Global South[91], the HIV epidemic today has changed considerably (UNAIDS 2011). While representations of HIV on a global scale have also changed significantly, international media and research initiatives tend to focus on experiences in Africa and Asia[92]. Both Stoler (1995) and Puar (2007) argue that constructions of the racial and sexual 'other' in the Global South have been integral to understandings of European/North American sexual subjectivity and citizenship, both historically and contemporaneously. While current research and media representations of HIV draw a boundary between the material, cultural and health-related experiences in the Global South and the Global North, Stoler and Puar argue that there are many social, cultural and political crossings of this imagined geopolitical boundary. As outlined earlier, Massey (1994) has argued that understandings of that which lies beyond borders is constitutive of the border itself and that which lies within. This section explores what role understandings of health, illness and risk in the Global South had in the constructions of risk for participants. Given that one-third of the men in this study made reference to experiences of or people from the Global South, this section considers how constructions of these places, and people *from* these places, contributed to ideas around risk, community and responsibility in relation to HIV prevention for these men.

Illness, Africa and Othering

Five men in this study spoke specifically about the HIV epidemic in the Global South, usually referring to Africa.[93] These references were often made in comparison to experiences in the UK or in other developed countries such as the US. For instance,

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[91] The term Global South will be used in this thesis to refer broadly to low and some middle income countries, which are typically although not exclusively based in the Southern Hemisphere. This terms draws on contemporary discourse in international 'development' and will be contrasted to the Global North, which historically has included North America, Western Europe and Australia, but is not limited to these places. For a detailed discussion of this terminology, see Rigg (2007).

[92] The advent of successful HAART has not only affected those in countries that have access to affordable health care, but increasingly, ARTs are being made available to large number of people in many countries in the Global South. This is a result of internationally brokered trade agreements that allow for generic ARTs to be manufactured and distributed via public health programmes (both state and/or NGO run) at significantly reduced costs. The system is far from perfect: it is continually under threat by changing international trade agreements; millions of people still do not have access to regular and reliable supplies of ARTs; and those who do have access may have to prove certain criteria to be eligible to access medication through certain programmes. However, significantly more people on a global scale have been able to access ARTs in the 21st century. See www.unaids.org for more information. The representation of these changes might not have changed as much as the experiences of HIV have, but media stories are now slightly more heterogeneous in their coverage of 'Africa' as they now include stories around treatment activism, international targets for treatment campaigns and the involvement of international aid.

[93] In some cases, they referred to experiences in 'Africa', as though it were one homogenous place.

Steve (teens) described his concerns with HIV in Africa *and* the UK by drawing on statistics.

> *Like, for example, in Africa, 9 out of, or was it, 9 out of 10, cause I know the statistics, like the statistics in Africa are really really high. I was like, if it got that bad over here, then, we'd be bad.*

As demonstrated throughout this thesis, public health statistics have been an important element in shaping participants' understandings of risk. Steve's understandings of public health statistics helped to form his perception of the HIV epidemic in Africa. Although the rates regarding the African continent are not 9 out of 10, they are considerably higher than those in the UK and across most parts of Western Europe.[94] Steve's use of these statistics suggests that he felt the situation in Africa was lacking in any sort of hope, as he reported incredibly high numbers of HIV positive people living there. However, the image Steve painted was more complex than this. His comment '*if it got that bad over here*' suggests an anxiety for the increasing numbers of HIV in the UK. His comments indicate his concern about how an illness, which remains unchecked, can become an epidemic. Moreover, these comments suggest he was concerned that the experiences of HIV in the UK could also become as bad as in parts of Africa should appropriate preventative measures not be taken. Although Steve did not discuss a physical or material connection between the UK and Africa, this comparison highlights the ways in which he sees potential similarities in the development of HIV in the UK and in Africa. This comparison to Africa demonstrates how HIV is something Steve feels he needs to be concerned with in the UK and how he fears the development of the illness.

Jeff (30s) also evoked images of Africa and HIV when describing his early impressions of the illness and what it meant for him. Jeff explained how he was afraid of contracting HIV in the 1980s and early 1990s and how he associated it with being gay. The latter association was a contributing factor to him not coming out as gay for a number of years.

> *I wanted to have a go, but I didn't want to run any risks, catchin' anything. I mean, I wasn't quite sure at the time, the only thing I had in my head was AIDS. Um, and you heard it on the telly, people dying from it, Ethiopia, and you know,*

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[94] According to the latest UNAIDS report (2010), there are 22.5 million people living with HIV in sub-Saharan Africa, with an estimated total population of over 863 million people (UN 2010).

and I just kept thinking oooh. That's the one thing that probably scared me into using [a condom] time and time again. And you know, refused anything unless they had it on.

As outlined above, the history of HIV has not been limited to gay men, 'Africans' have also been constructed as a vulnerable or highly affected population, both in the early days of the epidemic and now (Patton 1990, 2003; Treichler 1999; HPA 2009). Jeff's conflation of contracting HIV as a gay man with people '*dying from it [in] Ethiopia*' also highlights how perceptions of HIV were tied both to being gay in the UK and to experiences of HIV beyond UK borders. While his main associations with HIV were with the experiences of the gay community in the UK, the fear of what happened in Ethiopia also compelled him to use a condom in his sexual encounters with other men to prevent HIV. Although Jeff did not suggest the experiences of HIV would be the same in both places, the stark images he described echo Steve's fears of what might happen if the spread of HIV was not prevented in the UK.

Both Steve and Jeff's descriptions of HIV in Africa indicate their general concern about HIV prevention in the UK and fed into individual responses in sexual practice. However, the influence of ill-health in the Global South in relation to risk goes beyond HIV and individual responses. The impression that these countries had underdeveloped or non-existent health care systems, and the effects of this on the population, was raised in relation to experiences of ill-health for gay and bisexual men in the UK. For example, Colin (20s) described how his primary association with syphilis was with people who did not have access to appropriate health care:

> *my brother's a doctor and uh, when he was a student I used to go through, cause you know they have these photo books where they kind of describe conditions and show photos of people with it. And they had all these pictures of people in West Africa who had syphilis, because it's a lot more advanced there, and um, it just looked really gruesome. And I was thinking god, you know, they in undeveloped countries they must have such terrible problems where they don't have proper medical facilities. Um, and that's what I associate syphilis with really so it was surprising when they told me there was a real problem with it.*

Having been told about syphilis in the GUM clinic, Colin described being surprised that this was an illness affecting gay and bisexual men in the UK. That Colin linked this '*gruesome*' illness with lack of '*proper medical facilities*' points to an impression of syphilis as something that can be managed when the population has access to appropriate facilities. It also indicates how the experiences of people in West Africa

were exacerbated a result of poor health infrastructure. Colin's reaction implies a connection between the availability of health care and the experience of illness. While Colin did not suggest that access to health services would eliminate all illnesses, his comments indicate an assumption that treatable infections such as syphilis would have been addressed within existing 'western' health systems, in the same way that polio had been nearly eliminated through vaccination programmes in North America and Western Europe in the 1950s and 1960s (Wilson 2009). Colin considered syphilis to be an issue of under-resourced and/or poorly developed health systems and would not affect him directly. These three examples highlight the ways in which this group of participants framed their understandings of prevention and health care through images and/or impressions of experiences in the Global South. They did not necessarily see a material connection between these disparate experiences, but considered how they illustrated the need for prevention and adequate health care.

Edward (60s) made more explicit links between experiences of illness in the Global South and health in the UK. He explained how for many people in the UK contemporary understandings of HIV meant that it was simply not a real risk because it was perceived as being an 'African' problem and therefore a distant issue.

> *I think for those people who go and work and come back from say Africa, suddenly realise how real it is. But Africa's a long way away, in the same way San Francisco was a long way away in the 80s. It's happening over there, it'll never happen here. But we know how quickly things spread. Four cases of swine fever in Mexico and we have two in Scotland because people travel.*

Edward made analogies with swine flu,[95] as well as with references to early beliefs that HIV was an illness which only concerned gay men in certain parts of the US. He was critical of the perspective that experiences in the UK would be unaffected by the current epidemic outside of the UK. Edward highlighted the importance of increased international travel in connecting the UK to places further afield. These comments suggest that, for Edward, the issue is not simply about travelling to places which have a high prevalence of HIV, but also that we are now more intimately connected on a very global scale, even when we are physically located in the UK. In making these material

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[95] At the time of the interview in 2009, cases of swine flu had been identified in Scotland, and as having 'originated' from Mexico.

connections beyond national borders, Edward demonstrated how the international or global network to frame his understandings of health risks *in* the UK.

Understanding Vulnerability, Rights and Risk in the UK

In addition to identifying places as risky, participants made a link between risky places and people *from* risky places. A small number of the men reported how they thought people from outside of North America and/or European countries had limited awareness of sexual health. For example, Simon (30s) described people who lived outside of the UK and the US as generally not being aware of the risks of HIV because of social and/or religious oppression.

> *I think yes, the gay community is aware in the North East about the risk of HIV, I think in the wider world it isn't. Because if you go to places like, because of the religious faith and social reasons, you go to places like South Africa, you go to places like, I mean my partner is from the Philippines, there is great stigma about people having anything wrong with them, you know, this, in their kind of community and their world. But certainly within the UK, I think the gay community, and in the United States, is fully aware of the risks of HIV in this day and age.*

Simon directly compared the knowledge of people in South Africa and the Philippines to men in the UK and the US, and especially to the gay community in the North East. This was an important positioning of not only his knowledge, but also the knowledge he perceived to circulate amongst gay and bisexual men in the North East. Simon felt that stigma played an important role in the low levels of awareness amongst people from South Africa and the Philippines and that social and religious practices in these places meant that important information around HIV, and sexual health more generally, was not discussed. In contrast, Simon's comments that the gay community in the North East was '*aware*' implied that he felt HIV and sexual health *were* discussed in the UK. Simon went on to describe how people from the places he spoke of might pose more of a risk to others when they were in the UK because of this lack of discussion and subsequent lack of concern for health.

> *If you have, maybe oral sex in other parts of the country or other parts of the world or with people, perhaps, from other – not being racial or anything – but you can tell straight away from stereotypes from people you meet come from South Africa or this kind of thing, even having oral sex with lads like that might be a concern if they've maybe got a split lip or anything, because there isn't*

*health concerns in that part of the world and people, and also stigma, and they
may not be aware of um, not just AIDS but hepatitis and all the rest of it...*

Simon was adamant that he was '*not being racial*' but described how he felt people
from these places were risky. He believed the risk of HIV, Hepatitis and other STIs
posed by men from South Africa was significantly higher than the risk posed by men
from the UK. He linked this assessment to the lack of concern for health due to
ignorance or lack of education, as well as to the social stigma he perceived to be
prevalent in South Africa and the Philippines. The way in which Simon constructed
South African society and people from the South Africa as risky signalled the
importance he assigned to the cultural and social influence on both sexual health
environments in particular places and on people from these places.

Similarly, Paul (30s) associated cultural and religious reasons with risk in certain places
and with certain people. Paul described North Africa as a place where many gay men
would go specifically for sex with men.

> *Yeah, that's where um, Kenneth Williams, he used to go to North Africa,
> because the Muslims can't have sex with a woman until they're married. So the
> young guys who aren't married have sex with each other. So it's classed as the
> norm for guys to have sex with each other but it's not talked about. They don't
> go out and say 'ahahah'. You know. 'I shagged this one' cause they don't, they
> definitely don't. But you go to places like that, you're more at risk.*

Paul made a direct link between the perceived suppression of sex and subsequent 'risky'
sexual practice. He explained how he felt the suppression of sexuality by Islamic
cultural and religious traditions led to North African men engaging in highly risky
sexual practices with each other and with tourists. He explained how he felt there were
high levels of STIs because the men did not know about safer sex practices and did not
have access to sexual health services (which could, for example, have provided free
condoms). Like Max, who linked his visits to perceived 'risky' places such as
Manchester with a subsequent need to go to the GUM clinic, Paul explained how he
would always go for a sexual health check up as soon as he returned from a holiday in
North Africa. Such practices, he explained, were because of the high risks of STIs he
imagined he had potentially been exposed to in that locale. Where Paul described the
broad social reasons for this 'risky' sexual environment, he did not consider the risks of
infection that tourists might pose to these men. He associated the origin or reason for
risk of infection with the social and cultural environment of places like North Africa,

coupled with a lack of access to health services. The views expressed by Simon and Paul show how they established links between good sexual health and sexual rights, such as access to sexuality education and freedom of sexual practice without discrimination.[96] They described how men in or from developing countries were unable to make healthy 'choices' in their sexual practice because of external forces, such as social and/or religious stigma. Moreover, for Paul and Simon, these men faced structural barriers in accessing sexual health education and services. The ways in which both participants assign blame to a lack of sexual rights (e.g. freedom of sexual practice, access to sexual health services) and structural barriers for an increased risky sexual environment shows how they did not perceive these individual sexual actors as acting irresponsibly. Instead, these men were constructed as innocent 'victims' of an unfair, unhealthy and repressive society. While some men in this study described those perceived as promiscuous and risky as irresponsible, as discussed in the previous chapter, men from these risky places were positioned as victims of structural – social, cultural, religious – repression, and therefore, *could not be responsible* sexual actors.

Where Simon and Paul described how men in or from other places did not have access to sufficient or effective sexual health education and/or services, other men in the study felt that this lack of education and general lack of access to sexual rights would have a negative impact on their experiences in the UK. Colin (20s), for example, described how he felt people from other, less 'open' places might be more vulnerable to sexual exploitation or experience poor sexual health in the UK. Colin explained how his personal encounters contributed to this perspective:

> *my partner is from [country in the Middle East] and a lot of immigrant communities, particularly new immigrants, refugees, asylum seekers, people like that, come from countries where there's no sex education or um, you know there's not really any information about condoms and stuff. There might not, although they'll be available, they might not be widely available and those people put themselves at huge risks because they don't have, they just don't have that kind of grounding in sex education and also relationships and making decisions about what's risky and what isn't. And um, I suppose the people that I'm thinking of who don't appreciate the risk that they put themselves in are the people who've arrived in the country in the last ten years, maybe?*

Colin attributed the vulnerability of people from certain immigrant populations to ignorance and lack of experience. Unlike the repression and/or intense social and

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[96] See the WHO definition of sexual rights detailed on p 2 of this thesis.

religious stigma identified by Paul and Simon which created *barriers* to 'good' sexual health, Colin emphasised how an *absence* of knowledge around safer sex practices and lack of experience in relationships might lead to risky sexual practice. Furthermore, Colin expressed concern that under these circumstances individuals might not be able to navigate the sexual risks in the UK because of this lack of experience. Colin's comments point to the importance he placed on sexuality education in protecting oneself from risks in sexual health. They also show how he felt that the presence of sexuality education, condoms and information more generally, which he felt were generally available in the UK, contributed to his and other men's ability to navigate these risks. This direct link between lack of sexuality education and risky sexual practice indicates how Colin and other men in this study judged British men differently from those men who originated from countries in the Global South especially in terms of responsible sexual practice. Whereas the risky sexual practice of some recent immigrants may be attributed to their increased vulnerability and lack of experience in their country of origin and therefore may not be seen as irresponsible, the same sexual practice is deemed as irresponsible in men from the UK because they are presumed to have had access to the necessary sexual health education and experiences to make healthy – and responsible – decisions.

Where Colin described how he felt sexuality education was an important element in enabling responsible sexual practice, other study participants explicitly linked sexual rights to sexual health. While discussing HIV and his concerns that low rates of HIV in the UK might make people complacent, David (40s) raised the issue of legal barriers in India established during British colonial rule and the connection to increased risk of HIV on a global level.

> *It's always oh, people forgetting about [HIV] and lots of places in the world where it's not even discussed. You know, like, for example, India apparently, the infection rate there is going through the roof because it's not addressed. It's still illegal to have gay sex there, I have a friend who is Indian, who you know, was a partner of mine at one point, but then he moved back to India. Um, and it's illegal there and you know, they still use the Victorian Laws that got repealed here. Um, and there's not likelihood, I mean there's movement to, on the back of trying to reduce AIDS, to get it decriminalised and to get it more discussed and what have you. But you know it's fiercely opposed. So you know, around the world, Africa, India, um, and um, the UK statistically, it's still rising, it's still in there. And people are still catching it.*

David compared the legal barriers in India to the UK, emphasising how the UK had repealed these '*Victorian Laws*' which were generally seen to be impeding HIV prevention work in India. [97] By comparing the legal status of homosexuality in both societies, David expressed a belief that sexual rights – in this case the right for men to engage in sex with other men without legal or social discrimination – were integral to HIV prevention. He felt that the Indian HIV rates were high because men who had sex with other men in India did not have access to appropriate sexual health information and services. By invoking this example in relation to his perception that men in the UK are complacent, David's statements suggest that he felt gay and bisexual men in the UK did not face the same legal and social barriers as men in India and, therefore, did not have the same *excuses* for increasing HIV rates. That is, where the structural barriers in India led to high HIV rates, the absence of these barriers in the UK meant that the rising rates seemed to be a result of individual sexual practice that did not conform to safer sex community standards. These comments suggest that place plays an important role in judgements of risk, not only in relation to location of the illness explored in the first section of this chapter, but in relation to how individuals are enabled to engage in responsible sexual practice.

This section has considered the ways in which constructions of risky places beyond UK borders, and constructions of people from these places, influenced understandings of risk and responsibility for men in the UK. Participants described how images of illness in the Global South played a role in their individual sexual practice and their perceptions of the need for adequate health systems. These men highlighted the importance of a society that was free of social, religious, cultural and legal barriers to both HIV prevention and homosexuality. They also stressed the importance of sexual rights to safer sexual practices. By invoking images of places they imagined to be hostile to these essential elements, and describing the ways in which they perceived people in or from these places to be adversely affected by these poor sexual health environments, participants highlighted the importance of individual responsibility in sexual practice in the UK. Because gay and bisexual men in – and to a certain extent

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[97] David was referring to Section 377, the law which established homosexual sex as illegal, and which was originally implemented during British colonial occupation of India. There has been considerable activism in India in opposition to this law. In July 2009, the law was overturned, after an 8 year long case brought against the law by the Naz Foundation (India) Trust. For more information on the repeal, see http://news.bbc.co.uk/2/hi/8129836.stm [accessed 8 February 2011]

from – the UK were not seen as subjected to these structural barriers, participants' comments implied that there was no excuse for them not to be responsible sexual actors. In other words, access to adequate health care, sexual rights and equality legislation are the elements which *enable* responsible sexual practice within a biosocial community.

Negotiating Risks in Public Spaces

Bell and Valentine (1996:7) have noted the 'hegemony of heterosexual social relations in everyday environments.' However, certain public spaces have been used by gay and bisexual men explicitly for sex and have gained an important place in community sexual practices. Generally known as cruising sites, these spaces are where men cruise or look for sex with other men. There are a number of cruising sites in which sex can take place, such as parks, forests, lay-bys and public toilets (cottages).[98] Twenty of the twenty-three participants referred to cruising or cruising sites in their interviews in some way and held strong opinions about risks in these spaces. This section will therefore specifically consider cruising spaces and address if and how participants used these spaces. This section will explore what the use or non-use of these spaces meant for constructions of risk and how these spaces were considered risky. This section will also consider the changing use of these spaces and the ways in which participants reconciled these changes with notions of personal responsibility and community norms.

Risky Spaces

The majority of participants described how they did *not* use cruising spaces for sex at the time of the interview. Of these participants, five men described having previously used cruising spaces for sex in the past, but that they asserted that no longer used them because they saw them as risky. They explained how they generally did not associate these spaces with risk of infection, but with other formss of risk that they wished to avoid. Three of these men explicitly spoke about the risk of being arrested. Nigel (50s) described his fear of being arrested when he had used cruising spaces in the past and explained how he felt it could have ruined his personal and professional life if he had

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[98] There are a range of housed spaces which facilitate sex between men, known as Public Sex Venues (PSEs), and in which 'cruising' can take place. These include saunas, bars and/or clubs with dark rooms and sex clubs. However, this section will primarily discuss outdoor and/or public spaces which have not been 'designed' for public sex due to the wide range of opinions and experiences of these spaces amongst participants.

been arrested. He stopped using these spaces when he came out as gay. Both Jeremy (40s) and Oscar (50s) described being arrested when they were much younger. Oscar explained how he was arrested over twenty years ago when he was in a cruising area, resulting in a permanent criminal record. He was especially upset about this because he was not engaged in any sexual activity when he was '*pounced on*' by the police. This criminal record continued to have negative consequences for Oscar. He described being a long-term member of and holding a position in a church which had recently brought in criminal record checks for people in certain positions. When he received his report, he explained what was written:

> *And they said, they said I was soliciting. I was a prostitute. What a wording to have. It's wrong, isn't it? I mean anybody, see the thing is, when I saw that, I said that I had to resign from Ministry. I, I mean the thing is, if I showed that, I mean, could mean anything to people, couldn't it?*

Oscar felt he had to resign from his position, rather than explain what had happened. He was clearly deeply upset about this situation. He explained how he could no longer go to cruising areas after the arrest because of the continued upset. Jeremy described being arrested in a public toilet in the 1980s and how the police later visited his house to ask him questions about another investigation, potentially exposing his arrest and sexual practice to his family. Jeremy described how he would go through phases of avoiding public toilets for sex as a result of this arrest and scare, but how he did not stop entirely using these spaces for sex until he came out about his sexual practice with men.

In addition to the threat of arrest, some of these men described the threat of violence in these spaces. Jeremy reported a fear of football fans harassing him and other men using a public toilet close to the St. James football grounds in Newcastle in the 1980s.[99] Other men spoke about these fans causing trouble after a match or other groups of presumed straight 'lads' harassing gay men in well known cruising areas for entertainment. Paul (30s) spoke of the threat of drug users targeting men in cruising sites for theft because they knew the gay men would not report the crime:

> *They think you're not gonna go to the police, because you're in the gardens, you're in the cruising area, so you're not gonna go to the police and say 'I'm a gay man and I was cruising and I've been robbed.'*

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[99] A number of men reported how this public toilet across from St. James' Park was once a well known cottage, but no longer existed.

The perception that men who used these spaces were vulnerable was exacerbated by a number of stories of serious incidents of violence. Nigel (40s) described hearing about '*people from the travelling community*' with chainsaws chasing men who were cruising at the Testos roundabout in South Tyneside. Quite a number of men in this study reported hearing about a man who had been fatally stabbed in '*the gardens*' while he was cruising. Some men, like Paul (30s) and Max (30s), reported being attacked in a cruising area. Although Max[100] did not stop cruising as a result of this experience, he was clearly haunted by this incident. He explained how he got very anxious when he saw large groups of men together and how, in some cases, he would run away if they got too close. He also described avoiding cruising areas at night. The threat of violence in cruising areas is not new and has been well researched (Flowers et al. 1999; Brown 2000; Tomsen 2006). These areas have long been targets of police raids and attacks from certain members of the public, although organisations like MESMAC NE now work with the police to reduce threats of attack and reduce the impact on the 'public' in general.[101] This history and ongoing concerns around violence speaks to the ways in which participants constructed these spaces as risky and felt the need to negotiate their own safety within these spaces.

A small group of men reported never having used outdoor public sex spaces, not because they feared the threat of violence, but because they believed these spaces did not provide enough privacy or anonymity. Two men in this study – Rick (50s) and Omar (30s) – described how they were married to women and were therefore secretive about their sexual practice with men. They explained how they could not use these spaces without fear of being seen by people they knew, highlighting a risk in the perceived lack of privacy. They both preferred using saunas because the latter provided controlled entry, assured privacy and gave access to condoms. Omar described how he could see who was around before he went into the building and how he could therefore make sure he was not identified by anyone he knew. Rick explained how he could not carry condoms with him because his wife might find them and ask questions. While he did use public toilets sometimes, he would only use these spaces to pick men up and go

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[100] Max was not one of the five men who reported no longer using these spaces. However, he is included here as he is one of the participants who described being attacked.

[101] As partners to this research, employees at MESMAC NE spoke about regularly working with police, especially in relation to outdoor public sex environments. For example, police LGBT liaison officers participated in a MESMAC NE organised workshop in May 2010, where findings from this research were presented.

somewhere else for sex. He explained how he was dependent on the men he picked up to have condoms. In a sauna, however, condoms were provided and were not something he felt he needed to worry about. Omar and Rick, as well as the five men who reported no longer using cruising areas or public toilets, constructed these spaces as risky not because of the risk posed by infection but by outside sources. That is, they could not control the circumstances of the physical environment or the people who were there and felt this was too much of a risk for them.

All of the men described above, who had used cruising sites but described them as risky spaces, were over the age of 35. In contrast, of the eight men who described never using cruising sites or public toilets for sex, only one was over the age of thirty.[102] Most of the men who described these spaces as risky were under thirty. Some agreed with the above descriptions of these spaces as risky because of the perceived threat of and stories of violence. However, most of the men in this younger group felt there was also a significant link between these spaces and the risk of STIs and HIV. Having never used these spaces for sex, some men described how they *imagined* what happened there or how they were told what happened in these sites from their friends. For example, Jack (20s) explained:

> *I've spoken to a lot of gay men who have gone down before. And they're just, they just don't care. They just, as long as they get their shag. Yeah. And fix if they're on drugs as well... I mean, I'm not saying everybody does. But a lot of people I've spoken to don't use protected sex.*

Jack's impression of cruising spaces was that they were full of men engaging in risky sexual practice and that there was a greater chance of contracting an STI (mainly because men were not using protection). Jack also made reference to drug use, pointing to a certain group of risky people he believed used this space. In addition to his belief that men in these spaces were not using condoms, he felt these men were also using drugs and would be less able to make informed decisions: '*if they're on drugs and down in the garden, they're not as aware as they would be if they're sober.*' This combination of unprotected sex and potential drug use, as well as the implication that men were only after '*a shag*,' relayed through the stories that other, often older gay men had told Jack,

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[102] Jeff who was in his early thirties also described never having used these spaces.

led him to believe that this was a highly risky space for him and his friends.[103]

For some men, this construction of cruising areas as risky, because of increased chances of infection, was also affirmed through experiences with sexual health services. Colin (20s) explained that on his first visit to a GUM clinic, he was asked if he had ever used these spaces for sex.

> *The HIV counsellor said to me before I started my relationship with my partner is, you know, well, have you been cruising, or have you been cottaging and this and that and the other...and um it really annoyed me actually, because I just kind of felt like, well, you're just, I'm kind of slightly disgusted that you'd make that assumption about me and how I behave.*

Colin was upset that the counsellor might think he used these spaces and interpreted her question as an assumption about what gay men do. Eager to reassure her that he did not go to cruising sites, he said '*to the counsellor, you know I think that sort of thing is really disgusting and I would never do that. And she did say, good'*. It was important for Colin that the counsellor did not think he used these spaces and that she was aware of how he found these places '*disgusting'*. That the counsellor responded by saying '*good*' reaffirmed for him that these spaces were more risky and that it was not responsible to use them. Colin explained:

> *I just think it's disgusting. I really just don't understand how people could enjoy that unless they get some kind of thrill out of the fact that it's so dirty and sleazy and so risky. And I just think that's a bit [pause], like I said it's seedy, it's unpleasant, it's wrong!*

Colin's disgust and rejection of these spaces as '*seedy', 'dirty'* and '*sleazy'* highlight his concerns about what it meant to be responsible in his sexual practice as a gay man. Colin felt that engaging in sex in these spaces was '*wrong*' and that he hated how this practice was associated with all gay men. He did not want to be included in this category but felt that the existence of these physical spaces made people think that this was what '*all gay men'* did. Colin's reaction was similar to Simon's concerns about the representation of gay men as promiscuous discussed in the previous chapter. Both were concerned that they would be judged by their work colleagues or health staff as engaging in risky sexual practice as a result of the presence or awareness of the risky

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[103] It is significant that the issue of drugs and/or alcohol in relation to risk in sex did not emerge as an important theme in the interviews given the focus in health policy and research in this area (Keogh et al. 2009).

sexual practice in which gay men were 'known' to be involved in. In contrast to this perceived image of gay men, Colin tried to demonstrate how he did not use these spaces, outwardly rejected them and tried to establish himself as a responsible sexual actor and gay man, in both the eyes of the HIV counsellor as well as in the interview.

Other men in this study under 30 who did not use cruising areas did not necessarily reject these spaces as risky. Gerry (22) had not heard of cruising areas until he began to do some work in sexual health promotion. He explained how, as long as people used condoms, the location of where the sexual encounter took place did not influence the level of risk of infection. In many ways, he felt that having sex with men in public spaces in terms of risk of infection was potentially similar to

> *picking up a stranger in a bar...[they could be] there all night and they'd gone and had sex with someone and then another person and another person and they just kept on coming back. There's no way for you to know that. There's an awful lot of trust involved there.*

Gerry explained how the risk of infection was not determined by the space in which sexual partners were encountered. However, he reported not using cruising areas for sex. Peter (teens), Steve (teens), Wil (20s) and Frank (20s) all discussed how neither they nor their friends, as far as they were aware, used these spaces. They described how they felt these spaces were generally used by older gay men and how they preferred meeting other men in bars, on the internet or through friends. This generational difference regarding cruising areas and public sex suggests how community norms of where sexual practice takes place may have changed for men under thirty. Although the perception of sex in public was not always associated with risk of infection, the majority of men in this section associated this space with *some* forms of risk. For many, these risks were enough for them to either change their sexual practice, or to not engage in sex in public settings.

Contesting Risk in Public Spaces

In contrast to the above descriptions, five men in this study reported using cruising areas, and public toilets, for sex. Two of these men were in their thirties and three were over fifty. In contrast to the depictions of cruising areas as risky, many regular users of these spaces described them as safe and social places. Joe (50s) explained:

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[In] established gay cruising places, I think it tends to be relatively safe. I think you're much more likely to have a problem if you're in a public area where it's perhaps not likely to be a gay cruising area. Like a public park, public places. Because I think you're much more likely to meet people there, on the off chance that they're gonna stumble upon you. Whereas I think specifically in gay cruising places would be avoided by the general public. Unless they were there deliberately to do some harm.

Joe's comments reflected what most of these five men said about these spaces.[104] Generally, those men who continued to cruise did so in established gay spaces, areas well known to many gay and bisexual men in the North East. While these spaces might not be free from harm, most felt they were safe spaces because they were usually used only by men looking for sex. In some cases, these spaces were seen as safer than other areas where cruising could take place. For example, in the first section of this chapter, Matt described sticking to established gay cruising spaces in London, a city he perceived to pose a greater threat of physical harm than Newcastle. Cruising sites provided him with a sense of safety while in a place that was unfamiliar to him or more specifically, while he was feeling at an increased risk of harm. This informal social organisation of public space for gay and bisexual men created a physical and social environment within which they could access sex in a reasonably quick and anonymous way, while remaining relatively safe from physical attack. These men also described a tacit agreement with the public, which meant that these places were generally out of the way of public sight, and consequently were perceived to do little harm to those who were not cruising. Max (30s) explained how he did not '*want people to see [men] having sex in public.*' He described being concerned about the '*public*' – people who were not gay or bisexual men looking for sex – and that he was careful to manage the sex he had in these spaces so that he was not seen by the general public. Many of the men who used cruising sites agreed with Max's sentiment and reported following a similar practice.

In addition to providing an environment where men could avoid offending a non-cruising public, these spaces also provided a sense of safety for a number of men. In other words, according to participants, it served sexual and social needs of most men who came to these sites. Andrew (30s) described the reliability and safety involved in

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[104] Of the five men who described cruising regularly, Max (30s) was the only participant to describe these spaces as risky in terms of violence.

going to cruising sites on his lunch break or after work for a '*sexual fix*'. Visits to these spaces for him were scheduled, or fitted in around his existing work day. Joe (50s) described how these spaces also acted as a form of sociality.

> *You can often see the same people there, over a period of time, so you know, I just nod and say hello sometimes and I've ended up chatting to people sometimes, you know, forget what you're there for. And it is a sort of a social gathering, you know, you see the same old people, like you would if you were standing on the same metro station coming to work or something like that.*

Joe's comparison of cruising sites to a regular metro station shows how he felt these spaces were familiar and part of a social routine. Where Andrew appeared to use these spaces for sex only, Joe likened them to a '*social gathering.*' Although these men used the spaces differently, they both expressed how the presence of lots of men in one particular area was a positive experience. In comparison to the ways in which some men associated an increased likelihood of infection with the presence of large groups of gay men in urban centres (as described earlier in this chapter), these men argue that the concentration of lots of gay men at cruising sites creates a safer, more discrete and sociable environment. In other words, the men who frequented cruising areas felt that large numbers of gay men actually made the spaces safer for sex.

In contrast to the perception of some participants that sexual practice in these spaces was risky in relation to infection, all five men described how the sex they practiced in these spaces was low risk in this regard. All five described using condoms for anal sex, if and when that occurred. Condoms were not used in oral sex, a practice which the men felt was in keeping with established community norms and which was not perceived as high risk. These men described how this practice was not specific to them, but what was also what other men were doing in these spaces. Indeed, they emphasised how other men using these spaces adhered to the perceived community norm of using condoms. Joe (50s) commented how he regularly saw used condoms on the ground and how he perceived this to be evidence of ongoing safer sex practice. For all of the men that described using cruising sites, they stressed how sex in these spaces was planned and which, for them, meant they went with condoms and lube. For example, Andrew (30s) described always having condoms with him whenever he went to these spaces for sex. He explained how his sexual encounters were always planned:

In the vast majority of times that I'm prepared, I have condoms with me. Always in my car, often in my bag, certainly in my pocket when I go out, if I'm going out for that reason, so that I'm always prepared, because to be fair I rarely have sex and don't expect to have sex. It's generally planned. I know it's coming, as it were. I either intend to go cruising or I've arranged to go and meet somebody for sex or I'm with my partner and I expect to be having sex with him that evening, or whatever. For instance, I rarely take condoms to a bar or club because it's not an environment where I meet men for sex.

In addition to planning his sexual encounters, Andrew also identified certain spaces with having sex and the need to be prepared. He explained how he did not see bars or clubs as spaces where he met men for sex and how he did not take condoms with him to these places. In contrast, cruising areas were a space which he went to for sex and would therefore always bring condoms and lube with him. Similarly, Matt (50s) explained how he planned out his sexual encounters in the public spaces which he used for cruising and how he would bring what he needed for his safer sex practice. He described how he had recently gone to a particular space in a rural part of Northumberland to find men for sex.

I went up there and took a blanket with me, and a towel. And there's some beautiful grasslands and the areas covered with bushes, and that sort of thing, beside a lake. So I went into sort of a clearing that was surrounded by bushes, perfect place really. So you put your blanket down, towel down, condoms, lube, and poppers....Now because I had condoms, I didn't need to involve myself in the conversation.

Matt described how he not only was prepared for these sexual encounters with condoms and lube, but how he did not have to talk to his sexual partners about the use of condoms: he laid them out clearly so that they were not only accessible but also visible to his sexual partners. Matt and Andrew's description of their planned sexual encounters not only include the use of condoms, but they also signal the ways in which these men negotiated their preference for sex in public spaces with established community norms of safer sex practice.

Although around half of the men in this study described using public spaces for sex at some point in their lives, only a minority of participants described how they continued to use cruising spaces or cottages for sex. Moreover, the physical spaces in which cruising took place had significantly decreased. Matt (50s) and Jeremy (40s) spoke about a number of public toilets that were no longer used for cottaging or which have been closed. Many participants spoke about how *the gardens*, one of the more

'infamous' gay cruising spaces in the city, had been redeveloped into apartment complexes and was therefore no longer used as a space for sex by gay and bisexual men (Casey 2007). The decrease in space where one could have sex in public coincided with what some participants perceived as a significant change in community sexual practices. Edward (60s) described how he felt cottaging and cruising in public spaces had all but disappeared, as sex between men had been decriminalised and sexual practice had become a private issue. He explained how such changes had gone some way to influencing *where* people had sex, especially those men under fifty who would have access to more options such as saunas, gay bars and clubs and through the internet. Andrew (30) also commented on this apparent decrease in the use of public sites and the drop in popularity of cruising amongst gay and bisexual men.

> *they are becoming very unpopular. I mean, socially they've always been very unpopular of course, and they are getting closed down, what have you. But they are becoming really unpopular in sort of the gay community now, you know, gay men talk of them in very, uh, distasteful terms...I'd say [it is] sort of looked down upon. Um, and you know if I talk to, um, some friends now, particularly younger friends, and ask them you know, do they or have they gone cruising or do they go cruising, typically people's answer is no. So you often have to ask them twice, you often have to say, oh, I do have you never been? Um, but, you know typically they'll sort of talk now about, oh, well, no, it's so cold and it rains and things like, God. And maybe it was just necessity and you, you know, and maybe it was just necessity and there was nowhere else to go...*

Andrew laments the loss of cruising spaces and the increasing disapproval of these spaces he perceived by other gay and bisexual men. His observation that younger men especially either refuse to admit or simply do not use these spaces was confirmed by the experiences of the men under thirty in this study.

This section has considered the ways in which public spaces were used by gay and bisexual men for sex and the risks they associated with these spaces. Only a minority of men described what they perceived as a link between increased risk of HIV and STIs and the sexual practice in these public spaces, despite having never used them. The potential risk of violence and arrest, along with the status of one's public sexual identity, were important factors in the decision to use these spaces. Moreover, the reported sexual practice and perceptions of some of the men under thirty in this study suggests changes in community norms of sexual practice. Where the physical locations of cruising spaces have decreased, there has been a significant increase in options for

many of the participants to meet men for sex in bars, clubs, saunas and the internet. Such changes in space suggest a significant shift away from public, outdoor meeting places to forms of social and sexual practice organised around commercial and domestic spaces.

Conclusion

This chapter has demonstrated the ways in which place and space played an important role in the sexual practice of participants and how they judged and responded to perceived risks. The first section has shown how regional identity and familiarity with a particular gay community, in combination with the interpretation of biomedical knowledge and definitions of perceived risky sexual actors, helped to establish cities like London and Manchester as highly risky places. In contrast, for many of the participants, gay and bisexual men in the North East were established as responsible sexual actors, contributing to a perception of a responsible, local gay community. This distinction highlights the ways in which the boundaries of an imagined biosocial community may be affected by geographic place. The second section showed how judging people *in* or *from* particular places played a role not only in establishing definitions of responsible sexual practice, but also in identifying the necessary social, health and legal systems within which one can be a responsible actor. By drawing on the imagined restricted experiences of sexual actors in or from the Global South, participants described how the availability of sexuality education and sexual rights were integral to good sexual health. These elements were established as essential for sexual actors to be able to make 'responsible' and safe decisions and choices in their sexual practice. The final section highlighted the ways in which personal risk – through physical violence, social exclusion or peer practice – has contributed to changing community norms in the use of public spaces for sex. These changes, in addition to the closing down of physical spaces, and the increasing availability of commercial, domestic and virtual spaces for the use of sex, indicate a potentially significant shift in sexual practice and identification of risk on a community level.

Chapter Seven – Conclusion: Reimagining Risk, Imagining Communities

Introduction

This thesis has explored how gay and bisexual men in the North East of England understand and respond to risk in their sexual practice and what influences these understandings and responses. In contrast to concerns of safer sex 'fatigue' or HIV treatment optimism highlighted at the beginning of this thesis, findings have shown how participants described creative and reflexive sexual practices which addressed multiple risks, including HIV and sexually transmitted infections (STIs), and which were embedded in particular biomedical understandings. Participants reported drawing on embodied understandings of illness, a hierarchy of 'risky' sexual acts, and the importance of condom use in their identification of risk and their safer sex practice. In addition, participants used epidemiological surveillance data, experiences of regular testing for HIV and STIs, and experiences in sexual health clinics to inform understandings of risk. However, these biomedically based understandings of risk, embedded in sexual practices which prioritised harm reduction, were framed by memory and notions of community and responsibility. For many men, this harm reduction approach meant a sexual practice that prioritised the prevention of HIV and was tied to a *sense* of community and sense of shared history. While little was known about syphilis in particular, the men in this study described the ways in which responses to STIs were a part of their risk management strategies. These strategies encompassed not only condom use, but also a wide array of sexual, biomedical and emotional responses and were influenced by identity, space, place, age and generational experiences. Moreover, this research has shown how these reported risk management strategies were framed by perceptions of community sexual practice and affected by changing community norms. For example, participants described the ways in which they perceived, adhered to and/or rejected community norms of sexual practice and how these practices informed their sense of responsibility for themselves and for others. Consequently, this research has shown that notions of risk and responsibility in sexual practice can mark the boundaries of community, highlighting the ways in which experiences of community, sexual health and risk are intricately connected. The remainder of this chapter outlines the contributions this research has made to the study

of sexual health, risk, and gay and bisexual men. It will also lay out some emerging issues and questions for future research.

Contributions to the field

This thesis has explored the ways in which an *imagined biosocial community* provided an important framework for negotiations of risk and responsibility. The analysis of 'biosociality' (Rabinow 1996) in conjunction with 'community' has highlighted how particular understandings of the biomedical and the social worked in combination to inform and affect understandings and responses to risk. Furthermore, this combination of the biomedical and the social in risk management strategies was embedded in imagined community sexual practices. For instance, the intimate practice of looking for physical signs of illness, the ways in which illness was imagined to be *in* the body, and the reliance on biomedical diagnostics and monitoring to 'check' that their sexual practice had indeed been successful in reducing risk of infection all point to the ways in which the biomedical was integral and grounded in *social* responses to risk. This thesis has demonstrated how these strategies were not only based on a combination of the biomedical and the social but also how they helped to form a sense of belonging to a particular community with an imagined shared history and shared experience of being affected by HIV. In other words, this imagined biosocial community was not based on sexual identity alone, but was also formed through a perceived shared risk, experiences, history and prevention priority in relation to HIV. Risk management strategies were negotiated within a framework of community norms of sexual practice and were integral to defining the very boundaries of these imagined communities. However, these community boundaries shifted over time, and were affected by age, experience, serostatus and geographic location. These shifting boundaries demonstrate how risk was configured in diverse ways along established and new forms of inclusion and 'othering.' Moreover, this has important political implications for the cohesion and/or fragmentation of 'a community' of gay and bisexual men more generally.

In offering the notion of an imagined biosocial community, this thesis makes an important contribution to existing debates and explorations of risk, sexuality and HIV. While biosociality has been explored in relation to HIV and, to some extent, sexuality (Davis and Squire 2010; Davis 2010), bringing together the concepts of biosocial *and* community has allowed for a critically nuanced exploration of how identity and

imagined community histories frame the relationship between the biomedical, sexual practice and responses to risk. There have been many criticisms of the increasing medicalisation of HIV prevention and treatment (Kippax and Race 2003, Keogh 2008, Dowsett 2009) and of the move away from the 'community' responses to HIV of the 1980s and early 1990s. These criticisms often point to a fragmentation of community safer sex practices as a result of a more individualised and biomedical response to HIV. In response to these criticisms, this thesis offers a complex analysis of how understandings of and responses to risk are dynamic and have engaged with a changing epidemiological and political context. Moreover, this research interrogates the notion of individualisation in this context and demonstrates how risk management strategies continue to be framed by different forms of community dynamic and norms. In other words, this thesis has argued that responses to risk were not simply an adoption or rejection of biomedical information in an increasingly individualised context. Instead, biomedical knowledge and a changing epidemiological context have been incorporated into understandings of norms of community sexual practice. Biomedical information was interpreted and negotiated in relation to an established harm reduction approach that considers sexual health of oneself and of sexual partners. This analysis builds on Rose's (2007) notion of biological citizenship as it unpacks and examines the specific forms of identity and notions of responsibility attached to a particular illness. However, it adds to Rose's concept as it considers how an imagined community history influences contemporary understandings of responsibility to others. It was not just the way in which participants considered themselves to be affected by HIV that was important in risk management strategies, but how the imagined shared experiences and history of HIV played a significant role in their contemporary sexual identity as gay and bisexual men.

As outlined above, this thesis has offered the notion of an imagined biosocial community in the way that participants described a community of gay and bisexual men with a particular history of HIV experiences and identities. While I have described how participants drew on the notion of being a part of this particular community, the way in which 'community' was invoked was significantly affected by age, generation, location, and sexual practice. These varying factors signal how *multiple* communities were imagined. Thus imagined biosocial communities were configured along many and diverse lines of exclusion, which had a significant impact on understandings and

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perceptions of risk. These new modes of exclusion and 'othering' have important political implications for HIV advocacy and activism amongst gay and bisexual men, especially as much HIV prevention work is premised on the notion of a gay 'community.' Moreover, allegiances or membership of particular communities came at the expense or the exclusion of others. For instance, the importance of local communities of gay and bisexual men, as described in Chapter Six, saw the exclusion of men from outside the region as responsible sexual practice. The broad exclusion of HIV positive men as acceptable sexual partners, described in Chapter Five, highlights the ways in which the construction of the irresponsible and/or risky sexual actor was negotiated through both biomedical and social practices. Thus, the politics of community development in relation to HIV for gay and bisexual men will need to address the multiple imagined communities and consider how allegiances and notions of responsibility to others is influenced by age, serostatus, geography, sexual identity, sexual practice, and even engagement with the health services.

Chapter Four demonstrated how the biomedical was embedded in perceived community sexual practices and the way in which these practices were imagined in relation to a history of HIV throughout the last thirty years. In this respect, safer sex practice was not merely based on the incorporation of all biomedical information relating to risk for gay and bisexual men, but guided by the imagined cultural and historical significance of HIV. This harm reduction framework was based on the notion of biomedical risk, sexual identity and imagined (and experienced) community history. The different responses to HIV and syphilis described by participants further demonstrated how social and cultural factors were critically important to the successful and enduring uptake of particular safer sex strategies. Unlike HIV, syphilis did not have a cultural connection or shared history for participants. Indeed, syphilis remained largely absent from perceived norms of community safer sex strategies. The broad exclusion of explicit syphilis prevention highlights the way in which an imagined biosocial community in this case prioritized HIV prevention. Much like the experience of gay and bisexual men in Seattle, as explored by Michael Brown (2006) at the start of this thesis, the described community practices of safer sex in this research point to a fulfilment of responsibilities of community members *viz-a-viz* HIV prevention. It is not, as Brown explains, a demonstration of 'irresponsible' sexual practice which does not prioritise or even ignores the prevention of other sexually transmitted infections. Instead, this practice

should be seen as a sign of how belonging to or membership in a particular community can instil a specific set of priorities and responsibilities. In other words, the community norms of sexual practice described by participants were based on a response to a community-identified risk of HIV. This priority in risk management outlines the importance of community, identity and history in relation to responses to other infections. It also raises the issue of how perceptions of community sexual practice are critical in addressing risk in sexual health, and how the fragmentation of 'a' gay community (in terms of political identity) may translate in complex ways into sexual practice. Although this study did not explore 'identity' per se, it has demonstrated how the cultural and historical associations with a gay identity played an important role in the uptake of safer sex strategies. Thus, while the meaning of sexual identity may have changed for many gay and bisexual men over the past thirty years, the political significance and history of HIV has been seen to play a critical role in how risk is responded to in sexual practice.

Where Chapter Four explored how the biomedical was embedded in community sexual practices, Chapter Five considered how the boundaries of imagined communities were negotiated through the identification of 'other' risky sexual actors. In particular, this chapter explored how responsibility within imagined biosocial communities was based on not only a notion of harm reduction, but also entangled with concerns around identity, reputation, 'monogamy,' and biomedical technologies and information. This set of criteria for judging responsibility in sexual practice highlights how risk was tied to established and new forms of othering. Thus, while harm reduction formed an integral part of sexual practice, participants placed considerable importance on *how* attempts to reduce harm were demonstrated to others. In many cases, sexual actors were assessed through a set of biomedical criteria: responsibility was described to others or enacted through mechanisms such as regular HIV and STI testing, adhering to treatment, and regular condom use. Moreover, judgements around promiscuity and harm to others were aligned with an absence of testing and condom use. These practices applied to sexual actors *within* imagined communities, as well as to the way in which the reputation of a community of gay and bisexual men as responsible sexual actors was understood. However, while there was a clear adoption of public health guidance in relation to engagement with sexual health services, judgements of responsible sexual practice were also tied to a changing sexual politics which increasingly privileges

monogamous sexual relationships that are publicly and legally recognised. In other words, judgements made about the responsibility of sexual actors were not solely based on the biomedical, but also on contemporary notions of sexual citizenship. Duggan's (2002) concept of homonormativity and related arguments around increasing conservatism in relation to the public image of gay citizenship are relevant here. Participant narratives of responsibility in sexual practice highlight a subtle shift in perceived community norms from a variety of configurations of sexual partnerships and relationships to an increasing emphasis on monogamy and/or a limited number of sexual partners. For those men who did not adhere to this emerging image of responsible sexual practice, there appeared to be an increased requirement to test for HIV and STIs and to use condoms in order to demonstrate how they continued to be responsible sexual actors who sought to reduce harm to others. This increased responsibility of these 'other' sexual actors – i.e. those who do not conform to a particular image of a responsible sexual citizen – can also be seen in how men living with HIV were expected (and felt the need) to ensure harm reduction in relation to HIV. The biomedical identity of HIV positive men has become established within community sexual norms as a significant factor in judging risk and labelling risky sexual actors. This supports the arguments of Flowers (2000) and Race (2001) around the emerging importance of HIV as a biomedical and social identity and its exclusionary effects, marking a contrast with early community responses to HIV. While the assessment of risky sexual actors by participants in this study cannot strictly be aligned with particular generations of gay and bisexual men, these new and increasingly complex ways of othering demonstrate how changing social and biomedical environments have a significant impact on how both sexual and biological citizenship is understood and enacted and how these forms of citizenship impact on understandings of and responses to risk within imagined communities.

Chapter Six also considered how risk was configured through the process of 'othering', with a specific focus on the ways in which the boundaries of imagined biosocial communities were affected by space and place. Geographic locations such as the North East, for many participants, played an important role in the identification and response to risk, especially in how gay and bisexual men from outside this region were framed as potentially risky sexual actors. Some participants described not only how they modified their risk management strategies while away from 'home', but also how they linked the

perceived stability of the local gay 'community' in the North East to a lower risk of HIV and STIs. In many ways, these comments suggest that 'familiar faces' and places were perceived as making it easier to regulate and understand local community norms of sexual practices in relation to risk. This construction of a 'local' gay community in relation to HIV prevention points to the ways in which the notion of an imagined biosocial community allows a more nuanced exploration of how 'community' is not solely based on a gay identity or a shared epidemiological category. It is also importantly affected by how a 'local' community is imagined in relation to place, and how this is affected by the demographic characteristics of a particular region, the specific history of gay community activities of this region, and the perception of who is a part of this local community. Furthermore, this chapter also points to the ways in which the invisibilisation of race is connected to understandings of risk and to notions of sexual citizenship. While not explicitly stated by participants, discussions of place – both in terms of the North East and more globally – signal the way in which 'whiteness' and identity were important factors in the construction of risky sexual actors and/or settings. In many ways, the emphasis on rights and the perceived capacity to exercise sexual rights for the men in this study have important implications on who is seen to be able to be a responsible sexual actor, and therefore, who may be included or excluded from an imagined biosocial community.

The research has also identified and addressed particular gaps in the field and, in so doing, has made an important contribution to debates around risk, sexual health and safer sex amongst gay and bisexual men. For example, in contrast to much research on sexual health, HIV and gay and bisexual men in the UK, this study has looked specifically at experiences *outside* of major urban centres with large gay and bisexual populations such as London and Manchester, and focused on the relatively under-researched North East. It therefore provides insight into the experiences of gay and bisexual men outside of these high HIV prevalence and well-researched regions. Furthermore, it also offers an analysis that situates risk in a spatially and socially specific context and offers rich comparative material with which to understand HIV, sexual practice and risk across the UK. This study will go some way towards informing the sexual health provision for gay and bisexual men in the region, and will offer possible insights for similar geographic contexts. It will also contribute to the wider sexual health practitioner and research community in the UK. For instance, Chapter Six

described the ways in which the use of public spaces for sex was not necessarily perceived as a risky practice, at least in terms of risk of infection, by a small subsection of participants who reported using these areas. These participants described how they perceived regular condom use to be a community norm in these spaces and reported taking condoms with them and using them in these spaces. In contrast to the perception that sex in public poses a greater risk of infection, these practices and observations suggest that sexual encounters in public spaces can be planned and can adhere to a safer sex sexual practice that incorporates condom use. This finding highlights how changing community norms of sexual practice can be observed through the consideration of how risk is spatialised and should be taken on board by those working in HIV prevention and sexual health.

In response to Kippax and Race (2003), who identified the need for social sciences to catch up with how biomedical developments in HIV are understood by 'MSM', discussions in Chapters Four, Five and Six help to bridge this gap, by looking at how participants drew on biomedical knowledge and experiences to inform their safer sex practices. While participants did not demonstrate 'expert' knowledge in relation to syphilis or the most recent advances in HIV treatment, they did demonstrate embodied understandings of risk and a wide awareness of biomedical information (including epidemiological surveillance data, treatment in clinics and testing for infection) which contributed to the location and management of risk in *certain bodies*. Moreover, the research has shown how risk evaluation is a temporal process. Participants described the ways in which *not* contracting infections confirmed that their risk management strategies were effective. This points not only to the importance of experiential knowledge, but also to the importance of biomedical markers and the incorporation of diagnostics into risk management strategies.

Where Prestage et al. (2009) have noted a lack of research amongst different age groups of 'MSM' in relation to HIV, Plummer (2010) has called for an exploration of generational experiences of sexuality and HIV. This thesis has explored and offers insight into the ways in which different generations of gay and bisexual men negotiate risk. The research has considered how men from three different age cohorts responded to risk in light of their differing experiences of HIV, sexual rights and socio-historical

context. It has also analysed how age and generational experiences affected these responses. For instance, Chapter Five explored the ways in which notions of responsibility in sexual practice were negotiated in relation to perceived community norms but it also examined how these notions of responsibility differed and were affected by generational experiences. Older men described the ways in which their responses to risk were embedded in a sense of a broader, imagined gay community that responded to HIV, and in some cases loss, homophobia and lack of rights. In contrast, younger participants situated risk within a considerably different social and community context. I would agree with Plummer, however, that 'generational cohorts cannot so easily be named' (2010: 172) and suggest that generation alone does not provide a definitive framework through which to explore issues of risk, health and responsibility. The boundaries of these generational groupings interact with space and place and in many cases were blurred. Such intersections suggest that generation-specific responses to risk need to be located within a broader social context. In particular, the changing social, legal and cultural norms of the 'gay community' in the UK were seen not only through the ways in which men of different age cohorts responded to risk, but also through the ways in which these men related to community and community sexual practices over time. For instance, the incorporation of testing for HIV into a regular sexual health practice, changing attitudes to use of public sex environments amongst the majority of gay and bisexual men, generational concerns around the 'reputation' of gay men, and community responses to men living with HIV were documented as issues that many participants recognised as having changed over time and as concerns with which they were trying to come to terms in relation to their own sexual practice.

This thesis offers new and original research on syphilis and its relation to HIV amongst gay and bisexual men. Over a decade after the re-emergence of the infection, this research has shown how syphilis is not well known amongst gay and bisexual men. Moreover, those who receive a syphilis diagnosis struggle to understand what it means both medically and socially. Chapter Four detailed what participants knew about syphilis and how it was incorporated into their safer sex strategies as part of their general approach to STIs. Participants' experiences of syphilis since the late 1990s, described in Chapter Five, point to the ways in which sexually transmitted infections and related illnesses are increasingly perceived as private. In *some ways*, the isolating experiences of a syphilis diagnosis are similar to the experience of an HIV diagnosis.

While respondents knew much more about HIV than syphilis, those experiencing either syphilis and/or HIV in this study described feeling atomised from a community of others with similar experiences. Such isolation suggests that, although the epidemiological and cultural histories of these illnesses are very different, HIV and syphilis may be *differently* similar in how they are experienced. In other words, both are described as isolating and private issues. However, many of the men indicated how syphilis has *not* been incorporated into community sexual practice amongst gay and bisexual men. Here, we see the ways in which the symbolic and/or cultural meanings of illness play an important role in the uptake of biomedical information. For instance, it is important to address whether associations with a largely heterosexual history of syphilis (Gilman 1987; Quetel 1992; Hayden 2003) have played a role in the way the illness has been understood by contemporary gay and bisexual men.

Findings from the research suggest that HIV has been – and continues to be – privatised. As discussed in Chapter Three, many of the participants not only recounted how they spoke very little about HIV with their peers, but also how the interview itself was a welcome space to talk about these issues. Those participants who had been diagnosed with HIV and/or syphilis in particular described how the interview provided them with an opportunity to talk about these concerns in a safe, non-judgmental environment. While qualitative interviews can have this type of 'counselling' effect (Rickard 1998), this specific response indicates that social spaces to talk about HIV and related issues are being closed down. This observation is further reinforced by the experiences of participants discussed in Chapter Five in relation to HIV and disclosure. The stigma surrounding HIV positive men, and their treatment – perceived and described – as risky sexual actors to be avoided, meant that disclosure of HIV status was made socially very difficult. In many ways, the availability of treatment for HIV has enabled this silence around HIV and made it very difficult to disclose one's serostatus and/or to be visible as HIV positive. As many gay and bisexual men in this study described distancing themselves from associations with HIV, their response suggests that HIV may be the new 'closet' and that those men living with HIV are unable or unwilling to 'come out' as HIV positive. It is important to consider whether the location of this research bears any impact on these findings and whether the low HIV rates in the North East play an important role in this privatisation.

There is a considerable concern in public policy around the influence of drugs and alcohol on risk and sexual practice amongst gay and bisexual men (Keogh et al. 2009; Race 2009). It is significant that this topic did not emerge as a major theme in this research. This does not mean that drugs and alcohol are not an important area of exploration. Indeed, this focus could provide a particularly interesting avenue of study, especially in relation to social practices in domestic, commercial and public settings. However, I would argue that a focus on drugs and alcohol in relation to risk tends to reinforce the notion of rational sexual actors, whose rationality is temporarily 'suspended' as a result of the drugs or alcohol. This implies that there are certain acts that someone would not take part in if they were not under the influence of alcohol and/or drugs. As Race (2009) and Dean (2009) have argued, this establishes certain sexual acts as pathological and does not consider the multiple ways in which risk is judged and responded to. Although I do not discount the importance of drugs and alcohol in some – or even many – cases of sexual practice, this research has explored the number of ways in which participants addressed risk in their sexual practice, rather than looking for reasons which might temporarily suspend a rational risk response.

Emerging Areas of Research

A number of important issues have emerged out of this study and will provide rich areas for future research. As outlined earlier, this research has highlighted the ways in which responses to risk are affected by generation. Where this research established three age cohorts – or generations – of gay men to explore, the boundaries between these three groups of men were often blurred. For instance, in the discussion in Chapter Five of reasons *why* men apportioned guilt or innocence to those men who contracted HIV and how this was rationalised, the reliance on generational boundaries did not fully address the many ways in which understandings of HIV were and are affected by notions of responsibility. I would argue that in addition to generational differences, it is important to explore how meanings of community sexual practice and relationships with communities affect understandings of responsibility and whether these understandings map onto particular age groups. In particular, a rich area of exploration would be to specifically explore how attitudes towards and experiences of 'community' for gay and bisexual men affect serodiscordant relations and how this correlates with age.

The research has demonstrated how particular understandings of biomedical frameworks play an important role in the constructions of risk. This emphasis on biosociality shows how gay and bisexual men have an established history of integrating certain biomedical developments into their sexual practice. As the field of HIV prevention and treatment develops, and increasing emphasis is placed on ARVs through 'treatment as prevention' and PrEP (Paidan et al. 2008), further exploration with gay and bisexual men in this area is necessary to see how biomedical practices are incorporated into sexual practice. However, as this study has shown, the ways in which biomedical discourse is understood and applied is framed through community sexual practices. It is important, therefore, in any future research to address how biomedical *and* social factors would work together in the uptake and adherence to biomedical risk reduction interventions.

This study has suggested that both biomedical and social factors have played an integral role in notions of responsibility *to* an imagined community of sexual actors. It has also highlighted the importance of and the negotiations that take place within an imagined biosocial community. Moreover, it has further shown how changing sexual politics and biomedical developments have affected this imagined biosocial community. I would suggest that such changes point to the ways in which both biological and sexual citizenship play a critical role in sexual health. While much research has been undertaken in the areas of biological or therapeutic citizenship (Rose 2007, Nguyen 2007) and sexual citizenship (Bell and Binnie 2000; Richardson 2005; Brown 2006), there has been very little exploration of the ways in which these two forms of citizenship intersect and overlap. I would suggest that further exploration of how these different forms of citizenship work together to affect risk and sexual health would make an important contribution to both areas of enquiry.

The research has suggested that the experiences of men in the UK are situated in a global context. Participants described the ways in which they felt access to sexual rights, including not only legal rights but also access to sexual education, sexual health services and lack of discrimination, enabled a 'healthy' sexual practice. Further

exploration of the ways in which global representations of sexual health and rights influence sexual practice in the UK would provide a rich area of study. It would also address the ways in which mobility, media and global politics impact on constructions of risk, health and responsibility.

Appendix A – Interview Guide

Risk in general

1. Amongst the gay men that you know, what do you think risk in sex means?
    o For instance, can you describe or give me an example of a situation that is risky? What are the risks in this situation? (risk of what? Of whom?)
    o Where would this take place? Who might be involved? (explore: time of day, location, people, age, feelings or emotions, response, etc)
    o Can you think of other risky situations? Can you think of other risks?

2. Where do you think risk is most likely?
    o Explore time of day, location, people, age, feelings or emotions
    o Why do you think *named examples* are most likely? What is it about these situations that bring risk?
    o Where is risk less likely?
    o Are there particular places that are risky?
    o Are particular people more risky than others? (or less risky than others?)

3. Can you tell me about a time when you felt at risk or when you were in a risky situation?
    o What happened? (as above, explore time, location, people, age, feelings or emotions, response)
    o What were the circumstances?
    o What made you think this was a risk or risky situation?
    o How did you deal with the situation?

HIV

4. Amongst the gay men that you know, do you think HIV is still considered a risk?
    o Why or why not?
    o What is it that is considered risky? (eg. People, acts, personal health, location, etc?)
    o Is HIV considered a risk by some men and not others? (age, behaviour, location, time, etc)
    o Is HIV seen as a risk for some men and not others?
    o Is it seen as a risk in some places and not others?

5. Are you concerned about HIV?
    o What in particular are you concerned about? (risk of transmission, stigma, health concerns, etc)
    o Do you think HIV is a risk for you? or What are the risks of HIV for you? *(if appropriate)*
    o How do you respond to these risks or concerns?

6. Has there been a time in your life when you've felt differently about HIV?
    o I.e. When you were younger? (explore different contexts, eg. Relationships, health status, emotions, location, role, etc)
    o If yes, what has changed? (location, people, self-confidence, health status, relationships, etc)
    o Do you think men who are older/younger than you would answer in the same way?

Syphilis

7. Do you think the gay men you know are aware of syphilis?
    o If yes, what is known about syphilis?
    o Do they talk about syphilis? What do they say?

8. Do you think most gay men think syphilis is a risk that could affect them?
   o Do you think gay men are aware of the risks of syphilis?

9. Is syphilis a risk for you?
   o Are you concerned about syphilis?
   o Where have you heard about syphilis?
   o *If no awareness of syphilis, broaden out to other STIs*

10. Do you have the same concerns around syphilis that you do to HIV?
    o Why or why not?
    o How do they compare? How are they different?
    o Is one more of a concern for you than the other?

Managing risk

11. How do the men you know respond to risk of HIV and syphilis?
    o What does this involve? Can you give me some examples?
    o Do you think their responses to risk change in different contexts?

12. Can you tell me more about how you deal with risk in sex?
    o For instance, how would you respond to risk in some of the sexual contexts we've been talking about? Can you give me some examples of this?
    o Has anything in particular played a role these responses? (health information, person you were with, state of mind, etc)

13. Have there been times when you have dealt risk in a different way to what you've just described? (e.g. when you were younger, different sexual partner, different place)
    o If yes, can you tell me what happened?
    o Did you act differently when you were younger or in a different situation?
    o Does the person you're with play a role in how you approach risk?
    o Does the space you are in play a role in how you respond to risk?

14. Scenario: What would you do if a sexual partner did/didn't want to respond to risks in the same way that you do? E.g. did/didn't use a condom, engage in penetrative sex, etc.
    o Has this ever happened to you? What have you done? How did you decide what would happen (negotiate practice)
    o Did this change the way you think about risk in sex or your own sexual practice?

Close

15. Is there anything else that you'd like to say or comment on?

Appendix B – Diagram of Recruitment Access Routes

Submitted to LREC Ethics Committee to explain Recruitment Strategy.

Code: PP = Potential Participant; CI = Chief Investigator; HW = Health worker (e.g. health advisor, nurse) or community development staff (e.g. MESMAC employee)

Access Route 1: Potential participant responds independently to available information without direct/personal intervention by health worker, community development worker or Chief Investigator

Brochures and/or posters left in display areas in key locations with permission, such as MESMAC offices, GUM clinics, MESMAC notice boards in the community, libraries, etc. This could also include advertisements in culturally appropriate magazines and links from the MESMAC website to the project website.

↓

PP picks up brochure or poster, reads advertisment, or clicks through to project website.

↓

PP contacts CI directly for more information, either by text, phone or email. CI sends PP participant information sheet and letter for more information and agrees to discuss this once received (Letter A & Information sheet A sent)

↓

Discussion by phone or email: CI explains research and selection criteria to PP based on content in the information sheet; CI answers any questions PP has about their participation; CI considers PP's suitability for participation according to established selection criteria

↓

If PP & CI agree to interview, time, date and location arranged; allow PP more time to make a decision; opportunity provided for further discussions/questions before meeting up

↓

PP and CI meet, discussing further questions and consent for participation; if PP consents (signs consent form A), interview takes place; option provided for PP not to go ahead with interview

↓

After interview, recording transcribed and sent to PP (now participant) for comment if requested

Access Route 2: Potential participant advised of project by health or community worker and provided with brochure and/or information sheet.

HWs will be briefed on the research project by the CI before any advertising/notification of research takes place. HWs will be asked to mention research to PPs (selection criteria outlined by CI at briefing meeting) and to provide brochure and information sheet about the study.

During the course of their work, HW tell PP about project and provide information, including a brochure and information sheet.

Scenario 1: CI in the building at the time HW meets with PP, e.g. during a drop in session

- **Scenario 1A**: If PP is interested in the study after speaking with HW, PP can speak to CI directly about the research in a private space
- **Scenario 1B**: If PP is interested in the study, but does not want to speak to CI at that time, PP gives HW or CI contact details for CI to follow up

Scenario 2: If CI not present at the time of HW meeting PP

- **Scenario 2A**: If PP is interested in the study, PP gives contact details to HW, for CI to follow up
- **Scenario 2B**: If PP is interested in the study, PP follows up directly with CI through email and/or telephone information provided in brochure and/or information sheet

Once contact is made between CI and PP, discussion takes place by phone: CI explains research and selection criteria to PP based on content in the information sheet provided by HW; CI answers any questions PP has about their participation; CI considers PP's suitability for participation according to established selection criteria

If PP & CI agree to interview, time, date and location arranged; allow PP more time to make a decision; opportunity provided for further discussions/questions before meeting up

PP and CI meet, discussing further questions and consent for participation; if PP consents (signs consent form A), interview takes place; option provided for PP not to go ahead with interview

After interview, recording transcribed and sent to PP (now participant) for comment if requested

Potential ethical issue: HW mentioning the research project in a clinic appointment could potentially be inappropriate given potentially stressful circumstances (e.g. positive diagnosis of an STI).

Strategy: CI would emphasise at research briefing with HWs that participation should be voluntary and that HWs should not raise the research project if the potential volunteer is distressed, using their professional judgement. HWs could also mention research outside of appointment system, should the opportunity arise (e.g. at an event) HWs may see clients on a regular basis, possibly over years. On this basis, HWs will have established a good rapport with clients and will have insight as to whether they should be approached.
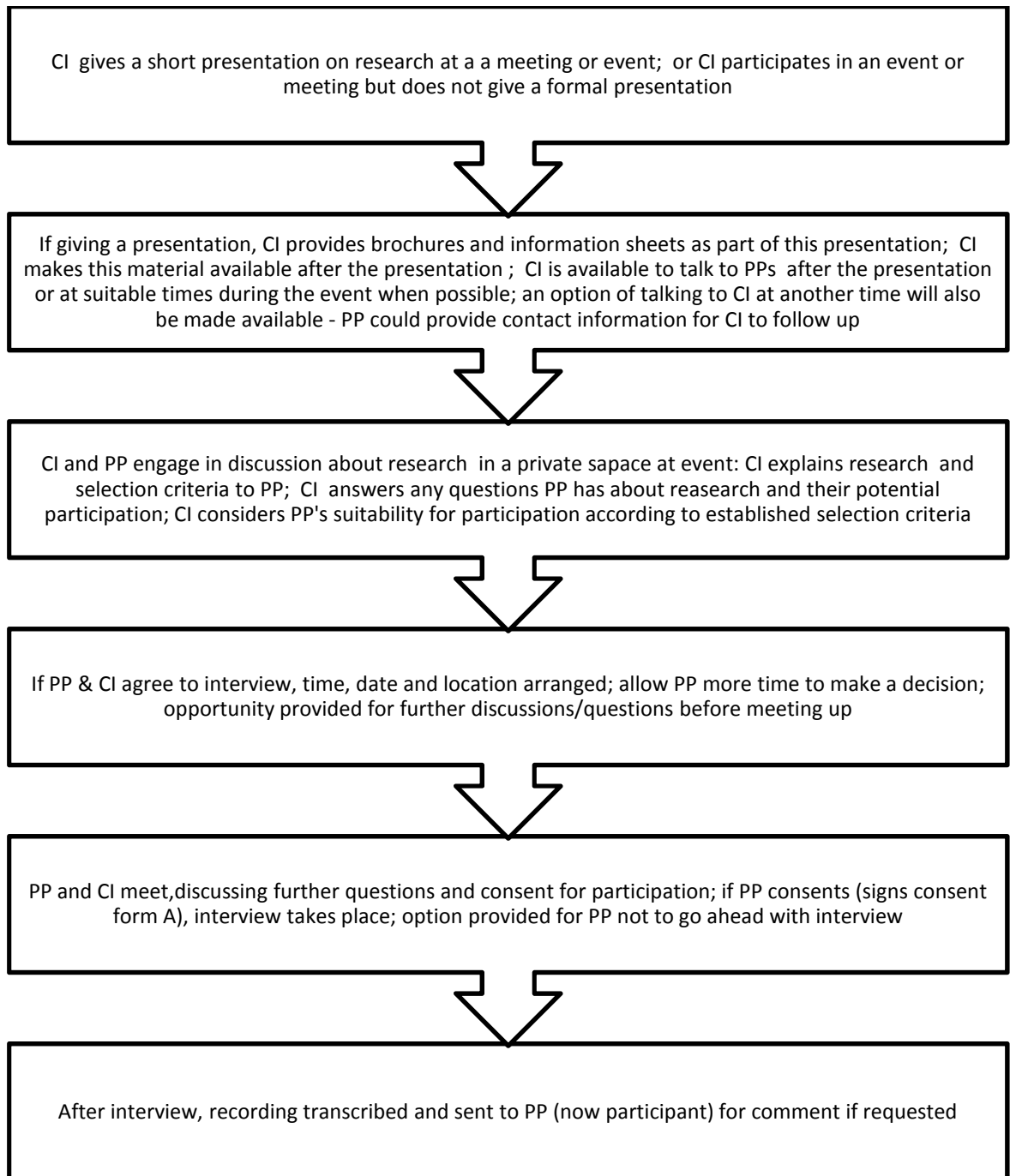
Potential ethical issue: CI is present in the building when HW meets PP. Meeting with the PP at that point might compromise anonymity or confidentiality.

Strategy: In order to ensure confidentiality, should the CI be in the building and available to meet PPs, a private room or space will be arranged for a brief conversation. This initial meeting will provide the opportunity for the PP to ask more questions about the research, but a follow up discussion will take place, once the PP has had the time to read the information sheet and think about participation.

Potential ethical issue: In order to avoid losing PPs, contact information may be provided by PP for CI to follow up. Information provided via HW could compromise anonymity and confidentiality of PP's participation.

Strategy: Any contact information will be provided voluntarily by the PP. The PP's medical records or file *will not* be accessed at any point.   Any contact information provided to the HW will be given to the CI immediately if in the building. If the CI is not present, the HW will give the information to the CI by telephone. Alternatively, the CI will check in with HWs periodically to follow up on any outstanding collected PP contact details. However, the HW will not know whether the PP ultimately agrees to take part in the research.

Access Route 3: Chief Investigator is at an event or meeting and engages in discussion with potential participant

CI gives a short presentation on research at a a meeting or event; or CI participates in an event or meeting but does not give a formal presentation

If giving a presentation, CI provides brochures and information sheets as part of this presentation; CI makes this material available after the presentation ; CI is available to talk to PPs after the presentation or at suitable times during the event when possible; an option of talking to CI at another time will also be made available - PP could provide contact information for CI to follow up

CI and PP engage in discussion about research in a private sapace at event: CI explains research and selection criteria to PP; CI answers any questions PP has about reasearch and their potential participation; CI considers PP's suitability for participation according to established selection criteria

If PP & CI agree to interview, time, date and location arranged; allow PP more time to make a decision; opportunity provided for further discussions/questions before meeting up

PP and CI meet,discussing further questions and consent for participation; if PP consents (signs consent form A), interview takes place; option provided for PP not to go ahead with interview

After interview, recording transcribed and sent to PP (now participant) for comment if requested

Potential ethical issue: Discussion with PP in group situation could compromise anonymity of potential participant.

Strategy: This is simply a discussion about the research with no pressure or expectation of participation. CI will offer to follow up discussion in private or at another time, depending on circumstances, either in person or by phone/email. PP will also be able to contact CI at a later date.

General notes around anonymity of participants:

Sending information sheet to PP: If a letter and information sheet is sent out (as in scenarios 1 where there is no direct contact with PP) to PP, this potentially compromises the anonymity of the participant (re: ensuring complete anonymity of participant and not having any contact or identifying information linked to transcript, etc).

Strategy:

- Where possible, information will be sent email
- Information sheet will be made available to download on the research website
- Destroy all contact information once interview completed.

Sending copy of transcript to comment on once interview completed: CI offers to send transcript of interview to participant to review and make comments on, or simply to provide them with a copy. This again could compromise the anonymity of participant if transcript sent to physical address. This may also compromises security of transcript/information as material is sent to participant.

Strategy: A question will be on the consent form asking participant if they would like to receive a copy of their transcript or outcome of the study. CI will then provide a range of options in discussion with the participant about how they would like to receive information. Options would include:

- Transcripts will be sent via email addresses to avoid linking physical address/contact details to transcript; transcripts will be encrypted ensuring that only PP can access transcript electronically (details can be arranged by text or phone)

Appendix C – Recruitment Brochure

The images below were folded into a three panel brochure, with the panel with the photograph on the cover.

Useful Contact Details:

For more information about sexual health, GUM clinics, safer sex or other things you may be concerned about contact your local service.

Newcastle

MESMAC
11 Nelson Street, Newcastle
0191 233 1333
www.mesmacnortheast.com/

Newcastle Sexual Health Centre
New Croft House, Market Street
Newcastle, NE1 6ND
0191 229 2999
www.gumnewcastle.nhs.uk/

Gateshead

STAG Project
13 Walker Terrace, Gateshead
0191 490 1708, www.stagproject.org/

Gateshead Sexual Health Services
0800 42 20 200

North Tyneside

1 to 1 Centre
Brenkley Avenue, Shiremoor
0191 297 0441
www.northtynesidepct.nhs.uk/services/community-services/sexual-health

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RESEARCH PARTICIPANTS NEEDED

- Are you a man who has sex with men?
- Do you live, socialise or use sexual health services in the North East of England?
- Are you aged 18 or over?

If so, please take a few minutes to read this leaflet. Feel free to pass it on to others who may be interested in taking part in this research.

For more information, contact Ingrid directly on:

Mobile: 07599 805305

Email: reimagining.risk@newcastle.ac.uk

http://research.ncl.ac.uk/reimaginingrisk

MEN WANTED!

Research participants needed for study:

Reimagining Risk

Newcastle University **E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL**

Reimagining Risk: exploring understandings of risk in sexual health in the North East

Background

I am a PhD student based at Newcastle University researching understandings of risk in sexual health amongst men in the North East of England who are gay, bisexual and/or who have sex with other men.

I am looking to interview men who are 18 or older and who fall into one of the following groups:

- Gay men
- Bisexual men
- Men who have sex with other men

I want to hear about your views and experiences around syphilis, HIV and risk in sexual health. I would welcome responses from men of all backgrounds, regardless of age, disability, race, religion, belief or class.

The study is based at Newcastle University and has been funded by the Economic and Social Research Council and North Tyneside Primary Care Trust.

Aims

The aims of the research are:

- To explore what men know and think about risk in sexual health
- To explore what influences men's understandings of risk
- To compare men's specific understandings of syphilis and HIV
- To explore how these beliefs and ideas play a role in men's choices and decisions in relation to sexual practice and sexual health

Findings from this study will contribute to developing sexual health services and how they can support individuals to improve sexual health.

What will this involve?

I am looking for men to interview for the project. Interviews will last approximately 1 – 1 ½ hours and will be recorded. Interviews will be strictly confidential and anonymous. You do not have to give your real name. Travel expenses will be reimbursed.

How can you find out more?

If you would like to know more about this project, or are interested in taking part, please telephone, text or email Ingrid at:

Mobile: 07599 805305

Email: reimagining.risk@newcastle.ac.uk

http://research.ncl.ac.uk/reimaginingrisk

School of Geography, Politics and Sociology
Newcastle University
Claremont Bridge, Claremont Road
Newcastle-upon-Tyne
NE1 7RU

Reimagining risk: Brochure   Version 1 14 July 2009

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Appendix E - Postcard

This postcard was used from June – August 2009 to recruit men aged between 18 – 30.

Appendix F – Recruitment Activities 2008 - 2009

Access Route 1 - Advertising

	Where	When, how often, etc
Online Advertising		
	MESMAC website	Announcement and link to Reimagining Risk site from October 2008
	University of Newcastle Websites	Links from my Student Profile on GPS website and on PEALS website, November 2008
	GAYDAR Banner	Banner appeared on Gaydar for users registered in the North East from January to March 2009
	Newcastle GUM website	Link to Reimagining Risk website from syphilis section of this website
Print & Posters		
	Flyers at reception in MESMAC	From October 2008
	Posters brochures and postcards at two saunas, three bars and one gay shop with MESMAC material; posters at cruising sites	MESMAC outreach staff distributed this material regularly at these sites from October 2008 and throughout the recruitment period, to July 2008; postcard targeting men under thirty distributed from May 2008 – July 2008
	Out Northeast, LGBT magazine	Short announcement in news section of this magazine in December 2008 World AIDS day issue
	LGBT Federation North East newsletter http://www.lgbtnetworknortheast.co.uk/	Short announcement in this regular newsletter, distributed on email list

Access Route 2 – Recruitment through Sexual Health and Community Development Staff

	Where	When, how often, etc
Gateshead		
	Gateshead GUM Clinic Brochures available from November 2009	Initial meeting with sexual health staff November 2009; Follow up with staff in January 2009, further follow ups by telephone. Brochures available in waiting rooms and counselling rooms. Staff agreed to help with recruitment.
	Community Development Sexual Health Services	Initial meeting October 2008; staff spoke to members of PLUS youth group and facilitated my attendance at STAG group (for MSM)

Newcastle		
	Newcastle GUM Clinic	Initial meeting with GUM research committee to seek approval September 2008; subsequent meeting with sexual health staff, including health advisors and with health assistants, October 2008. Follow up on phone with key contact, despite attempts to visit again. Brochures available in waiting room and counselling room. Staff agreed to help with recruitment.
	MESMAC	Meeting with MESMAC staff in November 2008 to discuss research and request assistance for recruitment. Brochures available at MESMAC offices and staff agreed to help with recruitment.
North Tyneside		
	North Tyneside One to One Centre	Initial meeting with sexual health staff November 2008. Follow up with key contact periodically throughout research period. Brochures only available in counselling rooms, as concerns around visibility in waiting room. Staff agreed to help with recruitment.

Access Route 3 – Presentations given at workshops, meetings

Organisation	Meeting	Date and location arranged
MESMAC	Mesmac young men's group	December 1 2008, Mesmac Offices
	GMFA workshop: Confident Cruising	January 31st 2009, Mesmac Office
	HIV + men's group, meet Thursdays at Mesmac	February 2009, Mesmac Office
	GMFA workshop: Finding a boyfriend	April 4th 2009, Mesmac Office
Stag Project, Gateshead Sexual Health Services	Regular Stag meetings with men, described as typically non-'scene' users	Initial meeting on November 3rd; Returned to this group April 20th
Newcastle Pride	Had a stand at Newcastle Pride; spoke to people about the research	Newcastle, July 2008
	Had postcards at MESMAC/STAG stall; spent time at stall to talk to people about the research	Newcastle, July 2009

Appendix G - Animated Gaydar Banner

The images below are of an animated Gaydar Banner, which appeared on Gaydar for men located in the North East for approximately 6 weeks (January – March 2009). The banner was linked to project website: http://research.ncl.ac.uk/reimaginingrisk/

Image 1:

Image 2:
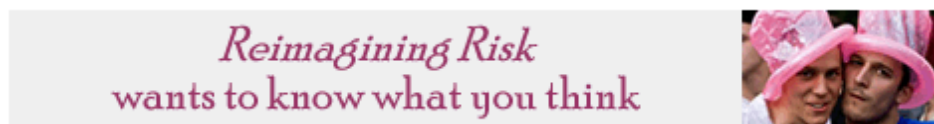

Image 3:

Image 4:

Image 5

Appendix H – Participant Information Sheet

Participant Information Sheet

Project title: Reimagining Risk

You are invited to take part in the research study: *Reimagining Risk*. Before you decide it is important for you to understand why the research is being done and what it will involve.

1. What is the purpose of the study?

I am a PhD student at Newcastle University, supervised by Professor Diane Richardson and Dr. Janice McLaughlin. This research is exploring experiences in sexual health amongst men in the North East of England who are gay, bisexual and/or who have sex with men. The main aims of the research are:

- To explore what men know and think about risk in sexual health
- To explore what influences men's understandings of risk
- To compare men's specific understandings of syphilis and HIV
- To explore how these beliefs and ideas play a role in men's choices and decisions in relation to sexual practice and sexual health

2. Why have I been chosen?

I would like to speak with men who live, socialise or use sexual health services in the Newcastle, Gateshead and North Tyneside areas and who fall into one of the following groups: gay; bisexual; and/or a men who have sex with other men. I aim to interview approximately 25 - 30 men to discuss the themes identified above.

3. What will happen to me if I take part?

Your involvement in the study would be to take part in an interview where we discuss: your understandings of risk in sexual health; what influences these understandings; what your specific understandings of syphilis and HIV are; and how these understandings and experiences impact on sexual practice and safer sex. You do not have to have had an infection for your views to be of value to this study. The interview will probably last between 1 hour to 1 ½ hours depending on how much time you have available, and how much information you want to share. I will record the interviews with your permission. The recordings will be written up and you will be offered a copy of the transcript, encrypted and sent via email, to keep.

It is up to you to decide whether or not to take part. You do not have to give your real name. If you do decide to take part you will be given this information sheet to keep. You will also be asked to sign a consent form and provided with a copy of this. If you decide to take part, you are still free to withdraw from the study at any time and without a given reason.

4. If I want to take part, what will happen next?

If you decide you want to take part in this study, you can contact me, Ingrid. You can contact me by text or phone on 07599 805305 or by email on reimagining.risk@newcastle.ac.uk. You can also find out more information on: http://research.ncl.ac.uk/reimaginingrisk/.

I will explain what the research is about, what will be involved in the interview process and can also answer any questions you might have. You can then decide if you want to go ahead with the interview and we can arrange a suitable time and location. The location will be both safe and confidential, and will be in a private room at the university or another space such as MESMAC offices , the North Tyneside 1 to 1 centre or Gateshead sexual health services. Travel costs will be covered by the project.

5. Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. The only contact information required will be either a mobile telephone number or email address. All interview recordings will be destroyed at the end of the research. Your name or any contact details will not be recorded on the interview transcripts. In addition, any details which potentially could identify you will also be removed or changed. My academic supervisors (listed in section 8) will have access to the anonymised transcripts of your interview, but I will be the only person to have access to the original recordings of the interview, your consent form and any of your contact details.

Your participation in this study will not be discussed with other interviewees, or any sexual health professionals (this includes those who work with MESMAC or in any of the Newcastle, Gateshead or North Tyneside sexual health services). Your name will be changed in the research and I will ensure that your involvement remains entirely confidential and anonymous.

I am not under an obligation to report anything you say that could be defined as illegal. However, disclosure may be required if you were to say something that potentially indicated that you or someone else was at risk of harm. If you said something of this type I would indicate this and you could then choose whether or not to continue the discussion. We would also discuss what the next steps would be.

6. What will happen to the results of the research study?

The results of the study will be used in my PhD thesis and in reports to health services. The material will be presented at academic and professional conferences and in academic journals. The findings will also be shared with groups who work in sexual health and with gay, bisexual and men who have sex with men. In addition, a summary report of the findings will be available from the MESMAC and research websites once the study has finished. Anonymity and confidentiality will still be in place in all cases. Findings from this study will contribute to developing a better understanding of how sexual health services can support individuals to improve sexual health in the community.

7. Who is organising and funding the research?

The study is based at Newcastle University. It is being funded by the Economic and Social Research Council (ESRC) and the North Tyneside Primary Care Trust. I am working with North Tyneside, Newcastle and Gateshead Primary Care Trusts and with MESMAC. However, this study is independent of the health services and MESMAC.

8. Contact for further information

Ingrid Tel: 07599 805305
Email: reimagining.risk@newcastle.ac.uk
Website: http://research.ncl.ac.uk/reimaginingrisk/

Academic Supervisors

Professor Diane Richardson
Tel: 0191 222 7643
Email: diane.richardson@ncl.ac.uk

Dr. Janice McLaughlin
Tel: 0191 222 7511
Email: janice.mclaughlin@ncl.ac.uk

Thank you for reading this information sheet, and if it is possible, participating in the study. The following page provides more information on sexual health services available to you.

More information about sexual health for men who are gay, bisexual or who have sex with other men

MESMAC

MESMAC is a community support service for gay and bisexual men. It has offices in Newcastle and Middlesbrough, but works across the whole of the North East. MESMAC provides a range of information and advice on sexual health, and available services in the region. To find out more, or to contact MESMAC, ring them on 0191 233 1333 or go to:

http://www.mesmacnortheast.com/

Terrence Higgins Trust (THT) is a non-profit organisation that works across the country. THT websites provide a wide range of information on gay and bisexual men's sexual health. The following THT websites provide information on:

- Sexually transmitted Infections: http://infections.chapsonline.org.uk/Home/
- GPs and gay men: http://gpsandgaymen.chapsonline.org.uk/
- Using condoms: http://condoms.chapsonline.org.uk/Home/

More information about sexual health services in Newcastle, Gateshead and North Tyneside

For more information about sexual health, GUM clinics, safer sex or other things you may be concerned about contact your local service in:

Newcastle

MESMAC North East: 0191 233 1333
11 Nelson Street, Newcastle   http://www.mesmacnortheast.com/

Newcastle GUM Clinic   0191 219 5013
Newcastle General Hospital,   or 0191 219 5011
Ward 34, Westgate Road   www.gumnewcastle.nhs.uk/

Gateshead

STAG Project,   0191 490 1708
13 Walker Terrace,   http://www.stagproject.org/
Gateshead, NE8 1EB

Gateshead Sexual Health Services   0800 42 20 200

North Tyneside

1 to 1 Centre   0191 297 0441
Brenkley Avenue
Shiremoor, NE27 0PR
        www.northtynesidepct.nhs.uk/services/community-services/sexual-health

Appendix I – Consent Form

Participant Consent Form

Project title: Reimagining Risk

Researcher: Ingrid Young

Please read, tick each of the boxes and sign at the bottom.

1. I confirm that I have read and understood the information sheet dated 14 July 2008 for the above study. ☐

2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐

4. I know that participating in the research will not affect the services I can get at MESMAC or any sexual health services in Newcastle, Gateshead or North Tyneside. ☐

5. I understand that the interviews will be recorded and agree to have my interview recorded. ☐

6. I understand that any dissemination of the findings will not identify me by name. ☐

7. I understand that the information I give will be treated in confidence. ☐

8. I would like the opportunity to see a copy of the transcript of this interview, sent as an encrypted file via email. *Yes/No*

9. I agree to take part in the above study. ☐

Name ....

Signature ....

Date ....

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