How to be a healthy homosexual

A study of CHAPS HIV health promotion with gay men

Peter Keogh

Original Research Report

Acknowledgements

I would like to thank the men who so generously took the time to take part in this study. Without their willingness to share their experiences so honestly with us, this research would not have been possible.

Thanks also to the CHAPS workers who consented to be interviewed and courageously agreed to let us quote them. Their openness regarding their professional trajectories and concerns allows us all to learn.

I am also grateful to Will Nutland at Terrence Higgins Trust Lighthouse for having the foresight to release CHAPS R&D monies to support this study and the tenacity to bear with it to completion. Finally, thanks go to Michael Stephens, Ford Hickson and Peter Weatherburn for their careful review of earlier drafts of this report and helpful comments.

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1   **Background**

1.1 THE COMMUNITY HIV/AIDS PREVENTION STRATEGY (CHAPS)

CHAPS is an England-wide gay men's HIV prevention initiative funded centrally by the Department of Health and co-ordinated by the Terrence Higgins Trust Lighthouse. It is a partnership of eight health promotion agencies supported by two research institutions. CHAPS is currently in its fifth year of operation and has produced important strategic development tools, notably *Making it Count* (Hickson *et al.*, 2000), an integrated HIV health promotion framework for gay men which is being adopted by an increasing number of health authorities and third sector agencies. The significance of CHAPS as a ground-breaking health promotion intervention for gay men should not be understated. It marks both significant state commitment to the prevention of HIV transmission among gay men as well as unprecedented collaboration amongst community health promotion agencies.

The purpose of this report is to present an examination of the broader social and political role of CHAPS. CHAPS involves the expenditure of state resources on increasing the social and personal capital of a marginalised and stigmatised group. It therefore constitutes a far reaching state-funded intervention into the lives of gay men. The power of this intervention is increased by the fact that it operates through the medium of health promotion. This is because health promotion enters into all areas of life: on an individual level: (e.g. education, assertiveness training, smoking cessation training), on a structural level: (e.g fiscal or legal reform) and on a biomedical level: (e.g. screening and immunisation). Therefore, an analysis of CHAPS allows us to examine both the nature of state-funded interventions and the broader role of health promotion in gay men's lives. That is, we can analyse the role of health promotion in defining emerging gay communities and the relative power of the health imperative (Lupton, 1995) in shaping the experiences of individual gay men.

CHAPS has traditionally striven for consensus and political neutrality. However, questions emerge regarding how political and professional imperatives influence the way that CHAPS interventions are constructed and disseminated. In this report, we present some of the results of an investigation of the political, social and cultural imperatives which are attended to in the production of CHAPS health promotion materials as well as the factors which influence how they are received. Rather than evaluating the efficiency and effectiveness of the CHAPS process and the acceptability of its outcomes (Weatherburn *et al.*, 2001), we have conducted an investigation of CHAPS within the tradition of sociological critique (see Thorogood, 1992). We have, therefore, questioned the idea that health promotion for gay men is in the best interest of it's target group and analysed instead the ideologies that underpin it as well as the social norms of those doing the targeting.

Through this analysis we hope to show that health promotion within CHAPS, though highly individualist in approach, avoids, on the one hand, what Crawford (1977) has dubbed 'victim blaming', and on the other, being overly paternalistic or disempowering (see Beattie, 1991). Instead, we will show how CHAPS has taken a middle ground which might be termed 'neo -liberal' (Rose, 1993). That is, a construction of the gay man as "enterprising, self caring, managing risk and seeking health" (Bunton, 1997). This report has the practical utility of throwing some light on the relationship between the CHAPS framework and CHAPS interventions as well as identifying the various imperatives to which CHAPS workers attend. Through this reflexive exercise we hope to highlight both the limitations of health promotion as well as clarify where it can exclude some while increasing the social capital of others.

Before presenting our findings, it is worth prefacing this report with some general comments about the political aspects of health promotion. The fact that health promotion is itself professionally and socially situated cannot be ignored. Beattie (1991) defines four approaches to health promotion (health persuasion, legislative action for health, counselling for health and community development for health) and points out that depending on one's interpretation, all seek to gain the individual's adherence to the imperatives of personal health. Therefore, health promotion is not merely about promoting individual choice, but rather about persuading, enabling, empowering, or compelling the individual to make the 'right' and 'healthy' choice. Differences emerge in terms of definitions and approaches. Beattie argues that such differences are politically and professionally riven. Health promotion policies swing:

> **"...between the most fundamental poles of social theory and political action: between individualistic and collectivist modes of interventions and between paternalistic 'imposed' and consultative 'participatory' forms of authority" (1991:179).**

The appropriate way of 'doing' health promotion is also contested along professional lines. Different professional sectors tend to migrate to different role specificities. That is, where the individual worker or agency fits into the health structure tends to influence the approach they take. Generally speaking, the divide is between those who favour a top down professional approach and those who favour a bottom up participative or consumerist approach. As practitioners, Beattie concludes, we need "to become much more familiar and more comfortable with the range of antagonistic value positions..." (1991:184)

Bunton and McDonald (1992) stress the importance of countering these political and professional differences. Instead, they emphasise the importance of inclusivity and flexibility in health promotion planning. That is, an integrated response to individual or lifestyle factors (e.g. education, assertiveness training, counselling) and structural elements (e.g. fiscal or legal reform) is key to a successful health promotion strategy. Moreover, medical approaches (e.g. screening and immunisation) have the value of bridging the gap between individual and structural approaches. Regrettably, this has often not been the case in community health promotion for gay men. Voluntary or third sector agencies have tended to concentrate on individual factors, medical approaches have operated, for the most part, independently in clinical settings, while the connections between structural conditions and HIV have rarely been articulated or acted upon.

Making it Count is a landmark document, not only for HIV prevention with gay men, but for health promotion generally, because it marks a practical attempt to link all of these factors in a meaningful way. That is, to bring diverse disciplinary definitions of health promotion (individual, structural and medical) to bear on the aims, approaches, methods and outcomes of national HIV prevention for gay men. In spite of this, both CHAPS and *Making it Count* do not escape being politically and professionally situated. *Making it Count* is typical of an over- riding trend which has seen health promotion move from merely educating individuals and populations to increasing the individual's capacity for choice. However, when health-seeking behaviours are to be encouraged, such as avoiding the transmission of HIV through sexual contact, the opposed notions of coercion versus voluntarism come into play. Questions emerge: should choice and individual self-determination be promoted at the expense of larger epidemiological imperatives? How is health and choice to be promoted? When these questions are asked about a group to whom choice and freedom have traditionally been denied and where the disease in question threatens to stigmatise those who contract it, these questions become particularly poignant. This report attempts a deeper analysis of these questions.

1.2 BEYOND EVIDENCE

CHAPS basic research has tended to concentrate on quantitative and qualitative descriptions of HIV-related sexual behaviours and HIV prevention needs. The evaluation programme has focussed on developing a model of intervention performance and measuring the acceptability, appropriateness and effectiveness of health promotion campaigns (Weatherburn *et al.*, 2001). In 1999, CHAPS commissioned a study to look reflexively at CHAPS within the context of broader social, political and cultural dimensions. Titled *Beyond Evidence,* the study attempts to take a 'sideways look' at health promotion production and consumption. That is, to analyse health promotion outside of its evaluative or evidential framework, looking instead at the social and political significance of health promotion, both from the perspective of those who produced it and from the gay men who comprise its target audience.

Our analysis has three parts. Through interviews with CHAPS workers, we examined the political and cultural conditions of the production of CHAPS intervention. Second, we analysed the contents of the mass media campaigns themselves. Third, we conducted interviews with gay men in order to investigate the ways in which health promotion in general is used (that is, what impact it has on gay men's personal lives as well as how they construct their own definitions of health).

1.3 METHODS AND DEMOGRAPHICS

Data for this study were taken from three sources. First, in-depth, face-to-face interviews were conducted with ten health promoters from several CHAPS partner agencies. Although the majority of these interviews were with managers of agencies, interviewees also included those involved with the design and delivery of direct contact interventions. All interviewees self-identified as gay men. With the permission of the interviewees, all interviews were audio tape-recorded and fully transcribed. A case by case analysis was followed by a thematic content analysis.

Second, a total of 153 mass and small media products of CHAPS partner agencies (although not all were CHAPS-branded products) were grouped according to their subject matter and analysed.

Finally, in-depth, face-to-face interviews were conducted with forty gay and bisexual men. Thirty of these were selected from a pre-existing panel of gay and bisexual men resident in London. The remaining ten men were recruited by CHAPS partner agencies in Bristol and Manchester. The men resident in London were selected and assigned to one of two groups according to their use of health promotion in the year prior to recruitment. These groups were men who had proactively engaged in interactive health promotion in the previous year (for our purposes, those who had accessed either a group or sought personal counselling for health) and those who had accessed none of these interventions. The ten men in Bristol and Manchester were recruited opportunistically on the gay scene and assigned to a group retrospectively. All respondents were given semi-structured interviews which lasted between 45 minutes and two hours. With the respondents' consent, all interviews were audio tape- recorded and full transcripts were made. A case by case analysis was conducted on the transcripts to generate initial analytic themes. These themes were subsequently developed through a full thematic content analysis.

In order to aid disclosure and to protect the anonymity of the workers who took part, we agreed not to present demographics for the health promoters sample. The demographics of the sample of gay and bisexual men are presented in the table below.

AGE	
Range:	17 - 67
Mean age:	33 years

HIV TESTING HISTORY AND STATUS	
Last test result positive:	11
Last test result negative	25
Untested	4

ETHNICITY	
White British	31
White Other	2
White Irish	4
South Asian	2
Black Carribean	1

OCCUPATION	
Currently employed	25
Currently student	8
Retired / Medically retired	6
Unemployed	1

The numbers in the two groups are as follows:

Experienced no health promotion interventions	17
Experienced groupwork and / or counselling	23

The remainder of this report is divided into three parts. Chapter two examines the production of interventions presenting data from worker interviews and analysis of mass and small media interventions. Chapter three analyses the role of health and health promotion in the lives of gay men and presents data from interviews with gay men. The final chapter is a discussion of these findings.

2 The production of health promotion interventions

In this chapter we concentrate on how health promotion 'constructs' the healthy gay man. We examine the imperatives that health promoters attend to when they formulate health promotion and how these imperatives influence their practice.

2.1 INTERVIEWS WITH HEALTH PROMOTERS

Our interviews with health promotion workers concentrated on how they defined gay men's HIV related health needs, what they considered the most appropriate health promotion response and how their opinions on these matters were influenced by their political and professional positions.

2.1.1 Definitions of health

Although interviewees came from a variety of political backgrounds, they all shared, to some extent, what Bunton (1997) describes as a neo-liberal notion of health associated with the *New Public Health* (see also Lupton, 1997; Nettleton & Bunton, 1995). Within this understanding, health is holistic, integral and all encompassing. This has a number of implications. First, sexual health is more than the absence of clinical symptoms, but deals with physical, mental and emotional well-being.

> **"I don't want to quote that WHO thing but essentially [sexual health] is about the integration of someone's physical well being and their mental well being in relation to the sex that they have. And it's not about the sort of absence of an STI. In fact I think you can have STI on really good sexual health."**

Moreover, all aspects of life are the rightful provenance for health promotion: an individual's schooling / education, work, social, emotional, intimate and sexual life. Interviewees often constructed environments as either sexually unhealthy or healthy for gay men. For example, family environments and school were often seen as unhealthy places for gay men.

> **"...so you are on your own in your family, you are on your own in your class, you are on your own in your school, you are on your own in your community so I really believe that gay men turn it in on themselves. Everything that happens to them is their fault because they are the way that they are. If they could only be straight they wouldn't have these problems."**

Second, (and most importantly) good health (sexual or otherwise) is not a given, but a lifelong developmental process. Gay men are not born in a state of sexual health and do not generally emerge as sexually healthy adolescents. Therefore sexual health is an imperative which involves work on the self. This is either a process of self-realisation (accepting and recognising who one is) or self-actualisation (actively working on the self).

> **"Is there a sense in which gay men can just be naturally healthy?**
>
> **I think it depends on where an individual is. I think if an individual has reached a certain level of self-awareness, [...] Not aspirationally achieved but to just accept that I am and get on with it. For other individuals I think there is need to achieve that, so I have to go to the gym to achieve that or I have to eat the right things to achieve that, I have to not smoke or drink as much or whatever. There are other individuals who don't think they can ever achieve it and are sitting at the bar, smoking and having unsafe sex or whatever because that achievement is too far away [...] it's more about protection and preservation than trying to attain perfection."**

Health has a value dependent on the individual.

> "...I don't think we can re-position gay men to aspire to health but I think we can reposition men to understand value in longevity and a more holistic approach to life..."

The value of health is variable, that is, the concept of health has to be weighed against and is influenced by other important personal concerns.

> "I think whilst the WHO's definition is quite interesting, possibly the least useful definition there is because it's so aspirational that it's unachievable. My take on health is that people trade on various aspects of their health and put different values on aspects of their health. And people would only change a particular behaviour or whatever if the pay off of the other behaviour is high enough."

Moreover, health cannot be an end in itself, rather, good health is a means of attaining other worthwhile things.

> "It's about health as a means to an end [...] Health isn't a state that's worth attaining just for itself."

2.1.2 Gay men's health needs

Gay men are perceived by interviewees to be at a disadvantage when it comes to either sexual or general health. That is, compared to the general population, they are in no greater or lesser need of health (in the sense that everyone needs it), but there are greater obstacles to their achieving health than their heterosexual counterparts. This disadvantage is conceptualised in a number of ways. First, sexual health services (sex education, GUM and reproductive services etc) are perceived to be inappropriate for gay men. That is, sexual health is defined in terms of reproductive capacity, men's sexual pleasure defined in terms of the penis, sexual relations defined as heterosexual and sexual risk associated with avoiding pregnancy and STIs.

> "But my take on it is that the things that mitigate against gay men achieving health are actually barriers rather than implicitly because they are gay men, yes? So it's lack of access to services, lack of appropriateness of services that are a bigger issue around gay men's health rather than being gay."

> "I don't think that health services, whether they are primary health services or not, are always geared towards meeting the needs and the demands of gay men and there's an inherent barrier to gay men in many health services because of their sexuality [...] How many gay men don't access other health services because they don't want to expose their sexuality or their HIV status? Because of the homophobia they've experienced in the past they don't want to experience it again."

Second, social norms and laws are not geared towards promoting gay men's sexual health. For example, inappropriate sex education as well as legal, social and cultural prohibitions on same-sex sexual expression.

> "You know, I do think that we all do carry baggage around with us. Well I carry baggage around with me from where I come from culturally and stuff about gay men and gay sex still, you know. Clearly that has an impact on the type of sex that I have but also what I think about the type of sex I have once I've had it."

Third, societal prohibitions have personal or psychological effects: societal hostility to homosexuality (dubbed 'homophobia') not only inhibits gay men's capacity for sexual health, but leads to negative self-image and low self-esteem (dubbed 'internalised homophobia'). This leads to self-destructive behaviour (for example, lack of self-protection from STI's, an inability to form fulfilling relationships etc.) and damaging behaviour toward other gay men (likewise expressed through emotional, sexual or physical abuse of partners).

> **"... you could argue directly that unsafe sex happens potentially because of someone's experience of homophobia or that kind of internalised homophobia."**

> **"Gay men value future health less so than the mainstream population [...] I've seldom heard a heterosexual say, 'I'm not bothered if I don't live past 30. I'd rather not live past 30', which I've often, often heard expressed in a number of different ways from gay men and that seems to be an issue [...] But for gay men generally I think.... I don't want to say internalised homophobia but I think that whole thing of self-acceptance and all that sort of stuff or lack of self-acceptance is a pre-curser to a lot of that kind of nihilism..."**

Interviewees differ on how they interpret these effects. For example, some felt that all gay men suffer constitutionally from internalised homophobia (a minority suffering acutely) whilst others felt that all gay men are vulnerable to the homophobic attitudes of others. One's sexual health is determined by the extent of that effect. There is a kind of professional 'epistemology' regarding gay men's sexual health being established through professional practice. Central to this epistemology is the notion of degree: that is, one's sexual health (or lack thereof) is always a matter of degree which can be affected positively or negatively by external circumstances. The job of sexual health promotion is to 'maximise' the 'degree' of sexual health amongst gay men.

2.1.3 Personal capacity for health

Interviewees were asked to discuss interventions which they felt were most appropriate to maximise health. In general, they tended to support individual approaches (such as education and/or counselling for health) and societal approaches (such as changes in laws and policy governing sexual and intimate conduct) in order to allow gay men to increase their personal capacity for health. They also supported educational interventions to increase gay men's knowledge regarding STI's and HIV. Interviewees were invited to discuss interventions to increase personal capacity for health further.

Whereas it was clear that personal capacity for health could be increased through counselling, this did not describe fully the range of interventions under consideration. Moreover counselling was not supported by all interviewees. Some saw it as keeping men in a state of 'thrall' or dependency. For others, it was too extreme an intervention (both in terms of cost and 'depth'). Other interventions to increase personal capacity might include peer education, group activities and mass media (being, strictly speaking, neither societal, legislative nor necessarily educational and yet social in the sense that they are interactive).

The overall character of interventions to increase personal capacity for health is that they act on a personal or biographical level. Interviewees reported that these interventions aimed not necessarily to educate nor to be prescriptive, but rather to create an environment where gay men could choose how to conduct their sexual and intimate lives. Three inter-related concepts informed these interventions. These were the capacity to choose, self-knowledge and self-determination. The healthy gay man was rational, capable of exercising, acting upon and taking responsibility for his own choices. However this was not unproblematic as it involved promoting choice itself. There is a clear resistance to health promotion which has any obvious moral or prescriptive message.

> "It's difficult because that means that we always have to define what we think good health is. And there is a notion too of anyone who doesn't live up to our perception of good health is somehow a failure and that can almost reinforce what we might see as negative behaviour. So I think it's quite a dangerous one. I mean looking at stuff, for example, the anti-smoking stuff, that was really interesting the way that those campaigns moved on from, 'Smoking actually is really bad for you', to particularly targeting women saying, 'Smoke and you are a really bad mother'. And the John Cleese thing that they did and stuff like that were really pathologising all the information and were really quite un-useful and I think really quite unethical."

Instead, health promotion should enable gay men to make choices (in the sense of creating their own life possibilities). To merely give them a range of options from which to choose would return to prescriptiveness. This interviewee talks of providing gay men with the freedom to determine their intimate relationships, but not in a way which merely gives them the capacity to copy heterosexual norms. Individual freedom should be promoted:

> "...not in [that] way ... that sort of 'this is what we should be perpetuating instead of this', I'm not interested in that. I'm interested in people making their own choices about what they want but being fully aware of the reasons why they are making those choices."

Interviewees were informed by the perception that there was a lack of choice in gay men's intimate or sexual lives. That is, unlike heterosexuals, gay men were not provided with clear options, life trajectories, ways of living or narrative models. Moreover, their formative environment was unlikely to provide them with the necessary skills to create their own successful and healthy intimate lives. Quite the opposite. The negative effects of homophobia provide gay men with negative or destructive patterns for intimate relationships.

> "I still think there is a lot of judgement, or men judge their own relationships, or their sexual relationships against the heterosexual norm and all the rest of it and long-term relationship stuff. I do think lots of gay men still judge their worth or the worth of themselves in terms of the relationships that they have."

Sexual health therefore becomes associated with the capacity to make choices around one's sexual and intimate life, to determine one's own intimate pathways and ways of being. Choice promotes personal happiness, well-being and health. Therefore, the 'ideal' subject of health promotion (the sexually healthy gay adult) is one who has the capacity to determine his own destiny through the control of his environment and the making of rational personally beneficial choices. Conversely, signs of sexual ill-health are behaviours which are irrational, personally damaging or uncontrolled.

> "You know... The bit after people [have] cum and [they're] feeling shit or not feeling at all satisfied by the type of sex they had. I mean I work with loads of men who go cottaging loads and will damage themselves afterwards.
> *In what way?*
> Oh pull toe nails out, cut themselves and stuff. You know, and that's not because the sex was bad it's how they felt about the sex."

There is however, a tension in this construction. It is not simply a matter of replacing a prescriptive imperative with an imperative to act on choices. For some interviewees, promoting the capacity for clarity in thought and self-determination seemed to override other health-related considerations. That is, all actions are justified, so long as they are carried out with self-knowledge: a self-knowledge and determination that can be occluded by social or group norms.

"One of my current theories is that men actually decide what they want to do before they go out and do it and being drunk or being drugged up is an excuse to allow them to do it or being in a backroom is an excuse to allow them to be able to do it. You can find any excuse for the behaviour that you want to indulge in but you've decided beforehand that you want to indulge in that behaviour. You've come to the conclusion that that's really what you want to do but because you feel so guilty and because the community norm is use a condom every time if you don't want to do that then you are a bad boy."

"I don't think it's a problem that people are having unprotected sex. I think it's a problem that transmission is taking place and I think it's a problem that people don't understand why they are having unprotected sex that they may not want to have. Or they are having unprotected sex that's putting them at risk that they don't really want to take. But having unprotected sex isn't the problem per se."

Therefore, it would be a simplification to conclude that CHAPS workers have merely rejected prescriptiveness in favour of a certain *laissez faire*. The political imperative which values individual choice, self-determination and self-knowledge has to be balanced with an imperative around personal responsibility. The freedom to act on choice (self-determination) also implies personal responsibility (the message is: 'choose what to do, ensure that you know why you are making that choice and beware the consequences of your choice for yourself and your partner/s'). Moreover, important public health / epidemiological imperatives came into play. We can dramatise the tension between these imperatives by reference to a group intervention carried out by a CHAPS partner. This was an on-going series of smoking cessation workshops for gay men. Our informant describes the process of planning the intervention. Of particular interest is the planning team's reaction to orthodox practice around smoking cessation.

"We went on a course which is run by a local health promotion unit and to collect some resources some of which we used. We focussed a lot more on men's emotional, psychological, spiritual feelings than the cessation course did which was much more about, 'This is what your lung looks like and here is a horrible video'. We decided not to use that model.

Why did you decide to do that?

It just felt better for what we were trying to achieve which wasn't to get men to stop smoking. It was just to encourage them to think about what they were doing and what impact it was having on them and on others and looking at exploring how they could achieve stopping if they wanted to but there was no pressure to stop.

It's interesting the difference between the way that you would choose to do smoking cessation with gay men and the way that the health promotion unit would do it. Can you think of anything that might account for that difference?

[...] our approach is more holistic. We don't think you can... you can't take away an element of a person and expect them to address something that is fundamental to their core because for a lot of men... a lot of gay men, particularly those men coming along to the group or expressed an interest, they are saying to us that smoking was an important friend, someone that they relied on as a crutch [...] There was nothing wrong with the training that the health promotion carried out. I'm sure it was fine and it obviously works for some people but we came away from it feeling that we were... almost like it was a kind of being told off and I don't think necessarily gay men need to be told off and that is why I think we took the decision not to use that model and go for more empowerment actually than that kind of disempowerment that... I think from our experience of working around... if you think about HIV prevention and think about prevention work with positive gay men that message, you know, 'This is what you are going to do. This is what's going to happen', doesn't work. So we already had the knowledge that we had to have a different approach and it was much more... we needed to be much clearer that actually you were dealing with the whole holistic approach."

Reducing the number of gay men who smoke was not the prime aim of the intervention and it was certainly not to be achieved either through fear tactics, or a straightforward presentation of medical 'facts'. The intervention intended to go deeper than that. The issue of smoking was to be addressed by encouraging men to be self-aware about the decisions they were taking when they chose to smoke. In addition, the issue of smoking was to be addressed with full awareness of the social and structural conditions surrounding the health of gay men and with an absolute and conscious rejection of any possibility of prescriptiveness. Again, self-determination, self-knowledge and choice emerge as the means through which 'health' for gay men is to be achieved. Most importantly, smoking was addressed 'holistically'. That is, not only is the personal or symbolic meaning of the behaviour addressed, but the process of changing behaviour is something that effects the individual's emotional, psychological and spiritual being. In other words, gay men are not told what to do, neither are they presented with evidence and encouraged to make 'the healthy choice'.

Rather, they are engaged in a process which mobilises the discourses that shape their experiences (exclusion, sanction and homophobia) in order for them to undertake a deep personal transformation. Whether or not one gave up smoking was secondary to the aim of transforming the political, social, psychological, emotional and spiritual conditions within which one does or does not smoke. It is paradoxical therefore, that although the intervention is deeply liberal in it's ethos and supportive in the extreme of the individual's right to self-determination, it is also deeply normative in the sense that, although it avoids telling us what to do, it specifies a way of doing what we do: there is an appropriate and an inappropriate way to smoke.

2.2 HEALTH PROMOTION MATERIALS

We explored these tensions further by examining the contents of 153 printed resources (mostly small media) produced by CHAPS partners. We looked at resources under three headings: emotional / mental health; homophobia; and HIV prevention. This review aims both to highlight tensions and explore the nature of interventions intended to increase personal capacity for sexual health.

2.2.1 Resources dealing with mental and emotional health

Resources dealing with mental / emotional health tended to fall into three categories. The first alerts the reader to ingrained damaging beliefs and attitudes which he may have developed through heterosexual socialisation and encourages him to question, interrogate and reject these. The following text is typical:

> **"We grow up, we discover we're gay, sometimes we get called 'poof' […] a lot of straight society likes to keep us powerless […] With all this shit, some of us can believe it too. This can affect how we feel about ourselves and other gays. If you feel this way: QUESTION IT! See if it is really true, test out these beliefs you have for yourself.[…] Make up your own mind and if you need help, talk to an advice line..." (Emphasis in original)**

Similarly, the following:

> **"Quite often, the things we get criticised for can be the things we may like about ourselves. This may be from other kids, our parents or our teachers. Often this can just chip away at our self-worth. Not automatically accepting the values of others (and lets face it, the gay scene also has its share of judgmental values) and learning to like some of the things that make us different, can help to increase our sense of self-worth."**

> **"We have the option to change the things we don't like about ourselves and the right to keep the things we do like. It can take time and it isn't necessarily easy – but it is worth it."**

In these resources, poor mental health is equated with past experiences: childhood, family, school etc. The imperative promoted is self-interrogation and self-realisation. The way to health lies in an interrogation of oneself, a rejection of past harmful incidents which leads to self-knowledge and clarity. Thus we fabricate or actualise a healthy self, or we 'recognise' ourselves for who we are. The process of self-determination (defined as hard work, but worth it) is a function of health for gay men.

Other resources define the commercial gay scene itself as mentally damaging. One booklet *(Same Old Scene)* constructs the scene as simultaneously a setting for happiness and fulfilment and for personal misery. It uses statistics to show that men who use the scene can often feel lonely, have poor self image etc. In doing so, it allows the reader to recognise these symptoms in himself. The booklet also constructs a symptomology of mental ill-health around the amount of sex that men have: too much sex is a symptom of low self-esteem; too little sex is a symptom of a lack of personal assertiveness. Therefore, an indicator of relative health is defined in terms of a surfeit or deficit of sex. The solution to these symptoms is once again self-determination. Men are exhorted to take control, to decide what they want and to find ways of getting it. In contrast to the scene, involvement with health promotion activities is encouraged.

Another type of resource highlights psychological stresses that gay men endure (such as homophobia, HIV and AIDS, body image problems etc). The reader can diagnose himself in relation to a checklist of symptoms and is advised, should he exhibit these symptoms, to seek professional help. Again, self-diagnosis, self-determination and self-care is stressed.

> **"There is nothing to be ashamed in seeking professional help – it is the best thing you can do for yourself in the circumstances..."**

We can discern two health promotion imperatives. The first involves self-determination and personal transformation (through self-analysis, communitarian health promotion or professional medical or psychiatric help). The ideal subject is responsible, self-determining and self-creating, divorced from past or childhood (generally described in terms of negativity or harm).The process of 'accepting who you are' is also a process of self-creation or self-realisation.

The second imperative is for emotional and sexual continence: having the right amount and the right type of sexual relationships (be they emotional or sexual). The ill gay man is mentally or sexually incontinent, out of control. This imperative is taken up in the following:

> **"It's so easy to live for the moment. It can be difficult to put off a bit of immediate pleasure in order to gain something in the future – whether that's your self-development, health or career. Feeling good about yourself comes when you know your priorities and HAVE CONTROL OF YOUR LIFE. 'Life should be lived to the full.' However, being gay needn't mean having to go out all the time, whether through fear of missing out, or pressure to conform. There's more to life than the scene." (Emphasis in original).**

Sex must not be used for the wrong reasons. One advertisement advises the reader that it is inappropriate to use sex for company or as an ego boost, these should be obtained through friendship. But unlike sex, friendship means we need to "invest time and effort". Another postcard promotes sexual assertiveness saying "You have the right to ask for what you want just as much as your partner. You both have the right to refuse to do something that you don't want to do. This includes sex that isn't as safe as you want it to be." Thus, it modifies the imperative of sexual continence. Here, sexual self-determination is a right, but it also involves work: with rights come responsibilities. The tension between being non-directive and promoting choice becomes strained.

> "Though sex is still exciting and enjoyable with a condom, we can't make you use one. But have you thought about the consequences if you don't? RESPECT YOURSELF. You're in control of your life. You're in control of your health. You make the decisions. Are they the right decisions for you?" (Emphasis in original).

Choice, self-determination and sexual continence are again stressed as the indicators of self-respect. However, responsibility is also present: is it the right decision?

2.2.2 Resources dealing with homophobia

The theme of self-examination, personal change and the development of self-knowledge is developed in resources dealing with homophobia.

> "Homophobia [...] can cause stress, worry and depression. It harms our physical and mental health. It can affect how some of us value ourselves and our future. We might try to cope with the pressure through drink, drugs, smoking or sex."

The concept of internalised homophobia depends on the idea that we develop a negative self-image from the attitudes of others towards our sexuality during our socialisation. Health promotion resources tend to construct internalised homophobia as a specific health problem, the symptoms of which manifest in both personal and social discord. On an individual level, this is an intemperate attitude towards alcohol, drugs and sex and an inability to care for the self. On a social level, it is an inability to treat others appropriately or with respect.

> "The scene should be our place to be ourselves and to have fun – so why do we so often give off attitude and put up barriers?. We can all go elsewhere to be treated like that..."

> "One of the best things about being gay is being able to have one night stands, shag around and really enjoy sex without feeling bad about it. So why do we often spoil it?"

The curative imperatives to internalised homophobia are two-fold. The first imperative lies in self-examination and self-knowledge. When we know who we are, what we want and how to get it, we are worthy of love.

> "A lot of us take pains to make ourselves physically attractive – whether it's clothes, gym or a haircut. But what's more attractive than a confident guy who knows what he wants and get it without putting others down? LOVE YOURSELF." (Emphasis in original).

The second imperative is to take part in communitarian activities to cure the social manifestations of homophobia. This might often be reporting homophobic crime, but also relates to gay social spaces.

> "If you ever feel that the scene isn't quite what you'd like it to be, don't just whinge about it – do something. Be a part of the solution, not the problem."

Therefore, the imperative is again remedial and reforming, both of the self and of the environment surrounding us: self-examination, self-knowledge, self-determination and engagement in social reform as a personal health strategy.

2.2.3 Resources dealing with HIV risk

If the imperative of health is self-determination and sexual continence expressed in terms of both individual order (self-respect and personal integrity) and social order (treating others with respect), how do resources approach reducing HIV risk? Some deal with the split between rational and irrational thought processes, a sedimentation of cognitive psychology theory.

> "There have probably been times when you've done something and on reflection you wonder why, and wish you hadn't. Your brain works in two ways: On-Line: this is how we think in the heat of the moment, just focussing on sex and a good lay. On-line, we can give ourselves excuses to fuck unsafely. Off-Line: this is how we think in the cold light of day when we know what's safe enough for us, can look at our 'excuses' and see them for what they are [...] Understanding on-line / off-line thinking can help you maintain safer sex."

A range of resources play on this distinction between a rational and irrational self, including the latest CHAPS mass media intervention *(In Two Minds)* which associates rational thought with the brain and sexual self-protection and irrational thought with the penis and immediate sexual gratification. Often the distinction is between the self pre-sex (irrational) and after sex (rational).

> "If you find yourself about to fuck without a condom, ask yourself if you are prepared to deal with the negative consequences of the assumptions you are making – that you allow yourself to become infected or that you infect someone else. Before that fuck think of the assumptions that you make and remember that you read this card – and that when the sex is over, you may not believe those assumptions."

The emphasis is again on self-knowledge, transparency and sexual continence which promotes self-protection. Other resources promote self-knowledge: knowing why one engages in risky behaviour and knowing what types of behaviour one is willing to engage in.

> "When I have unsafe sex, I don't always know WHY [...] Problem was I could never decide how safe was SAFE ENOUGH for me." (Emphasis in original).

Resources that deal with relationships also stressed clarity and honesty between sexual partners.

> "Many of us slip up at some time, We don't have clear agreements about sex inside relationships, never mind outside! Can we talk, openly and honestly? Do we really listen and hear without judging?"

Others rely on the imperative to only act on clear unequivocal knowledge. The message is always to "assume nothing" about yourself or your sexual partner. It is also important to articulate the questions you should ask yourself about sexual partners "Do you think he might have HIV?". This emphasis on knowledge as a protective strategy accompanies the use of HIV testing as a prevention strategy. Many resources encourage us to think about our own HIV status.

> "Ever thought you might be passing it on?"

Similarly, resources about relationships now discuss the merits and demerits of HIV testing in order to ensure that decisions are rational: based on clarity and knowledge.

> "LOVE HIM, TRUST HIM, BUT ASSUME NOTHING [...] I realise now I could be infected. It's been tough for both of us – but we've decided to get tested together. I just can't believe we got so complacent and took so many risks with each other". (Emphasis in original).

The health imperative therefore is for self-exploration, self-knowledge, communication and rationality which is characterised as an antidote to sexual intemperance or dangers associated with love and trust. Above all, the emphasis is on personal responsibility for action.

What is significant about all of these advertisements is that they are not prescriptive. They do not tell the reader what to do, rather, they are normative: they show the reader how to be. They illustrate

healthy ways of being. The significance of a this shift from prescription to normativity cannot be underestimated. Health promotion now constructs gay men as no longer intrinsically risky individuals, but rather sees them as having a capacity to manage risk. However, this involves several processes of differentiation: infected men from not infected; temperate behaviour from intemperate; rational from irrational; self-knowing from ignorant. Moreover, it involves providing gay men with a range of imperatives with which to regulate their own conduct. This process also involves a greater concentration on the production of knowledge and narratives about how to be a healthy gay man. That is, we see an increase in representations of normative behaviours and the production of images and narratives for gay men about how to conduct their lives generally.

One no longer demonstrates one's 'gay healthiness' by doing something (wearing a condom), but by *being* something (temperate, transparent, considerate, assertive, clever etc.). Health promotion does not depend on the governing of others towards a certain epidemiological end. Rather, it now engages in a more subtle process of promoting self-governance. That is, it seeks to create subjects who are capable of regulating their own behaviour to a certain common good (in our case minimising behaviours which are likely to transmit HIV sexually). This necessitates increased and deeper intervention of health promotion into the lives of gay men. As health promotion seeks to regulate by means of incentive rather than censorship, it talks about more than behaviours, engaging instead in a socially constructive task that goes to the heart of the individual. This might be defined as promoting gay citizenship.

3   Gay men and health

In this section, we examine health and health promotion from the perspective of individual gay men. That is, we focus on how they experience health, how they construct their ideas around health and their attitudes towards health promotion. Men were recruited and assigned to one of two groups according to their use of health promotion (see section 1.3). We will contrast the attitudes of men in the two groups at the end of this section. Before this, we discuss the range of ways in which men characterised their health and the different life experiences that lead to these characterisations.

3.1 WAYS OF UNDERSTANDING HEALTH

Our analysis allowed us to differentiate three factors which influenced how gay men characterised personal health. The first relates to constitutional health. That is, good or ill health is the result of genetic, familial or class-based characteristics. The second relates to common life narratives. In the case of gay men, we identified two: first, the influence of coming out and second, experiences of the HIV epidemic. The third relates to a notion of health as an imperative that can be attained through a lifelong process of self-examination and personal change. We call this aspirational health. As these are the factors which influenced how one characterises one's personal health, they will also be instrumental in determining one's personal expectations around health and the amount and nature of actions one is willing or able to take to either improve or transform one's health status or avoid hazards to health. It is important to note that what we are presenting is a crude and artificial formulation of the complexity of men's experiences and thoughts regarding their own health and as such does such complexity a disservice. Moreover, these factors are neither unique nor mutually exclusive. That is, for the vast majority of the men we interviewed, all three factors interacted and contributed to personal perceptions of health.

3.1.1 Constitutional health

The first factor which influenced men's attitudes towards their health was the extent to which they saw their personal health as determined by factors outside of themselves and over which they had little control. That is, health is integrated with factors which are not related to sexuality, but to familial, historical or social structures such as class. The individual is therefore determined to some extent by his physical and social constitution. Here, health is seen in terms of fixed quantities: you either have good health or you do not. This sense of determination might be related to genetic triggers which could define life or death.

> **"It doesn't matter how many different pills you pop or tests you take, if your number is up at 45, that's what's going to happen".**

It might also be related to one's general state of health. Some felt that there was an innate physical disposition towards good or ill health.

> **"You're either healthy or you're not. Some people are born sickly and others in rude health".**

Another way in which this pre-determination was expressed was in terms of setting parameters around what one might expect of one's health. This man talks about his mental state:

> **"I have a theory [...] that everybody has a natural happiness level and there is very little you can do to move it [...]. Some people are naturally happy and some people are naturally less so. And I think underneath I am naturally less so."**

Men talked of a number of characteristics which might lead to such pre-determination. Familial factors tended to predominate. Some men expressed this in terms of genetic or constitutional familial traits.

> **"I'm healthy. I come from a scarily healthy family that live to a ripe old age. I'm expecting to be going on for another 50 or 60 years. [...] my father is 87, his father died 4 years ago at 105, my grandmother died 2 years ago at 97, my mother died 2 years ago at 87. They are just scary. You know, they all lived on their own and looked after themselves."**

For others, early socialisation was crucial to determining their health.

> **"My parents taught me to take things in moderation, eat well, sleep well, work well, enjoy life."**

Often this was related to the occupation of parents. This might be seen as an advantage.

> **"We grew up on a farm. Tons of good food and fresh air. I'm not saying that the food was always the healthiest by our standards now, but I was brought up with an understanding of the value of eating well, taking things as they come and getting plenty of exercise and fresh air."**

Or as a disadvantage.

> **"My mother believed in feeding us all up to the gills with everything the farm provided. Plenty of high fat, high cholesterol food. They [parents] still eat like that and I get ill from it every time I go to visit. I think that's why some of us [siblings] are overweight now."**

Parental occupation interacts inevitably with class. Here are two cases of how class and occupation was seen to determine health. One in terms of life expectancy, the other in terms of socialisation.

> **"I went to boarding school, the public school system forces you to be healthy."**

> **"...generations of mining stock, we've all keeled over at some stage from rampant emphysema."**

The time and place in which one grew up was important.

> **"I honestly think that being born during the war and all the deprivations our parents withstood at that time, the lack of food, the uncertainty. It affects the way you are, your lifelong health."**

> **"A typical 1970's suburban household. Lots of crappy fast food, lots of overheated rooms and lots and lots of antibiotics every time you got ill."**

Finally, cultural or ethnic background played a role.

> **"My parents had that old fashioned Irish Catholic attitude towards sickness. You never see the doctor, the only reason for not going to school is if you are actually dead. My mother used to horde pills and potions [and] stuff that she got from her friend who was a nurse and it was like, here's a pill, now get to school. No-one knew what the pill was actually for .... and there wasn't that much available in Ireland then [1970's]. Everyone was dirt poor and miserable. [...] It all rubs off on you."**

3.1.2 Common life narratives

The second factor which influenced men's constructs of their personal health were specific narratives to do with their sexuality. That is, some men drew connections between their experiences as gay men and their perceptions of and attitudes towards their health. However, it must be stressed, that this was a matter of degree. Some saw no connection between health and sexuality.

> **"Why do people let it dominate their entire life and every decision they make, every misfortune, every illness is because, 'Oh because I'm gay'. To me that's just crap. Okay you are gay, big deal, but there are so many more important things in life that to me take priority."**

However, there were few who discounted a connection between the experience of coming out and their health. Typical in this respect was the conviction that coming out had a beneficial effect on mental health and well-being.

> ***"When you were a teenager and you say you became less healthy, what do you think that was about?***
>
> **I don't know, probably a lot of it was down to the fact that I was coming to realise that I was gay. I didn't really fit in with most of the people I knew and kind of withdrew from the social scene a bit and kept myself to myself.**
>
> ***So why would withdrawing from the social scene have much of an effect on your health do you think?***
>
> **Because I tended to spend a lot more time indoors, I would spend a lot more time in my room [...] And because I tried to avoid doing sports at all."**

For many although there is no beneficial connection per se between being 'out' and health, being 'out' allows one to take better care of one's health than one would otherwise. For others however, the experience of coming out was described as moving from a deep feeling of personal fragmentation and alienation to a sense of completeness or belonging. These men talked of health in a very different way. For them, good health, whether constitutional or genetic could be badly undermined.

> **"I was a sickly child. [laugh] Right through until I was about 21.**
>
> ***When you say sickly child how do you mean?***
>
> **Asthma, eczema, migraine...**
>
> ***So what changed that you became healthier?***
>
> **I came out when I was 16, well I was 15. But I think when I was 21 and I moved to London I lived in a relationship and enjoying London in the late 70's.**
>
> ***So how did your health problems abate at that stage?***
>
> **I think a lot of them were... I'm taking a holistic view. A lot of them were anxiety or fear based – swollen glands, things which were not specific, not specifically related to any infection or any sort of specific disease but I was always anxious.**
>
> ***Do you think you were a bit psychosomatic?***
>
> **In the true form of it yes, yes."**

Links between sexual identity and health were not restricted to the start of sexual careers. They were frequently referred to in connection with health and well-being in middle and old age. Frequently, men talked about the lack of appropriate narratives or normative ways of being to guide as they got older. For some, this was seen as an advantage as the restrictions placed on many heterosexuals might be avoided.

> "...perhaps gay men are a bit more selfish therefore they only have to concern themselves about themselves whereas, you know, men who are married for example and have kids and all the rest of it and don't have the time to consider that. They rely on their partners to provide healthy meals."

Others however, saw this as a disadvantage and merely as a form of 'extended adolescence': because they did not have children, gay men could spend more time and money taking recreational drugs or forging unstable relationships which was detrimental to their health.

> *"Why did you say that gay men smoke more and do more drugs? What do you think that's about?*
>
> It's sheer peer pressure. It's the playground. One of the joys of being a gay man is you stay in the playground a lot longer.
>
> *What do you mean by that? Why can't you do that if you are straight?*
>
> Well statistically a significant proportion of straight men will rush off and bond and breed and things and do all that. We sort of continue having tizzes with boyfriends and all that sort of stuff..."

Others saw these behaviours as symptomatic of social alienation. That is, gay men tended to engage in unhealthy behaviours precisely because there were no acceptable social roles for gay men to occupy.

> "The scene is a nasty place to be middle aged. You see these blokes well passed their sell-by dates doing whatever [drugs] they can and you think 'coronary material there' [...] but what's the option? Where do you go after forty?"

There were often contradictions regarding what was considered appropriate behaviours for older gay men. Some talked about the difference between themselves and heterosexual friends or siblings.

> "We all know how a sixty year old married woman with arthritis and a dicky heart is supposed to behave. I'm the same age and still out there every night [....] I'm not sure whether that has a good or a bad effect on my health. She might die through sheer boredom. I'll probably be found [dead] in the backroom after closing time [laugh]."

Others welcomed stereotypes of behaviour for older gay men.

> "We've both got pretty lucrative pension funds. As soon as the house here [London] hits a certain value, we're off down to Cornwall to run a B&B. [...] I know it's a cliche, but it's one that I'm happy with."

It is hard to assess the extent of the effect that AIDS has had on gay men. The scale of the personal and social disruption it has wrought would indicate that a consciousness of the disease is likely to underlie all of the perceptions we have reported. However, it is in relation to gay narratives that the subject of HIV emerged with greatest frequency. This is especially in relation to its capacity to disrupt or transform life narratives. We do not report specifically on the experiences of the men living with HIV in our sample. This is because such experiences have been reported elsewhere (Rooney *et al.*, 1997; Keogh *et al.*, 1997; 1998; Green *et al.*, 2000) and because we could never hope to do justice to their complexity in the limited space afforded here. Suffice to say that the different ways in which the disease has altered the lives of gay men living with it are countless. Instead, we will focus on how the affects of HIV and AIDS on gay social groups has impacted on the experiences of the men within them: that is, how social aspects of AIDS effects individuals.

In high prevalence areas, age in relation to HIV was crucial. Older men talked of having survived an experience that had decimated their peers. That is, there were a generation of men for whom there was neither a blueprint for living nor the critical mass of men to create it. Men in their thirties talked similarly, but also talked of the lack of men from older generations. In many senses therefore, for men in their thirties and older, there was a sense in which ways of living were having to be reinvented. This thirty-eight year old says:

> "...gay friends are either younger or much much older than me, either in their twenties or early thirties or their late sixties. I did lose a lot of the friends of my own age [...] I think there'll be problems when I hit forty because I'll be too old to go clubbing and far to young to retire [...] what happens next?"

AIDS effected men in other ways. For some men, the experience of the HIV crisis changed for ever their perceptions of their own bodies and how they managed personal health. This quote is from a man who presumes himself to be uninfected:

> "My sense of the 80's for the gay community [...] is just about every sexually active gay man of that era went through a phase of being convinced they were going to die. I don't know a single gay man who didn't, who self-diagnosed, normally wrongly, but self-diagnosed and were convinced they were going to die which when you are relatively young, when you are in your 20's is not a fear you expect to go through and I think that changes you fundamentally to have gone through that fear and then come out the other side. I think you become much more self-possessed.
>
> *How do you come out the other side?*
>
> [laugh] By not dying.
>
> *By not dying...*
>
> Well you self-diagnose because everyone is paranoid at the time and, 'Oh fuck! I may or may not be ill', but then you start to put it in a context and you hear news on it and I think most people come down to the conclusion that it's a hideous illness but it's only one of many, you may or may not have it, the chances are you don't, shit happens to anybody anytime, you put it into a context.
>
> *In terms of the way you look at your health what kind of effects does that have?*
>
> I think most people are more careful [...] Typically in your 20's you don't expect to be contemplating mortality, I think. I don't know what young gay men do now but we did. So you start to make positive, active decisions about, 'Well okay obviously I'm going to die sometime but do I want to influence how it happens and should I be doing things now that influence it'. You are very active in adopting safer sex which the vast majority did and do."

This man reports an unusual experience (contemplating mortality at twenty years old) made doubly unusual by the fact that all of his peers were similarly engaged. He talks about the need to put both disease and mortality into perspective and to consciously adopt self-protective behaviours. He also talks about surviving, not the disease, but the psychological changes that the presence of the disease in his life has forced him to make. That is, he accepted his own essential vulnerability, fragility and mortality at an early age and that influences his perceptions of health throughout his life.

3.1.3 Aspirational health
The third way in which men characterised health was one where it was seen as perfectible or aspirational. That is, we are not naturally possessed of good health, rather, we must work towards it. Health is personally constructed. The less common form of this narrative concerned notions of physical perfectability: the body was seen as a machine which could be exercised, worked upon and perfected.

> "Sometimes, I see my body like a car or something, you just want to build it up to get the best performance out of it and so that it'll last you as long as possible without breaking down."

The second narrative was both more common and more complex. Here, health is seen as holistic: the health of the body interdependent with the health of the mind.

> "The mind and the body are connected, if one's not right [...] the other can't be."

Good health is a lifelong pursuit, created by the self, both through healthy behaviours (such as a balanced diet, exercise etc.) and through a constant exercise of self-surveillance. The self is monitored for signs of good or bad health.

> "I'm more aware of myself now. I can see the signs when I'm in for a depression, it's like I can see myself going down and I know that I have to do something."

> "...up all night, not eating properly, too much stress, you've got to keep an eye on these things. If I start getting headaches or grumpy I know I'm going to be in for a bad time."

In gay men, a construction of health as aspirational is often informed by life experiences (see the section on life narratives above) or by the perception that gay men are at a health disadvantage. Therefore, some saw the state of being gay as intrinsically unhealthy because of self-hatred or internalised homophobia.

> "We're taught that we're useless. If you put such a low value on yourself, you're not going to look after yourself"

Others talked about aspirational health in more positive terms. That is, health is seen in terms of personal capital which can be built upon and used in order to increase personal happiness and well-being.

> "You really can't be without your health. It's vital [...] it's an investment. Everything I do, swimming, eating well, meditation, relaxation, they all... they all...I suppose they help me live better, work better and get more of what I want. It's an investment for the future."

3.2 MAINTAINING AND IMPROVING HEALTH

We asked men how they felt gay men's health might generally be maintained or improved. That is, whether or not gay men had particular health needs and how such needs might be met.

Many were of the opinion that their sexuality impinged, not on their need for health (they were in as much need of health as anyone else is), but their capacity to gain or maintain health. This was seen as a function of the loss of traditional support structures such as the family. For some, the answer lay in organised health promotion services.

> "Do you think (health promotion) services have any affect on us?
> Yes I do. I think in one sense it's given... I mean a counsellor is in my opinion no better than a good friend [...] And I think because of the way London in particular and Manchester and other big cities are constructed it's difficult for people to have the same sense of community that might exist otherwise for people who are able to talk to their families, their friends, whatever. So I think the reason why there are so many counselling organisations and counsellors is because it is actually meeting a real need to talk and get a better sense of reality."

For others, the answer lay in increased self-reliance and in new support networks.

> "Lots of gay men and lesbians move away from their families, to the cities where you are kind of on your own. If you're ill, you have to rely on yourself more, or on your friends. [...] Most straight people move from one family and into another."

> "We're not going to get more heart attacks or liver disease worse than everyone else, just that when we do get them, or we get old, we're going to have to manage things differently than if you were in a straight surroundings. AIDS should have taught us that"

Others saw broader political imperatives in this communitarian response.

> "I think it's breath-taking the way in which the gay community responded in the mid 80's to [HIV]. [...] for the first time gay men took a degree of political power, over a particular subject, and used it. I thought it was interesting because it was in an era, the Thatcher era, of, 'No such thing as society. It's up to you to fight for yourself and do your own thing. If you fail then you rot in the gutter and if you succeed you earn squillions of pounds'. That was the dominant political ethos and you could argue that's precisely what the gay well community did. It was a pure Thatcherite response. We said, 'We have got a problem and we are going respond to it and we are going to demand the money and the access to the information and blah, blah and we will throw complete tantrums if we don't get it' [...] We actually got quite impressive funding levels compared to other illnesses."

These responses might suggest that for gay men, health is bound up intimately with sexual identity and might be maintained through communitarian, if not political responses. This, however, would be a misrepresentation. We have seen how various factors inform personal constructs of health, some of them to do with sexuality and gay identity, others to do with more general social structures (such as family, class, cultural or ethnic background) and common perceptions (the notion of health as aspirational for example). The latter are factors which gay men have in common with other individuals and groups. For those men who felt that sexuality put them at a health disadvantage and might be addressed through communitarian interventions, there were others who made no connection between sexuality and health and managed their health in different ways. Some felt that there was no need to expend resources on health promotion for gay men because, as a group, they were powerful enough to maintain their own health.

> "Compared to the rest of the population I don't see why [health promotion] would be essential. I think you would probably find that gay men probably look after themselves better than straight men so therefore... You wouldn't necessarily think it was all that necessary."

For others health maintenance was entirely down to the individual and had nothing to do with sexuality. This man found lumps in his armpits.

> "You know, I sort of... you grope around your little bits periodically and if there is something there that shouldn't be there you go and do something about it.
> *How did you get in contact with... which doctor did you go to?*
> I went to the local practice around the corner and just demanded to go the... all I wanted was a letter of introduction to the [local private hospital] and I just went [there] and had the operation in 48 hours.
> *How do you know what to do?*
> Well you just know that if you've got lumps in certain places that you shouldn't have lumps. 99% of the time it's nothing to worry about but you check it out."

For this man therefore, although health is very much a personal responsibility, he deals with it according to his own resources (private health care and assertiveness). Others felt that they could rely on more traditional support networks both to deal with illness and in terms of day-to-day social support.

> *"Who would look after you if you were seriously ill?*
> **Well, the hospital first, and then, obviously, my family."**

> **"I suppose one of the things that sustains me is my faith and the support I get from one of the priests I see."**

It is clear, therefore, that although sexual identity has a bearing on health, attitudes to health will also be informed by life experiences (some of which will have been connected with sexuality, others not) as well as other social factors, such as family and class background.

3.3 ATTITUDES TOWARDS AND USE OF DIRECT CONTACT HEALTH PROMOTION

We end this section by contrasting the opinions of men who had taken part in direct contact health promotion (counselling and/or groupwork) with those who had not. We examined the motivations of men who had done so in the previous year and for those who had not, we asked their opinions of such interventions.

Among those who had accessed counselling, there was great variation in the way counselling was used. Some engaged in a time limited or one off encounter. Short encounters were generally to deal with some short-term difficulty. For example, loss of employment, illness etc. It was also common for men to undergo one or two sessions of counselling, invariably around an HIV test. Men varied in their reactions to this.

> *"What did you get out of it?*
> **I don't know, something, I'm not sure what. I never thought I'd be the type to go to a shrink. It's just that my friend and my doctor thought I'd get something out of it. It was good, weird at first [...] I couldn't see myself doing it for long, let's put it that way [...] It's just not me."**

> **"It's part of the deal that you had to go through it to get [the HIV test result]. It was more for them than for me."**

> **"[Counselling] didn't work for me. I stuck it for about six sessions and I felt it was completely self-indulgent and wasn't going anywhere.**
> *Why did you go?*
> **Because of this thing about feeling generally on the unhappy side of the scale. [...] I went to one that was actually recommended by my GP and it just felt completely unstructured. I would basically go in this room, pay this woman a heck of a lot of money and she would play no part in the process. [...] I felt like I was talking in an empty room..."**

Other men entered counselling as a response to some sort of crisis in their lives (the death of a loved one or a mental health problem). Some saw this a remedial process based around exploring a particular problem.

> **"It's going to take a long time to get to the bottom of why I'm so prone to depression and maybe I'll never be cured of it [...] therapy helps me to know it and deal with it."**

In contrast, some men saw counselling as a lifelong process which touched all aspects of their lives.

> **"I'll always be in counselling on and off. It's like a tool for life for me, a basic need."**

Not surprisingly, those who saw counselling or therapy in this way related their need for it either to childhood conflict, or to what they saw as unusual trauma (for example, multiple loss as an adult or abusive childhood relationships).

> "I'm not saying that all gay men are psychopaths or mentally ill, but people of our age [mid 30's] have had to put up with a lot of shit really. Family, society and then when you get through that, Bang! It's AIDS next, then all the friends you've made start dropping around you and you're frightened for yourself."

Some men who had never undergone any counselling had neutral attitudes towards it.

> "It's not something I would ever rule out. I don't think it's shameful or anything, it's just that I've never felt the need for it."

For others engaging in counselling was a sign of personal or constitutional weakness.

> "I think we are so... too reliant on it these days. Strength comes from within. Any time there is any kind of crisis or whatever, 'Oh counselling here, counselling there'. Why can't people just deal with it on their own? Again, if you've got a strong family and a strong circle of friends or you've got inner strength you deal with it. You know people are so easy to... I think a lot of it is an excuse for failure or to give up, 'I'm really settled in my life so I can't possibly deal with anything else'. I mean get a grip."

In the case of groupwork, a similarly diverse range of reasons emerged. For some, engaging in a group was part of a life-long process of drawing on community sources of support. This man who is forty years old and has always been politically involved says:

> "It's quite natural for me to turn to other gay men and lesbians for support on many things. I always have done. It's not 'a group' but a way of tapping onto other people's experiences. In this case, it's about 'Oh my God, I'm forty!"

Others joined short term groups on specific themes in response to a particular crisis, such as the break up of a relationship or a death.

> "I didn't think I'd be that effected by it [ending of a relationship]. I felt very alone and when I saw the ad for the group, suddenly it seemed appealing."

Others went for a range of reasons, to broaden their sexual horizons, to enter into different parts of the gay scene, to increase their sexual confidence or to make new friends. This man went to an SM workshop.

> "[I went for a] better sex life, start a sex life of interest to me but which I don't have... or I have very limited experience. Maybe to get into a slightly different crowd, meet some new people and in a safe environment. I could go [...] to Hoist or Fist or anything. I just don't know what to expect. So I would much rather go to something like a course for a weekend where I could talk to people who go every bloody week or whatever."

The respondent was asked why he thought such a course might be paid for through health authority funding.

> "Oh I can see the controversy for the Daily Mail but [laugh]... But I guess SM sex has potential for being unsafe [...] but I guess there is blood involved and so... If people are going to do it then it's right that people should be introduced to doing it safely and I don't see any different

between that and giving people needles for people who decide they want to inject themselves. You can't pick and choose which personal preferences because if people have a view that drugs is wrong and fisting is wrong then nobody should get any support."

Finally, there were those who equated groups with personal inadequacy

"I think some people can't deal with life and they need the kind of support that a group offers. You know, people maybe that don't have family or friends that are supportive and meeting up with strangers for support."

We have seen from this chapter that there are many factors which influence how gay men perceive of and maintain their personal health. Some men saw it as constitutional: something that has it's own reality outside of their efforts to change it. Others saw health as something over which one could have personal control. However the extent to which men were able and willing to take control varied. It was clear also, that how one conceives of one's health is related to one's capacity to maintain or improve one's health. Similarly with men's use of health promotion interventions. We cannot say that particular types of health promotion are appropriate for men with particular constructions of their own health. Rather men used health promotion interventions for a range of reasons and exhibited a range of attitudes towards them.

4. Discussion

In this final short chapter, we will attempt to summarise the varied findings of this study. First we will identify the overriding values and imperatives informing health promotion as it is currently practised within CHAPS. We move on to assess the extent to which these values are shared by individual gay men, the way in which they either use or do not use health promotion and whether they concur with or resist these values in their lives.

4.1 CHAPS HEALTH PROMOTION

We have seen that the values which underpin health promotion for gay men are based on ideas of individual self-determination. Moreover, health promotion seems to operate according to an imperative of self-examination and self-reflection. The purpose of this is increased self-knowledge which leads to greater transparency and greater understanding of personal actions. At the root of this is the incentive to fundamental personal change. Gay men are no longer encouraged to *do* the right or healthy thing, but to *become* the type of person who does the right or healthy thing. In this way, health promotion remains about promoting the healthy choice. This is appropriate as health promotion is about promoting health *through* choice, not merely about promoting choice. However, the way this is being done is changing. Gay men are no longer censored for being deviant, intrinsically risky or pathological. Rather they are invited to manage their own health and make their own decisions in ways which are beneficial both to themselves and to society at large.

These predominant values are informed by two narratives. The first concerns the notion of the 'damaged' gay man. That is, past and present societal values and attitudes leads to the formation of a negative self-image (internalised homophobia) which must be countered by remedial activity, personal reflection, self-knowledge and change. This relates to the second narrative. Internalised homophobia must be identified and expelled. One of the main impetuses of health promotion is to do this by assessing whether or not our actions, feelings and decisions are personally controlled. Pathological behaviour is now described as that which is uncontrolled or incontinent. In other words to act in an uncontrolled manner, is to be ill. If the health imperative for gay men is a lifelong process of personal change through reflection, such change is calibrated through assessing how controlled or beneficial our behaviour is.

4.2 UNDERLYING TRENDS

In this report, we have described a shift in health promotion for gay men away from directive or censorious messages to normative health promotion. This shift is by no means universal. It is easy to find many current examples of health promotion which attempt to compel gay men to certain behaviours based on epidemiological or clinical imperatives. However, the importance of this shift cannot be underestimated, not because we feel that it is necessarily good or bad, progressive or regressive, but because this shift reflects other major changes in the way that gay men are perceived, described and served by society at large.

4.2.1 Changes in health promotion theory

On a very basic level, this shift is emblematic of changes in broader health promotion theory and practice. Currently, HIV health promotion for gay men balances precariously between the different ways in which the individual relates to the world around him. What might be called the more orthodox structural factors which influence people's health (such as class, ethnicity and occupation) have long been the focus of leftist health education and health promotion. However, more recently, health promotion has tended to focus more on individualistic identity categories rather than

structural ones, especially when dealing with so-called diseases of affluence as well as sexual and mental health. Thus, individuals of all classes, genders and ethnicities might be targeted because of their age (as in the case of smoking or cervical cancer screening) or their gender (as in the case of breast cancer and fertility). This is because, more and more, we are targeted because of our susceptibility to particular medical conditions rather than our overall susceptibility to ill health. Class and ethnicity have become less the concern of health promotion and more the concern of social welfare policy. This has allowed health promotion to work at an individual level (even if it does use mass media) at the expense of larger structural factors. It should not surprise us that this ethos of individualism emerges strongly when we analyse health promotion practice.

Perhaps the reason that such individualistic health promotion seems to be so appropriate for gay men is because the elements of the 'great gay mythic narrative' (the 'coming out' story) depend on just such a personal disavowal of class, familial, cultural or ethnic identities in favour of a neutral perfectible gay identity. The development of gay identity is often described as a process of self-interrogation, self-analysis and self-development. It is not surprising therefore that notions of 'health' for gay men which have arisen mainly out of the political imperatives of gay and AIDS activism might also be constructed in this way. Undoubtedly, the fact that we have all had to come out means that there are elements to our individual trajectories and sensibilities which might actually make us particularly appropriate subjects of health promotion. That is, the experience of many gay men has led them to be self-determining, self-creating persons aware of and willing to use their own social capital par excellence.

4.2.2 Changes in research practice

However, it is not only health promotion that has changed. Gay men are now being described in different ways. That is, the way that research produces knowledge about gay men has been transformed.

In the past, much international research regarding gay men and sexuality falls into one of two disciplinary types. The first is research which is strongly empirical, positivistic and predictive. That is, it starts from the assumption that certain behaviours (such as unprotected anal intercourse (UAI)) are intrinsically unhealthy. Therefore, the underlying assumption is that there is something 'wrong' with individuals who practice this behaviour. Research seeks to identify an underlying pathology. It does so, not by asking men why they engage in UAI, but rather by searching for 'predictors' of UAI (such as altered mood states, alcohol or drug consumption etc.). The result is that gay men's sexual behaviour and gay men themselves are generally constructed as pathological. UAI can never simply be, and certainly can never be the active or considered choice of gay men, but must always be a symptom of underlying psychological or social malaise. This research belongs to a long tradition of medical or epidemiological research which has the overall tendency of pathologising gay men's sexual behaviour. Although this research tends to predominate internationally, it is increasingly mistrusted by community health promoters.

The second disciplinary type of research on homosexuality belongs to a more recent tradition of cultural studies. This research tends to migrate to the other extreme of being almost entirely non - empirical. That is, it relies on an abundance of social and cultural theory and its focus tends to be on cultural artifacts (such as gay media, television etc.). This research has the capacity to be extremely beneficial. However it often lacks a grounded epistemological base (that is, it tends to concentrate on 'discourses' at the expense of people, things and concrete events). This means that its utility to applied social disciplines (such as health promotion or the development of social policy) is unfortunately limited.

The research which underpins CHAPS health promotion is however entirely different. It is carried out within a broad humanistic framework which places greatest emphasis on the thoughts, actions, opinions and feelings of the individual as he relates to his broader social surroundings. Moreover, this research has a broad disciplinary base. That is, it does not come from any particular academic discipline (such as sociology, economics, epidemiology or psychology), but rather selects different disciplines depending on the particular issue to be investigated. This research is also utilitarian. That is, it is responsive to health promoters' needs to increase the scope of their service to gay men. It therefore has a tendency both to value and to 'make sense' of the experiences and actions of gay men. If it has a bias, it is to assume that all sexual actions are intrinsically healthy and unproblematic until shown otherwise and that all gay men can and in general do behave in a personally beneficial way. It should not surprise us that these values are shared by health promoters working within CHAPS. That is, the hallmark of all healthy actions is that they are rational, controlled, the result of free choice and generally beneficent.

4.2.3 Broader social changes

Changes in the way that gay men are described by research, changes in health promotion theory and practice and the large scale placing of responsibility for promoting the health of gay men into the hands of gay community groups both reflect and influence changes in the place that gay men (and lesbians) hold within a broader society. It is possible to characterise health promotion as one of the ways in which gay men and lesbians have entered the sphere of governance. A social and political space has been made for us and, no longer outlawed, we are now governed, no longer compelled to health (through aversion therapy or compulsory curtailment of sexual activities), we are now incentivised to health (through an invitation to reflect on why we might want to engage in unhealthy behaviours). It is not necessarily only through changes in legislation that groups increase their social and political capital. The slow development of social policy and practice (such as that pertaining to health) is often powerful in facilitating the movement of marginalised groups 'in from the cold'. Disciplines such as health promotion have enormous capacities to change the way that gay men and lesbians are described and treated by larger society.

4.3 HEALTH IMPERATIVES FOR INDIVIDUAL GAY MEN

We have examined the larger political and social significance of health promotion for gay men. However, it is important to analyse the extent to which this resonantes with the health-related experiences of individual gay men. That is, the factors which influence how individuals define their own health.

When our respondents talked about managing their health, they talked about doing so as individuals. Health is clearly about personal responsibility and taking personal control, self-determination etc. However, both the extent to which men took control and the manner in which they did it varied greatly between individuals. Some men saw this as a lifelong developmental process. For others, however, it meant merely eating well and using a condom when it was appropriate. Others had simply needed help dealing with overwhelming trauma. Others had not. Finally, for some, the extent to which they either felt able or wanted to control their health was very limited. Even those who had used direct contact health promotion approached it with a range of attitudes and expectations.

Our interviews with gay men showed that there were a variety of factors which contributed to their personal constructions of health and the way in which they managed their health. For example, familial identities play a large part in determining their intimate lives, their personal potential and their goals. Personal narratives also played a part as did cultural background. These are what might be called structural factors. That is, social and cultural factors which underlie the experience of being a gay man which contribute fundamentally to our images of ourselves and our health. These are

things we cannot change such as our familial, class and cultural background. Such structural factors are likely to effect gay men in three ways. The first concerns our gay identities. Structural factors are likely to affect the experience of 'coming out', the ease with which gay identity is adopted and the extent to which social support structures are maintained or lost in this process. This will have a direct bearing on an individual's capacity to maintain his health. The second concerns the effects of the past on the present. Structural factors are likely to influence our lifelong attitudes towards health. That is, coming from certain class or cultural or religious backgrounds has fundamental effects on the ways in which we conceive of and treat our bodies, our attitudes towards sex etc. The third concerns our present circumstances. Gay men are not classless – either culturally or economically; and they will often maintain religious or ethical beliefs. One's socio-economic position, educational status and belief system will all have significant effects on one's capacity to maintain health.

We have found that health promotion is based very much within a discourse of individualism, rationality and self-protection which unfortunately does not encompass the myriad ways in which individuals manage their intimate lives and their health. If health promotion addresses gay men only through their commonality (the fact that they share the experience of being gay) it appeals to a very small part of their overall identities. It is crucial that health promotion for gay men engage with these deeper structural factors such as class, cultural or ethnic background, occupation. This is not to say that only certain categories of men will need targeting based on class, ethnic, cultural or religious factors. Rather, we must assume that all gay men are influenced by structural factors. Some to a greater degree than others. The implications for the practice of health promotion are greater than they would first appear. It is important to resist the temptation to place these structural factors outside the remit of 'gay men's health promotion' as somehow the responsibility of generic health promoters or those dealing with ethnic or cultural minorities. It is also vital not to discount the thought processes of those men who are influenced (as we all are to some extent) by their cultural, familial or class background as irrational. Rather we must question the rationalist individualistic bias that informs how we, as health promoters, construct 'health' for gay men. Not to do so is to appeal first and foremost to the 'gay man' and secondarily to the complex individual. However, we risk more. We risk branding men who can not or will not engage with individualistic health imperatives as failures.

In view of this, it should not surprise us that there is increasing evidence to show that men from certain class, cultural and ethnic backgrounds are not only more likely to be involved in exposure and transmission of HIV, but also are less likely to engage with the health promotion currently available (Bochow, 1998; Hope & MacArthur, 1998; Hickson *et al*., 2000). We suggest that this is a function of the way that health promotion operates rather than any particular propensity for ill health or risk taking on the part of these men. We conclude that it is not enough for gay men's health promoters to turn their attention to the 'problems' of class, ethnicity, race, occupation, but rather to question the ways in which health promotion is carried out. In short, we are more than merely gay men. We exist within a broader social and cultural framework which includes our families, our class, our ethnicity and our cultural inheritances. Showing us how to be 'healthy homosexuals' falls far short of recognising the totality of our lives and fails to address us as whole persons.

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