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Imagining biosocial communities: HIV, risk and gay & bisexual men in the North East of England

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Abstract:

Many critics have charted an increasing biomedical and individualized approach to HIV prevention amongst gay and bisexual men, citing a significant shift in HIV policy and practice away from the community-based approaches to HIV prevention which characterized early responses. However, this dichotomous approach to ‘the biomedical *or* the social’ fails to capture the complex ways in which community-based approaches and sexual practice are already inextricably linked with the biomedical. This article explores how biomedical constructions of risk are embedded in the community-based bodily management and sexual practice of gay and bisexual men in the North-East of England. Drawing on Paul Rabinow’s concept of ‘biosociality’, the article proposes the notion of an *imagined biosocial community*: a community *of* gay and bisexual men who are *affected by and at risk of HIV*. Through this lens, the article explores how biomedical and sexual negotiations are situated in a broader history of illness, sexual politics and community. The article considers the importance of the biomedical in managing the body and the on-going significance of memory, community formation and identity in relation to ‘AIDS’. It then explores how the interplay of these elements are deployed or threatened within these imagined community norms of sexual practice, where responsibility to others is critical. In paying attention to an *imagined biosocial community*, this article demonstrates how perceptions of and adherence to imagined community sexual practice remain critical in addressing risk of HIV in an increasingly biomedicalized context.

In 2012, Swedish television aired a three-part drama called *Torka aldrig tårar utan handskar* by Jonas Gardell, based on his book of the same name. Broadcast in the UK in 2013 as *Don't Ever Wipe Tears Without Gloves*, the show follows two Swedish gay men in Stockholm in the 1980s, who discover a community of other gay men, love, friendship and, ultimately, loss. Through the memories of Benjamin, we witness a community affected by the HIV epidemic. The viewers witness the death of most of Benjamin's friends, epitomised by the long, drawn out and emotionally devastating death of his lover Rasmus, and see clearly the homophobic attitudes of family members who refuse to acknowledge that their sons and brothers died of AIDS-related illnesses. In stark contrast, the memorial of Benjamin's eccentric friend Paul takes place in a theatre and is full of music, dancing, campness and laughter, standing against the homophobia and discrimination of and isolation from mainstream society many are shown to have experienced at the time. These shared moments of 'community resistance' are juxtaposed with an image of Benjamin 25 years later, who explains how the advent of medication has dramatically changed the experiences of HIV. We learn through a consultation with his doctor that Benjamin is also living with HIV, but that his immune system is healthier than it has ever been, as is indicated by clinical biomarkers including an undetectable viral load. This contemporary, medicalised and individualised experience of HIV is a radical departure from his distant but still emotionally haunting memories of a gay community who cared for, looked after and loved each other.

This shift from a 'history' of community responses to the contemporary biomedicalised management of HIV and individualised response to risk of HIV is a narrative shared across many national contexts (Adam 1999, 2011). Many have argued that this shift was marked by the advent of HIV treatment in the mid-1990s, and more recently, with the introduction of new, biomedical HIV prevention interventions (Kippax and Race 2003, Kippax and Stephenson 2012). But does this increasingly biomedicalised management of HIV truly reflect a departure from shared community practices? How have biomedical transformations of HIV – and illness more broadly – affected the way in which prevention *is done* or is *imagined*? While the biomedical is often contrasted with the social in relation to illness prevention (Nguyen 2010), this article specifically interrogates the relationship between the two. In other words, how does the biomedical shape and how is it shaped by social practices of communities affected by HIV? Moreover, what roles do bodies, so powerfully affected by HIV in the 1980s and 1990s, currently play in this relationship? This article explores the way

in which biomedical understandings of HIV and management of risk is embedded in the community-based bodily management and sexual practice of gay and bisexual men in the North-East of England, who have been and continue to be affected by HIV.

HIV, community and the biosocial

The history of community-based responses to HIV by gay and bisexual men in the 1980s in a range of European and other high-income countries is well documented. Numerous critics have charted how the development of safer sex as well as continuing HIV prevention emerged from community-based sexual practice and activism (Crimp 1988, Berridge 1996, Adam, Duyvendak, & Krouwel 1999, Flowers 2001, Patton 2002, Kippax & Stephenson 2012). However, the introduction of the HIV antibody test in the late 1980s, the advent of effective treatment in the 1990s, and more recently, a move to using HIV treatment for prevention, all signal an increasingly biomedicalised and individualised approach to HIV prevention. Critics such as Susan Kippax and Kane Race (2003) argue that this approach to HIV prevention and management reflects a shift away from the social and collective practices which have sustained effective responses to HIV prevention to date. While Gary Dowsett (2009) and Martin Holt (2011) have challenged the notion that one, overarching and unified gay community ever existed, Kippax *et al* (1993) have documented the ways in which sexual practice in relation to HIV are informed by their social location, and how these *can* include a *sense* of community. It is important, therefore, to consider how community is – or how communities are – imagined, and what impact this ‘imagined community’ (Anderson 2006) has on sexual practice. I would suggest that, within this context of an ‘imagined community’, we consider how the biomedical *and* the social interact, shape each other, and work together to affect collective norms of sexual practice and HIV prevention.

Paul Rabinow’s (1996) work on ‘biosociality’ describes new forms of collective identification which are emerging as a result of the new genetic era. Rabinow (2007) explains how the term was meant to help think through how different and new forms of sociality could emerge at a time when understandings of what illness was were changing. Along with Rabinow (2007), Sahra Gibbon and Carlos Novas (2007: 3) outline how biosociality ‘attempts to name the kinds of socialities and identities that are forming around new sites of knowledge (genetics, molecular biology, genomics) and power (industrial, academic, medical)’. Biosociality, or the biosocial, considers how collective identities are formed, placing its emphasis largely on the biomedical marker of illness or being *at risk* of a

particular illness. The medical and social discourse around and the ‘community’ responses to HIV have reiterated how gay and bisexual men are perceived to be at high risk of HIV infection. I would suggest that this group of men has and continues to live with a heightened sense of being or assumed to be at risk of HIV within everyday sexual practice. As a result, it is not unreasonable to imagine how perceptions of and response to this risk *may* be integrated in collective sexual practices. Where the biosocial was originally intended to explore experiences of genetic risk and identity, the experiences of gay and bisexual men and their relationship with HIV might be considered in a similar way: the demand to test frequently for HIV; the assignation of an identity to those who test positive for HIV; and the regular monitoring of viral loads of those HIV-positive individuals in an attempt not only to maintain their health but to ‘protect’ the health of their sexual partners. This does not mean that the experiences of gay and bisexual men are solely determined by HIV or that every man will be concerned with or even affected by HIV. However, this approach allows us to interrogate the relationship this particular group of men has in relation to biomedical risk of HIV and how this relationship is perceived and negotiated. Moreover, it explores how gay and bisexual men negotiate these factors within their sexual practice through the notion of an *imagined biosocial community*: a community of gay and bisexual men who are *affected by and at risk of HIV*. That is, this is not about *all* gay and bisexual men but a community of gay and bisexual men. In considering the dynamics of an *imagined biosocial community*, this article explores how biomedical and sexual negotiations are situated in a broader history of illness, sexual politics and community, and this may be important to understandings of risk in sexual practice.

The study

This article draws on in-depth interviews from a qualitative study on the understanding and management of risk with gay and bisexual men in the North-East of England. This study considered how gay and bisexual men, regardless of HIV-status, managed risk of HIV and syphilis at a time when syphilis had re-emerged as an epidemiological concern, and when HIV rates amongst gay and bisexual men were continuing to increase (HPA 2009, HPA *et al* 2011). Understood within a wider context, UK HIV rates amongst gay and bisexual men are amongst the highest in Europe. However, the numbers of gay and bisexual men living with HIV in the North-East were amongst the lowest in the UK (ECDC 2013, HPA *et al* 2011). Anecdotally, many attribute these low (although rising) rates to fewer numbers of gay and bisexual men who live in this region, as well as to the region’s perceived geographic and

cultural distinctiveness to the rest of the highly urbanised and more densely populated UK (Nayak 2003, Casey 2007). In fact, much research on gay and bisexual men, in relation to sexual health, identity and/or culture, tends to focus on experiences in larger, urban gay-epicentres (Brown 2008). This study sought to understand the experiences of gay and bisexual men who inhabited what Brown terms the more ‘ordinary’ spaces, away from the larger and more urban gay centres of London and Manchester.

Participants were recruited with the help of research partners through clinical and community settings: recruitment material was displayed and distributed by sexual health staff in three sexual health clinics and by MESMAC NE (a gay and bisexual men’s sexual health organisation), in relevant gay bars, saunas, cruising sites and at appropriate sexual health events. Twenty-three men, identifying as gay, bisexual and/or as men who have sex with other men, aged 18 – 63 took part including: 7 men aged 18 – 29; 7 men aged 30 – 44; and 9 men aged 45 and older. All but two participants identified as white, British, and 2 participants disclosed their HIV-positive status. While these men reflect the general demographics of the North East in terms of ethnicity, ‘whiteness’ as a cultural category is produced, lived and regulated in a myriad of ways (Nayak 2003). As such, this was not a homogenous group of men, but one comprised of diverse identities and experiences in relation to class, education, dis/ability, employment, migration and sexual practices. Written consent was obtained from all participants and confidentiality of participant information, interview recordings and transcripts was assured. The study received ethical permission from the Sunderland NHS Local Research Ethics Committee. Semi-structured interviews were organised around contemporary and historical experiences of and concerns with risk in sexual health, HIV, syphilis, and risk management. All interviews were conducted by the author. While gender difference between interviewer and participants played an important role in shaping the interview, other intersectional experiences and identities relating to sexuality, education, nationality, occupation and age also contributed to the interview dynamic and outcome (Manderson, Bennett and Andajani-Sutjahjo 2006). Interviews were digitally recorded, transcribed verbatim and anonymised. All transcripts were analysed thematically by the author, who identified both recurrent and divergent themes through an iterative and inductive process of analysis (Strauss and Corbin 1998).

Imagining risk on and in bodies

Historically, a distinction has been drawn between ‘expert’ and ‘lay’ health knowledge, where the latter signifies non-medically trained individuals who develop their own understandings of biomedical knowledge (Lupton 1995). However, many have argued that individuals are increasingly developing an expertise of highly technical biomedical information in relation to their own health concerns (Petryna, 2002; Rose 2007; Nguyen 2010). This section considers how risk of HIV was identified and understood biomedically and what impact these understandings had on the management of bodies.

Importance of bodily fluids

A significant number of participants described their understandings of risk of infection as tied specifically to the body and to the management of bodies in encounters with others. Some explicitly mentioned the transmission of bodily fluids as perhaps the most important risk in sexual health. Using phrases such as ‘*avoiding transmission of those bodily fluids*’ (Jeremy, 40s), and using a ‘*protective barrier*’ (Max, 30s) to avoid or reduce contact with bodily fluids, the men described biomedical understandings of how the transmission of HIV and STIs takes place between bodies. Andrew (30s) referred specifically to biological processes when he described how people make judgements around risk in sex:

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

Andrew’s description reflects a basic epidemiological understanding that the transmission of HIV and other viruses takes place by physically entering the blood system of another body, either through blood or semen, and that this can happen through the exchange of bodily fluids during sex (Flowers 2001). Andrew and many of the men in this study were not only familiar with this idea, but also suggested that it was basic knowledge that most gay and bisexual men would have about sexual health.

There were two notable exceptions to Andrew’s assertion about the biomedical knowledge of HIV transmission; two men mentioned only recently having learned about the specificity of transmission via bodily fluids. Jack (20s) described initially being afraid of meeting someone he knew to be HIV positive because of his uncertainty about how HIV was contracted:

R: ...my initial reaction was oh, if I touch him I'll catch it.

I: Really?

R: Yeah. When I went to his house, I didn't want to use the toilet. I know, it's silly.

I: But a lot of people think that.

R: Yeah. But I don't think that now. And uh, I know you can't catch it if you, like, kiss someone, or share the same fork for example. Or even a bottle of water. You can't catch it that way. Obviously it's just through sexual intercourse. Or blood transfusion.

Jack's initial fear of transmission through touch and not an exchange of intimate bodily fluids was something that Rick (50s) also described being concerned about before his own diagnosis with HIV. It was only once he had been diagnosed with HIV and learned more about the illness, he explained, that he became aware of the need for an exchange of blood or semen for the transmission of HIV: *'Well, I know that unless you're gonna inject somebody with your blood, it's very difficult to catch it off somebody. You know, semen.'* The way in which both Jack and Rick spoke about the specific means of transmission suggests that this information had only recently been incorporated into their sexual practice. Moreover, these encounters, with people or the illness itself, had a significant effect on how they understood their own bodies and the bodies of others. While their self-reported lack of knowledge around HIV transmission was unusual amongst research participants, their reaction to this new epidemiological information reflects the ways in which the majority of participants drew on embodied understandings of risk.

The importance of bodily fluids in understandings of risk echoes other studies. Richters et al. (2003) highlight the cultural importance of bodily fluids in identifying risk amongst gay and bisexual men: HIV-positive gay men in Australia described how sexual acts perceived to result in the exchange of bodily fluids, such as anal intercourse, were identified as risky and seen as the most likely point of transmission. Richter *et al* reported that a hierarchy of risky sexual practices was echoed by participants in this study. A majority of men described stopping or reducing the transmission of bodily fluids in sexual encounters as a priority in the prevention of HIV and other sexually transmitted infections (STIs). This meant managing their own bodies as well as the bodies of others. Most men reported how preventing the transmission of bodily fluids was most effectively achieved by either using a condom when having penetrative anal sex with another man or abstaining from sex with anyone else. As one of the participants stated: *'I would suggest the only safe sex is no sex at all, or sex with yourself'* (Joe, 50s). He went on to explain *'...I don't believe anything is safe if it involves*

somebody else. But some things are riskier than others, and some things aren't as risky.'

These comments reiterate how the management or control of bodies – and more specifically, the control of bodily fluids – in sexual encounters was seen as an integral feature in the identification and prevention of risk of infection by participants.

Reading the body

There is a long history of looking for corporeal signifiers of illness (Brandt 1986; Gilman 1988; Mort 2000), especially in relation to HIV. Physical signs such as lesions from Kaposi's sarcoma – a well known AIDS-related illness – were often used to represent AIDS in the media throughout the 1980s and 1990s (Watney 2000; Hallas 2009). This classic and culturally significant sign of AIDS shows the perceived embodied reality of the illness with the presence of the virus in the blood made visible on the skin. For many gay and bisexual men during this time, the physical markings were both a sign of a risk of infection in potential sexual partners, and a physical reminder of the on-going social stigma of HIV. Furthermore, there was much effort focused on treating and/or hiding the lesions as a way of managing not only the physical signs of AIDS, but also the social and cultural stigma that came with it (Crimp 1992; Couser 1997). Since the advent of successful HIV treatment and its success in preventing the development of AIDS, cases of AIDS-related Kaposi's sarcoma have almost entirely disappeared (Russell 2007). HIV is now, generally, not visible on the skin. However, the cultural and historical significance of these early physical signs of HIV, as well as the longer history of sexually transmitted infections being marked on the body (Brandt 1985; Gilman 1988), highlights the ways in which corporeal markings of illness have and continue to play an important role in how illness is imagined, identified and managed.

In addition to being concerned with the exchange of bodily fluids, some of the men described how physical signs of infection present *in* the body could be visible *on* the body: an infection that was present in the blood and/or semen could show up as something physically visible on the body, meaning that the external body could be 'read' for signs or marks of illness. Over half of the men in this study spoke about looking for visible signs of infection on the body such as a rash, lesion or wart, whether in relation to themselves or on the bodies of their potential sexual partners. David (40s) described keeping an eye on the body of his sexual partners, and staying clear if he saw '*something obviously glaring like a genital wart.*' Nigel (40s) also explained how he developed a routine of looking for signs, both in his younger

days in response to HIV and syphilis, and again, more recently, when he had been told that syphilis had returned as an STI risk for gay and bisexual men:

...the first thing I used to do is...to look around for evidence of um, you know, lesions, or chancres, because that was the visible demonstration of somebody who was infected with HIV, with syphilis, rather. And so you used to look for things like that. Um, whereas I think ever since the syphilis thing has crept back in, you know...I found myself doing that again. That I would look for visible signs, and you know, if there were any sort of marks in the genital area that I didn't like the look of...

Nigel's practice of looking for signs of illness signals how he incorporated new epidemiological information about a re-emergence of syphilis into a longer history of embodied risk assessment strategies.

However, this reliance on physical signs as an indication of illness, whether on or in yourself or others, was not held by everyone. Some men were insistent that lack of symptoms was not the same as good health or lack of infection. For instance, Oscar (50s) described how he was scared of contracting syphilis, given its prevalence and the fact that '*there's no symptoms*'. Other men asserted that you cannot tell by looking at someone if they are HIV-positive or have STIs. David (40s) stressed that '*somebody could look the figure of health and then could have HIV, you would never know until they told you.*' Alan (40s) explained that '*with HIV and syphilis, you carry those infections for many years without showing any physical signs for the damage it's causing to you.*' While Alan's comments might point to the failure of the body to make visible that which lies within, this logic is still grounded in how participants imagined risk of HIV as embodied, if not always visible. Thus, the differences expressed between participants about the degree of transparency of the body to indicate HIV or other STIs demonstrate the complexities of both understanding and negotiating embodied forms of risk.

Some men described *imagining* where potential or actual risk was located on the body. Max (30s) explains the particular location of transmission, in this case, of syphilis:

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

Max's description suggests that it was only by coming into contact with that particular body part that resulted in his infection. Similarly, Rick (50s) identified the location of his HIV acquisition: *'I've had bad gums as well, you see, in me mouth. And I think that's where it's happened, I think.'* For both Max and Rick, identifying the particular physical location of transmission suggests an embodied understanding of risk of infection: they both identified specific parts of their body and/or on the body of their sexual partners where they were potentially exposed to this infection. This was significant in terms of how the men viewed their own bodies as being *at risk* of infection: it was not simply the contact of bodies that poses a risk, but the contact of specific body parts where this transmission can take place. The reliance on a particular biomedically grounded understandings of risk, including looking for observable signs, the knowledge that an infection may be asymptomatic, or imagining the specific location of transmission demonstrates how the corporeal management of infections, grounded in biomedical discourse, were central to HIV risk construction and an integral part of community norms of sexual practice.

Negotiating community, memory and AIDS

As Sontag outlines biomedical understandings of risk cannot be disentangled from a broader social and historical understanding of illness, culture and 'community' (Sontag 1989). Community responses have significantly marked experiences of HIV over the past 30 years (Kippax and Race 2003; Patton 2002, Keogh 2008). This section explores the ways in which memories of AIDS¹ and its impact on communities of gay men, have played a role in contemporary understandings of HIV, and how this is shaped by generational experiences.

Living through the 'nightmare'

Participants over the age of 45 all described how personal experiences of AIDS from the 1980s stayed with them over the previous 30 years. They described how these experiences had a significant influence on their own understanding of and response to HIV, but also how these experiences were *shared* with other gay and bisexual men. Losing friends was one of the most striking shared experiences. Matt (50s) explained how: *'men of my age have lived through the same nightmare as I've lived through, when it comes to losing friends'*. Matt

¹ The use of AIDS in this context refers to the specific experiences of the 1980s and 1990s in the UK, a period where the absence of effective treatment for HIV resulted in the development of AIDS and the death of thousands of people (Berridge 1996; Watney, 2000; Kippax and Race 2003).

recounted how ‘8 of [his] close friends died’ and Oscar (50s) described how he ‘lost about 20 friends’. These men explained how these deaths had a lasting impact on their understanding of what became known as HIV and how it was formulated as a painful and real risk in their lives. This was especially demonstrated by both of them becoming visibly upset during the interview when recounting these experiences.

It was not simply the number of friends affected, but also the circumstances in which these deaths took place. Edward (60s) described a particularly upsetting experience:

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

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

Shared stories of community loss

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

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

Andrew framed his encounters with these older men in bars within a broader historical context of gay 'community' development, where older men played a key role in educating younger men about gay social practices and spaces, including HIV prevention. Within this context, Andrew described how he took messages about HIV prevention on board because they had '*so much power from those men because of what they were involved in in the 80s*'. For Andrew and other participants, discussions with men who had experienced the impact of the early AIDS epidemic first-hand made them acutely aware of the history of HIV for gay and bisexual men. In spite of not having direct experiences that were similar to those of the

older participants, this cross-generational sharing of ‘community’ memories of loss due to AIDS described by participants helped to establish *them* within a community of shared experiences and pasts.

Other men under the age of 30, who did not describe this direct cross-generational sharing of experience and memories, explained how their exposure to HIV was often through media representations of HIV. A number of younger men described how these representations made a significant impact on their early awareness of HIV. Jack (20s) described being made aware of HIV through a newspaper article:

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

Although Jack was very young, he described how this introduction to HIV was linked to homophobia in his grandmother's very angry reaction and how this memory had stayed with him over 20 years later. Very early memories of gay men and HIV were common amongst men under 30 in this study. Colin (20s) explained how he remembered public health advertisements from when he was very young:

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

Colin would have been 6 in 1987 when the *Don't Die of Ignorance* campaign was aired (Berridge 1996). Will (20s) also described an early exposure to HIV through the UK television series *Eastenders*, where one of the characters, Mark Fowler, was diagnosed with HIV in 1991 (Geraghty 1993). Although the character was heterosexual, the introduction of HIV into a mainstream television programme marked Will's early memories and understandings of the illness. Will explained how he ‘remember[ed] growing up with that story’, and explained that he ‘would have been, you know, 8,9, maybe 10, beginning of my sort of adolescence. And I could start understanding that sort of thing’. Will would have been around six when the story line first appeared. These media representations clearly made a

strong impression on several of the younger men in this study, as demonstrated through their personal memories of iconic AIDS events at a very young age. I would suggest that these cultural references illuminate how certain events are remembered collectively and how they become a part of a shared or 'community' history. For instance, Portelli (1991) explored how a post-World War II community in northern Italy collectively 'misremembered' the date of death of a factory worker, which was believed to be the cause of an important factory strike, when they were interviewed over twenty years after the fact. Portelli argues that this factual inaccuracy should not be taken as a mistake or a sign of the fallacy of memory, but as a way of highlighting the importance of collective memories in forming community histories and creating community meanings around these shared experiences. I would argue that the younger men in this study, regardless of whether or not they remember these experiences from such a young age, used these collective memories to signal their belonging to a community of gay and bisexual men that was significantly affected by the AIDS crisis of the 1980s and 1990s.

Although some participants described understandings of and encounters with HIV that were shaped by generational differences, they all described being aware of the history of loss, community responses, direct experience of homophobic stigma, cross-generational community building and iconic 'memories' of AIDS. Moreover, they reported how their own personal histories and contemporary experiences as gay or bisexual men were affected by these memories. The incorporation of a shared history of illness and loss into the personal memories and experiences of participants points to the ways in which a community of gay and bisexual men was imagined. Shared memories of AIDS played an integral role in how they imagined a community of gay and bisexual men to be affected by HIV and the ways in which they were a part of this community. This is not to say that all participants imagined the same community, but that many described a community which held these elements in common, and one within which they felt they were negotiating their own sexual practice. As I explore in the final section of this article, membership of this imagined community had implications beyond the sexual practice of individual community members.

Sexual practice in imagined biosocial communities

As outlined earlier, community practices of safer sex amongst gay and bisexual men emerged from harm reduction approaches to HIV prevention. While many critics have expressed concern at the potential loss of these community-based approaches, participants in this study

described an imagined *biosocial* community of gay men affected by HIV: an imagined community grounded in a shared embodied understanding of biomedical risk of HIV, managed through collective practices of harm reduction and shaped by the memories of AIDS. I would contend that we could describe it as an imagined biosocial community because of the way in which ‘community’ members articulated a consideration for the responsibility for the health of others *within* this imagined community and for whom they assumed shared responsibilities in HIV prevention. This final section describes three examples of how this shared responsibility was grounded in sexual practice.

Trusting an imagined community practice

While the imperative to use a condom for anal sex was considered to be strong amongst most of the men in this study, a minority of participants described occasions when anal sex without a condom was different from ‘barebacking’ (Dean 2009). They explained how these occasions took place within a particular context and may be described as what Kippax has called ‘negotiated safety’ (Kippax and Race 2003:3). That is, HIV risk reduction is negotiated through means other than condom use. While Kippax describes this negotiated safety within the context of ‘regular’ partnerships, some of the men elaborated on how they employed a similar strategy with ‘non-regular’ sexual partners. Matt (50s) described how he had multiple sexual partners and regularly used condoms for anal sex with these partners. However, he also explained how he practised anal sex without a condom with one partner in particular: *‘there’s a guy who I see very regularly...and he doesn’t like being fucked with a condom. So therefore, he doesn’t have many sexual partners....’* Matt described how his decision to have condomless sex was not one he made lightly and was taken only in the belief that his partner had few other sexual partners. This decision was made only after he had tried to introduce condoms to the sexual relationship: *‘I say, look Luke, I’m happy to wear a condom. You know because I’ve got some sensitive ones, you know, that sort of heterosexual men use’*. As the insertive partner, Matt established how he was technically at less risk of contracting HIV than Luke. Moreover, he was also concerned about the risk *he* potentially posed to Luke and commented on how *he* was regularly tested for HIV and STIs. Emphasising the steps he took to reduce risk to both himself and his sexual partner, Matt explained how he was deeply affected by HIV and very concerned with the possibility of transmission. Throughout the description of his experiences with Luke, he tried to make it clear that anal sex without condoms with casual partners was an exception to his regular sexual practice with other men:

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

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

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

Matt's need to reassure me that this was not his regular practice suggests he felt that anal sex without condoms was socially unacceptable amongst most gay and bisexual men. He explained how his 'regular' practice involved being consistently tested for HIV and STIs, using condoms for anal sex with other men, and having unprotected anal sex with only one person whom he knew and trusted to have few sexual encounters with others. This last element, of trusting that this partner would not have many other sexual partners, was grounded in a perceived community practice of men regularly using condoms for anal sex with their sexual partners. In this context, Matt's negotiated safety can be seen as an extension of community sexual practices. Rather than being an exception to the rule, Matt's example highlights the ways in which participants described adapting to sexual and emotional situations while still adhering to the prevention of harm based on a biomedical framework. This practice also takes into consideration the potential harm that might be done to each other, as seen through the negotiations with sexual partners that took place in each encounter. Matt's concern with conforming to community practice reflects how many participants spoke about a sense of responsibility to reduce harm in relation to HIV prevention. This responsibility was not only in relation to avoiding HIV themselves, but also in relation to preventing their sexual partners from potentially being put at risk of HIV; the prevention of HIV transmission was understood as both an individual and collective responsibility for most men in this study.

Rationalising risk reduction for others

Nearly all participants reported what they perceived as a community practice of unprotected oral sex. This practice was grounded in a safer sex ethic based primarily on HIV prevention. While many described being concerned with contracting an infection, others described themselves as part of a community of sexual actors who affected each other. Thus, it is not simply the shared goal of preventing HIV that influenced many men's sexual health strategies, but a more general concern for others. Reflecting the rationale of many men in this study, Andrew (30s) described how he weighed up the risks of HIV, STIs and his sexual practice as it affected both his sexual health and the sexual health of his partners:

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

Andrew's risk logic within this extract highlights how he adheres to both an epidemiological hierarchy of risky sexual acts and a hierarchy of STIs. The success of this logic is reaffirmed by being HIV and STI free for 14 years. However, what I would like to draw attention to here is the way in which Andrew describes reducing the harm posed to both himself *and* to his sexual partners. While he described largely being concerned with the transmission of HIV and was satisfied with the very low risk of this taking place, he also spoke of the possibility of transmitting other STIs to other men. For Andrew, his safer sex strategy was not merely about preventing *him* from contracting an infection, but also about reducing the risk he posed to his sexual partners. He felt that the nature of his sexual practice was such that it would

significantly reduce, if not eliminate, the chances of passing on an infection to a sexual partner. This concern demonstrates a practice based in a sense of responsibility not just to the self, but also to others in his imagined ‘community.’

The anxieties of imagined biosocial communities

As outlined above, ‘barebacking’ is the practice of anal sex without the use of condoms. The majority of men expressed criticism of the act, and the practice was often referred to with disdain. David (40s) explained how barebacking was something that he and his friends all agreed was not acceptable:

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

All participants claimed that they did not have bareback sex and none described themselves as barebackers, even when they described having anal sex without a condom. Barebacking was generally seen as what a small minority of *other* gay men did, and a number of participants commented that they felt barebacking was *not* an established community practice. However, some participants were concerned that bareback sex *could become* widespread amongst certain groups of men, and were concerned with this ‘threat’ to perceived community norms of sexual practice. Nigel (40s) described how younger men might be more vulnerable to ‘unsafe’ influences, such as bareback pornography.

What I am sort of conscious of, particularly, and I think it’s, and I think the impact of pornography must influence people. This great, um, desire for bareback porn. And you know the number of younger people you see in these, you know, videos and films and things and they’re having bareback sex and I think that must influence younger people. Which I think is like, that’s a real concern for me because I think there are younger people, you know, completely different generation who weren’t exposed to that government campaign, the hard-hitting government campaign. Or actually seeing situations, you know, where people are actively, not recommending but they’re not sort of highlighting the risks about um unprotected sex.

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

Conclusion

Don't Ever Wipe Tears Without Gloves depicts a striking transition from a collective gay community of the past affected by AIDS, to a post-AIDS individualism of the present. In contrast, this article has described a dynamic, imagined community of gay and bisexual men based on collective practices forged through both social and biomedical structures. While the increasingly (bio)medicalised management of HIV is often seen as individualising, the experiences of the men in this study point not only to how HIV prevention *is done*, but also to alternative and collective forms of belonging through the care of and responsibility to those in an *imagined biosocial community*. We have seen how the embodied management of risk,

which drew on particular biomedical understandings, was integral to notions of risk of HIV in sexual encounters. In addition, this article has shown how participants imagined a particular ‘community’ history in relation to AIDS and how this ‘shared’ history has affected contemporary notions of HIV as an ongoing risk. Participants described how perceived norms of community sexual practice were based in a harm reduction approach that prioritised HIV prevention. These practices included not only condoms, but also a combination of biomedical and social HIV prevention methods such as negotiations with sexual partners and HIV testing. Moreover, central to this practice was a concern not only with individual sexual wellbeing, but also with the sexual health of other men and therefore a sense of responsibility to prevent harm to others. While this work draws on the concept of biosociality, it also seeks to expand it. Firstly, this work depicts forms of biosociality which emerge not only in response to a particular illness, but which are also formed and sustained through *existing* collective practices. Unlike the focus on biosociality and genetics where biosocial communities are formed through, for example, the identification of genetic illnesses (Rose 2006, Gibbons and Novas 2007), biosocial responses to HIV in this study were seen to emerge from existing collectives of gay and bisexual men whose experiences were often already grounded in a history of oppression and stigmatisation (Watney 2000, Weeks 2007). Secondly, forms of activism and citizenship practised by biosocial communities are not limited to *health* acts. Coalitions of actors demanding access to testing, treatment and care form an important part of the history of many illnesses including HIV. Yet, also significant are the intimate sexual acts of an imagined biosocial community through which community members practice collective forms of harm reduction and care. While biomedical technologies are often seen as the dominant framework for thinking about both the prevention and management of HIV, this article has shown how the shared memories and collective practices of communities affected by HIV continue to play a formative role in how HIV prevention is done.

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