THEN AND NOW

Gay Men and HIV

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THEMATIC OVERVIEW

The discussion of post-AIDS initiated in 1996 is not over (Dowsett 1996; Dowsett and McInnes 1996a,b). Post-AIDS refers to how gay men live separately from, and in relation to, HIV. There has been a decrease in interpersonal contact with the epidemic for HIV negative men and an increase in distance from the effects of the epidemic. This often involves HIV positive as well as HIV negative men. Doing gay separately from HIV, however, has become more than distancing from the social effects of the HIV epidemic. Most gay men still practice safe sex most of the time, but gay and safe sex cultures are dynamic and adaptive. Put simply, doing gay is about living a gay life. Safe sex fits there, but has an increasingly abstract relation to HIV as both epidemic and virus.

New ways of living gay are constantly developing. Social possibilities that were once formed in a direct relation to homophobia and HIV are now less so. Crisis and oppression are not as determinant as they once were. Media representations and new media technologies (www, internet) have changed the number and kind of available social resources and contribute significantly to social options. In this changed environment, differences in 'ways of doing gay' are apparent (McInnes *et al* 2001a), even where normalisation seems to be the dominant trend. For the purposes of these prefatory remarks, three quick examples will do. Firstly, there is now a distinct movement amongst some gay men toward family formation and parenting as part of how they do gay. This differs from how gay men once moved away from family and parenting in the process of establishing their gayness. Secondly, however, difference with heterosexual norms is maintained amongst many gay men by the open negotiation of non-monogamous relationships. Thirdly, increasing numbers of gay men negotiate their gayness by actively distancing themselves from community and scene. New social options produced, in part, by new media technologies make this possible. Amongst gay men themselves these differences are explored, disputed, negotiated. In terms of public representation, 'gay men are allowed to "be" gay so long as we forgo sex with other men' (Dowsett 2003: 243).

Early in the HIV epidemic, crisis provided a direct link between ways of doing gay and HIV. Notions of community, community attachment and safe sex cultures were central.

This is no longer the case, and crisis formulations cannot simply be reimposed. The social relations on which each of these concepts was based have changed. This process was accelerated by the relative successes of Highly Active Antiretroviral Therapies as a treatment for HIV infection. Treatments successes changed social possibilities, even where side effects and efficacy remain issues for those taking them. One consequence of this general social shift is that in public health epidemiological and behavioural notions have moved to fill the gap between gay and HIV. The result has been a renewed naivety from some biomedical practitioners of public health about what might constitute effective HIV health promotion in the face of increases in new HIV infection notifications and increases in sexually transmitted infections. That, in turn, has sharpened the political edges of how to respond. Basil Donovan, Director of the Sydney Sexual Health Centre put it this way: 'it is naïve to assume that good HIV control is synonymous with good STI control' (Donovan 1998: 216).

That bio-medicine has an important place in HIV prevention and living with HIV is a given. But as Ross Duffin, a long term HIV educator, recently wrote: 'In the United States and to a lesser extent in the United Kingdom the responses to rises in new HIV infections have been dominated by traditional medical public health responses. *These have not worked anywhere in the world to contain the HIV epidemic'* (Duffin 2003).

The essay 'Then and Now' suggests that as part of the response to increases in Australia, we seriously consider the diversity that now constitutes ways of doing gay and its relevance for health promotion. While this diversity may have limited explanatory value for current increases in new HIV notifications, it's quite possible it has implications for future infections. As I argue later, for many, safe sex is arguably an aspect of doing gay, rather than something done in the name of health. Consequently, there are sometimes strong tensions between public health priorities and community-based HIV prevention respectful of gay social and sexual practices. This tension can't be resolved by sternly laying down safe sex 'law'. It requires negotiation and brokering. This negotiation needs to occur within gay cultures as well as between public health and health promotion. Preventing that negotiation by hamstringing health promotion produces and intensifies ways of doing gay that put the practitioners at risk. Being sidetracked by only protecting or celebrating the practices rather than also challenging them also puts people at risk.

While the lives of many gay men have been irrevocably changed by the experience of HIV and its effects, there are now many others who haven't had the same experience. The upshot in daily life for many gay men, at least some of the time, and irrespective of their HIV status, is a decentering of the risks of HIV infection. It's arguably multi-dispositional, formed both inside and outside of an ongoing awareness of safe sex 'lore' and of what infection and treatments can bring. In that sense it's a stance involving a range of assertions, refusals and calculations that is both life affirming and sometimes very shortsighted. For many living with HIV the emergence of these perspectives has been a confronting phenomenon, even as they have experienced the possibility of living lives outside of the experience of illness. For some of them, after coming to terms with a diagnosis of infection, there are long periods where living with HIV is not regularly experienced as involving illness or as posing a daily threat to mortality. For others, treatments efficacy and side effects require daily regulation, often in a social context of poverty. As Bartos argued in 1998, there is no unitary experience of HIV amongst people living with the virus (Hurley 2002a; Ariss *et al* 1995).

Sustained rates of condom use amongst HIV negative and HIV positive gay men and HIV testing amongst negative men have generally accompanied decentring of HIV. Even so, these have been also accompanied by increasing rates of anal sex with casual partners and increasing rates of unsafe sex in these contexts (Van de Ven *et al* 2003; 2002b). These data are often interpreted by health practitioners and journalists as explaining recent increases in HIV infection. That is an assumption. It's one thing to identify paths of possible biological transmission, and another to prove that these are the actual paths along which infection is occurring. There's a case for arguing that prejudices about public sex and casual sex are blinding some public health officials to the multiplicity of social contexts involved in infection. Having a life and enjoying it is part of the mix.

Education involves a mix of bio-medical information, cultural information, social relations and modes of delivery. The social relations involved include reflexivity as a major form of social literacy. That is, the capacity to reflect on the relation between self, culture and various practices. Both 'negotiated safety' and 'strategic positioning', for example, rely on

reflexivity as much as they rely on a steady flow of up-to-date information. Reflexivity involves continual incorporation of new information into repertoires of everyday life, but the key aspect of these repertoires is their ‘practiced’ nature. By ‘practiced’, I refer to the constant, shifting iteration of ways of doing things. That these ways of doing are unevenly practiced and require more practice is consistent with being reflexive.

As novelist Perry Brass wrote of Quentin Crisp’s response to gay liberation: ‘The new gays wanted to be like the boys-next-door. They wanted to take all the difficulty out of gayness; whereas Crisp saw it like ballet, an artform that requires practice and hidden sweat for it to seem "easy." ‘ (Brass 2000) While doing gay for some is something now done as far from art as possible, it’s still the case that ‘practiced’ sex is and needs to be artful, as in learned wittingly. I write, in part, of those gay men who do gayness away from practices of friendship and the scene and ask questions of what this means for HIV prevention.

The assumption that new infections mean educators or researchers are wrong in attributing ‘sophistication’ to gay cultures is to misunderstand how information is ever-changing. Yes condoms stop HIV, but what makes this ‘interesting’ or ‘useful’ information now? Many more people die on the roads in Australia every year than die of AIDS, yet almost no-one uses this as an argument for use of public rather than private transport. ‘Keep it simple’ in this context sets up a scenario in which the desire for fewer infections is mistaken for a strategy, in which the newly infected are stupid dupes of bad health promotion and the commentator is the knight in shining armour. Quentin Crisp long ago put paid to the romance of ‘the big dark man’ who makes it all better.

It is a nonsense to assume that identifying a biological transmission route by itself provides the basis for a successful HIV prevention campaign. It’s a compounded nonsense to then think that identifying safe ‘behaviour’ in the sense of isolated mechanical acts gives any greater educational sophistication. Nor does collapsing HIV and sexually transmitted infections into the one notion of ‘safe sex’ get us very far with gay men’s education. It’s time for public health practitioners to start listening to HIV educators and well-informed sex practitioners again so that together they can work out an array of possible responses.

The essay suggests that we resist obvious assumptions about the cause of new infections. In particular, it suggests we resist seeking single cause explanations or assumptions that casual sex resulting in HIV infection automatically occurs primarily in sex venues. Firstly, there is no set of definitive reasons why the increase should be understood as having intrinsically different causes than those involved in ongoing infections over the last decade. Secondly, it needs to be remembered that ‘home’ is one of the contexts of casual sex, as are the emotional desires for both safety and excitement. Thirdly, context involves meanings as well as places and practices. The desire for pleasure, to be loved or to experience intimacy or to be lost or just to have a different experience of living all play out in various ways of doing gay.

For some, doing gay is seen as inexplicable or morally reprehensible. For others, many of them gay, doing gay needs to be circumscribed by respectability and social or political acceptability. Neither of these responses enables professional best practice in health promotion. Instead they replace it with moralism or emotional reaction, and arguably contribute to the problem while posing as offering a solution.

Shifting sexual practices amongst gay men are themselves framed by constant movement in politics and policy and by differences amongst gay men. How these affect the social relations that impinge on sexual practice requires ongoing consideration. In the meantime, a sustained commitment is needed to multi-faceted health promotion programs that interact respectfully with lived cultures and continue to actively intervene in them.

‘Any discussion on the meaning that specific sexual acts bring to one’s life is absent from our understanding of desire. If the act of being fucked, and having a man climax inside, provides some men with a visceral sense of intimacy, trust, of being possessed, how does the introduction of a latex barrier transform the significance and symbolism of the activity. What new meanings and values arise from reconstructed anal sex?’ (Rofes 1996: 146)

‘One aspect of the nature of fucking without condoms is the tension between our desire to do this and the knowledge that it can lead to further HIV transmission.’

(Parnell 1997)

‘Unsafe sex is also rational behaviour…a wider understanding of rationality is needed: one that includes longing and love as motives for action.’

(Prieur 1990: 109)

An educational strategy ... for preventing the further spread of AIDS must operate at the intersection between the physical action through which the virus is transmitted, and the meanings through which the action is apprehended and experienced and through which it can, therefore, be re-shaped.

(Connell *et al*, 1988:3, cited in Bartos and Middleton, 1995: 10)

We need to take some responsibility for our own history ... It is not nostalgia. If one is going to go to all the trouble to be gay, one ought to do a more interesting and useful job of it. Models do exist in our recent past. They should be recalled.

(Michaels, 1990: 92)

INTRODUCTION

'Then and Now. Gay men and HIV' is closely informed by gay and HIV social research into how gayness is being done. The lived cultures of gay men are at its centre[1]. The essay is offered as a resource for reflecting on the relation between aspects of everyday life in a media culture and HIV education, policy and research.

The current moment is troubling. Firstly, there have been numerical increases in new HIV diagnoses and incident infections, though the increases have not yet affected the trend of infection over the past ten years. For the individuals infected, of course, it's a whole other story. It is a moment characterised also by particular takes on gay men and sex, by what seems to be a diminishing national AIDS advisory structure and by the effective sidelining of gay community perspectives in the management of the current national strategy.

Some discussions of the increases in HIV infection are spooked by the uncertainty of relations between ways of doing gay, health and HIV. Commentary is horrified at the reported increases and is fuelled by anxiety and anger, as well as by ignorance, near panic, narrowness of thought and elements of homophobia. Wider understandings of what it means to do gayness disappear, and with them goes attention to, amongst other things, the emergence of quite different ways of constructing gayness, excitement and 'safety'. This puts a premium on a calm understanding of what might be going on and how to respond.

[1] I use 'culture' generally to refer to the social production of meaning and to psychic processes of sense-making in everyday life. I add 'lived' to distinguish this sense of culture as ordinary sense-making from versions that discuss culture primarily in terms of artefacts and artistic or spiritual value by forcing a distinction between 'high' and 'low' culture. Everyday life includes 'high' and 'low'. That is, it involves barbecues and sex venues, reading romances and watching Australian Idol as sites of social sense-making, as well as what it means to attend the opera and art galleries or to read Jane Austen. Personal sense-making differs in that sense to institutionalised attributions of value, even though they are formed in relation to each other. The question of value from my point of view is both internal to particular lived cultures and a matter of differences between those cultures, as well as involving hegemonies. How we position ourselves in relation to these differences is a separate, important issue. For a discussion of the theoretical complications of notions of 'lived culture', 'everyday life', 'experience', 'structure' and individualisation, see Probyn's *Sexing the Self* (1993*)* or de Certeau's *The Practice of Everyday Life* (1988) or Williams *The Long Revolution* (1961)*.*

In ‘Then and Now’ I reassert a point made by Gary Dowsett: safe sex culture is a gay culture organised, but not defined, by its response to HIV/AIDS. It’s not just a set of sexual practices developed in response to a virus: “for gay communities safe sex culture and gay culture are inextricably entwined” (Dowsett 1996a: 69). Yet, we are forced by politics to reinvent the wheel over and over. An imaginary figure again haunts the landscape: the wanton gay man. He lurks mostly in the shadows, at the edges of official utterance, but is, somehow, unspeakable, except as opinion by the odd journalist. He is here and not here. He is the stuff of nightmare, a kind of Freddy from *Nightmare on Elm Street* (Dow 2000). Perhaps naively, I had not expected to see him again. I heard the screams at his return, reportedly blood-swollen with desire, his bare back glistening with the sweat of lurid thrusting, and saw him projected onto the larger than life screen of public health and safety. In this case it is a public health street screen formed from journalism, a political insistence on seeing the internet as a source of generalised moral danger, responses to HIV notifications by worried public and community-based officials and all round finger pointing from inside and outside gay communities. The screen now has surround sound, but it is a retro season of gothic horror.

The implicit task in much biomedically driven public health narrative is to save ‘us’ from this man by making him ‘safe’. How do you make this man safe? You turn him into a version of your public self: a hygienic citizen who ‘behaves’ sexually. He may still be gay, we’re not prejudiced after all, but he will remove the threat of HIV by not speaking sex unsafely. He will remain silent on his pleasures and refuse to behave in ways that allow ‘us’ to represent him as a threat to public order, because really, you know, this is not what ‘we’ want to do. He will be a good boy and keep us happy. If he doesn’t, we may have to take stronger measures.

In the meantime gayness proceeds. It’s not determined by public health or HIV education. Recognition of that has been clearly present for a long time in HIV social research (Kippax *et al* 1993; Dowsett 1996a; Prestage 1996) and HIV education (Duffin 1997). The lesson drawn has been that HIV education and health promotion work best as respectful interventions into the lived cultures. The politics of the present mean that

this perspective on professional practice is embattled and has been for the past six years (Puplick 1997).

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Almost all my writing is ‘occasional’ in the sense that it is produced for a purpose, an occasion. This essay is no exception. In *The Virtual Republic*, Wark speaks of the essay as ‘a kind of hypertext…one particular way of negotiating passages through knowledge and experience’ (1997: xx). I note here the example long set by the work of Dennis Altman and the ways it keeps sexual politics firmly in the public sphere. Wark argues elsewhere, in a discussion of public spheres and public intellectuals, that the essay is ‘a vector across the cultural landscape, that seeks to connect thought and feeling regardless of “rank”. But in order to function as such, the essay has to question established hierarchies of cultural value and the powers that be which are vested in them’ (Wark 2002).

I work in a context where research is governed by strategic requirements (National AIDS Strategies) and is rapidly applied to practical problems in health promotion, community advocacy and programme and policy development. This gives a particular utility and authority to research reports, but it also pressures the research in ways that sometimes make me uncomfortable. Good research requires time for reflection. It is not just a matter of speedily gathering data, collating it and disseminating it. On the other hand, it is publicly funded. I work mostly with highly experienced practitioners – of pill taking, of research, of HIV programme delivery, policy development and advocacy - and together we engage in reflexive analyses. They bring informed understandings of their practice, and the practice of others. We share our understandings of lived cultures and consider their implications.

I don’t claim a uniqueness of perspective. My writing may be written alone, but it comes from long-term engagement with the work of others. Much of my own learning has been collegial, interactive and frequently sharp. ARCSHS is a multidisciplinary research centre. We work constantly at an interface constituted and framed on the one hand by social science, public health policy and practice, medicine and science, and on the other by collaboration with organizations, practitioners and individuals representing the

populations, subcultures and networks in which we do our research. The Commonwealth funded Living with HIV Program is a collaborating program with the National Centre in HIV Social Research. These interfaces are permanently characterised by change, negotiation and, at their best, highly creative tension.

The number of people in HIV social research nationally is relatively small. They are characterised by their commitment, intellectual collaboration and sharing of experience. There are also strong disciplinary and theoretical differences and difficult personalities. Sometimes, these produce extraordinarily moments of intellectual engagement and personal support. Most HIV social researchers in Australia have backgrounds in social science, especially behavioural, cognitive and social psychology, sociology, epidemiology, health and sometimes education. My training was in Humanities. I work from a Cultural Studies perspective in which questions of methodology are informed by textual and narrative analysis, writing practice, various forms of discursive theory (linguistic, Foucauldian), social semiotics, media theory, ethnography, sociology, history, politics. Multidisciplinarity is an everyday fact of life in my field and I engage often with questions of interdisciplinarity that are often more defined by methodology than method.

For social scientists, the methodological field is divided into quantitative and qualitative projects. The breaking of the field into two like this gives a strange take on how the empirical emerges for someone who does *social* as distinct from *social science* research. For me, ‘takes’ need of necessity to be sufficiently flexible for the ‘social’ to shine through over the method, even though it is the method that is meant to guarantee the shining. This means I prefer methods in which ‘experience’ is given a voice, though it too requires analysis. That perspective, however, still has to consider a small question of the official purchase of research. It doesn’t matter to most funders or hard scientists that Dickens successfully critiqued counting in *Hard Times* (1854). The critique might stand, but its power is partly nostalgic. It doesn’t matter to the extent that counting counts powerfully in the social construction of reality. Foucault understood that in his discussion of populations and social technologies as tools of governmentality in the nation state. This doesn’t, however, require ceding the ground to quantitative analysis.

Most quantitative researchers I engage with are well aware of the limits of what can be said on the basis of their results. They are aware too that when the instrument of data collection is a survey it shapes what is asked about and how. What I see is the kind of methodological thought that prefaces and informs the design of their research before it gets anywhere near the actual instrument and the care taken with analysis. Amongst the best of them, and for all the disciplinary differences, I see practices at least as well informed as those in what they would call qualitative research. My focus is on meaning and practice, rather than on numbers, but these interact and of course cultural studies has its own challenges to face in this area (Jacka 1994).

Why put forward this essay now? Because current media and policy fixations on gay men and gay sex are creating political urgencies based on reductive, misinformed understandings of what it means to be gay and how that relates to long term living in an epidemic. These issues are collapsed into anxieties about how behaviour change might be achieved, anxieties that forget twenty years of sustained shifts in sexual practice and the dynamism of a well informed present. Even to say that much is to be increasingly heard as placing insufficient emphasis on recent shifts in the number of new HIV infections. Forgetting can, however, sometimes be aided by reminding. Without understanding, interventions around HIV become increasingly ill-informed and moral judgement replaces policy and practice.

THEN AND NOW. GAY MEN AND HIV

> A culture of behavioural surveillance disappears gay. (Smith 2003)

> I am not an AIDS denialist…gay men's sexual cultures do…present a range of health challenges. I am simply someone who demands new and clearer perspectives…While I have no difficulty believing that more men are sexing without condoms…I consider the popular explanations to be more akin to misguided folk wisdom…Many thoughtful gay men hunger for a deeper and more complex analysis of what's going on…Health advocates frequently mistake our boredom at their superficial and vapid analyses for complacency about the health of our communities. We care deeply about the wellbeing of gay men's communities; we are simply enraged at the repeated manipulation of statistics and emotions in the name of HIV…And we hunger for vision: a new vision for HIV prevention…of gay male communities… of gay men's health and wellness. (Rofes 2002)

> Our analysis of health promotion might … be described as re-constructing certain types of gay men, not as deviant, but in Kinsman's (1996: 402) terms as merely 'a variant from the norm'. Thus, gay men are being granted a very limited social legitimacy. The question therefore remains: does this model of health promotion meet the needs of all gay men? Empirical research suggests increasingly that the answer is no. (Keogh 2003)

This essay is an extended reflection on some of the relations between gay men, sex, love and HIV. It reflects on what HIV social research in Australia has and hasn't told us about these relations and on how these categories are put to work. In that sense, as ever, sex, love and HIV become abstract. Smell, touch, sight, hearing and taste all but disappear.

I begin with some personal remarks on my entry into HIV research. This gives readers some indication of how my thinking in this area has developed. I believe also that longer term perspectives are useful in considering the present moment, even as I insist that understandings of the present are best not *over* determined by the past. This is part of my argument that while there is little evidence indicating any major shifts in how HIV negative gay men are becoming infected, there is a growing body of work indicating new trends in how gay men do gay and where they position HIV. These shifts in the doing of gayness involve both HIV positive and negative men. They directly affect how HIV health promotion can be done effectively now, and they may have implications for future contexts of infection.

What I note initially are the shifts in my work since I wrote:

> Writing about sex is one thing.
> Writing erotically is another.
> Licking is something else.
> (Hurley and Hutchinson 1991: 19)

As indicated in the Introduction, I'm a social researcher working at an interface with social science. In my 'home' disciplines, writing is at the forefront as part of content. It signifies. However most social science research has little time for the erotics of writing. It's about 'reporting', 'describing', 'explaining', 'analysing'. It's writing 'about' sex. Even so, I share with the best of social science an interest in social theory, including sex theory, and I enjoy writing non-fiction. In the dark years of the late 1980s and early 1990s, as the death rate from AIDS soared, I sought consolation in writing. I wrote in part about sex and love, in a collaborative effort with Jan Hutchinson, and together we co-authored the mix of essays and fiction that became *TwoTiming. Sex, writing and the writing of sex*.

Then and Now. Gay Men and HIV differs from both *TwoTiming* and the standard research report. It contains no fiction, and does not focus on the presentation of new 'data', as distinct from researched understandings of present tendencies. For the room to do this, I am grateful to Professor Marian Pitts, Director of ARCSHS.

Throughout the 1980s, as HIV affected what seemed like every aspect of gay life, I maintained a steady focus on gay cultures, documenting and discussing gay and lesbian writing and how gayness, lesbianism and sex might be written and represented (Hurley 1990, 1991b, 1996a). It's an interest I have maintained, even as I was drawn into much closer consideration of HIV and its effects. I first spoke and published directly on HIV and AIDS in response to a report from the NSW Upper House Inquiry into medically acquired HIV, with the encouragement and support of Ken Davis, then an educator at the AIDS Council of NSW (ACON), and my colleague Dr Jeannie Martin at the University of Technology, Sydney. I wanted to find a form of writing and analysis that put the voices of people living with HIV at the centre of what was being said (Hurley 1992).

It was about then too that Gary Dowsett encouraged me to apply with him for a Commonwealth AIDS Research Grant, and it was after a session reporting on the research to a Commonwealth workshop (Hurley and Dowsett 1994) that the Director of the National Centre in HIV Social Research, Dr Susan Kippax, invited me to be the plenary speaker at the Centre's annual conference in 1994 (Hurley 1995) and was instrumental in my invited presentation to the Biopsychosocial Aspects of AIDS conference in 1997 (Hurley 1997b). In 1995, at the invitation of Greg Millan, then Manager of the Gay Men's Education unit at ACON, and with the aid of an Australia Council grant, I became Writer in Residence at ACON. There I renewed acquaintance with Ross Duffin who in turn invited me onto the Campaign Working Group of the Gay Education Strategies Project at the Australian Federation of AIDS organizations (AFAO 1995b). I began what has become a close, ongoing engagement with the production and evaluation of HIV educational materials.

I am describing my trajectory in these years for other reasons as well. Firstly, it is generosity, intellectual collegiality and an open hearted mutuality that I am remarking, as well as a close relation between myself as a researcher and writer, other researchers and HIV education. Secondly, for much of this time I wrote and spoke on grief. I had been somewhat disconcerted by one reviewer of *TwoTiming* describing it as imbued with a 'gorgeous melancholy'. It was the 'gorgeous' that shocked. I knew about the melancholy. I subsequently began what became a long consideration of grief and its

effects (Hurley 2001c; 2000; 1998a; 1997a; 1996b; 1995). That grief affected sex and love I had no doubt, though the how has always been harder to analyse. Understanding that grief was an early instance of virtual reality came as more of a surprise. It became more obvious after the death of Princess Diana.

Lumby has discussed the virtuality of grief this way:

> The global mourning for Diana, then, might better be understood as a collective mourning for authenticity - a public recognition that the social can no longer be readily separated from its representation and circulation in popular culture, that there is no obvious place 'outside' the transparency machine of global media and that lines between the private and the public are no longer clear.
>
> To argue the above is not to argue that the social no longer has 'real' effects. It's to suggest that our experience of the social is now fundamentally tied to the fact of its representation. The phrase 'global mourning' keys us in to this shift. Mourning, in Western culture at least, is regarded as quintessentially personal expression that indicates an intimate relationship to the deceased. A global mourning makes no sense in these terms because it necessarily implies a response to a mediated event. The fact that millions of people responded to Diana's passing as if a close personal friend had died is a strong indication that the media and its casts of characters have passed seamlessly out of the virtual and into the real. (Lumby 1997)

We can query the ‘seamlessness’ of the virtual and the real, but in the process we have to face what I see as the core of Lumby’s analysis: ‘the social is now fundamentally tied to the fact of its representation’. Following on from this, we might also say that what died with AIDS was the notion of an authentic gayness, if by that is meant a single, fixed way of being gay. That’s a painful remark, given that many gay men have died, but it’s also a way of confronting what for some is an unpalatable reality. Amongst what some of us grieved, I believe, was the passing of an innocent notion: the promise of gay liberation, a promise of what might have been (Hurley 1996d). New forms of gayness have emerged.

In the mid 1990s, national HIV educators were being continually accused of imposing the Sydney epidemic on the rest of the country. This claim had two parts. The first was that the resources produced were not appropriate for many of the local clientele. The resources allegedly projected 'inner city gay', as though gay and community were the same wherever one went. There was some truth in this claim, but it was ever complicated by the fact that more than half of the people living with HIV in Australia lived in inner city Sydney. Sydney was, and is, the primary site of the Australian epidemic. The second was more puzzling, and seemed contradictory. Along with the claims of Sydney-centricity were descriptions of severe epidemic affect in locales with low HIV prevalence and few deaths (Darwin, Adelaide). When asked who they thought of amongst the dead, the names given were almost invariably part of international popular culture – Freddy Mercury (from Queen) and Rock Hudson were common examples.

Later investigations of local 'communities' did indeed identify differences (McInnes *et al* 2001a), and from their work I have taken since the concept of 'doing gay'. Before that though, I puzzled over the emotional virtuality of community and grief, beginning to link them with the media circulation of gayness and AIDS (Wilding 1998). Initially, I muddled what was happening, first conceptualising the relations in 1995, wrongly I now think, as 'a sentimental narrative' (Hurley 1996b), rather than understanding them both separately and together as effects of a globalised media system and new media technologies that have qualitatively changed the possibilities for 'doing gay'. The connections between these possibilities and their effects on how gay men relate to HIV are still barely understood, notwithstanding the burgeoning body of work on film, the internet and the globalisation of sex (Altman 2001).

In 1998 I left UTS and went to work briefly for AFAO, before being hired by ARCSHS to become Researcher in Residence at AFAO. In that role, as a researcher of HIV treatments education, I investigated *inter alia* the media's place in HIV treatments cultures. Out of that research came the concept of 'culture of care' as a way of analysing the social relations developed by people living with HIV and AIDS (Hurley 2002a). This period also involved close collaborations with the National Association of People Living with HIV/AIDS and the Australasian Society for HIV Medicine. I had turned my attention to the implications of media relays for HIV health promotion amongst gay men, the role

of HIV positive people in creating quasi-clinical social spaces and to treatments as a social rather than only medical technology.

I might also say that this trajectory of collaboration and intellectual collegiality was also deeply affected by what it meant to live and work in close proximity with HIV positive people, mostly, but not all, gay men and lesbians.

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'Then and Now' is a response to the ways recent increases in HIV notifications have been reported and discussed. As a whole, it invites consideration and reflection, seeing in them the grounds for informed program development. I'm well aware that people are busy and want quick, easily digested answers. In that sense, I am writing against the grain. I'm writing from a position that puts a premium on the long term sustainability of the social relations that are the bedrock of safe sex cultures.

Here I consider what HIV social research and community-based health promotion have taught us that might be of relevance now. I have broken these considerations into four parts:

I. Strategically positioning the present
II. Doing gay
III. Sex, intimacy and love
IV. Gayness, health and education

In western countries, narration of the self through sexual identity (not sex, note), and the narration of sex through health, while not particular to gayness, do have gay specific effects. 'Then and Now' discusses gay men, sex, love and HIV from several angles: how doing gay is thought about, public health as protection of populations, and health promotion as practiced by community-based HIV educators. Together they constitute a strange matrix in which gay men, sex and a virus appear and disappear, sometimes together, sometimes separately, sometimes as glorious, other times as potentially riddled with disease. My interest here is strategic: how is gayness thought and what

forms of gayness become unthinkable[2], where does sex play out in this and what are the implications?

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'Two months ago a man rimmed me for the first time.
You had to peel me off the ceiling,
what a sensation!
All I knew was that I wanted to sit on his face.
I would have loved for him to fuck me.
Doing what he did really opened me up.
I would have loved his dick up my arse.'

(Bartos *et al* 1994)

***

I. Strategically positioning the present

Safe sex practices emerged before scientific confirmation that AIDS was caused by HIV, before a test for HIV was available and before government funding for community-based, HIV education. Gay activism installed safe sex cultures. At the moment it did so, much of lived gay experience was being defined by the threat of strange diseases that rapidly resulted in horrible deaths. The earliest responses were to what was first called GRID (Gay Related Immune Deficiency) then AIDS. It's not my purpose to be nostalgic about either mobilisation or safe sex cultures being driven by those affected. Rather, I'm

[2] Though 'gay' is often used in tightly delimited ways for much social science research, in other contexts it is a highly mobile concept. In almost all my major work on lived cultures of same sex desire, I have written inclusively of men and women, see, for example, the Introduction to Hurley 1996. In this publication I am focussing on gay men, but from a point of view critical of identity politics. I see 'gay' when used of men as inclusive of same sex desires, various gender inflections including gender disruption, and politically as 'a constituency of shared interests in relation to the workings of police, state and other institutions of power' (Watney 1987: 25). This is not the same, however, as automatically assuming the need in every circumstance for political coalitions based on multiplication of sexual identities (GLBTI). I've always liked Watney's understanding of 'community' as an umbrella term that allows us to make demands on the state but tells us little about desire (Watney 1987: 24-28). If we begin there, then the field of same sex desire and its regulation can be characterised by productive engagements with indeterminacy as well as by political necessities.

drawing attention to how safe sex cultures were constituted and then to what has changed since then. Firstly, safe sex cultures were not just a set of sexual practices developed in response to a virus: "for gay communities safe sex culture and gay culture are inextricably entwined" (Dowsett 1996a: 69). Secondly, safe sex culture is a gay culture originating in, but no longer defined by, or for many 'experienced as', a response to HIV/AIDS. This is the phenomenon known as post-AIDS (Dowsett 1996: Dowsett and McInnes 1996b). For many, safe sex is arguably an aspect of doing gay, rather than something done in the name of health. Consequently, there are strong tensions between biomedical and population health priorities and community-based health promotion driven by gay social and sexual practices.[3]

These tensions are evident in the work included here. They are perhaps magnified as I write because of my strong sense that the core lesson of the response to HIV in Australia is being progressively diluted: affected communities are at the heart of an effective response. They are magnified too by my own refusal to narrate gay only in relation to HIV or to health more generally. As I shall indicate later, there is some evidence to suggest that those forms of health promotion governed primarily by the moral imperatives implicit in some biomedical public health practice rather than by the diverse needs of lived gay cultures are antithetical to those cultures and to HIV prevention.

While the position I am creating is challenging politically, it's not idiosyncratic, either in Australia or overseas. Nor is it particularly new. Though the arrangement of public health is quite different in the United States, there have been some similarities in the tensions over sexual practice and safe sex. Sean Strub, for example, a columnist in *Poz*, argued in 1999:

> When Michael Callen, Richard Berkowitz and Dr. Joe Sonnabend wrote *How to Have Sex in an Epidemic* in 1983, they were viciously attacked. Critics charged that their information -- and their invention of safer sex -- encouraged gay male promiscuity and exposed an unattractive side of gay male culture. Today, few

[3] Sexual practice is enormously powerful conceptually as a way of understanding the sociality of sex: 'a kind of practice through which living bodies are incorporated into social relations…[and] the politics of transactions between embodied persons' (Kippax *et al* 1993: 46).

would argue that the booklet's risk-reduction message saved many thousands of lives.

….

Many do not live by the condom code and -- short of enduring the mass deaths my generation endured -- they never will. To reach these men, activists in cities nationwide have worked to develop a new model -- nonabsolutist, nonpanicked, nonjudgmental prevention that focuses on community building, sexual empowerment and harm reduction. Negotiated safety -- such as "bareback" sex between two same-serostatus partners -- is an essential aspect. A just-released Australian study shows that this strategy is far from 100 percent successful, but still an improvement on a one-size-fits-all, "just say no" approach.

The tragedy is that my generation of AIDS opinion leaders denies what these younger men say they need while holding tight to prevention dollars. For the most part -- GMHC's harm-reduction program is a rare exception -- we've persisted in throwing money at increasingly ineffective campaigns designed for a different era. And we've forgotten that **disapproval of barebackers' behavior has no more relevance to how those funds *should* be spent than does the disapproval of homosexuality, teen sex or IV drug use**. (Emphasis added)

I have quoted Strub at length for a number of reasons. Firstly, his identification of safe sex cultures as a risk reduction response is still timely, even though it was originally risk reduction in a context where it was not known that the cause of AIDS was a virus. It is timely, because it links risk reduction to the ‘livedness’ of responses and puts HIV education in this context. These responses are not produced by educators or researchers, even though they ‘name’ them. Secondly, though it is framed in terms of community building, Strub’s comments are an example of an historically and socially informed ethics of mutuality (Race 2002a,b). Thirdly, Strub understands that moralism provides no basis for health promotion. Finally, he makes explicit the ways post-AIDS plays out for some ‘younger men’. That he also misrepresents Australian research by confusing negotiated safety and a non specified context of ‘barebacking’ is a major problem. I suspect I need to make it very clear for the wilful reader that I am not endorsing unprotected anal sex in casual contexts. Like Strub, I do argue that **framing all unprotected sex as unsafe undercuts good HIV health promotion**

A similar position was put earlier by Duffin in Australia when changes in the rate of unprotected sex became visible:

> *Blaming educators or negotiated safety for these changes (in rates of unprotected sex) shows a staggering inability to think about complexity and ever simplifies needed responses.* (Duffin 1997: 2)

Researchers were also flagging the challenges:

> *[F]or our peers have passed us by. This far into the epidemic knowing what we know now must lead to the conclusion that these endless refinements of safe sex strategies are inevitable. This demands that educators think ever clearer thoughts ... educational credibility is seriously at stake if we simply re-assert some outdated notions of bottom line safe sex for all, some incorrect assessments of risk, and demonstrate thereby a failure to keep up with the changing epidemic.* (Dowsett 1996b: 71)

> *[HIV positive] men are actually making decisions long before any sort of educational strategy is developed.* (Prestage 1996: 91)

In the meantime the population of people living with HIV has changed in certain key ways. It still overwhelmingly involves gay men and the median age of new infections hovers at about 33, and there is a significant group aged 30 and under - something like 30% of people with HIV. In addition, as far as I can work out from available surveillance data, about 20% of people diagnosed with new HIV infection were infected from about 1995 onwards.

There have been increases in HIV infection in three Australian states (NCHECR 2003). It might seem dangerously perverse then that I continue to assert the presence of an ongoing dynamism, adaptability and creativity in Australian gay safe sex cultures. This assertion is accompanied by the recognition that aspects of those cultures are fragile and pressured. Two key factors in assessments of fragility are firstly rates of unprotected

anal sex between sero-discordant men, especially where one participant is known to be HIV negative and the other of unknown HIV status, whether in casual contexts or with regular partners. The second factor is the decline in treatments uptake by HIV positive men in the face of side effects.[4] These factors can interact. There is some chance that so-called community viral load is masking some increases but even so any masking effect is not obvious[5]. As Van de Ven *et al* (2002a) have argued of strategic positioning (risk reduction during anal sex by the minority of sero-discordant gay men practicing unsafe sex), we appear to be dealing with complexity not complacency.

One of the aspects of the earlier, crisis driven response was its capacity to mobilise 'community' in support of safe sex. For the first ten years, HIV education proceeded on the basis that all unprotected sex was unsafe. Unprotected sex, however, stayed present in some of the practices that made up, in Dowsett's phrase, 'the *ongoing* sense-making exercise' that is safe sex culture (1996a: 23. Emphasis added). Sense-making was, and is, a collective, dynamic social practice. It's a long argument, and one I can't detail properly here, but I would argue that the response to HIV 'made' the organised 'community' in Sydney and Melbourne. By 'made' I refer to its construction organisationally and politically, and the kudos that came with the exercise of social power. This 'community', that was to feature so centrally in subsequent research, was forged out of, and by, nascent community-based organizations (Gay Rights Lobby, Mardi Gras), movement activists and activism, gay media and a rights aware clientele from the social and sexual 'scene' (Johnston 1981;1983).[6] The result was a highly powerful, rolling accumulation of social capital and capacity directed toward self defence and against social hostility. The media hostility unleashed by the death of the three Queensland babies from contaminated blood produced an embattled defensiveness (Altman 1986: 185-186; Willett 2000) that further fed solidarity and collective responses.

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[4] Figures on uptake vary between different studies. See Grierson *et al* 2003:15-16 and Van de Ven *et al* 2003: 6.

[5] "(T)he dynamic between interventions which may decrease HIV transmissions such as combination ARV treatment or vaccines, and changes in risky behaviours, which may increase HIV transmission, is complex and not easily predictable" (Law 2001: 99)

[6] Basically, I'm arguing that in effect the HIV response consolidated community formation, as distinct from initiating it, and that it did so in relation to movement, the lived culture and the scene), and that social research reinforced this formation. In that sense, I disagree with those who argue that community was strongly formed before HIV. See also footnote 10. Pre-AIDS discussion of the shift from ten years of civil rights and 'movement' politics to 'community' as a politics can be found in Johnston 1981.

Safe sex became culturally normative. Safe sex culture was, as Dowsett says, ‘an intelligent reading of gay sexual activity’ (1996a: 79). It often wasn’t recognised as such publicly. Ongoing vicious gnorance amongst public figures didn’t help, as Fred Hollows demonstrated in his attacks on gay men and the national AIDS strategy in 1992 (Willett 2000).

Neither community nor community attachment strategies, are irrelevant today, but they are less powerful because they have more limited salience for the ways men do gay. Structures, social relations and forms of association are all changing (Grierson 1999). Their development is ongoing, just as it was in the initial response to HIV and AIDS, and just as it was before the arrival of HIV (Altman 1972, 1979; Reynolds 2002c; Wotherspoon 1991).

Once the detailed social research began to emerge in the later 1980s, tying safe sex to community attachment, both research and HIV education had an added rationale. I return to this research shortly.

Several comments might be made about this brief account of the first ten years. Firstly, it makes visible the ways fear of the virus made safe sex a ‘forced’ choice. The force was always simultaneously biomedical and socio-political. Secondly, safe sex culture and its associated sexual practices are pressured by the link between community-based, safe sex advocacy and the results of HIV social research. Thirdly, at the end of the 1980s, sex continues to be shaped by a well founded caution in educational response. In the face of pervasive, visible mortality and morbidity, and ongoing surveillance of how gay resources could be, the situation could hardly have been otherwise.

There was no real question, up to this point, of most HIV positive people being ‘out’, though events at the Third National HIV conference in Hobart during 1988 were to change this rapidly (Ariss 1997; Barry 1998). Nor was ‘disclosure’ necessarily supported, even inside AIDS Councils. In a way the problem for HIV positive people then seems eerily similar to some of what is being said today in public health: ‘All I became was a person who could spread HIV and hadn’t I better remember that’ (Duffin 1990).

Implicit in much of what I say below is that the concept of a sero-divide between HIV positive and negative gay in 2003 has limited general explanatory purchase on how HIV positive men are living gay post-HAART, as distinct from specific health implications. There was considerable initial hope and caution around the possible effects of HAART (Brotherton 1997; Brotherton and Duffin 1997;Keenan 1997), a caution that has continued in the face of side effects and resistance (Batrouney 2001). However, whatever else has happened, rates of morbidity and mortality did drop dramatically. Some HIV positive men have celebrated this (Honnor 2000; O'Donnell 1996). Many of the men who have benefited from treatments live out their lives without their HIV status dominating everyday life. Pill taking routines, side effects and experiences of illness, what happens in social networks and disclosure in sexual situations all complicate this remark, as do major questions of poverty. Bartos and McDonald's work on HIV identities (2000) made clear however that these matters are dealt with in several different ways amongst people living with HIV. For some negotiating this has been more than a little conflicted, as indicated in Grierson's work on relations with HIV community:

> I want to stay aloof from all this sort of thing to some extent cause I don't want to get into a morbid sort of frame of mind. I don't want to be hanging around with other people who are focusing on the symptoms and illnesses. I don't know how to deal with that because at the same time I don't want to feel like I'm disdaining people who are ill. I don't want to sort of think, ah well I'm not ill so I'm not going to have anything to do with you poor sods who are. … If I was constantly associating with … a group of positive people, I might start getting to that sickness mentality you know. (Grierson 2001)

Discussions of emergent formations have focussed on clinical relationships to treatments and on the relationships between HIV identity and ways of living with HIV. These shifts sometimes signify that it is illness that is becoming the focus, rather than an HIV positive diagnosis (Willis 2002). Men 'do' gay and 'have' HIV. It's educationally challenging (Canavan 2001). The concept of being a PLWHA has a political history that has been significantly reconfigured in a health policy environment that focuses on individuals as health consumers. Together with a privatising of HIV experience into the clinic, and a

shift in gay cultures to post AIDS perspectives we have seen a renewed focus amongst people living with HIV/AIDS on their wider quality of life.

To say this is not to set up another divide, that between positive men living well and those who are ill. In a discussion of how unhelpful notions of crisis are HIV Health Policy Analyst Kirsty Machon puts the point that the question of whether there is a crisis for people living with HIV:

> Implies that without a 'crisis', you somehow don't have a problem. Without a 'crisis', there is apparently no reason to be working in HIV, providing services, encouraging research or providing information about HIV treatments. (Machon 2001: 134.)

It's fairly clear in Australia at least that for some HIV positive gay men the period of improvised optimism that has come with HAART, and has required a re-configuration of education and care and support services, has left them feeling as though community no longer cares. Their sense of 'belonging' has come often from AIDS activism, advocacy and cultures of care, as well as from being gay. Secondly, when gayness itself changes, when the experience is middle age, whether HIV positive or not, then the places and processes in which one experiences 'belonging' are suddenly not what they once were. They have become for some anxiety producing unknowns. Thirdly, and this is the hardest for some of us to accept, when the lived experience of gayness is primarily mediated by media relayed, commodity relations rather than a forged political bond then the terrain on which 'belonging' can be now thought is, on first sighting, unrecognisable. The consequence is that sometimes we hang-on to the old, fear the future and are prone to experiencing the present as only frustrating.

The issue is not one of denying that 'the modern lesbian and gay scene is on the whole a remarkable *achievement*, of the greatest complexity' (Watney 2000: 17), but of understanding that commodity relations have re-written the experiences of clubland, the scene, doing gay and HIV identities. It's not a matter of being vulnerable to 'blood-sucking corporate interests', but of understanding that the social spaces in which one publicly experiences gayness are overwhelmingly commercial (Mort 1996). This began

emerging at the same historical moment as HIV and AIDS called for enormous political effort. It's an extraordinary 'moment'. Because, right when we want to refuse 'making commodification a general metaphor for contemporary culture rather than a specifically delimited form of historical relation' and right when we want to 'assert the extent to which non-commodity relations have been central to recent historical development' (Wark 1992), we are forced to acknowledge that both processes are occurring simultaneously, and that one is dominant whether we like it or not. Gays and lesbians have never been in this position before. It further impacts very heavily on gay men living with HIV when the tension between these two processes are intensified by treatments uncertainty.

A political analysis based primarily in experiences of both gay liberation and the last twenty years of AIDS politics by itself doesn't let you understand how much the possibilities of gay sociability have changed. If you are thirty now, gay liberation was over when you were ten, and awareness of HIV was a condition of coming out at twenty. The relation between these possibilities, and sexual practice has implications for safe sex cultures. Sex is not necessarily any less pressured, but the experiential context of it has changed (McInnes and Dowsett 1995: 26).

Some of the detailed processes involved here became visible by 1990, more so, but not only, for HIV negative men.

In 1990, Vadasz and Lipp published extracts from interviews with fifty gay male couples. They organised selected quotes from the interviews thematically. Some quotes indicated how men were experiencing pressure inside relationships - 'I found it frustrating because we were in a relationship and *still* had to have safe sex' (56) - and the choices some HIV positive men were making:

> It's up to them. I don't think I should be the one to say 'OK, well put it on', when they know the story about me. If I'm telling him to put the condom on I feel like I'm nagging him because of what I've got. (56)

This is complicated. 'Having' the virus is represented as a personal issue, and the tone hovers on resentment at the effects this has for the HIV positive man in the relationship.

Knowledge is shared – 'they know the story about me' – and there is a refusal of sole responsibility for safety – 'it's up to them'. The notion of 'shared responsibility' implicit here is not reduced to disclosure. Disclosure becomes the beginning of an ongoing, sometimes conflicted incorporation of knowledge into a relationship, a social practice.

The quotes also showed HIV negative gay men in intimate relationships trying to force a distinction between unprotected and unsafe sex within their choice of partners with the same or unknown HIV status:

> When Darryl and I first started to have sex together – it was first of all safe sex for about the first three times we met and then something else started to happen and we paused and we thought 'What the hell'. And we felt so close to each other, so much for each other that I actually said to him, '**If you've got it** then I'll be quite happy to have it too (57, emphasis added).

When rereading the groundbreaking work of the Social Aspects of the Prevention of AIDS research project (SAPA) (Kippax *et al* 1993; Dowsett 1996a), I'm *now* struck by how obvious it is in the data that gay men would, if they could, seek a way round the virus. All the clues are there in the persistent presence of withdrawal, only 'topping', and not using condoms. It is also apparent that some gay men also engage in wishful thinking. The ongoing rate of HIV infection tells of the riskiness in these practices. Neither fear nor being informed were stopping unsafe sex.

Biomedical public health and some health promotion continually falls back into a position that understands these practices unidirectionally, as ill informed, rather than as multidirectional *dispositional*, acts. Duffin long since indicated other possibilities when he drew attention to infection amongst the highly informed (Duffin 1996: 5). The health beliefs model in which beliefs are connected to simplistic models of behaviour and behaviour change is very difficult to shift. It seems to promise answers, and people go with the promise time and again even after it is broken over and over. The key problem for this model is that well-informed people become infected. Once HIV was identified, and knowledge of it became widespread, **HIV infection amongst the knowing could no longer be understood only in terms of a fixed notion of base-line information or**

knowledge or attitudes or beliefs. Other concepts and ways of thinking are needed. One of them that is useful is Bourdieu's notion of 'dispositions'.

Dispositions are practiced ways of being. They generate ways of doing things and forms of interaction with other people. They encompass intentions, self-reflection, predisposed structures of thought and feeling and how social narratives are used as resources. This is an element in the conceptualising of the social aspects of 'practice' and part of what marks the concept of 'practice' out from 'behaviour'. Practice and behaviour are not synonyms.

I'm using 'dispositions' here as a way of focussing on the present, without forgetting the past. Too often historical accounts disappear the present by making it *only* an effect of the past.[7] The consequence is that we cannot understand what is happening and we look perpetually backwards not forwards. Disposition allows for an active looking forward that acknowledges the present is made up of different times. As Raymond Williams suggested, the present combines residual, dominant and emergent trends and structures (Williams 1977; Hall and du Gay 1996).

The current moment is 'new' in the sense that emerging trends in doing gay are changing the mix of social relations. At the same time, increased HIV incidence probably remains largely an effect of residual and dominant social trends. However, my sense is that we are seeing also a dispositional shift in relation to the risk of infection that cuts across these trends.

Dowsett (1996a) framed some of the SAPA data involving 'the assessment of the safety of sex practices' in terms of 'experience':

> For many practices, the least experienced underestimate the safety, and possibly restrict the range, of sexual activity available to them; the most experienced underestimate the risk of practices they are used to. (78)

[7] A point first made forcefully to me about the perspectives of young gay men by Aldo Spina, then an educator at ACON.

This is still, I believe, absolutely salient today. We have to face, however, what seems to me blaringly obvious. In the case of 'the most experienced', it's about dispositions that include knowledge of 'risk' but don't make it definitive in what is done sexually at any given moment. It's not so much a cognitive 'underestimation' as the effect of how HIV is positioned dispositionally. This is what I was gesturing at with my opening remark in the thematic overview that the risk of HIV infection has become abstract.

In effect, post-AIDS now relates not just to the decentering of HIV in relation to how many men do their gayness, and their active distancing from epidemic affect, but to the decentering in some men, at least at some times, of the significance of HIV infection. At a population level, this can be an effect of both active distancing from HIV and close association with it. So there is both 'strategic positioning' in casual sex as a way of assessing and reducing risk amongst the 'knowing' population, and a range of other dispositions amongst the 'least experienced' that involve high levels of risky unprotected sex. It would appear that 'safety' in both cases is configured dispositionally in relation to other considerations that can't be explained cognitively.

I'm not ignoring the shifts in the kinds of information involved in sexual practice (Rosengarten *et al* 2000), nor the ways in which knowledge is positioned when safe sex is socially individualised (Race 2002a, b). There are multiple clues here, I believe, into why the mean and median ages of new infections are creeping upwards. The men we know to be most informed and probably most 'affected' by the epidemic are still becoming infected. There is an openness to the possibility of infection in their practice, even where that's not their *intention*. Does this also link to decreasing social attachment and sexual opportunity consequent on aging? Perhaps, but it also relates to all the unexplored factors that result in what becomes in the research 'strategic positioning' and simple unsafe sex.

Initial workings out of safe sex cultures were marked by 'rapid generational change' amongst existing layers of gay men (Dowsett 1996a: 21). How is it we have not spoken of why this capacity for innovation wouldn't continue as new layers of gay men emerge? It's gayness they emerge into experientially, rather than 'epidemic affect' and they are not pressured socially or sexually in the same ways as in the 1980s. The 'context' of

'experience' has changed. I will return to these issues shortly in relation to 'emerging', aging, friendship and 'attachment' and raise the possibility that the social relations constitutive of earlier safe sex cultures have changed.

The discussion so far puts the focus on the social aspects of sexual practice. There is a tendency amongst proponents of social marketing to mistake high levels of health literacy for practiced ways of being sexual. **The challenge for those engaging in unprotected sex involving risk reduction, whether they are highly informed and socially 'attached' or less socially attached, becomes one of making sex more 'practiced' or practiced differently.** I'm referring here to dispositions, not to techniques or acts as such.

II. Doing gay

Home and safety

Commodification

Anxiety

HIV Social Research

Like Rofes, I am not denying what's occurring in terms of increased HIV infection. The Gay Periodic Surveys tell us that gay men's sexual practices now involve more anal sex and more unprotected anal sex in casual contexts (Prestage *et al* 1999; Hull *et al* 2002). The social research on 'casual' sex indicates informed improvisational capacity, high levels of self care, degrees of risk taking and unsafe sex (McInnes *et al* 2001b; Van de Ven *et al* 2002a; Willis *et al* 2002a). Rates of testing and condom use remain very high (Van de Ven *et al* 2002b). HIV positive gay men continue to build cultures of care that are mainstays of HIV prevention (Hurley 2002a).

It's how what's occurring is understood that's at issue. I want to keep the long term sustainability of gay sociability and mutuality at the forefront of discussion, health promotion and research. I use the plural 'cultures' because it's empirically true that there are several kinds of gay culture and varieties of safe sex practice (no anal, 100% condoms, negotiated safety). There are also as well as degrees of risk taking with

unprotected anal sex in casual contexts (strategic positioning) and ongoing unsafe sex. It's a mistake, I believe, to link these practices too tightly with sub cultures or groups. They are tried on by the same individuals in different contexts, in closely followed moments and with shifting dispositions.

We need to sharply consider plurality, differences in ways of doing gay (McInnes *et al* 2001). Ways of doing gay are affected by opportunity, locale and social density, but they are also dispositional. Sometimes they are associated with quite different ways of constructing 'safety'. Some ways of doing gay construct safety only in classic safe sex terms: through an understanding of sex and risk of transmission. Other ways of doing gay construct 'safety' in relation to gayness, rather than specifically to sex. These ways of doing gay are becoming more visible, are arguably increasing and play out in a media culture that is marked as much by the active political calculation and brokering of caution as it is by sex and/or pornography. These calculations can be seen amongst active watchers of television, as seen in these examples of viewers' discussions of the U.S series of Queer as Folk in Australia.

We need to recall firstly that the original British series circulated as video and DVD, after it could not get Australian television distribution. Secondly, the opening line in the U.S series is: 'The thing you need to know is, it's all about sex'.

> Blog 1: Yeah they do cut quite a few frames here and there, i came to the conclusion its usually frames that show full body sex shots. It is silly, because, like it was mentioned earlier, if ppl are watching the show, then they're not going to be bothered about that sort of thing. Another thing they cut, quite a lot was the pilot episode. There was a whole "rimming" scene and some dialogue that they cut between B and J. I think this is why it's taking so long for the DVD's to be released in Aust, because they're thinking about what to edit etc, if anything. (http://oz-expression.nu/forum/viewtopic.php?t=104. Posted: Wed 23 Apr, 2003)

> Blog 2: What they seem to be doing is removing all the man/boy "in your face" shots. Most of the "telephone" scene was close ups of Justin or Brian, or the "over Brian's shoulder" shots. The full length shots of Justin lying on the bed, with

> Brian sitting on him were almost completely omitted. They do seem to have done quite a skilful job. I didn't even remember the missing dialogue in the telephone call, until I compared my tape and the DVD directly. Anyway, if this is the price we have to pay to get exposure across Australia, then I think it was an "acceptable" compromise...Just remember this is on broadcast television, not cable. (http://groups.yahoo.com/group/Queer-As-Folk/message/9007)

The blogs indicate the range of opinion: 'it is silly…' and 'if this is the price…'. They involve competing estimations of what it is possible and desirable to represent in a media relayed public sphere. In this discussion, commercial media regulate both the link between sex and doing gay and the brokering of caution. In health promotion, HIV is the link between sex, doing gay and the regulation of caution. At issue is what can be represented in the name of gay sex.

> *Mediascapes refer both to the distribution of the electronic capabilities to produce and disseminate information…and to the images of the world created by these media…What is most important about these mediascapes is that they provide…large and complex repertoires of images, narratives and ethnoscapes…in which the world of commodities and the world of news and politics are profoundly mixed* (Appadurai 1990: 9).

The quote from Keogh that opens this essay comes from his paper, 'How to be a Healthy Homosexual'. For those 'in the know', the title echoes a line from another time and place, the film *Boys in the Band*: 'Who was it that always used to say, 'You show me a happy homosexual, and I'll show you a gay corpse'. Keogh rewrites the original words, replacing 'happy' with 'healthy'. This shifts the melodrama of the original context, refuses the *faux* distancing device - 'who was it used to say' - and gives the line a mischievous twist, pulling it out of a sense of what was, and what might have been, into a knowledge of what HIV has meant for ways of living gay. Keogh's title though has more than one sardonic edge. While the title refuses the long face of tragedy by dosing it liberally with wit, his argument is that health promotion has installed new ways of being gay. Rather than understanding health promotion as telling gay men what to do, Keogh says it tells

gay men how to be. The argument is ambivalent about the necessity and force that give health promotion this power.

The notion of ‘making’ homosexuals resonates in popular gay cultures, separately from its appearance in social research. One example was that given in the earlier reference to Quentin Crisp and the notion of gayness being as ‘practiced’ as an art form. Another is the toilet wall graffiti that went ‘my mother made me a homosexual’ and the response ‘if I gave her the wool would she make me one too?’ I note in this quip the parody of po-faced versions of psychoanalysis and the lightness of deflection into the field of camp: ‘origins, who cares, it’s just knitting’. At which point round the bar or dinner table someone breaks into ‘is that all there is’. Keogh’s title in that sense has a fine feel for the ‘through line’, linking homosexuality then with a particular narration of gayness now, in the tradition of sharp wit. Other lines in the film come to mind: "One thing to be said for masturbation; you don't have to look your best." I can see it on a health promotion poster, but chances are it wouldn’t be approved.

Many gay men dislike this knowingness that requires an immersion in what they see as an imposed ‘gay’ or ‘camp’. For them it’s an historical leftover that excludes. Others want doing gay to be normal, a sub variant of masculinity, ring fenced from feminine contamination, but enabling of domesticity, design and dick.

That desire is one thing, living it out is another. None of masculinity, love, monogamy, and normalcy are proven predictors of safe sex, whatever other forms of social ease (‘safety’) they provide.

Oh yes, and ‘making’ it as getting laid, lifting the shirt, dropping the Calvin’s and taking it. Oh sorry, I thought you said you were versatile. Of course, I’ll come home. Do you live far? It’s better at home.

What we see is another negotiation of caution in which pressure is negotiated in relation to sexual possibility.

Home and safety

Home for some becomes a safety zone where disclosure of HIV status means ‘it’s alright not to use condoms‘ or condoms are ‘made’ irrelevant or where ‘I’m safe in my own bed’ or where.... ‘Home’, as in the first six months of a love relationship between men of different or unknown HIV statuses, is a proven predictor of new HIV infection.

There is nothing new here. In the early 1990s, though the incidence of unsafe sex at home varied between studies (Dowsett 1996a: 82), it did occur at home, rather than at sex venues, and it often involved younger men, men who are now in their thirties.

What has it meant to live over time in the face of disease and negotiate difference?
What have been the effects of this on sex, love and intimacy?
How is gayness done now by those heavily epidemic affected?
How is gayness done now for those less or not affected?

There is no surprise in the place ‘home’ holds. Once positioned as just another minority, gays share many social relations with the majority. A current characteristic of late capitalism is, as Delany notes, a particular defensive deployment of ‘safety’:

> Over the past decade and a half, however, a notion of safety has arisen, a notion that runs from safe sex…to safe neighbourhoods, safe cities, and committed (i.e. safe) relationships, a notion that currently functions much the way the notion of “security” and “conformity” did in the fifties. As in the name of “safety”, society dismantles the various institutions that promote interclass communication, attempts to critique the way such institutions functioned in the past to promote their happier sides are often seen as, at best, nostalgia for an outmoded past and, at worst, a pernicious glorification of everything dangerous: unsafe sex, neighbourhoods filled with undesirables (read “unsafe characters”), promiscuity, an attack on the family and the stable social structure, and dangerous, uncommitted, “unsafe” relationships…Such critiques are imperative, however, if we are ever to establish new institutions that will promote similar ends. (Delany 1999: 121-122)

While I am including ‘safety’ in various ways as part of the normalisation of gay, and in that process remarking on it as a response to social anxiety, I am not suggesting that it is all that can be said of what is going on.

Though ways of doing gay may be affected and constrained by the availability and relative density of social, political and sexual opportunities, they are also to some degree matters of choice. That is, locale (inner city, suburban, small city, regional and rural), age, health, income and commitments may affect choices, but they are not necessarily determinant of them over time. People travel and relocate as well as choose to remain where they are. All these factors play out in how gay is done (Wafer *et al* 2000). They inform social practice.

The same individual may also vary his sexual practice according to sexual context. From the point of view of HIV risk and behaviour, context includes partner choice, place and moment as well as factors such as HIV status, risk knowledges, wants, needs and kinds of sex. The result is a tightly constrained behavioural notion of context. How does ‘Saturday night at 8 o’clock’’ play out contextually when the bright lights beckon or loneliness looms or eyes sparkle across a dinner table? Using the SAPA data, Dowsett has argued that the contextuality of safe sex is not defined primarily by either sexual practice or by the immediacy that is *de facto* built into the behavioural version, though both are involved (1996a: 83). Contexts are socially structured (86). We need to account for both the wider relational factors and the circumstantial (83).

Ways of doing gay include, but are not defined solely by, practices of sexual safety, sexual styles and modes of gayness.

I’m using ‘modes’ to refer to social orientations. Modes are often distinctive of different gay subjectivities such as ‘club boy’, ‘suburban’, ‘camp’, ‘non-scene’, and may be associated with different sexual styles. Modes sometimes link with sexual styles. ‘Styles’ refers to a combination of kinds of sociability, practices and contexts. Generally, the more attached gay men are to gay social and sexual venues, the more at risk they are. In the case of *some* gay men who do not do gay socially, as distinct from sexually, a form of tactical distancing from gay sociabilities becomes potentially predictive of

unprotected and unsafe sex. However, if this occurs in contexts of low HIV prevalence it may also be less risky.

Distancing has been seen in the past as involving non gay-identifying men who have sex with men (MSM) who are not generally at high risk of HIV infection, as well as less socially and sexually attached gay men whose sexual practices put them at risk (Crawford *et al* 1998; Hood *et al* 1994; Kippax *et al* 1993, 1994). The strategy has been to use education to increase the 'attachment' of less attached gay men. As indicated earlier, the question has been one of how the associated 'experiences' of being MSM, or a non gay-attached gay man involve social relations and estimations of sexual safety. What are the dispositional effects of not relating to other gay men, especially if this involves not discussing sexual safety with well-practiced friends?

> But it wasn't until we started discussing it that we became concerned. It was just something that grew on us. We didn't stop having unsafe sex, we just decided it was appropriate to go and get tested (Vadasz and Lipp 1990: 59)

> I mean I have a lot of straight friends and that's perhaps one of the reasons why I haven't heard a lot of the campaigns. And when I do it's usually through other gay friends who found out through advertising. The circle I mix with we all go to the same place usually every time every week and I suppose if you don't do that you don't get this sort of information (Jackson and O'Donnell 1989: 167)

In order to discuss these issues, we need to further consider current ways of doing gay,

Current narrations of gayness move between accounts of social regulation and their histories, forms of sociability, desire and media representation. It's this 'movement' that matters, as much as the explanatory adequacy of any one narrative site. The movement invites, enables and incites the proliferation of ways of being. It characterises a social and imaginary space in which gayness is endlessly rehearsed, produced, consumed, lived, loved, decried, hated, celebrated. Each of these actions is as characteristic of one way of doing gay as it is opposed by another – 'non-scene, straight acting seeks similar'. Sometimes, in this movement, sex appears to be everywhere and, in one sense,

because it appears to be so, it is. Gayness becomes equated with energetic sexualised image, and is 'normalised' by and in its visibility.

In a media culture, this incessant movement isn't peculiar to either gayness or sex more generally. As Catherine Lumby once wrote of the media, somewhat exaggeratedly, 'these days, everyone appears while everyone looks on' (1997: 2). We might instance: cross-dressing heterosexual footballers, sports people coming out, presidents of medical associations, T*he Secret Life of Us*, *Queer as Folk*, gay.com, the possibilities of transsexual police, *Dawson's Creek, Big Brother, The Bill*. I can hear the hawker: all demographics catered for; all images potentially desirable; all real, and requiring analysis. It's not true though that 'everyone' appears. When did you last see an Indigenous gay man on any channel other than SBS and how often was that? Chloe in *The Secret Life of Us*, played by Nina Liu, a Chinese-Australian, is the first Asian lesbian character to ever appear in an Australian TV series[8].

So one part of any analysis might be about Anglo domination, and another could be about what happens to sex in prime time[9], but however modified it needs to be, Lumby's point about appearance still has some force. That force, however, tends to be unidirectional at a global level. It is governed almost entirely by media empires in the developed world, English as the globalising language, what counts as 'news' for global distribution and film and television distribution networks.

This selective cinematography of everyday life is not only artful and seductive in its sequencing of image, it also exceeds those notions of the real which pit reality against image. From this perspective, virtuality is real. 'Images' are ontologically part of the real, but are just as in need of epistemological justification and social analysis. The screening of excess occurs not only in multiplexes. If 'real' time is characterised by immediacy and instantaneity, one of its effects is to change the nature of the 'social' (Virilio 1995).

[8] See http://www.afterellen.com/TV/thesecretlifeofus.html

[9] ' "Queer As Folk, shown on the cable network Showtime in the US, is "light years away" from the growing number of prime-time shows with gay characters, he says, because it sexualises gay men. As a New York columnist noted recently: "Most gay characters in prime time aren't allowed to be sexual. They're only gay because they say they're gay" '(cited in Kermond 2002).

> It is the *immediacy* of information itself which can create crises …Speeding up the dialogue and increasing the number of messages leads to the situation where information and noise are indistinguishable. Moments appear where the details suddenly leap out and assume a significance of monstrous proportions…rather than suffer uncertainty caused by not knowing what is going on, the markets appeared to suffer from knowing too much (Wark 1994: 204).

The 'social' becomes partially analogous to a screen. Gayness is 'screening', coming to a public health statement near you, to a sex panic near you, to a warehouse apartment near you, to an HIV survey near you.

In the west, at least, gayness, sex and love are everywhere, incorporated by some into 'the great human drama'. "The drama of it takes over from the graphic sex scenes," the programming manager of SBS says of *Queer As Folk*. "It's such a wonderfully humane story" (Lancashire 2003). In the U.S version of *QaF 2*, Justin leaves Brian, choosing love not sexstacy. In *The Next Best Thing* (2000), Rupert Everett is pitted against Madonna over child custody, and the gay man emerges as deeply caring father outside of any notion of a previously heterosexual life. Times change.

Commodification

So initially my focus is on gayness, on how it is done and the structures, which affect its possibilities.[10] It's the starting point, not risk, not disease, not health. However inevitably they are intertwined[11], gayness and health are also separable. What became clear to me

[10] Raymond Williams: 'Social forms are evidently more recognisable when they are articulate and explicit...Many are formed and deliberate, and some are quite fixed. But when they have all been identified they are not a whole inventory even of social consciousness in its simplest sense. For they become social consciousness only when they are lived, actively, in real relationships...And this practical consciousness is always more than a handling of fixed forms and units. There is frequent tension between the received interpretation and practical experience...There are the experiences to which the fixed forms do not speak at all, which indeed they do not recognise. There are important mixed experiences where the available meaning would convert part to all, or all to part...Practical consciousness is almost always different from official consciousness.'

[11] In 2001 I wrote: 'There is no sharp distinction between everyday gay cultures and health discourse. As the American porn producer Paul Morris of Treasure Island Media said in a recent interview on gayhealth.com where he was asked about barebacking in porn:

> I'm not sure that I can agree with [such] a clean and simple differentiation between "public health" and "personal expression". They're complexly intertwined. Again, the basic issue is honesty. I don't see how the "public health" of gay men can be good if the realities and practices that define us are presented through the filter of a politically determined bias.

while reflecting on these matters is that my perspective on gayness has long been binocular.

One lens indicates that as gayness eclipsed HIV it did so much of the time as a form of commodity relation in a media culture. The lesson of the gay media, products such as books and music, advertising, internet services, hallmark events (Gay Games), dance parties and Mardi Gras is that aspects of community and identity can be not only constructed through them, but also bought and sold. In some ways, the emphasis on community and the response to HIV enabled this process of commodification.[12] For example, HIV health promotion in the form of advertising has been a major source of advertising revenue for gay media, circulating selected images of how one might be gay now. Ironically, commodification has brought with it also a proliferation of possibilities in the ways of doing gay and same sex desire. The multiplication of gay characters generally and gay series on television are but one kind of example. The commercial viability of the major gay websites is another. I have engaged with this phenomenon increasingly systematically, even as I was initially shocked by it.

Commodification as a wider social phenomenon arguably has much more variable relations to individualism and non-sharing than do practices of community. Commodified relations often radically shape, even as they fragment sociality and sociability. They can reduce mutuality to economic exchange, unless actively appropriated in other ways. However, social organisations acting in the name of 'community' may also enforce shared norms, impose ethics and exclude in unacceptable ways.

The other lens was on how commodification was appropriated and responded to in everyday ways of doing gay. People resist the effects of commodity culture and use if for their own purposes as well as celebrate it. These are active processes. Some of the best

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While I have some significant disagreements with Morris, his point that everyday life is already intertwined with health discourses is unassailable. The question is to what extent we wish to intervene in cultures of everyday life and when and how we might want to do so.' (Hurley 2001b)

[12] I'm not claiming any originality in focussing on the commodification of gayness (Altman 1982; Bronski 1984). I do believe, however, that locating commodification and gayness in relation to media cultures positions it quite differently to those accounts which (a) conceptualise the media only as vehicles of messages, (b) see virtuality as separate from the real and (c) don't have an account of how 'appearance' relates to everyday life other than through vague notions of circulation, or an epistemology that mistakes visual images for 'appearance'.

HIV treatments media have contested the social marketing of HIV drugs by pharmaceutical companies, and are key elements in non-commodified systems of social support (Batrouney 1999; Batrouney and Haire 1998a,b; Hurley 2001a).

Governmentality is part of the public health and psychology literatures (Lupton1995; Petersen and Bunton 1997; Rose 1990). Strangely, there has been little crossover between the scholarly literatures of commodification and governmentality yet these literatures indicate both are major fields of subjectivity formation and are built into critical practices of everyday life: 'the clandestine forms taken by the dispersed, tactical, and makeshift creativity of groups or individuals already caught in the nets of "discipline" ' (de Certeau 1988: xiv-xv). It's in the possibilities opened-up by these appropriations of commodity culture that I see fruitful grounds for learning and intervening. The culture provides resources that are adapted and incorporated into repertoires of everyday life. This allows for a focus on practice as a site of analysis (Bollen 1999; Patton 1993). In that sense, while I have adopted de Certeau's focus on 'practices of everyday life', and his interest in 'agency' in relation to them, I do not assume or position active consumption as 'outside of' commodification or governmentality.

'Clandestine' seems an odd word to use of public commodity cultures, if we think of it as referring primarily to secrecy. That understanding, however, simply assumes that everything not immediately visible has been deliberately hidden. We can think instead of clandestine as referring at least partly to matters clouded by the 'noise' of commodity culture, as 'simply' not visible in the public sphere until made so. 'Seeing' is an epistemological act, at least when it's part of social description and analysis. In that sense, unprotected anal sex in casual contexts (UAI-c) might be thought of as one of these clandestine forms of everyday gay life. But in what senses can UAI-c be understood, if at all, as part of commodity culture, and is it clandestine? It's been in the reports since HIV social research began. That's no secret, even if it is now partly repositioned as a site of 'strategic positioning' rather than automatically defined as 'unsafe sex'.

Reporting increases in UAI-c increases its visibility, as does repositioning UAI-c educationally in a risk reduction framework. UAI-c appears to offer a hook for

intervention. It is constructed as a site of stoppable infection. That, of course, assumes that the cultures of everyday life are open to this construction. Arguably, under crisis regimes they were. Univocality (speaking with a single 'community' voice) is characteristic of a crisis response. In a post-AIDS environment characterised by a fragmentation of responses, however, neither community-based sanctioned health promotion nor public health imperatives are easily orchestrated. Whatever the reasons for increases in unprotected sex, it clearly resonates powerfully for those who institutionalise it in their practice and/or in desire for its 'promise' (Vadasz and Lipp 1990; Parnell 1993). Somewhere here we are dealing with a powerful gay imaginary, a mobile psychic space constituted as much by the symbolic as by a mix of 'practised' activity, context, momentary desires and risk taking. And finally I assume that the same individual occupies this psycho-social space in different ways at different times.

The symbolic is occasionally acknowledged as part of sexual context (Dowsett 1994: 71) in HIV social research, but it rarely gets systematically researched and has almost disappeared from view in the current environment. Aspects of my own work on cultural tropes directly address this as part of social practice. My sense is that we need to insist on, for this purpose, a sharper sense of the differences between social and cultural practices. Bartos *et a*l (1994: 67) argued that:

> Men have developed highly individual risk assessment strategies which are strongly dependent on the affective and symbolic context of sexual interactions. For example, the condom is not only a means of preventing infection, but it is also a powerful symbol of HIV, AIDS and death.

My automatic urge is to see these 'highly individual risk assessment strategies' as sharing common cultural components. Symbols, after all, are culturally coded. However, I can't assume that cultural codes 'determine' individual appropriations. So the empirical question is **do condoms symbolise in the same ways post-AIDS as they did before?**

The relations between both the threat and the culture and the community-based organisations and the culture have changed, as the culture itself has changed. Health promotion is now a social brokering agent in a different way, if indeed what is now

referred to as ‘health promotion’ was ever usefully descriptive of what occurred in early HIV/AIDS education (Parnell 1992). Technically it has more ways ‘into’ the culture, but the proliferation of ‘ways in’ is also precisely descriptive of the ways the culture is now constituted and has changed and with it the relevant social practices.

But why instance UAI-c so quickly? In what ways does this speed of focus impose emotional *reaction* as a way of seeing and doing, inviting, at best, selective reference to investigation, and in what ways is *reaction* becoming determinant of *responses* in the public sphere? How does this speed impoverish our understanding of specific practices? I acknowledge here that we need to distinguish different urgencies and pressures: those attached to infection, those involved in political management and those affecting social research.

In relation to HIV, what is public is what is surveilled or ‘disciplined’. That’s the force of de Certeau’s initial use of ‘clandestine’: practices developed in resistance to social discipline. Whether these practices areresistant or more simply an effect of lowered HIV social visibility, it’s a mistake to let the field of HIV, much less of gay, be delimited by forms of epidemiology or behavioural surveillance. The cost is too high, not just for health promotion and the containment of HIV, but for understanding the complex series of relations between gayness and HIV in this country. Altman quotes Mark Merlis illuminatingly in this context:

> we will never own our bodies again, as [earlier generations of gay men] did. We are vectors now, or vessels, sources of transmission; our bodies belong to the unseen (Altman 2001: 69).

It’s a complicated remark, even though, in an obvious sense, the ‘unseen’ is the virus. There is a passivity inherent in what Merlis says (‘vectors’, ‘vessels’), as well as a fatalism – ‘our bodies *belong* to’. Complication comes when we understand that ‘gayness’ is the vector, but in the quote the discourse of gayness has been collapsed into (‘owned by’) that of the virus and this collapse has become, for many, the experience of embodiment. ‘We’ refers to a commonality of lived experience, but it’s a ‘we’ with a particular relation to an epidemic moment. For this ‘we’, that moment

constitutes a continuous present in which gayness is always and only experienced in relation to HIV and its traces.

Fatalism and risk assessment

A fatalistic attitude operates as a moderator of a wider set of risk assessments. Fatalism will incline a man to adopt an optimistic interpretation of his risk assessments in the decision to practise unsafe sex. Bartos *et al* (1994: 65)

I would argue that the 'we' in question was formed in the period of crisis, largely in relation to the effects of the epidemic and mobilising against it. However, when it meets up with commodification, and an explosion of other ways of doing gay, all sorts of other effects become possible. When media cultures circulate ways of doing gay, these 'images' become iterations of possibility, resources for developing or extending the doing. On those occasions when these cultural and/or health promotion resources combine with notions of time that link the past into a continuous present, quite distinct narratives of gayness emerge. In one, as a result of the effect of the epidemic, gayness becomes a vector of HIV.

In this narrative, infection is 'preventable' at any given moment by interrupting or disciplining sexual practices, but the possibility of infection is also sometimes processed *in this moment* as inevitable. Subjectivities oscillate between the possibilities. In another narrative, identifying as gay becomes separable from gay forms of sociability and this is sometimes constructed as separation from HIV. Infection lurches toward being unthinkable. In the search for casual sex or potential relationships, this discourse is often coded in lists of desirable attributes: 'D/D free', meaning drug and disease free, and 'clean'. When constructed this way, this too is at least partially a consequence of gay being narrated primarily in relation to HIV.

For others, the present is not constituted in these ways, and at least in terms of a 'continuous present' hasn't been for some time. A unified 'we' is refused as analytically helpful. Merlis was writing in 1998. Dowsett and McInnes challenged this form of thinking

in 1995 in the name of post-AIDS, arguing that many gay men in Australia had stopped doing gay primarily in relation to HIV and that health promotion needed to take this on board. The Education Manager of the Victorian AIDS Council, Chris Clementson, wrote recently of those gay men who entered gayness immediately after the gay liberation generation 'to the label of vector of disease via broader campaigns like the Grim Reaper' (Clementson 2002). He was distinguishing four different kinds of 'generational' relation to the epidemic, in order to make the point that the differences in these relations have to be taken into account by those who make accusations of complacency. In effect, he saw the claim of complacency as linked to that continuous present in which the desire for a 'unified community response' was still operative. Clementson was reiterating that for many the response itself had moved on and was no longer unified. He has taken post-AIDS into practice.

Many of the recent public reactions to increased notifications of HIV occur in this tense, but with no understanding of post-AIDS. They seem unable to do otherwise, but it's not the tense in which many do gayness. In this sense, a public health 'space' is being used to pull gay men into line, by calling on a medicalised continuous present that no longer resonates with what public health imagines is a collective experience.

My point here is educational. Community-based HIV education brokers the social relations between everyday life and HIV, not the other way round. It does so in conditions of increasing diversity. In a crisis moment it's possible for community intervention strategies to 'create a continuity between existing gay community and safe sex practice' (Dowsett 1996a: 70). However, when each of the key terms –'gay',' community' - signifies changing social relations, as they now do, it's discontinuity that has to be faced. The consequent temptation is to re-orchestrate crisis to make a new 'continuity'. This kind of manipulation undermines HIV education that tries to work with the discontinuities out of respect for the lived culture and out of knowledge of what 'works'.

When the incidence of new diagnoses and infections was falling, success was attributed to the safe sex practices of gay men. The 'success' overshadowed the continual occurrence of new infection annually. As the figures began shifting upwards in Victoria,

two things happened. Firstly, the trend established over the previous ten years disappeared from surface view. This doesn't mean the long-term trend became irrelevant, rather it was not referred to. Secondly, the 'newness' of the increases became the horizon, rather than any continuousness in ongoing infection. The same gay men became problematic, and talk of success quietened.

Discussion of time and tense is informative. Three different times are interacting: the past ('crisis'), the simple present (post-AIDS, post crisis) and the continuous present (permanent crisis/pre-crisis). For analytic purposes we might say that we are in a long transitional moment involving each of these different elements of time.

The men Clementson speaks of have removed themselves generally from passivity and created an active sense of the present. Whatever their HIV status, these men arguably occupy a range of positions in relation to both gayness and HIV. Some have extensive epidemic experience, are highly gay identified and have close relations with (other) people living with HIV. Some have come into gayness after the peak of the epidemic passed and others identify as gay, but don't identify with 'scene' based forms of association. If we see these groups loosely as formations, we can also see that within any of them it is possible to mistake the decentering of either or both gayness and HIV for being removed from the vector of disease. What they share is a resistance to constructions of gay primarily or only as a vector for HIV. These removals and resistances are inscribed in some ways of doing gay, but not, it seems to me, in particularly predictable ways. The challenge for health promotion in this context simply becomes harder and harder.

In exasperated accounts of these shifting formations that focus only on unprotected sex, and then as behaviour rather than as practice, it's not hard to see a surreptitious slide to a position where sex again becomes the vector for HIV. Biologically it is, but we have just spent over twenty years establishing that it's not just any sex, it's unsafe sex that matters, and that context is all if we are to understand that sex. In two other accounts, the vector is gayness. In the first sense, that used by Merlis, the impact of the epidemic and its representation have combined to determine experiences of embodied gayness.

In the second sense, there emerge varieties of doing gay that share a refusal to centre HIV, but then split over their relation to gayness.

Anxiety

Let's return to clandestinity for a moment, and reposition it. Two forms of anxiety propel UAI-c back to the fore: fear of infection and distracted anger. The first does so in a familiar way. Known amongst both HIV negative and positive gay men as 'AIDS paranoia' it is a personalised anxiety about infection: getting infected or unwittingly infecting. The second form of anxiety is often more socially visible, though it is a very particular inflection of the first in that it produces an account of UAI-c as bad behaviour and looks for someone to blame. This second version leaves us no wiser about what anal sex means in ways of doing gay or how it might be addressed more productively for prevention purposes.

This anxiety considerably narrows and sharpens the field of response and is performed as a *distraction* (Taussig 1992:146-147). It declares the problem as already known and named. Anxiety as distraction distances us from thinking otherwise - *barebacking is the problem* - by forcing us up against a very select image of infection. We are moved, forced into its path. It poses as a logic. *Unprotected anal sex is a risk factor therefore these particular new infections are caused by the wider breakdown in protected sex.* It hits us. We are not permitted to see it coming, to observe a trajectory, to reflect. Meaning is imposed. Sentimentality is reinstalled. In a quite different context, Bachelard put it this way:

> Images that are too clear…become generalities, and for that reason block the imagination. We've seen, we've understood, we've spoken. Everything is settled. *So we must find a particular image to restore life to the general image*. (Bachelard 1994: 121. Emphasis added.)

Anxiety in this second sense is an acting out which manifests as a form of angry abuse and keeps the meanings, as distinct from the practices, unknown, by pushing them into clandestinity. Why incorporate meaning into public discourse if it involves getting your head chopped off? There are better things to do.

When anxiety is morally imposed or politically intensified, the body of the gay man and ways of doing gay are made yet again the object of a medico-moral discourse of contagion. This imposition of anxiety occurred in quite precise, hateful ways in the 1980s. Simon Watney refers to how one commentator who blamed the spread of AIDS on gay men, said:

> We are going to be asked to spend a lot of money on a disease which could easily be prevented by people changing their lifestyles…I think this is a straightforward moral issue.

Watney commented:

> Were there a cholera outbreak in Glasgow he would doubtless show the same "common sense" by recommending local residents to give up the filthy habit of drinking water. (Watney 1987: 48-49)

In these particular medico-moral discourses the subject is subordinated to hygienics: yield up your meaning not as created in everyday life, but as our anxieties or rhetorics or instruments dictate. These rhetorics match those of tabloid journalism.

Frank Mort wrote:

> cutting down superstars and handsome young men in their prime, has made AIDS highly accessible to the long-standing protocols of popular investigative journalism. With their sharp polarities between health and disease, good and evil, they set up a direct relation between cause and effect and point to simple, graspable solutions (213)…When medical hypotheses were twinned with dangerous sex, space was immediately opened up for re-entry of the medical-moral repertoire' (Mort 1987: 215).

Others have written about public health media representations that in turn inform generalised social anxieties about contagion. For example, Kirsten Ostherr has argued that in the United States:

> The representations of contagion in postwar public health films negotiate the problem of (viral) invisibility by codifying and visually mapping the infectious zones of the public sphere. Because the spread of contagion involves spatial and temporal mobility, the epidemiological map must account for (at least) two different scenarios of contamination: the geographic infection, wherein bodily presence at a particular location on the map confers contagion, and the demographic infection, wherein contact with a particular type of person results in contamination. While both scenarios are generically codified, their iconography depends upon a discursive slippage that always threatens misinterpretation; whether invisible contagion is visualized through animated maps or through racially- and sexually-marked bodies, the indexicality of the image of contagion remains unstable at best…The coupling of intense anxiety about the global spread of contagion with representations of (often unsuccessful) attempts to halt the invasion of U.S. borders by invisible contaminants invests these films with a paranoia that structures the narration of contagion as a narration of conspiracy, driven by malevolent (anthropomorphized) viruses bent on human destruction…Contagion is everywhere, and less visible than ever, and this intensified pervasiveness of infection is only exacerbated by the use of increasingly sophisticated techniques for visualizing the invisible. (Ostherr 2001)

It's a fine example of Beck's risk society in which 'we' are all in permanent danger of a loss of 'security'. One of the alleged (minor) dangers in Australia is the sexually irresponsible gay man who 'dances with death'.

For those who think this is getting a long way from HIV prevention, the following questions might help restore the link.

- How do anxiety as abuse and anxiety as a mode of being in the world interact with self care over a period of years?
- What are the effects of having practices of self-care constantly surveilled?
- How is self care practiced when the possibility of HIV infection is (thought to be) removed?

For gay men who grew or grow up experiencing their desires as unacceptable or shameful and requiring, at least, discretion and carefulness it was a major shift to accept constant scrutiny. This, for some, was chosen in crisis, but that doesn’t mean the end of crisis has meant the end of scrutiny. It has rather set up a surveillance loop in which the scrutinised monitor very carefully how they are being looked at. This is particularly so when it comes to sex.

As I have written elsewhere about the representation of gay men and HIV:

> Paul Foss once asked in another context, a discussion of Bataille's novel *The Story of the Eye*, the following question: why so many eyes to guarantee that what is seen is not so much the horror enacted, but rather the horror of looking itself?
>
> AIDS and HIV have become obligatory references in narrative. But I would argue that when HIV/AIDS loses its horror, when it is enacted as a vector in the normalisation of gay, and when medicine is claimed as the saviour, as is yet again happening now, then anal sex drops out of view. Looking becomes merely an act of glancing. Eyes that glance don't often see. The brown eye is covered. It doesn't have to be looked at. Is not allowed to be looked at. Mustn't be looked at. The horror of looking at male same sex desire is itself normalised into invisibility. Naturalised.
>
> The eye closes tight.
> The ears with it.
> The nose is blocked.
>
> So gone are those farting sounds of a cock withdrawn by a butthole bandit, gone is the slimy sheen of shit on dick, on condom, and gone too the smell of freshly fucked undouched arse.

> What is not often seen is that these colours, sounds and smells are metonyms for aspects of gay male desire. That farting slurp is a signifier of romantic love, a sign of a gift. The arsehole is gayness as much as and as little as the Bridge is Sydney or Sydney is Australia.
>
> And when these go out of view, these unspeakables, these matters of dirt and detail, what goes with them are those paradoxical questions that only the best of AIDS educators and writers ask: why is it, in this country at least, where most gay men know about safe sex, do many gay men practice unprotected sex some of the time?
>
> And in some ways we do know why. Because it's in the differences that anal sex makes that many gay men situate themselves. And sometimes for the sake of that difference we put our lives at risk. It's often done in the name of love, it backfires half the time within new relationships, but it's done. The desire for love and a willingness to risk death.
>
> Love to love you, baby.
>
> It is here in this paradox that morality begins to re-emerge. Not as a prescriptive or regulatory moralism, but as an ethical exploration of emotion, of emotional extremity, of the modes and modulations of the spirit, of the sociability of intimacy. In that sense it's a traditional subject matter, but the writing of it is something else. To write it is to write in part the history of love between men. (Hurley 1998a)

It’s tempting to say that there’s not much clandestinity in gayness these days, not if we are speaking of the invisibility caused by fear and caution, as distinct from the sanitising of the visible. The love that dare not speak its name now loves to do so (McInnes 1997), and when it doesn’t do it for itself, social research or some other representation producing machine does it in its stead. However what seems transparent in this process, the sheer volume of images, equates particular kinds of gay politics, image repertoires and statistical trends with all that happens in the doing of gay. Identity politics become

the only lens. Recognising the power and extent of media cultures doesn't mean accepting that the range of representations is any more 'representative' than those produced in relation to medicine or health.

Together my binocular lenses put together a field of vision and in that field I see things: backs shining with sweat, smiles, eyes, hands held, lips kissed, dishes to be done – histories of the wonder and joy of touch between men and epistemologies of skin and the sink. Like *some* others, I also see dead people.

What are the links between wonder, skin, ways of living and ways of dying? In what ways are they complicit in searches for meaning through sex that backfire? Which of the links are blind to unproductive forms of denial and self delusion? What is seen and how is it seen? I twirl for angles of vision, focus, depth of field, clarity. As ever, I am distracted along the way.[13] What is that over there, behind those trees?

Social structures and subjectivities are brought together through notions of practice, patterns of association, the development of repertoires, policies and politics, the power of metaphor.

HIV Social Research

HIV social research in Australia has provided some fine work enabling discussion of the issues being identified here. I have in mind particularly five ongoing bodies of work:

- the original Social Aspects of the Prevention of AIDS (SAPA) study of the place of gay community in sustaining safe sex (Kippax *et al* 1993) and its later spin-offs, Sydney Men and Sexual Health, the Gay Periodic Surveys (Prestage *et al* 1999) and the Male Call/Male Out studies (Van de Ven *et al* 2001);
- the HIV Futures studies of HIV positive people in Australia (Grierson *et al* 2000*; 2002*; McDonald *et al* 2002)

[13] Taussig (1992) writes of how Walter Benjamin refers to distraction as distinct from contemplation. Distraction is 'a very different type of apperceptive mode, the type of flitting and barely conscious peripheral vision perception unleashed with great vigour by modern life at the crossroads of the city, the capitalist market and modern technology. The ideal-type here would…[be] movies and advertising, and its field of expertise is the modern everyday' (143).

- the ‘Post-AIDS’ studies that started conceptualising the multiplicity of modes of subjectivity emerging as gay broke free of HIV (Dowsett 1996; Dowsett and McInnes 1996a, b);
- the studies of the relations between HIV positivity, treatments, medical knowledge and their subsequent development into analyses of safe sex practices as social technologies (Race 2000; Race *et al* 2001a,b; 1999, 1997a,b; Rosengarten *et al* 2000)
- the ‘doing’ of gay, community and sex studies that reconceptualised patterns of sociality and association, the practices cutting across them, ways of addressing their intersubjective dimensions and their implications for health promotion (McInnes, Bollen, Couch and Dowsett 2001).

My own thinking is deeply indebted to these bodies of work and the work of HIV educators and advocates in thrashing out the implications of the research for HIV education, health promotion and advocacy (Dowsett *et al* 2001). I return to them, amongst other sources, time and again to force rereadings of what I am thinking and others are doing. The point of rereading is to find new readings and to install them in practice, rather than simply to find what was missed and stay stuck in an expanded version of where I began.

For anyone engaged intellectually with issues of HIV, gay community and forms of association, the SAPA project stands as a colossus. If you do what I do below, which is refer primarily to ‘scene’ and forms of social association rather than ‘gay community attachment’ as constitutive of a rudimentary taxonomy of doing gay now, it’s impossible not be seen as engaging with, if not contesting, how SAPA constructed the field. This problem is compounded if you also use data from that study which I do. I am engaging with SAPA. I do so with respect, and I am rethinking not the categories as such, but the meanings that can be attached to them now.

At the time (1985), SAPA was just about as good as it got internationally in sociologically informed, quantitative HIV social research: relationality of individuals to each other, to what they did and to wider social structures. It went way beyond either the asocial versions of individualised psychologies of behaviour that still bedevil health promotion or

the dissolution of the individual into the social characteristic of more socially determinist accounts. There were notions too of *repertoires* of sexual and social activities, and of *reflexivity* that still have major resonance today, though there are differences in how these are understood and used. 'Embodiment' is a little more difficult. On the one hand, it brings bodies into play, a strangely rare phenomenon in sex research. However, in SAPA it's still largely a biological notion thought through concepts of physical pleasure and sensation, which exclude the emotions from corporeality and locate them in a mind/body split.

SAPA was initiated by ACON (Kippax *et al* 1993: 21). 535 homosexually active men answered a 58-page questionnaire with almost 1000 items and the researchers sought statistical relationships from the answers. Five years later, 145 of the men were reinterviewed (Sustaining Safe Sex study, SSS). In SAPA, three measures were used to assess 'gay community attachment': 'sexual engagement, social engagement and gay community involvement' (109). Each measure had many items. I note three conclusions here that are key for my purposes.

The first conclusion, I note, is:

> Sophistication in sexual relationships and sexual practices is associated with gay community attachment…The best predictors of the adoption of safe sex practice were: sexual and social engagement in gay community – the greater the engagement, the greater the adoption of safe sex (122. Emphasis added.)

The second is:

> Men who engage in casual sex and seek sexual partners in a variety of venues are not necessarily socially or culturally/politically involved in gay community. (114)

This conclusion was later discussed further:

> it is as though their identity[14] is constituted in sexual rather than social or cultural/political practices, and for many, their sexual practices are separate from the rest of their lives. (118)

The third conclusion is:

> Men who are in contact with others, via attachments to gay community…are most likely to have changed their behaviour…Men who are isolated from others like themselves…are those least likely to change. (123)

When these men do change, they change relationship practices, rather than sexual practices (monogamy, celibacy, fewer partners) (123).

I have drawn attention to these conclusions for two reasons. Firstly, as part of a general acknowledgement of SAPA's founding contribution and the ways it has continued to influence how HIV prevention is thought about. Secondly, I draw attention to these conclusions as a springboard to going around the field in other ways. SAPA was central, productive and 'fruitful' in the construction of understandings of lived responses to HIV.

I guess 'lived' is the key word for me here. In the method section of SAPA, there is a discussion of gayness, the dynamics of sexual object choice and the possibility of 'different patterns of expression' in relation to class (34-35). The discussion argues that visible gayness is characterised by high levels of education and this makes education a characteristic of the population rather than an artefact of method. It's not the evidence I'm querying. I think the kinds of explanation put forward make sense: samples of men coming forward made up of those 'with the most social resources to resist threat'; occupational selection according to 'safety'; the effect of education and the centrality of universities 'to the formation of an openly homosexual identity'. Remember this is being done before the explosion in media circulations of gayness and in a very hostile, HIV phobic social context. Mobilisation of gayness was an absolute necessity and proved enormously productive.

[14] Identity is a vexed and complex notion and much depends on the angle taken. For example, Bartos *et al* (1994:27) argued that 'Personal identity is not reducible to sexual identity. For many, and perhaps most, MSM, concepts of self identity will not correlate to any specific sexual practices.'

The difficulty is that ‘gayness’ as a set of social arrangements prestructures ‘patterns of expression’ within a politically inflected understanding of ‘gay’. It doesn’t just do this in relation to class, but to the social construction of identity.

In acknowledgement of SAPA, I have already used some its key categories as found in earlier references to Dowsett’s discussion of community, context, social relations and social practice.

In addition, I have appropriated the notion of ‘doing gay’, though I wrench it from the context of the discussion and adapt it, because I find it very productive as a way of thinking both about different kinds of sociability and different kinds of self modulation (McInnes *et al* 2000: 11). I often then use terms such as ‘living gayness’ or ‘cultures of everyday life’ as other ways of taking about doing gayness.

‘Doing gay’ allows for a consideration of subjectivities in more extended ways than those found in earlier conceptualisations of gay community attachment. Given that they involve quite different kinds of research methods this is understandable.

What follows is an exploration of research and practice that draws on all these research projects and others, but is not a representation of them.

We can identify at least 3 modes of doing gay based on quite different relations to ‘the scene’ and locally available versions of community in Adelaide, western Sydney and inner Sydney (McInnes *et al* 2001a) and in Perth (Slavin *et al* 1998)[15]. Earlier discussions included class and NSW regional experiences (Couch 1999; Ariss 1997; Dowsett 1996a;). These three modes however are also complicated by virtuality as a form of metropolitan gayness made available wherever one lives by electronic and magazine media cultures. To quote Crisp once more:

[15] The density of what is available (clubs, pubs, organisations) is also clearly relevant.

> Those who once inhabited the suburbs of human contempt find that without changing their address they eventually live in the metropolis (Stewart 1995: 60)

I have suggested elsewhere that the force of Crisp's remark is to make the metropolis something other than an urban spatial reality (Hurley 1999: 277). It is, arguably, the 'appearance' of gayness (its being there and what it looks like) that is the locus of current self-modulations: its combination of promise and allure, and its failure to offer engagement with wider desires and different ways of being in the world.

The three modes are:

- Tightly identifying (gay and scene identifying)
- Loosely identifying (gay identifying, occasional scene user)
- None identifying (gay identifying, 'straight acting', scene indifferent/hostile)[16]

Note here that 'identifying' is not the same as 'attachment' as developed in SAPA. It is more loosely descriptive. I use it to refer primarily to forms of social and later sexual association, without tying it in advance to 'community'. That doesn't mean these forms of association can't be linked that way, but I am using it to explore what I see as emerging trends.

These three modes of doing gay, though disruptive of unitary notions of gayness, require ongoing development in relation to, for example:

1. Epidemic affect: how HIV status is lived in terms of degrees of exposure to the epidemic;
2. Cultural facility: with cultural codes, health literacies and interpersonal negotiation;
3. Politics;

[16] 'I am a fairly straight acting, down to earth guy, what you c is what you get. Not into going on the scene very much, but that doesn't mean I don't know how to have a good time. My good times are spent with good friends, going out to dinner, also love travelling to new places. I am a very loyal person and probably looking for a close friend, or maybe more, with a good heart, which I think is the most important thing!! If u think I sound OK send me…'

4. Generic factors: race, age, class, sexual experience, coming out.
5. Subjectivity formation: options, preferences, styles and practices;
6. Social narratives of desire, romance, love, intimacy, sex, partnership etc;
7. Media circulations of gayness: appearance and possibilities;
8. Methodological considerations.

In what follows, I am proposing these schematic brief accounts as the rudiments of a gay cultural sociology which still contains social structures, but is arguably more supple in how it understands the relations between individuals, sociability, structures and practices. It also allows us flexibility to appreciate the ways excessiveness spills over, blurring the analytic categories, allowing for recognition of their messiness, forcing a recognition of tropes (forms of cultural narration) as analytically illustrative of how things are done.

'Scene', of course, is no more transparent or less problematic conceptually than 'community'. They are often spoken as part of a mobile binary opposition, sometimes sharply distinguished, sometimes used synonymously, sometimes as mutually inclusive. Both McInnes *et al* (2000) and Keogh (2002b) have recently discussed this, partially in relation to 'coming out' and 'entry into'. Keogh's interviews with young gay men indicated that:

> the commercial London scene was constructed as a problematic, uncertain and yet a seductive and exciting place…at first sight…alien and exotic. It was "out there", a place to be "entered" with trepidation…a world of monstrous spectacle.

It was also perceived as a place of inauthenticity, not a place where one could make "real" friends, a contested place that one learned to negotiate however because one wanted to (Keogh 2002b).

Extrapolating, we might describe the non-identifying group, in this context, as those who do not *generally* desire either to enter the space or to learn how to negotiate it. They position themselves outside of it, at the same time as seeing the scene as having positioned itself as outside 'real life'. We begin to see the emergence of some pre-

emptive versions of gay sociality as 'unreal', in a quite different way to those who might discuss pragmatically its bitchiness or limits.

There is a fourth group that interacts in various ways with the other three, non gay men who have sex with men, and who have various cross-over cultural literacies[17] (Dowsett 2003, 1997). It is now unarguable that these men as a group (as distinct from any individual) are repressed homosexuals or 'closet' cases (Prestage 2002). They are (a) heterosexual, bisexual or refusers of identity labels, and (b) more likely to engage in unprotected sex than gay men, but are likely to do so mostly in lower risk environments (Bartos *et al* 1994; Van de Ven *et al* 2001).

'Risk environments' refers to HIV prevalence (and levels of viral load) in specific locations. If the virus isn't there you can't get it, however unsafe your sexual acts. This of course becomes complicated when we take into account, combinations of say, travel routes, regional concentrations of HIV positive and other gay men, especially in NSW and Queensland, and post Mardi Gras party events. The Vines study of Victorian gay men's social networks (Grierson *et al* 2003) suggests, however, that when travelling gay men practice the same kinds of unprotected sex as they do at home (Pitts 2003), but the issue of changing risk contexts and associated risk calculations remains as salient as ever.

These kinds of calculations occur in several contexts, as can be seen in a quote from another study:

> In the recent…periodic survey…there was a question at the end which said is HIV as big an issue for you as it was a few years ago?…I had to answer no…and three years ago it wasn't as big an issue for me as it had been three years before that and three years before that either and I think back then…I expend so much energy and worry…on being scared about HIV…I didn't have any more energy. I numbed my scare faculties, I suppose…but I think more recently…[if] somebody said they saw two young people fucking and having unprotected sex in the park,

[17] 'Australian masculine straight acting discrete bi guy. 28yo, tall, good looking, HUNG top. I am purely a top, I love to get sucked and enjoy fucking a nice guy or girl. I do not suck or get fucked.'

> well they might not be very much at risk (Sydney informant, Slavin *et al* 1998: 20).

Men who live in the midst of epidemics make their calculations relative to it, whether they are conscious of doing so or not. What the person quoted is aware of is uncertainty - 'well they *might* not be very much at risk' - and associated anxieties. Though they are speaking the diminution of anxiety, it is still there in the assertiveness of the construction. It's an assertion 'against' the dominance of anxiety. Factoring uncertainty and anxiety into considerations of proportion is a demanding way to live *and* it's a propellant of dynamic adaptation.

The site of this expressed anxiety is, not surprisingly, more often than not the inner city. It's useful to step back for a moment and recall that for many the inner city can only emerge this way because of its relatively recent social constitution as intensely gay, and thus as, in Sydney and Melbourne at least, epidemic epicentre. But as Chauncey points out of the United States, earlier last century 'many men…neither understood nor organised their sexual practices along a hetero-homosexual axis'. I'm raising the possibility that this organization is characteristic of the non-identifiers and that it may partly be not only a rejection of 'doing gay' but also an HIV avoidance strategy. There's not much new there, except that the emerging layer of gay men I am referring to as non-identifiers are in a sense new. They are post-gay.

Bartos said of men who have sex with men that 'these men's social isolation from the gay community was a powerful metaphor for their personal, physical isolation from the virus' (1994: 38).

Given decreases in the visibility of HIV and the kinds of contact people have with people with HIV, Bartos' comment may now be increasingly applicable to HIV negative men across all three modes of doing gay. Indeed, there is some evidence that suggests in sexual matters HIV negative men seek out other negative men, just as many HIV positive men say they prefer their sex partners to be positive. However of those HIV positive men in relationships, they are more likely to be in a relationship with a partner of HIV negative or unknown status (Grierson *et al* 2002).

It's not my intention to impose a post-AIDS perspective on all groups of gay men affected by HIV. The situation for Indigenous people has been different. Rates of HIV infection were not falling in the early 1990s (Guthrie *et al* 2000). It became clear though that treatments uptake amongst HIV positive gay community associated Indigenous men was proportionate to non Indigenous uptake (Hurley 2000d). While a majority of Indigenous people with HIV are gay associated, the ways that the virus has interacted with Indigenous sexualities has led to different outcomes in these communities.

The experience and possibilities of doing gayness and Indigeneity are discussed in various ways and places (Gays and Lesbians Aboriginal Alliance 1993; Willis 2003a, b). Of relevance here too is Gregory Phillips' *Addictions and Healing in Aboriginal Country* (2003). HIV positive Indigenous gay men and sistergirls are included, but not differentiated by sexual identity, in Willis *et al* (2002b). The Australian Federation of AIDS Organisations has auspiced community consultations and major documents on Indigenous Australian gay men and transgender people and on sexual health (AFAO 1998a, b). Three Indigenous gay men's accounts of gayness and community can be found in Hodge (1993). Hurley (1996: 1-2) contains a bibliography. Wayne King speaks autobiographically (1998) and Sydney experiences appear in Brady (2001). Tony Ayers' film *Double Trouble* (1991) and Noel Tovey's play *Little Black Bastard* (Benzie 2003) are also key documents. While discrimination appears as a major issue in all of them, there are also complex discussions of how sociality, the scene and community are negotiated.

On available quantitative evidence, and giving due regard to time of arrival in Australia, race does not appear to be significant in degrees of gay community involvement (Mao *et al* 2002b: 34; Prestage *et al* 2000a, 1999, 1996a, b)[18], though research into beat use suggests significant msm activity (Poetschka *et al* 1995). The proportion of Asian men who position themselves more loosely in relation to the scene seems comparable to non-racially aggregated proportions of gay men. However, if we think more widely about sociality, reported experiences of discrimination are high and narratives of everyday life few. The nature of these experiences has been explored in several qualitative studies (Jackson and Sullivan 1999; Ridge *et al* 1999). Other research has commented on

[18] See footnote 19.

discrimination in relation to HIV services (Pallotta-Chiarolli 1998) and the relation between gays from non-English speaking backgrounds and living with HIV was documented in Con Anemogiannis' film *The Last Coming Out* (1992).

The mode of doing gay that I have called 'tight' identifying has been politically dominant in constructions of community and has long mobilised control over notions of authentic gayness. Although there is an uneasy tension in Australian research between political histories and social accounts of community formation and activism (Moore 1998; Reynolds 2002c; Willett 2000; Wotherspoon 1991), I would argue that, even after allowing for shifts and differences in emphasis, historical narratives dominate most sociological accounts of the present. These accounts have tended to rely on a periodisation sequence (pre gay liberation, gay liberation/movement, shift to community) in which political notions of identity ('we') and community dominate the social. This is understandable given the importance of politics to resistance, to legalisation, to the development of the HIV/AIDS partnership and to wider social change. However there have been costs: a collapse of the present into the past, a failure to understand media cultures and a community-based, state-focussed, assimilationist reform agenda in which gays become just another mainstream minority interest group. The result is the projection of ever narrowing ways forward.

Community in this trajectory has also always been contested from within and from without (Ridge *et al* 1997). Multiplicity has been acknowledged:

> A kind of tribalism exists in the inner city of Sydney. The one thing that continues to characterise gayness, particularly for younger men, is a sense of difference. This may come to be manifested through sex, politics, fashion, music or language. It is often manifold and multivocal and is not necessarily oriented towards any traditional notion or expression of 'gay' 'dentity. Muscle/gym queens exist beside ferals, yuppies, ravers, skateboarders and bubblegum punks. There is a strong sense of play about all these groupings – and while many participants spoke of the sometimes oppressive hegemony of body culture in Sydney, all the tribes nevertheless play with each other's symbols and encounter each other at various social events ranging from dance parties and clubs to the opera.

(Slavin *et al* 1998: 32)

This interplay between sameness and difference is explicated within inner Sydney. Differences are acknowledged for both older men and with the ways identity is performed in Perth (33).

Politically, 'authenticity' has been fought over in terms of inclusion, exclusion and competing identity politics (Mardi Gras membership, Durber 1999) and more recently simply declared *passe* (Reynolds 2002a, b, c). While the *passé* discussion itself was too limited, it signified the emerging visibility of the 'loose' and 'non' identifiers and to some extent political mobilisation by the 'loose identifiers'. This isn't simply about inner Sydney as emblematic of a metropolitan gayness or even the more difficult assessment that for many community-based services are not understood as useful resources in doing gay.

Various studies are suggestive of degrees of looseness in social identity as a form of social relation. SAPA and the subsequent ongoing Gay Periodic Surveys in each capital city show gay friendships are suggestive of two versions at least of how gayness is done socially: mostly with or mostly without other gays. So while friendship may be central in both tight and loose/non identifying formations, it may be very differently arranged in relation to gayness and 'scenes'. The Victorian Networks Study extends this. Vines indicates that of those participants who have broad as distinct from close friendship networks, about a third have mostly heterosexual or 'some' gay friends, though there is no suggestion of sexual activity between them (Grierson *et al* 2003: 17). About 24% of the gay men saw themselves as having little in common with other gay men and about 20% replied that their gay identity was not important or irrelevant to their self concept (9-10). About a third of the sample lived outside the inner city of Melbourne (5).

I'm not suggesting that more familiar ways of doing gay have disappeared or even lost organizational dominance or their capacity to feed community events, which is how this argument is often heard, especially in relation to Mardi Gras (Hornery 2002: 31). Rather, as already noted, a range of ways of living gay and doing gay have emerged that position themselves against, outside of, or differently to notions of 'the scene' or 'gayness' or 'community'. The 'post-AIDS' break indicated earlier in the link between

tightly and loosely identified ways of doing gay and HIV is not peculiar to Australia (Rofes 1998), but some overseas discussion understood that what was emerging simultaneously was post-gay (Simpson 1996; Sinfield 1998).

At this point, discussion splinters. In the USA much energy has had to be directed at a defence of sex in the face of normalisation (Warner 2000), and federal government insistence on abstinence and restrictions on cultural relevance in HIV health promotion. In Australia, initial discussion of rising rates of anal sex, unprotected sex and unprotected anal intercourse in casual contexts was hamstrung by a reading of the data as, in effect, a breakdown in safe sex cultures, rather than as a dynamic adaptation in ways of living gay and living with HIV. The incomprehension that resulted intensified when unprotected sex began to be 'accompanied' by increases in new HIV diagnoses. The consequence has been ever increasing pressure on those living with HIV and those affected by it.

Discussions of 'normalisation' have rolled several phenomena into one and assume that normalisation has the same meaning in countries like Australia, Canada, the United States and Britain. There is a difference between normalising political agendas (same sex relationships, marriage), normalising as the incorporation of gay into the wider socio-cultural repertoire (television) and particular appropriations of it for individual ways of living gay. Many of the new ways of recognising how gayness is done involve recognising suburban ordinariness as much as, say, sexual adventurism or community attachment. Anti-gayness is now a critique internal to doing gay that is not the same as homophobia or notions of self-oppression and is against what is perceived as Gay Inc. Sometimes it recuperates homosexuality as an oppositional force (Durber 2001:12)

At other times, the 'new' anti-gayness is itself moralistic. The insistence on 'straight acting' (non-scene, no queens), for example, is often as hidebound as John Wayne. To say nothing of just as dead. It's quite incapable of even gesturally doing sissy politics with all the attendant anxieties and toughnesses demonstrated by McInnes' analysis of the Ian Roberts phenomenon (McInnes 2002). In that sense it has no relation to other ways of doing gay, except a similarity with 'closeted' behaviours. Nor, probably, do some inflections of it care that Johnny in Big Brother 1 chose to represent himself as a

desexed, nice boy version of public sphere gayness (Dowsett 2003). That's what elements of anti-gay want, sex invisibility and the erasure of gendered difference in understandings of how gayness can be done, rather than a resistant sex positive politics or gender politics. Luckily the public sphere in a media age is constituted by multiple media images - the opening masturbation sequence of *Loaded* also circulates – and there is resistance to the sexual sanitisation of Sleaze, the old and new Mardi Gras and other parties (Parnell 1997; Mills 2002; Bacon 2002)

I'm not interested in either/or accounts of these matters. There are as many difficulties in the alternative accounts of living gayness as there are in reiterations of community. The challenge is in creatively working them through. We can periodise stages in community formation in relation to AIDS and identity politics as much as we like, they matter deeply, but we won't necessarily be much clearer on how gay is lived now.[19]. The importance of McInnes and Dowsett's arguments is that they bounce off media culture manifestations of celebrity and spectacularity (Turner *et al* 2000), circulate competing images and arguments and resonate with other aspects of lived gay culture. Getting those arguments into wider, mass media circulation is not always the way to go, unless spectacle is the only desired end. As the George Michael toilet incident indicated, the only scandal was the media's exposing of itself (Lumby 1999: 207)

[19] This is a complicated argument as it involves how 'gay' is used in wider contexts, gay in relation to HIV and gay as inclusive of both HIV positive and negative men and an account of the relations between them. Bartos argued in relation to HIV that there are three periods: 'from 1983 until around the late 1980s, HIV risk was characterised as a collective experience….from roughly the end of 1980s through to the mid 1990s (it) was characterised by an increasing differentiation of HIV risk management strategies and a divergence between the expressed attitudes of HIV positive and HIV negative men…and the third period I propose is only beginning to emerge in Australia. It is characterised by a continuing proliferation of HIV risk assessment and minimisation strategies' (Bartos 2002 [1998]: 64-65). During discussions about gay and community with Craig Johnston, Craig referred me to Nicholson and Seidman (1995), saying ' On pages 119-123 [Seidman] describes three phases of "gay and lesbian intellectual culture". The 1st phase covered 1968-1975: its characteristic was that gay liberation was central. The 2nd, from the mid 1970s to the mid 1980s: characterized by community-building and political maturation - liberationist visions gave way to ethnic nationalist models of identity and single-interest group politics inspired by either a liberal assimilationist ideal or, in the case of lesbian-feminism, a separatist ideological agenda. The 3rd, from the mid 1980s to the present [i.e. mid 1990s]: characterized by continued community-building, a drive to become mainstream, and a widening gap between academically dominant discourse of homosexuality and 'everyday gay culture' - emergence of queer theory. Craig went on to say that he thought that 'Seidman was talking about the USA as much as England, but I think it holds for Sydney.'

Gay men are often positioned as vapid airheads in relation to celebrity. Lumby, however, notes with Marshall, that celebrity is caught up in the construction of the edge between 'the individual and the collective'. She argues that celebrities:

> can be understood as a kind of switching station for traffic between the public and the private spheres. As individuals whose bodies, emotions and intimate relationships are under continual scrutiny, celebrities are figures who literally live on a fault line between the public and the private. (Lumby 1997)

Because gayness, especially when related to HIV, is co-narrated with sex, its representation is often generated at the fault line. The earthquake metaphor has strong cultural resonance. Gay sex is often a point of social anxiety. Dollimore put it nicely:

> if, in periods of intensified conflict, crisis is displaced onto the deviant, the process only succeeds because of the paranoid instabilities at the heart of dominant cultural identities (1991: 237).

There is a form of classic pluralist liberalism in what I'm saying. This possibility of diversity matters, even if it means that simple diversity is what is heard first, rather than the distinctions between the different understandings of gayness involved in specific arguments. It's that multiplicity of media culture images and stories which prevents the total solidification of gay into the congealed coldness of a left over fried egg.

A liberalism of diversity, however doesn't mean anything goes. Liberalism doesn't take us very far in relation to sex and the public/private distinction. We also need sharp takes on specific practices.

We are seeing the growing recognition of ways of doing gay that now partially at least resemble ways of living once thought to be more characteristic of non gay men who have sex with men. How much difference does the identifier 'gay' make when

accompanied by a rejection of scene, camp, queens and a politics of difference?[20] Quite a lot, but they are differences distinct from those signified historically by formations of camp, AIDS organising or, perhaps, rights politics. Ironically, though, the solaces of shopping seem often to be shared. The pleasures of consumption may leave the analytic force of 'identity' in disarray. Class and income have an impact here, historically in discussion of community attachment and more recently in discussions of the pink dollar (Badgett 1998; Dowsett 1996a; Johnston 1999). Arguably, however, these discussions have not understood either the ways style is implicated in an aspirational politics of consumption in magazine and television cultures or performativity as a way of doing gay life (Bollen 1997, 1996).

At the very least, these newer, more loosely identifying formations constitute a political and social challenge for those who wish to speak 'on behalf of' community. These three modes of doing gay disrupt notions of community constituted primarily around geographic concentration and associated forms of political organisation and mobilisation. Socially, community looks more and more like the provenance of the first mode with seasonal clusters of the first and second modes: Mardi Gras and dance parties (McInnes *et al* 2001). Given the shifting nature of social geography in Sydney at least ('Oxford St isn't what it used to be') and the challenge posed nationally by recent events to community and community social capacities (Satellite media, gay games, old and new Mardi Gras and the hiatus in its televising) (Johnston 2003), this discussion is not simply academic.

British data indicate little association between Internet use to find sex partners and use of bars, clubs and social groups. This matches pre Internet data from SAPA. There are

[20] This isn't inconsistent with acknowledging the wider power of pop culture divas amongst gay identifying men. It arguably positions diva worship as one rite of passage into doing gay and modes of doing it that have various relations with the scene. So there is no immediate contradiction with, for example, Milnes' (2002) argument which contrasts different forms of tight identification: 'Though for many young gay men living now The Wizard of Oz, Mame, and Funny Girl may not strike any emotional chords, hero-worship of Kylie, Madonna, up-and-comers like Britney Spears on the mainstream circuit, and women like PJ Harvey, Christina Ricci and Courtney Love for the more indie-minded queer, remains pretty thick and fast on the ground. While many gay men profess to admire 'our own done good' like Michael Kirby or Ian Roberts, I would wager that a guest appearance by our own 'singing budgie' at a local gay venue or bookshop would garner twice as many supporters as both of the above combined. Thus announcements of the diva's death in the community are therefore premature and greatly exaggerated'.

both sharpish differences in sexual styles and quite different relations to gay social institutions (Weatherburn *et al* 2003). We know from Australian, U.S. and British data that gay men are high-end Internet users[21], but the ways the Internet appears to be used also suggest that the non-identifiers are increasing quantitatively and rapidly. The net is used ('mobilised') as a site of 'non scene' visibility. Given that gay.com at least offers 'scenes' (club kid, bear, etc) as part of its generic profiling, the profile template itself may be producing a an increased rigidity in self positioning. It's also the case, however, that these generic categories offer the ease of shorthand, codes, and that their base in U.S popular variants of gay is also recognised by some. Modes of net usage are often contradictory and tense, as anyone who spends time in chatrooms can testify.

For many loosely and non identified men, community attachment strategies are not generally appropriate politically or for general purposes of health promotion, as distinct from being made available as individual choices. All the evidence says these men too are relatively well informed about safe sex. However they are likely to be less well positioned to be well practised in negotiating particular kinds of experience or in more specialised risk calculations involving, for example, viral load in specific sexual contexts. This may well be true also for HIV negative tight identifiers (Rosengarten *et al* 2000). Loose and non-identifiers are also perhaps more likely to choose sex partners through metaphors of 'safety': well presented, 'clean', etc (Bartos *et a*l 1994). Smith's work on 'safety' in personal advertisements reported that 'the differential risks of HIV transmission associated with oral sex and anal sex were not reflected in the extent of reference to safety' (2000: 43). In the context of the absence of any change in mentions of safety over a decade in the ads (1985-1996), he speculated that 'the mention of safety

[21] 'About 50% of the 450 HIV negative men in the Sydney-based Health in Men sample had met sex partners from the net in the previous twelve months (Mao *et al* 2002a: 10). In 2000, about a third of the sample in the Asian Gay Men in Sydney survey had met sex partners through the internet and the report made a point of saying that 'contrary to some expectations, those whose primary language was not English were no less likely to use either personal advertisements or the internet' (Prestage *et al* 2000a: 37). The 2002 Melbourne Gay Community Periodic Survey indicated occasional (35%) and frequent (12%) use of the net to find sex partners (Hull *et al* 2002). While no strict comparison is possible, in a 2001 Melbourne study of mostly non-gay men (Pitts *et al* 2002), 8% of the men reported using the net to acquire sexual partners. Another 4% had used the net to start a relationship and 6.6% reported cybersex. For them, net use was a medium for sexual interest and gratification especially amongst younger, more educated users. Pitts *et al.* concluded 'no significant relationship was found between reported sexually transmitted infections and internet use…most internet use would seem to offer a relatively safe way of achieving sexual gratification.' (Hurley 2003)

represents some residual level of anxiety' (47). While specific knowledges to do with the negotiation of unprotected sex are unevenly dispersed, all the evidence suggests they are self taught by the well informed and can be learned by others. Supporting and enabling these processes is a key role for community-based HIV education.

The import of my own work amongst gay men living with HIV is that information loops in a media culture continuously inscribe dynamism into quasi-clinical cultures of care (Hurley 2000b). Those cultures can be diagrammatically represented. The first of the three diagrams following represented my engagement in 2000 with issues of HIV treatments information flow.

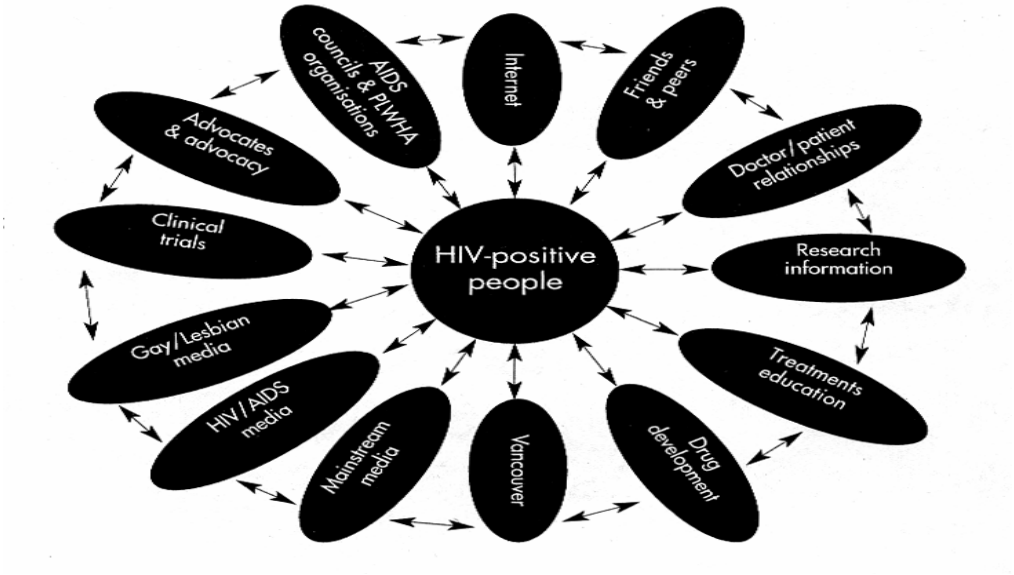

Figure 1: Information Loops

This diagram represented the processes involved in information saturation. It subsequently became clear to me that what I was doing was connecting these information flows into a reconfigured understanding of how people with HIV were living. This naming of 'cultures of care' was 'a way of conceptualising the social relations between health service providers, the people taking treatments, their social support networks, international media relays, community-based treatments media and the

development of practices of self-care' (Hurley 2002: 31). This shifts the information loops into a wider representation:

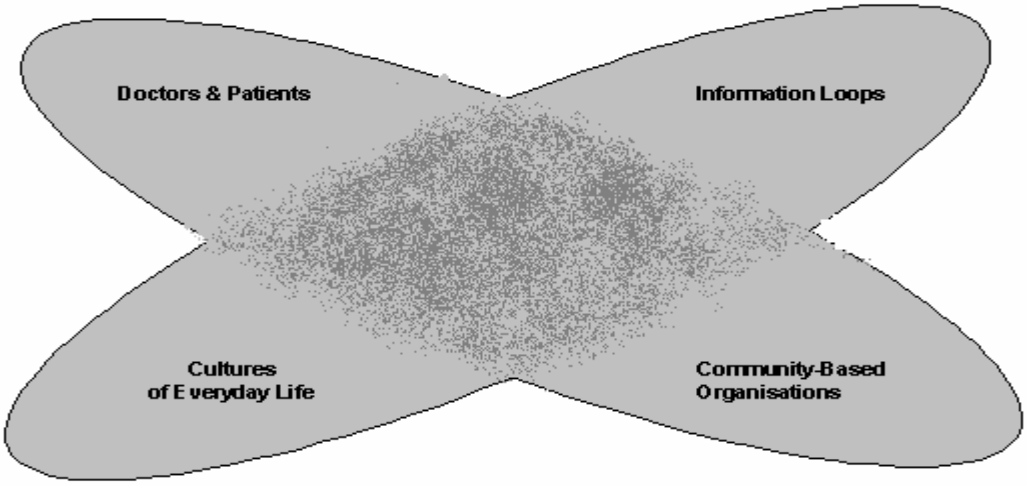

Figure 2: Cultures of Care

The darker area in the centre represents cultures of care developed by people living with HIV and their advocates. That is, the series of intersections or field in which people living with HIV negotiate well-informed, self care practices that are developed, shared and changed interactively through the agency of information loops. Race and Wakeford (1997) earlier suggested the centrality of sharing that I originally incorporated into the loop. Willis then developed cultures of care further with a discussion of the different rationalities involved between medicine and people treating (Willis 2002).

Other research indicates that everyday sex cultures are characterised by reflexive self care practices involving HIV testing, use of condoms, partner choice, negotiation of risk, and scientific and medical information (Race 2000; Kippax 2000). While their and my work was developed originally in relation to HIV treatments education practices, it has much wider implications for how we might theorise mutuality and sociability. Discourses of 'care' can be shifted outside of medicine and humanistic psychology into what de Certeau once referred to as a 'therapeutics of deteriorating social relations' (1988: xxiv), then, as needed, rearticulated in relation to them. The revised diagram below is an

indicator of possibilities rather than a static description. Each of its axes can be changed according to what it is we want to talk about.

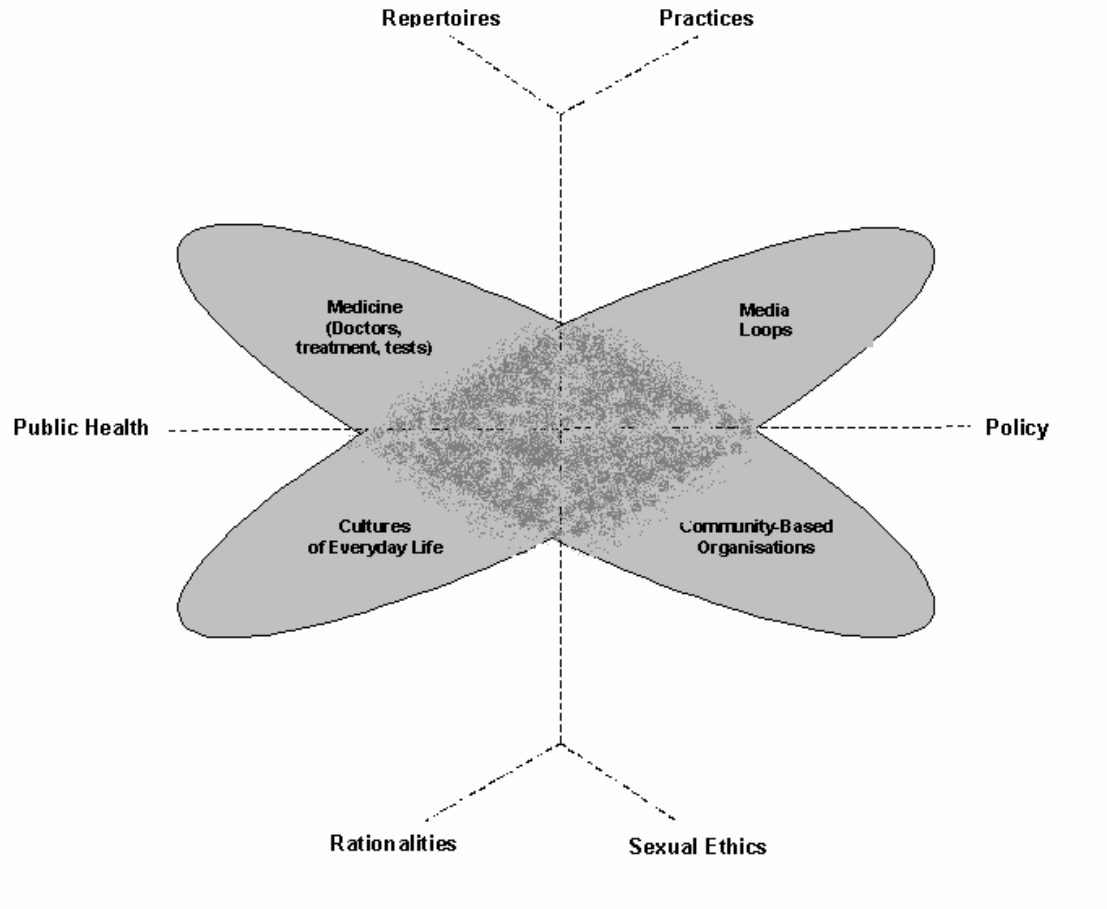

Figure 3: The Field of Doing Gay

With the addition of practices[22] and repertoires[23] of everyday life we can make the original description of cultures of care richer, and extend its conceptualisation of mutuality. More importantly, for my purposes here, we can also begin to represent the complexity of how doing gayness through practiced ways of being can be seen as linking to and interacting with wider social and cultural practices and structures. The relations should not be read as causal so much, but rather as involving interactivity and availability. Doing gay is an active negotiation of social possibility, including that between HIV positive and negative men. It can be understood as the ongoing development of practices of everyday life, as the development of personal repertoires and as 'practiced ways of being' in social, political and cultural contexts (Hurley 2001a).

Further evidence of doing gay as productive is garnered from analyses of use of sex venues and analyses of being involved in adventurous sex. Sex venues are often positioned as anonymous sites of infection involving dysfunctional individuals of negative, unknown and positive HIV status. Research indicates a wider picture. Whether in venues or at home, what we see is active, reflective, well informed engagements with sexual possibilities (McInnes *et al* 2001b, McInnes 2000/2001; Santana and Richters 1998). Rather than being seen as sites of acting out or relapse or risk or reckless endangerment, the analysis in effect posits them as ways of seeing inventive, everyday agency. This is not to say there isn't room for refinement of how these engagements are embodied practices (Race *et al* 2001), but it's a position that begins from social successes rather than imposed notions of structural vulnerability or marginality. They are descriptions of relative social plenitude in relation to available circumstances and

[22] In de Certeau, 'practices' are ' "arts of making" ' this or that, i.e. as combinatory or utilising modes of consumption. [They] bring into play a "popular" *ratio*, a way of thinking invested in a way of acting, an art of combination which cannot be dissociated from an art of using' (1988: xv).
[23] 'Repertoires' have been part of the conceptualisation of sexual practice in HIV social research since the SAPA study (Kippax *et al* 1993). However, the concept has also been used in a different way to describe collections of sexual and non-sexual practices. Poststructuralist uses informed by Foucault, Bourdieu and de Certeau have been accompanied by feminist and performative conceptualisations: 'the concept of performance directs the analyst's attention not to the internal psychological state or even the behaviour of a given player, but to formal, rule-governed actions…[in] ordinary encounters…there are performative protocols in play that require skill and creativity in the manipulation of space, movement, voice, timing, turn-taking, gesture, costume, and the rest of **the repertoire of enactment**' (O'Sullivan *et al* 1994: 222. Emphasis added.) McInnes *et al* have used the notion this way: 'Affective repertoires are learned in context by experience (through feedback provided by interaction) and they are thus the products of socially produced frames of roles, interactions, genres and modes of relating' (2003: 12).

options. I am now pushing these analyses further, suggesting that they be seen as paradigmatic of the negotiation of everyday life, of ways of doing gay in a media culture.

Such a proposal directly challenges human rights, welfare and health perspectives that simply impose legislative agendas based on structural analyses alone, or presume a generalised knowledge-lack and capacity- deficit in programme development. I can't argue this in detail here, except by further reference to how the shifting figures on HIV and sexually transmitted infections are being turned into rhetorical practices that deny validity to 'practised ways of being'.[24]The current unthinking extension of notions of 'safety' and 'safe' sex to STIs, for gay men, at least, has been one of the most myopic moves in public health and is doomed to failure. Gay men will be blamed for this rather than the sexual health thinking that produces the failure.

This is the force of Smith's quote at the beginning. A disease related culture of behavioural surveillance disappears gayness in the sense that doing gay never gets seen or understood in its own right. Rather it is made visible as a disease vector defined by men having sex with men. Australian public health in that sense is increasingly aping much bad American HIV social research, which in effect positions gayness itself as a risk factor. A concern about this in the U.S. context is partly behind the opening quote from Rofes. Sex between men is installed as a risk factor in its own right, particularly when that sex involves multiple partners. In the 1980s the challenge of a burgeoning HIV epidemic was met by an insistence that risk behaviour be put at the centre of analysis, not risk 'groups'. However, the ongoing narration of gayness via surveillance and disease continually pressures this distinction. The pressure is increased when governments and their associated funding and accountability requirements are homophobic (Johnson 2002;Sant 2002). In the current Australian context, respect for best practice derived from community-based practices has been displaced by non community-based political appointments to the relevant HIV committees and spurious

[24] 'Practised ways of being' isn't a naïve elevation of street theory, but a recognition that people live in relation to already circulating bodies of knowledge. In that sense, experience, however personal, is socially narrated. Nor does 'practised ways of being' imply that folk knowledges don't require constant monitoring for purposes of health promotion. Rather it says that the way to proceed is from those ways of being, not by imposing professionalised knowledges and ideologies developed elsewhere. See Dowsett 1996. I have borrowed the phrase 'practiced ways of being', in this instance, from the PhD work of Sue Dyson.

notions of 'evidence-based' research that can't deal with dynamic safe sex cultures as distinct from individual interventions.

‘Doing gay’ gives us ways of conceptualising the interaction between individuals, media cultures and social structures that don’t either ignore the individual or focus only on structures. It allows detailed analysis of how ‘practices’ develop in relation to the use of general socio-cultural narratives as resources, their adaptation and the emergence of dispositions. Media cultures have considerably expanded the social capacity to do gay, through modelling, adapting, resisting or critically appropriating available media narratives. This too has brought political challenges (Altman 2001).

III. Sex, intimacy and love

Sex does not need to be the only way we represent gay men’s expression of love.

(Ryan 2002)

If sex is always and only permitted by love then lust is created as the name for sex without love.

(Hurley 2003)

Discussions of sex, love and intimacy are often carried out in very limited ways. Love and intimacy are combined in relation to romantic partnerships. Casual sex is described as ‘anonymous’ and non-feeling. Intimacy and feeling-sex are seen as characteristic only of (‘regularised’) love.

The Ryan and Hurley quotes above are not contradictory. They come at questions of love and sex from different angles, but they share a refusal to think about sex and love as opposites. So Ryan is saying firstly that sex can be an expression of love and, secondly, love is not only about sex. Whereas Hurley is saying that if you begin from a position that forcibly ties intimacy and love together then casual sex will always be misunderstood as sex without feelings.

One problem with the notion that sex can occur without feelings is that it refuses to include physical pleasure within understandings of what feelings are. Feeling is defined

by emotions to the exclusion of sensations. It's as though the person experiencing the emotions has no body. Feelings are always 'finer'. Racing pulses, increased body temperature, the touch of skin, deeper or faster breathing are made out to be mere biological symptoms of something else: feelings. In the case of casual sex, bodily sensations and pleasures are then characterised as lust. Lust becomes corporeal and feeling is disembodied.

On this view, the body can be sharply distinguished from the person, or the mind or the soul. The mind and the soul become 'higher' faculties, the body is 'animal' and feeling is split off from and privileged over sensation. When applied to sexual interactions this dualism of body and mind forces an opposition between intimacy and sex.

My argument isn't that sex must always be part of love. Rather, I'm trying to clear the field so that sex, love and intimacy of many different kinds can be understood in their own right as forms of relating. One consequence of this would be the possibility of understanding the presence of some kinds of intimacy in what is called casual sex.

If intimacy is narrated only as emotional health, the actual pleasures of sex get nowhere near the surface, the detail disappears and with it the simple enjoyment of being lost in the flesh – 'take me away'.

The discourse of emotional health sits uneasily and oddly with that other great modernist narrative, sex as the site of identity. Sex becomes culturally over narrated and inevitably over rated as a source of significance.

How well does biomedically framed public health understand all this and what it means for living gay?

'Can't they just wear condoms?'

What does it mean to live with incessant calculations of the likelihood of viral transmission?

What does it mean to want love and home and do the calculations each time. *He's here, he must know the risks. He's here; he must be positive/negative/gay like me.* The original SAPA data pointed out that a substantial group 'acted as though *being in a couple* removed the risk from sexual practice - or made them willing to run the risk' (Kippax *et al* 1993: 73) By 1991 relationship change was beginning to appear as a tentative strategy of risk reduction (148).

How do you choreograph and/or perform uncertainty as a way of living and keep having sex? (McInnes and Bollen 2000) How do you do this in relation to how popular culture narrates the possibilities and promises of love?

Gay men are often panicked by love not sex. Being panicked by love - its absence, possibility, decline - is an ordinary story in popular culture which narrates romance as a universal prescription for happiness and as panacea for emotional challenges. Love panic is a dominant mode of sociality not an individual dysfunction. Nor is it particular to gay men, though we live it out in ways sometimes peculiar to our cultures. Many gay men yearn for love even as they simultaneously learn to ironise it. That is, they understand the gap between what is said about romantic love and how it is lived out. It is gay men's negotiations of this gap that partially explain the popularity of 'Queer as Folk' and the cult audience for 'The Golden Girls'. Irony merges with a bitter-sweet sadness and subjectivities oscillate between the desire for love, understandings of its possibilities and limits and forms of wit and humour.

Sometimes this oscillation produces a pornography of emotion in which love and intimacy become the official currency for sex. Say that you love me and you can have my arse. Other times, it may be characterised by sourness, bitterness and anger

Intimacy and love can be asked to mean too much, as can sex. I'm thinking now of those men who in casual sexual encounters who, even before their pants are down, ask if they can see the man they are with again. To my mind, the answer 'yes' gives them permission to continue with the sex because they hear the 'yes' as a marker, if not a guarantor, of a wider set of possibilities. The answer 'yes' lets them break through a

series of reservations about what they are doing, lets them construct a framework in which what they are doing makes sense.

How is this done in a social formation, which at an official level cannot deal with the lived distinctions its populace, makes between love, intimacy and sex?

Australian quantitative HIV social research has long used a useful distinction between regular and casual partners to describe unprotected sex in relation to risk. This has been the backbone of the evidence base for the viability of negotiated safety in relationships. Recent New Zealand research has shifted the discussion by pointing out that the nature of sexual partners can be thought more fluidly, some casual partners are regular, and when this is done the relations between regularity of partner and unprotected sex change significantly (Saxton *et al* 2003). Previously unrecognised shared patterns of unprotected safety and risk emerge. What's important for my purposes here is the productivity of the conceptual recognition that the relations between regularity and intimacy play out in various ways. These relations are masked if we only work with a regular partner/casual partner distinction that doesn't include factors such as length of relationship and an extended typology of 'partnership'.

When 'sex' and 'health' (disease) are narrated together with romance, love and intimacy, the pressure on sex and sexuality is enormous. For gay men, anal sex often becomes a focus of this pressure. It's a pressure that eroticises and it's not all glibly transgressive. The romantic discourse of 'connection' emerges, sometimes accompanied by lack of experience and/or extreme sexual passivity, other times by a hungry devouring in which the aim seems to be simultaneously a form of unity with, and a dissolution of the self into, the other. However the search for ultimate dissolution is also often seen in the most experienced of sex players, in the search for the sublime.[25] In each of these versions,

[25] Marcus O'Donnell (2002a) wrote evocatively of this in his obituary for Bill Phillips:

> A few weeks ago Bill wrote a story, "The angel of death," it began:
> *I am not afraid of him. On the contrary, he fills me with calm and confidence. This is encouraged by his altogether beautiful appearance. Not the Crone, nor the Grim Reaper: he appears to me as a man of astonishing grace. Winged, dazzlingly lovely in form and face, he is naked, blazing with light and life.*
> *I feel his presence behind me. His massive wings enfold me and he whispers in my ear: "Soon, my darling. Soon."*

anal sex is positioned sometimes as the gateway to heaven. Pleasure is sometimes, *but not always*, constructed as a response to homophobic puritanism. When HIV is caught up in this dynamic, notions of acceptable risk can shift considerably.

This raises the possibility that when public health and health promotion act together in the narration of sex and health they not only install particular ways of being gay (Keogh 2002a, 2003), but also do so in ways that are 'unhealthy'. They ask people and cultures to be other than they are, without offering the infrastructures that make this possible. Keogh is not dismissing health promotion in this discussion; rather he's identifying some emerging limits, particularly in relation to class and race in Britain. On his account, the non-identifiers lose out because dominant health promotion practices don't adequately address them and in that sense the model of health promotion does not meet the needs of all gay men.

One way of understanding this process of co-narration has been to describe it as a form of 'governmentality': the use of population health to produce certain kinds of subjectivities (the healthy citizen). The yoking of public health and health promotion in the area of HIV has increasingly occurred by making the health promotion more and more tightly accountable to the public health priorities of funders and to the perceived political fallout for (by?) their political masters. The result has been a sustained intervention into cultures of living gay. Community-based health promotion is often in the position of having to balance public health priorities with ways of living that know what they are doing and don't do it in ways that public health understands. The best of policy makers work in this gap.

Indeed 'health promotion' as a named practice emerges from public health not from the community-based practices that initially installed safe sex cultures (Parnell 1992). Those practices were carried out in the early years in the name of 'gay education' rather than in the name of health, but to an extent they were diverted and reformulated by the installation of professionalism in place of political mobilisation in the early 1990s (Patton 1990, Altman 1994).

This fills me with joy. I am desired, distracted by his passion for me.

Self-care is now individualised as responsibility and mutual obligation (Race 2002a, b; 2000), but it also exists within cultures of care, sociability and mutuality (Hurley 2002a). It's sometimes a different, more atomised form of sociality, especially in relation to medicine, that isn't always disliked or opposed. However, individualisation can play out in some odd ways, as noted in South Africa:

> The vaccine drive 'socialises' the disease in a highly distorted manner – not by lodging it in the social, but by relieving the individual from responsibility. (Maraise 2000: 47)

'Responsibilising', as Race has argued, is a part of the problem in a culture of long term treating such as exists in Australia. Where people live 'a kind of kamikaze existence', without treatments, individualisation is seen as having a different importance (Maraise 2000: 51). It seems more likely to me that in quite different contexts at least two problems are shared: biopublic health moralism[26] and an unfair burden of responsibility on HIV positive individuals. Intervention programs that don't accept that starting point as problematic are not going to work. Interventions have to resonate (51).

Gayness is now as much about 'I' as 'we'. To the extent that is about real choices, it is a social advance. Ways of living gay and the nature of community on which mobilisation depended changed just as rapidly as notions of care of the self.

There *are* 'knowables' about sex, and they are central to preventing HIV, but three issues at least need reference here. The first is that some health promotion practices, particularly those based only on social marketing, can't help but be both informative and sexual citizen forming. Secondly, whatever one thinks of that, publicly funded community-based health promotion often has to negotiate non-shaming versions of sexual citizenship with the politics of public health. This is central in Rofes' commentary on U.S health promotion and has import here as government becomes more active in resource approvals. Partly what is at stake is the public negotiation of the social acceptability of sexual difference, but my point is that resource approval processes themselves have to be constantly renegotiated. This element of negotiation can also be

[26] 'Cutting to the bone of conceptions of value, HIV/AIDS cannot but remain scandalous' (Jones 2001:6).

seen as a necessity of partnership in governmentality terms, as an active opportunity for the establishment of mutuality in partnership and as a challenge at both state and national levels.

Thirdly, cultural salience has been seen as necessary for good health promotion (Spina 1997; Nutbeam 1998), but it hasn't been at all well understood that it is as much the deliverable as is the information-based message. In fact, at moments of political stress, the salience is seen as problematic by politicians and their minders because it is aspects of lived practice, which are seen as causing the problem. That's a problematic distortion of a rightful focus on lived practice. In that tendency, homophobia replaces health promotion. The brokering of public health spaces, which incorporate, lived practice as central rather than as negotiables is a major priority.

The tensions produced in and by the brokering indicate a lack in the criteria by which the specifics of governmentality can be monitored for counter productivity for the populations concerned. Health promotion is a different form of surveillance to counting disease frequencies, but it is still surveillance and can be formulated in ways that disregard questions of quality of life as health outputs. A key issue here is uncertainty as a form of both professional knowledge and an epistemology of everyday life.

At least implicitly, Bartos[27] recognised the tensions this brings when he argued in 1996 that safe sex culture has an unspeakable under side: 'the inarticulate enjoyment of unprotected anal intercourse':

> Defying the tyranny of HIV brings with it two responses. One is the continuing, practical struggle to ensure that the categories under which sexual conduct develops can keep pace with the endlessly inventive and pleasurable practices of everyday life. The other response [unsafe sex] defies reason. The psychic effects of its contours may be described and may be displaced, but cannot be opposed directly by any program of political action. (Bartos 1996: 130)

[27] I have used this Bartos passage several times over the years. As I was working it again for this Introduction I happened to begin reading McInnes *et al* (2002) who also discuss it. There are similarities and differences in our reading and I use it to somewhat different ends.

The defying of reason should not be understood as ‘unprotected sex’ in the ways used now to distinguish it from unsafe sex. It refers to ‘unsafe’, without a notion of safe unprotected sex. I want to stay in this territory and delineate what I see as some key areas, areas that disappear not just in the face of rising infections and a fetishisation of barebacking, but are ruled out by some configurations of sexual health.

Bartos’ deft phrase ‘defies reason’ is configured next to the ‘continuing practical struggle…’. I read this at one level as positioning the defiance of reason outside of governmentality - the organising category of the Bartos essay - and outside of an instrumental rationalism. Here it denotes ‘unknowability’ and for some, conceptually, this would equate with irrationality. I would see it rather as living primarily through symbolic meaning or as sometimes an example of de Certeau’s resistance-clandestinity nexus. In another way, Bartos seems to make the ‘practical struggle’ social, derogating ‘the other response’ to the psychic, making it individual and mysterious, outside health promotion and governmentality. Here we start oscillating between epistemological unknowability and uncertainty about whether there might be techniques of knowing. Both unknowability and uncertainty about technical possibility are outside one sense of governmentality because that notion operates partly at population levels and seemingly not in relation to subjectivity where risk is in a sense lived out. However the point about governmentality is that it links populations as governable items to individuals through the formation of the self. Hence pedagogy is a crucial practice and ‘uncertainty’ is pulled into governmentality in the sense of using the term to describe producing ways of being. This is the great strength of McInnes *et al’s* work which provides a practical purchase on uncertainty and an antithesis to the mysterious as unknowable (2002). What producing ‘ways of being’ does do often in linking populations with individuals is become caught in behavioural individualism. The population becomes understood as an aggregate of individuals rather than as a category of analysis. In the end only the individual concerned can explain the circumstances of their seroconversion as best they are able, but this doesn’t reduce seroconversion to an unknowable event. Nor is it a failure in sexual citizenship as Dow (2002) seems to think, though the experience may well feel that way.

The ‘other realm can be understood pragmatically without instantly trying to tie it down epistemologically. It simply becomes those moments when cognitive knowledge is refused, repositioned or displaced. So, for example, we might speak metaphorically of

being ’lost in flesh’, ‘thinking with his dick’, ‘distracted’, ‘messy’, ‘feeling intensely alive’ or, in Gold’s term, ‘offline’.

McInnes, Bollen and Race (2002) go on to position cognitive knowledge within a very different paradigm to that of Gold, but one which keeps the notion of practical knowledges and capacities that allow us to enter this ‘other realm’. I want to do the same, as well as keep room for uncertainty and indeterminacy as part of the field. In my own work I have positioned some forms of transgression as being caught in a puritan dialectic (Hurley 2001b), and would still argue strongly that for some individuals this is a moment of stasis of varying length. However, I have made this argument by valorising the ordinary as a space outside of an ordinary/extraordinary opposition (Hurley 2001d; 255). I have also used metaphor to keep open areas of wonder, joy and awe as part of the ordinary. The effects of these are in part ‘unknowable’ *at the time*, if force-tied to explanations of individual acts of risk by people who otherwise ‘know’, at least in the sense that the metaphors slip, slide and soar out of containment. It’s characteristic of shame and anger, for example, that they prevent their being known *for now*. They are also the productive side of being ‘lost in the flesh’, pedagogically recuperable, much as McInnes, Bollen and Race indicate with their uses of ‘surprise’ and ‘joy’ in relation to adventurous sex.

These metaphors have flowed through much of my own thinking. While my work on treatments education has located people living with HIV within media pedagogies, metaphors such as ‘lost in the flesh’ resonate phenomenologically, and have informed my fiction and ficto-critical writings. To a large extent any pedagogy within them, as distinct from argument (‘the brown eye is covered’), has been structured differently. They have been written to invite and entice a willingness or a desire on the part of the readers to teach themselves (self iterate) any relevant cultural and sexual literacies. Implicitly I have used narrative and metaphor as invitations to model reflexivity by building reflexivity into the required reading and listening strategies. This is no different in principle to what David McDiarmid did with his computer generated Canon laser prints (Gott 1994: 158-159) or his series of posters for ACON (Gott 1994: 154). It’s a pedagogy that demands the listener/viewer/reader actively take on compositional form in the process of self-education. While this is anathema to lowest common denominator health promotion based round concepts of access defined by simplicity and clarity of message,

it's a standard technique in popular culture: the Simpsons; Kath and Kim; video clips. That is, popular cultures are themselves highly reflexive.

Research into peer education projects, educator practice, casual and adventurous sex has quite clear applications. McInnes *et al* (2001) showed that sex venue use is not ipso facto chaotic, but choreographed around various forms of familiarity and routinised 'organised' pleasure. Freewheeling is orchestrated. McInnes *et al* have gone on to show that whatever problems there are with the notions of choreography involved, there are real possibilities and practices of induction which allow for the learning of other's experiences of pleasure and safety in these environments (McInnes and Bollen 2000). The AIDS Council of New South Wales has been busy putting these into place, though restricted by public health policies that constrain their implementation.

McInnes, Bollen and Race (2002: 32) argue that:

> Health education is always a pedagogical project…Health…cannot simply be seen as an external element that should exert its force on sexual contexts. So rather than applying frames and provisions of health onto or into sexual contexts, work needs to be done within sexual health education to determine the ways in which health (discourses, strategies and practices) is already woven into the affective assemblages of sex and the place that they have in the learning that occurs therein and across time …

The notion of health as already imbedded is I believe crucial to valorising, but not romanticising, lived sex cultures as the habitus in which dispositions can not so much be formed – they are already – but reformed in ways consistent with how people learn 'on the job'. The 'improvisational capacity' McInnes, Bollen and Race identify in everyday sex and its transferability is central.

Bourdieu's notion of 'dispositions' allows us to think this territory generally without ceding it to radical forms of unknowability. I'm not alone in noting this (Kippax and Smith 2001; Willis 2002). The category of 'dispositions' refers to how sociality is incorporated or embodied into individuality and individualisation. What matters here is that 'dispositions'

gives us a way of understanding lived experience that are social rather than psychological, though it allows us to understand psychosocial issues. It also allows us to discuss how certain sexual cultures refigure what is thought to be reasonable.

The ways Bourdieu circulates in HIV social research are contestable. For example, while we might want to be able to say with Kippax and Smith that at a general social level passivity is often 'seen as' structurally feminised, and identify the sequential logics that then play out ('receptive' anal sex, passivity, vulnerability, masculinity issues) we have already conceded too much. Firstly, by accepting the perception as signifying a gendered theoretical framework and, secondly, by constructing the ground behaviourally: receptive and insertive anal sex. For purposes of discussions of power erotics that are not framed by gender determinist, heterosexual debates, there are other places to begin. We can also say that within specific 'knowing' sex cultures, 'receptivity' is 'active'. If we can begin there, rather than have to fight to stop the discussion continually falling back into anxieties of gendered vulnerability, then we can see aspects of sexual practice in other, 'new', ways. 'Receptivity' in this framework is phenomenological rather than behavioural, is consistent with how some sex cultures speak what happens within them and is dispositional – 'uppity bottom seeks…'. We are then able to acknowledge particular social aspects of sexual practice in which the binary active/passive has been sexually deconstructed, or is at least under erasure. In these sex cultures, the 'uppity' bottom can emerge and speak, the older can position themselves as 'boy' to the younger, Asian tops can seek and find WGM bottoms and the metaphor of the 'hungry arse' (the active anus) is given its full force (Dowsett 1996a: 205).

Within that dispositional frame, we can then also deal with vulnerability as power positive (an actualisation of idealised accounts of relationship intimacy). It's a relational rather than structural account and can still address problems with ways in which 'vulnerability' can be exploited. This latter would enable us to address the concerns Rofes (2002) had in mind when he referred to American data that indicated some new infections in age-mediated sexual interactions. We could do so, however, without automatically reading all structured social relations as exercises in repressive power. Notions of gender often get in the way here, an argument extendable to discussions of women in developing countries who are simultaneously lauded as stalwarts and positioned as victims with no

sense of the contradictions and confusions this brings (Crewe 2003). We need to be able to understand gay sexual practices and masculinities, not only in relation to initiation, and abuse, but as informative of mutuality and reciprocity. In that field, new dispositions become possible: endless inventiveness.

It's here too that gender can return in a more useful way. It can allow for the recognition of anxiety in relation to vulnerability as one characteristic of novelty in the negotiation of the mutuality. This is where the work of McInnes and Bollen has been particularly insightful.

At another level, however, Bartos links sexual conduct not to population health but 'to the endlessly inventive and pleasurable practices of everyday life'. There are versions of public health and health promotion for which the 'unknowability' of invention and pleasure is a huge problem. Public Health has no concept of pleasure or even of the body as social rather than only biological. Pleasure in its own right, and as part of health promotion, is dealt with by producing the figure of the 'complacent' gay man, recklessly infecting himself and others. This response is nasty. It says, well, we don't understand, but for the purposes of keeping the state and public opinion onside we'll speak as though we do and berate. 'Unknowability' might seem to offer a way of keeping the state out of the 'bedroom', but that simply keeps an untenable public/private distinction in play. It's a problem for positions which celebrate lived sex cultures escaping the reach of governmentality. In certain inflections, 'the psychic' is constructed as a romanticised realm of freedom in which the anus becomes the gateway to heaven and sexual adventurism a kind of 'outer'-space exploration. I'd like to see 'unknowability' positioned in relation to a shared ethics of mutually understood sexual practices rather than an individualist epistemology of 'not my problem'. Community-controlled (sic) health promotion makes this possible.

Political contexts complicate these matters enormously. In the United States federal government opposition to sexual explicitness in health promotion and insistence on 'abstinence' (and its construction in opposition to 'harm reduction' instead of as one option within a harm minimisation strategy) has fed existing discourses of sexual shame. I would argue that the consequences include constructions of realms of freedom which

simply operate as the other side of the same puritan coin. In order to undercut that, activists and theorists in the USA have organised grass roots gay men's health movements and defences of sex that don't buy into the binary (Rofes 2002). That was the point of 'sex panic' as a productively oppositional politics to the gay 'normalisers' (Warner 2000).

IV. Gayness, health and education

In Britain and Australia where public health systems benefit gay men as citizens, but also construct the 'healthy homosexual' quite differently, and many gay men live 'post-AIDS', gay organisations have moved to various degrees from being AIDS organisations to gay and lesbian health organisations. In this sense they have become non-government health organisations. However their origins in community activism have meant a commitment to pro-sex positions remains. The result is various discourses of health politics that maintain a much more diverse set of government funded health practices, particularly in the area of HIV. Increasingly, however, in Australia, political pressures are constraining what's possible.

In order to discuss these matters, I wish to maintain a degree of functional difference between biomedical and population based public health and community based health promotion, even though that distinction is harder to hold consistently at the level of 'community-based' organisations. The reason for the distinction is that in Australia, at least, we can identify a steady increase in tension between the imperatives of public health as distinct from those of health promotion for gay men, between primarily medical responses and social responses. For public health and some appropriations of it, gay men in effect are still risky individuals because the social values with which public health works only have room for 'the normal'.

Gayness is formally included in that 'normal', but only if it too is normalised. Community-based health promotion that still has organic connections with the everyday life of lived sex cultures, on the other hand, is able to begin from a twofold position: one that doesn't implicitly presume normalcy, and, one that, in Keogh's terms, 'constructs gay men as no longer intrinsically risky individuals, but sees them as having a capacity to manage risk'.

For gay men, the HIV epidemic meant that gayness and HIV became linked through the centrality of sex and sexual practices as organising categories of both gayness and viral transmission. In this sense interrogations of gayness were carried out in the name of HIV, rather than of desire, and it took some time for the insistence on the separation of sex, desire and the virus to become functionally clear. At the same time as this was happening, images of both gayness and the virus were exploding.

What I want to do now is configure in fairly rapid fire, the appearance of the good gay man in relation to public health, the public sphere and within some gay cultures.

In order to do this, I want to spend a little time discussing 'barebacking' in relation to some of the themes in this essay. I take barebacking to refer to a very specific form of unprotected sex. It's a form that poses as actively seeking infection as distinct from seeking to negotiate condom free sex that minimises the risk of transmission. The 'good gay man' is implicit in some discussions of barebacking and barebacking itself can be seen as a very particular way of responding to aspects of living in relation to the HIV epidemic. One of the difficulties with discussions of barebacking is that in American versions we rarely see any nuanced understanding of how it might be different from other practices of unprotected sex, particularly those involving negotiated safety in regular relationships, or even 'strategic positioning'. If we miss those distinctions we also miss, I suggest, that element of barebacking discourse that is 'cultic'.

We miss this if we have no an account of the social relations that produce the practice. Marcus O'Donnell has engaged seriously with the phenomenon, linking it with forms of gay sociability (2002b). He suggested that 'versions of community include elements of cult, benevolent society and activist minority' and that more than ever before the strands of this narrative are in conflict'. He sees barebacking as 'the most extreme version of a new radical gay myth… a narrative that most of us will not ever engage with personally' and argues that it is a narrative which,

> must be 'acknowledged rather than merely dismissed. These men, using the language of personal rights and tolerance on the one hand, and the language of

> the mystic outsider on the other are in their own way seeking to produce a new discourse about gay community and HIV positive identity.'

This is an important argument because it allows us to recognise the powerful force of barebacking as produced by media focus and as one way of doing gay. In turn we can then start to see some of the elements constitutive of the sex practices involved and work out how to intervene, whether to do so directly and how to have a useful discussion. As O'Donnell put it:

> Recent increases in the practice of risky sex and the rise of the so called 'barebacking' phenomenon has been almost universally bemoaned by gay leaders not just because of the inherent health risks but because it is seen to blot that impressive record. It is seen to mar the goodboygay image which has been achieved over the past decade through an appreciation of the gay community's heroism in the face of adversity. And interestingly most of the discourse - if you can call it that - about barebacking is about image not about health or harm minimisation. For the barebacker community - and it does exist through venues, parties and especially email lists and web sites - it is about reclaiming a radical sex image. For the popular press and even the gay press, it is about a 'phenomenon', usually personalised in narrative form, which includes the descent into a dark corridor or stairwell and entry into a forbidden world. Both narratives in their own way are about the rebirth of badboygay.

O'Donnell links 'the rebirth of badgayboy' to ways of engaging with 'death, loss and desire'. He is describing not advocating, seeking to understand how descriptions of the desire for sero-conversion:

> are an attempt to use gay sexuality and identity to go beyond everyday reality and everyday moral strictures. They seek in a highly provocative way to describe how to 'get unborn'. Many admit to chasing death but instead finding new life. Until we learn as a community and as individuals to engage again with the transformational aspects of gay identity, to play in our myths with both heretic

> and saint, we will always produce the type of cathartic rebellion represented by the giftgivers and bugchasers.'

Gayness, sex and love *are* everywhere, but when they are spoken by public health in relation to HIV they disappear. What appears in their place is the figure of the good gay man. Gayness is rewritten as a public health imperative. That imperative is writ large, not in the sense that gayness is promoted, but in the sense that public health constructs a screen on which gayness can appear. The screen has several grid lines that largely determine the nature of the appearance.

Public health involves assumptions, government departments, biotechnologies, bodily and behavioural screening and surveillance, health promotion, policy and, most importantly, populations. It is governed by an honourable history of saving lives, medicalised ways of thinking and doing and politics (priorities, funding, political will). It is multidisciplinary and has various fields of work.

What follows in Box 1 is a concise, *partial* description of the field of sexual health in the area of HIV. It is a discursive description in the form of a series of statements. What we see are not policy positions or consciously held beliefs but lines of thinking that impinge directly on how gay men as a population are 'understood'. These lines of thinking are often not particular to sexual health, but circulate there in various ways in different states and territories.

Box 1: Values in public health

The body is physical rather than biopsychosocial.
Sex is thought biologically and medically.
Situational sex is domesticated and occurs in the bedroom, unless no-one else is home.
Sex is best characterised by privacy.
Public sex is characteristic of gayness, teenagers and drunkenness.
Loving sex is thought in relationship models of (serialised) monogamy.
Monogamy is privileged as the frame of reference for partnership, love and sex.
Intimacy is defined by close personal relations that can only be properly constituted with a 'partner' over time.
Intimacy is characteristic only of loving monogamous relationships.
Romantic sex is romanticised. Candles are for lighting.
Love excludes lust.
Monogamy guarantees disease prevention and moral virtue.

Smell, touch, taste, sight and sound are diagnostic tools.

Semen is a disease vector.
Traces of faeces are faecal contamination.
Mess is for cleaning up.

Sexual health is defined by disease prevention and control.
Healthy sex is sex in the absence of disease transmission.
Sex is safe sex for healthy populations.
Safe sex is mandatory for at risk populations.
Unprotected sex is by definition unsafe.
Contextual calculations about the applicability of safe sex are prima facie signs of unreliability, irresponsibility and foolishness.

Safe sexual behaviour is about behaving.
Sexual health for at risk populations is about behaving well for a lifetime.

Life is defined as healthy life.
Illness involves various degrees of bodily collapse.
The end goal of 'life' is longevity.
Death is primarily a medical failure or the effect of a knowledge limit.

Youthfulness is defined by ill informed risk taking.
Ageing is defined by the control of bodily collapse.

Versions of these lines of thinking are also easily found in popular culture. If we modelled on *Will and Grace*, for example, we see the good gay man who for his entire adult life eats well, presents well, goes to his doctor, wears a rubber, is 100% risk free, leak free and behaves.

I would simply ask, which of these discourses has a proper place in public health?

'Trust gay men', I said as an invited participant in discussions of HIV and unprotected sex two years ago. In one forum I was mocked by one speaker and, in another, heard as minimising the difficulties in sustaining the levels of knowledge needed if gay men were to continue protecting themselves. I wasn't actually saying any of trust them and do nothing or gay men have done it all, nothing remains or …. Rather I was alluding to building critical interventions from a position of trust.

I'm reminded by those memories of a passage in Robert Reynolds' *From Camp to Queer* where he discusses early gay liberation and how it built 'new ways of being gay'. In a complex point about how 'goodness' and 'badness' function in different kinds of social theory and practice, Reynolds quotes Richards on how some practices involve 'a profound lack of faith in the capacity of human beings to give anything of permanent value to each other and mutually to constitute themselves' (2002c: 96-97).

While the nature of mutuality[28] in ways of living gay has changed remarkably in the past thirty years, all the social research evidence says it is still characteristic of lived safe sex cultures. The research also says that in an ongoing framework involving changing bodies of relevant knowledge there are uneven distributions and applications of those knowledges that put some people at risk. I want to use the notion of mutuality to discuss the widening gap between public health as an epidemiologically driven policy process and health promotion practices based on forms of sociability.

Disease requires public action. Sexually transmitted diseases must be contained. No problem. The problem comes with suppressed moral values. It seems as though, in this

[28] I am positioning 'mutuality' quite differently to notions of 'mutual obligation'. I see no reason why we should cede the ground of mutuality to a take-over bid by a punitive moralism.

framework, sex enters the public health arena only as a communicable disease and never as pleasure and desire and only in terms of the narrowest of social relations. So if HIV notifications increase and gay men are having sex in public then public sex must be what's causing it. Yet we have long known that 'home' is a site of infection (Gold 1991; Dowsett 1996: 82). One of the things we know about HIV infection is that it often occurs in the first six months of relationships between people of different HIV status. Infection often occurs in a context of love and it occurs at home. There is also increasing evidence that unprotected anal casual sex between men who meet at sex venues occurs after they leave the venue and go home together. The bedroom becomes a site of perceived 'safety', home 'feels' safe.

Where in all this can gay men go and not be at risk? When the answer 'feels like' it's nowhere, for those who value anal sex, what are the effects when HIV is both experienced and not experienced as threat?

Sex is about more than behaving and behaviour and it can't be understood using a bald distinction like public and private.

There is a liberalism at work in public health that still wants sex to be private even as all sorts of protective measures are taken publicly. It was a liberalism evident fifteen years ago in discussions of the 'innocent' victims of an infected blood supply and their right to compensation. In NSW the compensation process distinguished carefully between modes of transmission and the so-called question of choice. Choice was used to refer to both a 'lifestyle' and to informed, risky behaviour. I wrote at the time that what was being denied in the NSW proceedings was 'a population's claim to sexual legitimacy' (Hurley 1992: 151).

Now, there is a difference and a similarity with that earlier situation. It's not feasible to make a general claim in 2003 that gays as a population are being declared illegitimate. However, it is feasible to say that wide screen discussion of recent HIV infections is playing out a political tension that was evident in 1992. Recent infections are being framed as 'an arena of struggle over the gay male body as a sexual body'. Sexual activity is yet again being defined as contagious activity.

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