GAY MEN'S SEXUAL SUBJECTIVITIES IN THE AGE OF HIV/AIDS: A POSTSTRUCTURAL DISCOURSE ANALYSIS OF ACTIVISTS' EXPERIENCES IN NOVA SCOTIA

by

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ABSTRACT

HIV/AIDS has been a part of the lives of gay men and other men who have sex with men (MSM) for over 30 years. Despite improvements in treatment, access to education, and targeted efforts by public health and AIDS Service Organizations (ASOs), gay men continue to have the highest rates of HIV transmission and the most people living with the disease in Canada compared to other populations (PHAC, 2011). Through a Foucauldian conceptual framework and employing a qualitative methodology of post-structural discourse analysis this thesis examines how the social, cultural and political landscape of Nova Scotia and institutions, such as public health, contribute to the way we, as gay men know and understand ourselves in the modern age of HIV. To investigate these issues, I interviewed 17 HIV/AIDS activists in Nova Scotia and discussed various aspects of HIV/AIDS, including the history of the movement, the effects of health promotion policies and programs, the role of activism, the meaning of barebacking, the influence of social and political climates, and the impact these issues have on what it means to be a gay man in this province. These topics were covered to answer the primary research topic: How HIV discourse in Nova Scotia is set within the discursive field of gay men's sexual subjectivities. The findings of this study show that health promotion needs to bring a critical perspective to HIV-prevention efforts. With the intent to further guide health promotion efforts, this study contributes to our understanding of how HIV prevention programs and policies become part of the sexual subjectivities of gay men and, in turn, part of their sexual *experience.*

LIST OF ABBREVIATIONS USED

HIV - Human Immunodeficiency Virus
AIDS - Acquired Immunodeficiency Syndrome
MSM - Men Who Have Sex With Men
ASO - AIDS Service Organization
LGBT - Lesbian, Gay, Bisexual and Transgender
DSM - Diagnostic and Statistical Manual of Mental Disorders
UAI - Unprotected Anal Intercourse
NS - Nova Scotia
PHA - Person Living With HIV/AIDS
PHAC - Public Health Agency Of Canada
NSSN - Nova Scotia Sex Now Survey
ACNS - AIDS Coalition Of Nova Scotia
MacAIDS - Metro Area Committee On AIDS
ANS - AIDS Nova Scotia
STI - Sexually Transmitted Infection
GRID - Gay-Related Immune Disorder
NSPWAC - Nova Scotia Persons With AIDS Coalition
NGO - Non-Government Organization
WHO - World Health Organization
ART - Anti-Retroviral Therapy
S & M - Sadism & Masochism
POZ - HIV-positive
ACT UP - AIDS Coalition to Unleash Power
HAART - Highly Active Antiretroviral Therapy
NSPH - Nova Scotia Department of Public Health

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Chapter 1: Introduction

HIV has been a part of the lives of gay men and other men who have sex with men (MSM) for over 30 years. Despite improvements in treatment, access to education, and targeted efforts by public health and AIDS Service Organizations (ASOs), gay men continue to have the highest rates of HIV transmission and the most people living with the disease in Canada compared to other populations (PHAC, 2011). Research on gay men and HIV is not new, and many talented researchers and theoreticians have contributed to our understanding of the complex issues associated with the disease. Nevertheless, interest among social scientists has waned in recent years (Mykhalovskiy & Rosengarten, 2009). The failure to reduce HIV transmission among gay men, my involvement in the gay community, and my own contemplations of gay sex have led me to investigate how HIV impacts the lives of gay men and the way in which we, as members of the gay community, understand ourselves.

My approach to this project is to employ a Foucauldian conceptual framework and a post-structural discourse analysis to examine how the social, cultural and political landscape of Nova Scotia and institutions, such as public health, contribute to the way we, as gay men, know and understand ourselves in the modern age of HIV. To investigate this issue, I interviewed HIV/AIDS activists in Nova Scotia and discussed various aspects of HIV/AIDS, including the history of the movement, the effects of health promotion policies and programs, the role of activism, the meaning of barebacking, the influence of social and political climates, and the impact these issues have on what it means to be a gay man in this province. While the findings from this research touch on many facets of

HIV/AIDS and gay men in Nova Scotia, a key issue is how societal forces, including power influence what can be and what is said about HIV/AIDS and gay men.

Background

HIV/AIDS has impacted the community of gay men in immeasurable ways; the disease has had devastating effects most poignantly at the beginning of the outbreak but also subsequent effects. One of the compounding tragedies is that HIV not only seems to target specific groups, but also it is often a consequence of expressions of love, lust, desire and the very *identity* through which groups are understood. Adam, Husbands, Murray and Maxwell (2008) suggest, “It is perhaps ironic that HIV transmission might be presumed to be largely a question of individual characteristics when HIV is an infection that takes advantage of the human propensity for connection, bonding, and network formation through sex” (p. 421). In a broad sense, sex in relation to gay men is more than an act between two people. Rather, it is a way the public perceives and understands gay identity. HIV/AIDS ensures sexual behaviours remain at the centre of the debate regarding male homosexuality, generally, and the control of the further spread of the virus, specifically. With the emergence of the epidemic, the 1980s ushered in a new era in which public fear and misinformation about HIV/AIDS reinvigorated homophobia and heterosexism, while gay men, along with lesbians and others, including allies within the LGBT movement, struggled to draw much-needed attention to this issue (C. Patton, 1985, 1988).

The early 1980s have been regarded as a significant turning point for gay liberation, as the moral outrage over gay sexual behaviour found a new home within the institution of medicine (Numer, 2009; C. Patton, 1988). I have argued, elsewhere, that the AIDS epidemic of the early 1980s re-centered the moral outcry against gay male sex

within the institution of medicine, whether unwittingly or not (Numer, 2009). This period complicated the gay liberation movement because the identity associated with gay men moved back into the medical gaze. Institutionally, the psychiatric approach to homosexuality was somewhat dissociated with the removal of homosexuality as a mental illness from the DSM, but with the emergence of HIV/AIDS, gay identity was once again medicalized during the public health response. A complex situation arose, as public health and other medical experts wrestled with a response to the rapid spread of HIV. On the one hand, it was clearly *rational* to encourage gay men to either abstain from sex altogether or to always use condoms and limit the number of sexual partners, in order to save lives. On the other hand, the response brought with it a novel justification for condemning gay sex, one that reached beyond religious doctrines and medical or psychological pathologizing (C. Patton, 1985).

This tension brought about some division within gay communities, as certain groups of gay men believed that succumbing to the demands of government and public health institutions would signify a concession of the sexual freedoms they had been fighting for, while others were willing to make these concessions in order to reduce the spread of the disease. Closing bathhouses, bars and other areas where gay men met and had sexual encounters meant more than a stifling of sex; it was a condemnation of gay men, their community and their identity (C. Patton, 1985, 1996). Seldom has a complex constellation of events moved in sequence to write the discourse of modern public health on the bodies of subjects who are bound by a disease that strikes at the core of their identity and to use it as an expression thereof.

Within the discussion of the broader implications of HIV, identity, and gay men's sexuality, are the individuals at the centre of the crisis, many of whom are not alive to

share their experiences. Among those who did survive, some became activists and witnessed the evolution of the HIV/AIDS epidemic from an impending crisis that was a death sentence for friends and lovers to a disease that some regard, today, as a chronic illness (Weir, Crook, & Vanditelli-Chapman, 2003). There is a core group of activists who have had an insider's perspective on the gay communities throughout the HIV/AIDS era. It is often these individuals who hold insight into the way the social conditions surrounding HIV/AIDS have unfolded in different regions. I draw on these insights to better understand how social and political factors as well as the gay community itself have influenced local practices of sex. As the current literature on drivers of HIV transmission expands, particularly within socio-political contexts, there is an increased recognition that sexual practices often take on a local flavour, which should be considered in HIV-prevention efforts (Berg, 2009; Carballo-Diéguez et al., 2009).

I approached HIV activists because they have been part of the history of HIV in Nova Scotia and I sensed that they might have insight into the social conditions that influence gay men's sexual practices. The primary mode of HIV transmission between gay men is frequently referred to as barebacking. Barebacking, generally, refers to the practice of purposefully engaging in unprotected anal intercourse (UAI), though the complexities of this term will be explored below. The term is complex because it is increasingly recognized in the literature that barebacking does not occur in insolation from the culture and society in which we live (Berg, 2009). Researching the social aspects of HIV, however, seems to require gay researchers, including myself, to reflect on sexual practice, drives, desires, and behaviours as if we are absent from our own bodies.

However, our bodies are always in the picture, always the source of contention, and always the source of the challenges for HIV-prevention.

At the outset of this project, I imagined there was a problem that, at first glance, appeared somewhat simple. Yet, with greater interrogation, the virus and its manifestations revealed itself as being vastly complex: A great deal had been written about gay men and HIV/AIDS within the academic literature, but the rates of HIV transmission gathered by public health surveillance methods did not reflect any notable change in its incidence over the last decade or more. I am not the first within the HIV/AIDS research community to note this, nor do I claim to have new insight into how to stop the spread of HIV within my community. I do, however, offer an analysis that may begin to change the questions we are asking about gay men and HIV and perhaps shift the way we think about gay identity.

During the process of writing this thesis, Foucault's (1994) reflections on research resonated with me, particularly when he stated, "I still don't exactly know what to think about this thing I want so much to think about." He noted that his process "transforms me and transforms what I think," (as cited in Graham, 2007, p. 20). This work has, indeed, transformed me and what I think both about myself and about how HIV affects gay men. Later, Foucault notes, in this same interview, that he often writes about methodology retrospectively by "fabricating a method of analysis" (Foucault, 1994, p. 240). Though I would suggest that neither my methodology nor my method were complete fabrications, the progression of my theorizing is reflected in the analysis.

The process of writing this thesis has been transformative. Initially, my suspicion was that since barebacking had been such an important topic in the literature regarding gay men and HIV/AIDS, following this thread of discourse would bring new conclusions by employing a post-structural analytical framework primarily informed by the work of Foucault (though he himself avoided the label of post-structuralist). At present, I see barebacking as the act that is of greatest concern for HIV-prevention but also the place where gay men live out the tension between safer sex and the desire to have sex without condoms. It can be safely assumed that most gay men would prefer to avoid HIV infection. There is a method to avoid transmission in nearly all instances: the use of condoms. Despite this knowledge, HIV infections continue to spread among gay men in North America. This situation suggests that there are other forces that result in gay men having sex without condoms despite the chance of HIV infection. The forces that pull at gay men's behaviour are the desire to avoid HIV infection against the pleasure and eroticism associated with condom-free sex. The site where this struggle comes to the fore is in gay men's experience of sex and barebacking. I frequently refer to this struggle as competing discourses because in Foucauldian terms, discourse or the collection of thoughts about a particular topic produces people's experience.

Discussions of barebacking take place in various public spheres but often in very different ways. In public health the language revolves around prevention and safer sex practices. This often stands in contrast to mainstream discussions of barebacking in which there are erotic themes. For instance, gay porn has an increasing presence of bareback sex. These discourses create a tension in the gay experience. The issue becomes more complex because these two ideas, which involve pleasure and eroticism versus

responsibility, are not simply opposed, nor are there individuals at the centre of this tension vying for power or dominance over the other. All of this discourse contributes to the way we know gay men as sexual beings or as sexual subjects. The issue of power in this instance has more to do with how we come to know what gay men are as sexual subjects. Through repetition, all of the things that are said about gay men and the issues that surround them solidify the conceptualization of a category of people. Though certain institutions have an interest in controlling and producing the way gay people are understood, there is no single person that has control over the formation of this discourse. It comes together as a collective and makes things knowable. This knowledge creates the framework within which to identify what a gay man is. The field of knowledge is power. I use the term field of knowledge because it is produced through many sources. All of the talk, from public health, media, pornography, research and elsewhere within public forums where gay sex is discussed contributes to the field of knowledge about gay men.

It is not feasible to think that anyone could trace all of the sources of knowledge surrounding gay sexual subjectivity, but one can trace the effects of particular sites of discussion. These sites often have specific agendas that frame their position within the field of knowledge. For instance, some organizations might approach HIV-prevention with a condom-only position. This creates a discourse within the field of knowledge that says gay men should use condoms always when engaging in anal sex with other men. It positions a condom-adhering gay man as responsible and healthy. This is one example of how discourse might be produced in the way we know and understand gay men. Taking the previous example to the logical end, some research has suggested that as the discourse of safer sex has not been able to compete with the pleasure and eroticism presented in

other discourses such as porn. This failure has produced the effect of barebacking becoming the way gay men resist safer sex discourses.

While the overall thesis is about the competing discourses that vie for dominance in the production of gay sexual subjectivities, barebacking remains a focal point because it exemplifies how power relations—situated in institutions such as medicine, public health, research, and ASOs—create objectified bodies and subject positions. Barebacking can also be seen as a form of resistance to safer sex discourses (Holmes, Obyrne, & Gastaldo, 2006).

In his later work, Foucault instructs us to examine "forms of resistance against different forms of power as a starting point" (Foucault, 1982, p. 211) to push the boundaries of theory and practice. He offers this suggestion because analyzing power, itself, is not useful because there is no power without resistance. Power becomes visible as people resist normative forces. The paradox in this understanding of power is that resistance constitutes the very power it is resisting. This moves the examination of power to the subject because power does not operate in some external, ephemeral space. Rather, subjects embody power and make it known through their resistance to normative forces. In other words, power can be observed in the everyday practices of people.

According to Foucault then, an examination of resistance to normative forces illuminates operations of power. The effects of normalization is presented in the findings of this research as the subject position of gay men takes shape in the form of resistance against heterosexual hegemony within the Nova Scotian context. This is not, however, to suggest that the gay subject is merely constructed in opposition to heterosexuality; rather,

the gay subject is but one form that is discursively constituted and not a statement of truth about what it means to be gay. I note this because there are often taken-for-granted beliefs about what it means to be gay that are reiterated in the HIV-prevention literature. This very literature contributes to how gay men are historically seen and understood. To avoid being "trapped in our own history," I attempt to make clear that my findings are about the discourse of gay men and not a claim to have discovered an essential truth about who we are (Foucault, 1982, p. 210). The potential pitfall or "trap," as Foucault calls it, is to reify the fiction of stable identities based on the discourses that have been produced to date. This view of history produces a normative version or a "truthful" account.

Truth statements

One of the challenges of writing in the social sciences is to contribute to the knowledge systems Foucault spent much of his time critiquing. The outcomes of health research are often expected to produce "truth" claims that state solutions to problems and direct future research. The aim of this work is not to find a single solution to HIV transmission among gay men. If the outcome changes from fixing or repairing problems with gay men, then perhaps our relationship to the "truth" about gay men's health may be reconceptualised as a kind of fiction that we work to construct and deconstruct. In other words, interrogating the identity category "gay men" may, for example, disrupt the common assertion that we are victims of a homophobic society and, as a result, experience poorer mental health that leads to sexual risk-taking behaviours. Such a shift might be productive because this assertion not only objectifies gay men as psychologically damaged; it also positions us as an "at-risk" population within the public health rhetoric. The way public health has conceptualized and categorized gay men as at

risk has changed with the advances in treatment of the disease. Today, HIV is generally regarded as a chronic condition rather than a death sentence. Modern treatment not only means that people living with HIV/AIDS (PHAs) can live longer lives, but this recent progress also entails a change in the type of power that is employed in HIV-prevention.

Power

The early days of the HIV/AIDS pandemic saw more obvious forms of power at work as the heavy hand of the state closed baths, criminalized various aspects of HIV/AIDS and demanded safer sex. In modernity, however, these more obvious types of power, also known as sovereign power, dissipate under the guise of progress, equity and humanism (Dreyfus & Rabinow, 1982). Upon closer examination, it becomes apparent that the operation of power has shifted to more subtle forms, thus rendering overt resistance against sovereign mechanisms of power impalpable because there is nothing to resist against. These new subtle tactics are now utilized to more effectively play strategy games. Strategies or strategy games reference one of Foucault's ways of talking about power. He uses these terms to better describe the effects of power without necessarily referring to one-sided domination. To reiterate, however, power requires resistance, but when there are no overt power plays in the strategic games, resistance becomes frustrated and rendered flaccid. This point is exemplified in the latter part of chapter five, as participants recall a time when protests and public outcry against oppressive regimes were effective tools in power struggles related to HIV. As will be discussed, these tools are no longer effective.

Today, Western societies use modern forms of power in the management of public health to produce the "healthiest" possible population. The public health problem of HIV and gay men is no exception. Power is a mechanism through which domination effects can occur, but this effect is masked under the premise of good health and avoidance of HIV transmission among gay men. This is not to say that HIV-prevention efforts have no place within gay culture, but there is a power dynamic that produces the modern understanding of gay identity or subjectivity. It is from the specific locales of subjects that power operations can be observed. The mechanisms of power can been seen operating in institutions such as academia, public health, and ASOs as they attempt to manage and contain the spread of HIV infection. I will examine some of the methods of surveillance that have been put in place to properly observe, manage, contain, and produce the proper gay male sexual subject. Amidst these mechanisms, however, there is no single person attempting to gain control of gay men's bodies and dictate the sexual practices in which they should engage. Foucault points out that this is a most incisive method in which power operates: "Power is not totally entrusted to someone who would exercise it alone, over others, in an absolute fashion; rather, this machine is one in which everyone is caught, those who exercise this power as well as those who are subjected to it" (as cited in Dreyfus and Rabinow, 1983, p. 156). In what follows, the participants in this study describe their frustration in addressing HIV recognizing all the while that they, themselves, are part of the machinery that produces HIV discourse.

The Study

Initially, this research project set out to investigate how barebacking was taken up in the discourse of gay men's sex. As the project progressed, however it became apparent

that barebacking discourses are threads in which gay men have become knowable objects that have become the targets of HIV-prevention messaging and other public health efforts. The focus of this research became clearer during the in-depth interviews with self-identified HIV/AIDS activists and advocates. I used these interviews as the textual source upon which to employ discourse analysis. The participants have insight not only into the complex inter-workings of HIV-prevention and treatment but also into the culture of Nova Scotia. The analysis is not to suggest that HIV/AIDS, itself, is unique here; it is to suggest that the way gay men, as objects of analysis, are recognized and subject positions are produced is.

In Chapter two, the literature review begins by discussing the known history of HIV/AIDS in Nova Scotia, which explores the background within which the current situation is framed. As the literature review progresses, the institutions directly involved in HIV/AIDS activism and advocacy are described. This research is not about the institutions as structures, but rather about the way power operates through institutions (Dreyfus & Rabinow, 1982, p. 119).

Subsequent to the overview of the historical context and a discussion of ASOs in Nova Scotia, the literature review focuses on barebacking. The review of the academic literature related to barebacking illustrates the various conceptualizations of this concept and the tension the phenomenon creates within HIV discourse. Barebacking is the site where the various discourses that are interwoven come to the fore. This point is substantiated and is the rationale for the specific concentration on this topic in the latter portions of the literature review.

Chapter three outlines the conceptual framework for the study. In this section some of the tools Foucault theorized are presented and analyzed in relation to this project. The analysis offered here leads into the methodology and methods. Chapter four describes how a post-structural discourse analysis is used within a Foucauldian framework. The methodology elaborates on how the conceptual tenets lead me to my methodological approach. Subsequently, the specific methods are described based on the methodological work.

The fifth chapter begins the findings section by examining the various aspects of HIV in relation to gay men within the Nova Scotian context. The ways in which homophobia and heterosexism are manifested in Nova Scotia are at the fore of this discussion. The underlying premise is that these social conditions are interwoven into the subject experience of gay men, often with a local distinction. Succeeding this discussion is an analysis of the various considerations that influence HIV-prevention messaging concluding with a description of physicians involved in HIV treatment over the years. Chapter six analyzes how HIV discourse is involved in the production of the gay male subject as well as the concept of the gay community. The end of this chapter looks at "Who We Are" from the perspective of the activists in the study and interpreted by the Foucauldian conceptual framework. This section does not attempt to answer the question; but rather, to shift the discussion from a stable essence of gay men or the gay community.

As mentioned above, barebacking appears in various places in the thesis to illustrate the tensions in HIV-prevention discourse aimed at gay men. The primary tension that emerges is between the discourse of safer sex and the desire for pleasure and eroticism. It appears that to some extent these two discourses are at odds and create a

contradicting experience within the sexual lives of gay men: the desire to avoid HIV transmission while simultaneously maximizing the sexual experience. Chapter eight is dedicated to analyzing the specific topic of barebacking to see how it is interwoven into the work that activists do in the community. Here the aim is not to settle on a definition or to even implicate barebacking but to examine what is currently at the fore of the barebacking discourse within the local gay community. The final chapter of the findings section discusses the role of public health and health promotion in HIV-prevention in Nova Scotia. The purpose of this chapter is to look at some of the ways that HIV awareness and education has been taken up in public health discourse and how political and social factors were influential.

Chapter nine, the conclusion to this work, highlights the main findings presented throughout. Though often standard in health related disciplines, this thesis does not attempt to reconcile what is to be done about HIV and gay men; rather, it is meant to deconstruct some of the discourses that have produced the subjectivities of gay men in Nova Scotia.

Chapter 2: Literature Review

This chapter begins by describing the current rates of HIV/AIDS in Canada and provides a brief history of the agencies and issues associated with HIV/AIDS in Nova Scotia. The review presents the prevalence of HIV/AIDS in Canada and North America from a public health perspective in an effort to contextualize the disease among gay men and to identify gaps in our current understanding of HIV/AIDS nationally. After a brief discussion of the public health view of HIV/AIDS among gay men, I discuss some key moments in the history of HIV/AIDS in Nova Scotia including the evolution of AIDS Service organizations (ASOs) in the province. This material is presented because these issues appear in the findings of the research as participants describe the way our history has contributed to the current social conditions. To complete the review of the literature, the latter portion of this chapter will outline the evolution of the conceptualization and research on barebacking among gay men. The focus on barebacking is a point of departure for my own research, which intends to add to the compendium of information on the topic.

The Public Health Agency of Canada (PHAC) releases periodic surveillance reports on HIV/AIDS in Canada that track the rate of infections (incidence) and the prevalence of the disease among various populations. Despite numerous efforts to curb the rates of HIV infection among MSMs, the numbers have shown a steady (though not necessarily consistent) increase in seroconversions since 1996 (PHAC, 2007a, 2009, 2011). These data are relevant because they illustrate the importance of the current research on HIV and the gaps in the Nova Scotian context. From the outset, it appears as though this national reporting mechanism, used to track and report on HIV/AIDS, does

not present the fullest picture of this disease in Canada. First, the methods used to generate the data are typically limited to four provinces: Ontario, Quebec, British Columbia and Alberta, which account for 85% of the population and 95% of the reported HIV and AIDS diagnoses (PHAC, 2007a). It is possible that this emphasis on only four provinces may give an incomplete picture. Second, the description of HIV surveillance is based on estimates acquired from these same four provinces (outside Nova Scotia), whereas the specific survey data presented in the PHAC surveillance report relies primarily on one convenience sample of 310 MSMs that was conducted during Gay Pride Week in Halifax in a study entitled the Nova Scotia Sex Now Survey (NSSN) (Westhaver & Allen, 2006). Though there may be gaps outside of the four provinces upon which PHAC surveillance reports rely, the national HIV/AIDS surveillance data provides useful information for this study because the national picture of HIV is often applied to provincial contexts.

The following statistics are based on the information gathered from the PHAC National HIV Prevalence and Incidence Estimates Report in 2011. According to the report,

> [T]here were approximately 71,300 (58,600 to 84,000) people living with HIV/AIDS in Canada, 25% of whom were unaware of their infection (due to a lack of testing and/or diagnosis). The estimated number of new HIV infections in 2011 was 3,175 (2,250 to 4,100), which was similar to the estimate in 2008 (PHAC, 2011, p. 2).

Despite the increase in the prevalence (those living with HIV and AIDS) and incidence (new infections) of HIV among other historically marginalized groups, HIV continues to

overwhelmingly affect MSMs more than any other group (PHAC, 2011, p. 2). Specifically, PHAC states:

- At the end of 2008, an estimated 48% (31,330) of all prevalent HIV cases were attributed to the MSM exposure category.
- In 2008, MSM accounted for an estimated 44% of all new infections in Canada.
- An estimated 19% of HIV-infected MSM in 2008 were unaware of their HIV-positive status.
- Cumulatively to 2009, the MSM-exposure category accounted for 66.3% of positive HIV test reports among adult males.
- At the end of 2009, the MSM-exposure category accounted for 74.9% of cumulative reported AIDS cases among adult males. (Yang et al., 2010)

These statistics are presented to illustrate how the disease has impacted gay men and MSM more than any other group. Of import is that PHAC sees HIV as rising within the MSM group despite HIV-prevention efforts. Moreover, nearly one fifth of gay men infected with HIV are unaware of their status which suggests that promoting frequent testing has not been effective. According to PHAC, the recent increases among MSMs are due to the complexity associated with risky sexual behaviour, though the report does not expand on this claim.

To examine the Nova Scotian context, the PHAC surveillance used the 2005 NSSN study data to demonstrate the prevalence of HIV and the participation of risky sexual practice in Nova Scotia. It showed that among the 310 participants there was an HIV prevalence of 11.1% and, in addition, 20.2% of participants had engaged in risky

sexual practice in the previous year (Unprotected Anal Intercourse [UAI] is the measure of "risky sexual practice") (PHAC, 2009; Yang et al., 2010). Other studies in Canada found similar and sometimes higher figures with regard to risky sexual behaviour among MSMs. For Nova Scotians, PHAC (PHAC, 2007a) states,

> Data from the 2005 Nova Scotia Sex Now survey found no relation between income, education, age, ethnicity, relationship status, or drug use (with the exception of marijuana) and risky sexual practices. Moderate associations were found between increased number of partners, negotiated relationships, increased use of public cruising sites, and rates of risky sexual practice in the previous year (p. 63).

Though the PHAC (2007b) surveillance report only cites NSSN to briefly explain the context of HIV in Nova Scotia, there is a history here that includes government, AIDS service organizations (ASOs) and other health and social organizations. The NSSN survey was completed under the leadership of the AIDS Coalition of Nova Scotia (ACNS), the primary HIV/AIDS organization in the province. This organization is the current iteration of AIDS activism organizations in Nova Scotia. The ACNS, along with other organizations, grew from the efforts of individual members that made up its board, staff and volunteers, all of whom were influenced by the socio-political climate of the day. While it is not possible to capture a complete history of the HIV/AIDS movement in Nova Scotia within this thesis, a brief description will be provided with the intent of illustrating the backdrop upon which the current social forces that influence HIV and gay men's sexual practices are staged.

The History of HIV/AIDS in Nova Scotia

The following discussion of the history of HIV/AIDS in Nova Scotia will attempt to briefly illustrate the historical, political and social landscape in which this research is situated. Though it is not possible to provide a complete historical analysis here, there are several key events that were couched within a general social climate that can provide insight into the dominant discourses that frame much of the HIV-prevention work in this province. Key to this discussion is the understanding that the histories and discourses do not represent the entire HIV experience in Nova Scotia. Rather, it is an attempt to provide an overview of how and why HIV-prevention has been mediated and influenced by social movements and political responses.

I present the following material on Nova Scotia and AIDS service organizations because these histories play a part in producing the way HIV and gay men are understood today. The events in this section appear in the findings of this research as activists describe their experiences of living and working here. The history of HIV in Nova Scotia is explored to illustrate how the effects on the way we conceptualize things like Nova Scotian culture, gay identity and culture, and HIV, to name a few.

Brief history of social issues. Nova Scotia has been socially and politically involved in HIV/AIDS from the earliest days. Motivated by the unfolding and very real crisis that was not being met with sufficient response by public health officials, gay men began to organize formally and informally. The Gay Men's Health Crisis Committee was formed in the early 1980s, and by 1984 it became MacAIDS (Metro Area Committee on AIDS) to respond to the outbreaks of AIDS in the Halifax Metropolitan area. Concurrently, HIV was linked to AIDS and diagnostic blood tests were developed to indicate the presence of antibodies related to HIV. By 1985, "a small group of HIV

positive men begin to gather in a Halifax kitchen, seeking personal and emotional support" (Lorway, 1999). The kitchen party has been a long-standing tradition within the Maritimes, finding its roots in the ceilidh, a traditional social gathering of Irish and Scottish origin that still takes place throughout the region today (Lorway, 1999, p. 8).

Given the history of the area, it is no surprise that the first AIDS group in Nova Scotia gathered in a kitchen. As one examines the history of HIV/AIDS here, the image of the kitchen party resonates with meaning and there are a number of connections from this seemingly innocuous event. From the "outside," Nova Scotia gives the impression that things are a bit more formal here, that individual problems and concerns should not be broadcast and any deviation from social norms should be dealt with quietly. This has been true of many areas in Nova Scotia, but it is most pronounced in rural areas (Plumb, 2005). Nova Scotia is also widely influenced by religious traditions, where social issues, particularly those related to sex and sexuality, are not discussed publicly but rather through covert means. As Goodman (1988) suggests:

> This attitude toward homosexuality has prevailed for many years in most Maritime communities. Gays in small towns and villages have been known to their fellows as, perhaps, "odd," and might be the subject of a knowing wink or chuckle among the townspeople. But, as long as the person's orientation and practices weren't overt, many gay people have been able, over the years, to play important roles in their communities. (p. 245)

This situation illustrates that maintaining public silence in the areas of sexuality and other "sensitive" issues is highly valued. The private domain in which such situations are

communicated can happen in many places, but the methods through which this occurs entails unique specificity depending on the locale. It is telling that the first group of HIV positive men in Nova Scotia gathered in the kitchen to find emotional and personal support because this type of gathering has been and remains part of the culture.

The Eric Smith story. One major event in the history of HIV/AIDS in Nova Scotia was the removal of Eric Smith from his teaching position upon the discovery that he was HIV-positive and gay. In September of 1986, Smith sought treatment for a Sexually Transmitted Infection (STI) in Shelburne (1988). Without his consent, the physician ordered an HIV test and the physician's receptionist disclosed Smith's seropositive status to the Shelburne County District School Board. Eric Smith was subsequently removed from the classroom and given "administrative" duties (Jones & Sheppard, 1989). Ultimately, Smith was offered a position as an appointed member of the Nova Scotia Task Force on AIDS, which he accepted. His removal as a teacher downplayed the socio-political controversy surrounding his shift in employment due to being both gay and HIV positive. Jones and Sheppard (1989) recount that, as a result of these events, "Councillors of the Municipality of Shelburne voted in favour of banning homosexuals and AIDS-infected teachers, students and other workers from the classroom" (p. 104).

The municipality banned not only "AIDS-infected" people but all "homosexuals" (the term AIDS-infected is purposefully used to reflect the chronology of the disease and the social references of the time period). From the earliest days, AIDS and later HIV carried with it significant stigma, which in turn was connected to homosexuality. This rural community used HIV/AIDS to justify homophobia. This illustrates why later, some

people attempt to distance the gay community from issues associated with HIV/AIDS. HIV-stigma has historically been used to justify homophobia.

While some may argue that this was over twenty years ago, the findings will show how covert acts of homophobia and heterosexism persist within Nova Scotian society and various sections of government. The social conditions of homophobia and heterosexism broadly influence policy and decision-making around HIV-prevention and same-sex practice. The purpose of this section is not to suggest that Nova Scotia has not made gains in addressing gay rights and the stigma associated with HIV or that it is more or less homophobic than anywhere else. It is to say that the local practices play an important role in shaping the context of HIV-prevention and sexual practices here.

This section has focused on the historic interpretation of the culture of Nova Scotia in relation to HIV and the gay community as well as some key events. What follows will briefly discuss the evolution of HIV/AIDS organizations whose specific focus is gay men's health. This information is presented because these groups are primarily responsible for the HIV messaging that has been produced over the years. In addition, their relationships with public health and government appear in the findings as the participants recall these interactions and their impact on HIV and gay men. The formation and evolution of these organizations, as well as the major events that unfolded since the outbreak of HIV resonates in the activists' experiences presented in this study.

AIDS Service Organizations in Nova Scotia

The beginning of the HIV/AIDS movement in Nova Scotia is evidenced in the first AIDS group that formed to support gay men and provide information in this

province. As mentioned earlier, the Gay Men's Health Group was formed in 1982 and consisted of a conglomerate of gay activists and one physician. In 1984, the organization changed its name to the Metro Area Committee on AIDS (MacAIDS) because of the backlash regarding the word "gay" (1989). It was incorporated the same year and funded by Health Canada in 1985. This "grass-roots" group maintained its orientation through much of its subsequent activist work because of a core group of individuals involved in it. Since the primary focus of MACAIDS [later shortened to AIDS Nova Scotia (ANS)] reflected a provincial mandate that was focused on prevention, many people living with HIV/AIDS (PHAs) recognized the need for greater advocacy for those already infected (Lorway, 1999).

It is noteworthy, here, that the medical community originally labelled HIV/AIDS as "Gay-Related Immune Disorder (GRID)," but gay men in Nova Scotia were unable to use the word "gay" in reference to the activist organizations that responded to the epidemic again reflecting the socio-political climate. The group of men, mentioned previously, who met for support in a kitchen in 1985 ultimately worked to form the Nova Scotia Persons with AIDS Coalition (NSPWAC) in 1988. This group was "the third PHA-driven coalition of its kind to form in Canada and helped to change the face of AIDS, as PHAs took charge and ownership over the issues affecting their wellbeing" (Lorway, 1999). In 1989, the NSPWAC became the second federally funded HIV/AIDS group in Nova Scotia along with ANS. Though similar in theory, the mandates of these two organizations were quite different in practice. One PHA in the Lorway (1999, p. 14) Report suggested that "MACAIDS was very aware of its public image, so, as an education officer, I was assigned to work with prostitutes, the Black community,

women... the idea was well, we don’t want to upset anybody” (p. 15). Meanwhile, the foci of the NSPWAC were to create a safe space for PHAs and to actively protest against discriminatory policies and practices that existed within government, healthcare and other institutions in Nova Scotia. The report goes on to note that though the ANS “can be credited with targeted work with *Men who have Sex with Men* funded by NS (Nova Scotia) Department of Health, much of their prevention-education efforts were aimed at the ‘general public’” (p. 16).

Despite their divergent responses to HIV/AIDS, the ANS and the NSPWAC faced similar challenges. These two organizations began to lose support as the fervour surrounding the epidemic diminished in the media and also became less of an immediate political issue. In 1994, they came together, first, by joining offices, then by officially amalgamating into the AIDS Coalition of Nova Scotia (ACNS), which continues to operate in Halifax (Lorway, 1999). The rationale at the time, particularly from the federal government level, was that it was not necessary to have two organizations in Nova Scotia. According to a participant interviewed for the Lorway (1999) Report, however, the new organization of the ACNS did not continue the work of AIDS Nova Scotia (ANS), the latter which focused on HIV-prevention. Rather, the ACNS “took on the mandate only of the PWA coalition” (p. 21). Lorway (1999) goes on to conclude that the ACNS remains primarily a PHA-driven organization.

Current AIDS Organizations

The ACNS. The AIDS Coalition of Nova Scotia (ACNS) is this province’s provincially mandated AIDS organization. It is located in Halifax and the Northern AIDS

Connection Society and AIDS Coalition of Cape Breton and other organizations operate elsewhere throughout the province. The ACNS continues to advocate for people living with HIV/AIDS, an objective that was firmly rooted at the time the ANS and the NSPWAC amalgamated. The official website of the ACNS notes that 51% of its board of directors is made up of PHAs ("AIDS Coalition of Nova Scotia," 2010). This illustrates its commitment to the grass-roots movements of the original AIDS organizations in Nova Scotia. The ACNS offers services to PHAs and provides links to anonymous HIV testing services, information on HIV-prevention and education ("AIDS Coalition of Nova Scotia," 2010).

Nova Scotia Advisory Commission on HIV/AIDS. In 1989, the provincial government established the Nova Scotia Advisory Commission on AIDS to assist the Nova Scotia Task Force on AIDS. As mentioned earlier, this was one of the first projects set up to address HIV/AIDS in Nova Scotia and to provide a direction for government and non-government organizations (NGOs). The Commission, "established by an act of the Provincial Legislature (Chapter 9 of the Revised Statutes, 1989), is an arm's length body which gives policy advice on HIV/AIDS and its impact on Nova Scotians to the Government of Nova Scotia" ("AIDS Coalition of Nova Scotia," 2010). The Commission provides advice on a broad range of issues related to HIV, including prevention, education, social issues, and government services. It also developed the framework for "Nova Scotia's Strategy on HIV/AIDS," which was initiated in 1997 and released in 2003. The Commission continues to monitor and update the Strategy on a regular basis. Its governance and staffing are described as follows:

> Commissioners, including the Chairman, are appointed for a 3-year term by an Order-in-Council, for which they may apply for re-appointment. Commissioners are individuals from across Nova Scotia with a particular interest and/or expertise in HIV/AIDS. A representative from Nova Scotia Health Promotion and Protection is designated as an ex-officio Commissioner to facilitate communication and collaboration between the Commission and the Government of Nova Scotia. Three full-time provincial civil servants support the work of the Commission (Nova Scotia Advisory Committee on AIDS, 2010, p. 1).

This is a rather unique arrangement in which specific members of the HIV/AIDS activist community are funded by the provincial government and yet are somewhat independent in terms of advising the Department of Health and Wellness and the Nova Scotia Strategy on HIV/AIDS on related issues.

Nova Scotia HIV/AIDS Strategies, Research and Prevention Efforts

Nova Scotia strategy on HIV/AIDS. While community-based HIV/AIDS organizations underwent numerous changes in the 1990's, the government of Nova Scotia was also becoming more active. In 1993, it launched the *Nova Scotia AIDS Strategy*, which "outlined significant changes in the HIV/AIDS epidemic and in the profile of those becoming infected both provincially and nationally, necessitating a review of the priorities and needs" (Nova Scotia Advisory Committee on AIDS, 2010, p. 2). This document set the agenda for many of the HIV/AIDS priorities for the next decade. In 1997, the Nova Scotia Advisory Commission on AIDS called on the government to devise a renewed strategy to more fully address the complex issues related to both HIV-

prevention and people already living with the disease. Moreover, it was considered that the government's original strategy initiative lacked community input. As a result, in 2003, the provincial government released "Nova Scotia's Strategy on HIV/AIDS." Its particular focus was on populations at greatest risk within the newly implemented population-health model.

This renewed strategy had four overarching goals and 19 recommended actions for achieving these goals. Given the broad range of this approach, six actions were prioritized for the first phase of implementation. The strategy is underpinned by systemic community efforts, on the part of public health, that attempt to reduce the incidence of HIV. Despite the high rates of infection among MSM and gay men, these groups are not specifically named as the targets of these HIV goals and actions, but rather it is assumed that they are into account within broader identity groups. It should be noted that Nova Scotia's Strategy on HIV/AIDS is also a "living" document that is annually reviewed and updated by the Nova Scotia Advisory Commission on AIDS. For the sake of framing HIV in the Nova Scotia context, the Nova Scotia Strategy provides the rationale for the actions and programs aimed at both HIV-prevention and for addressing the needs of PHAs. The "population-health" model frames this document as well as the organizations tasked with setting the research agenda for Nova Scotia (Nova Scotia Advisory Committee on AIDS, 2003, p. 1). The population-health model and the social determinants of health will be discussed below.

The Sex Now Survey. The Nova Scotia Sex Now Survey (NSSN) is one of the few research projects conducted in Nova Scotia on HIV and gay men's sexual health. Sex Now projects across Canada include surveys that provide a snapshot of the current state

of knowledge and practice regarding sexual health among gay men in this country (Westhaver & Allen, 2006). Results of these surveys have been used to inform policy and decision-making in HIV-prevention. For example, the Public Health Agency of Canada sited the NSSN survey in its surveillance report on HIV (Westhaver & Allen, 2006). Despite the self-acknowledged limited scope of the NSSN, particularly the limited sample size and the distribution of the survey only at the Pride festival, the report has important implications for this research. More specifically, inferences can be drawn from the data about the uniqueness of the sexual health of gay men in Nova Scotia despite the survey's limited distribution (PHAC, 2007a).

The NSSN study reveals that although Nova Scotia is similar to many other areas of Canada, we can nonetheless see a local "flavour" (Westhaver & Allen, 2006). One marked difference is the percentage of known HIV-positive test results. Nova Scotian gay men accounted for 50% of all reported positive test results compared to 26% in Ontario (Westhaver & Allen, 2006, p. 4). Westhaver and Allen (2006) suggest,

> These variations should come as no surprise. While gay men in Atlantic Canada feel the effects of HIV/AIDS in a manner that is disproportionate in comparison with other Canadians—and thus share important experiences with other gay men in Canada—the texture of their story is shaped by regional and local considerations (p. 5).

Some of these considerations are taken up within the NSSN report including health policy, health-promotion efforts, social attachment, media, resources, social venues, the Internet, and more. Westhaver and Allen (2006) point out that it is important to consider

the social atmosphere with regard to gay men and HIV-prevention. This is because while choices about sexual practices are indeed personal choices, they are not wholly autonomous; such practices are set within the broader social and political contexts of gay men's lives. In other words, "risky" sexual practices are not merely isolated, individual decisions, rather they are "always made in relation to the social context in which we live and love" (2006, p. 7). Acknowledging the implications of context for sexual-health decision-making is a key concept for the NSSN project, which is informed by the population-health framework.

The population-health model considers the complexities embedded in decision-making. This model is an interesting choice for the NSSN project, as it makes visible the impacts of homophobia and heterosexism while contradicting some of the normative framings of the various "determinants of health". The determinants usually consider factors such as income, race, class, location and more (Raphael, 2004). But the connection between gay men's lives, the incidence and prevalence of HIV among gay men, and the health outcomes for gay men seem to transcend these factors. In other words, despite all of the potential "risk factors" that align with the determinants of health, these factors seem to have very little impact on the epidemiological trends in HIV transmission among gay men. Westhaver and Allen (2006, p. 7) point out that "the significance of a Population Health framework for understanding the consequences of the continuity and change in how gay men experience HIV/AIDS is to be found in the fact that it directs our attention away from individual or personal determinants of health to social and cultural considerations, including the impact of homophobia" (p. 8). The NSSN survey further suggests that, within the Nova Scotian context, there are emergent

factors that may influence "risky" behaviour and, in turn, the likelihood of HIV transmission. Among those at greater risk are individuals who closely adhere to normative sexual practices within the community (2006). The construction of normative sexual practices and the social outlets that communicate them will be the focus of this discussion with regard to the NSSN.

It is well recognized in the literature that Internet sites have become a popular avenue for men to meet other men for socializing, dating and often specifically for sexual encounters (Westhaver & Allen, 2006). This arena can have implications for local programming aimed at HIV-prevention for a number of reasons, some of which include the following: it may fall outside of health-promotion efforts; men are not required to take on a "gay identity" in order to engage in sexual encounters with other men; men can meet men without ever entering a physical public space; and, one can freely advertise erotic desires that may include bareback sex (Bolding, Davis, Hart, Sherr, & Elford, 2005; Davis, Hart, Bolding, Sherr, & Elford, 2006; P. N. Halkitis & Parsons, 2003). Within the Nova Scotian context, Westhaver and Allen (2006) note that "30% of those who responded to the survey indicated that they had used the Internet to find sex partners in the past year" (p. 17). While the usage rates of Internet sites in Nova Scotia is not particularly unique, as this occurs in many areas of Canada and elsewhere, it is important to consider that these sites allow the user to restrict their searches to local domains and types of sexual partners and practices. This situation allows even the Internet sites to take on a local specificity since the individuals often construct their online identities within a local social arena. Another key concept to consider is the malleable nature of the Internet social sphere. For example, websites may be discontinued, users may migrate to different

sites, and users may join or leave sites at different times for various reasons. Given the changing nature of the "cyber-world" and if HIV-prevention strategies aim to reach this often-unseen domain of sexual practice, it is important to stay abreast of the current trends in social sexual behaviour among gay men.

The impact of geographical location is the final concept for this discussion of the NSSN Project. The NSSN raises many questions regarding MSM sexual practice, but the NSSN survey emphasizes the need for HIV-prevention strategies that reflect the nature of the immediate social sphere (2006). The report suggests that the way men socialize locally may be different from the way they do so in larger urban areas where much of the mainstream health promotion efforts aimed at HIV-prevention are designed and distributed. The use of the Internet and other factors can have important implications, as men may look beyond the immediate region of Halifax for sexual partners (Westhaver & Allen, 2006). Consequently, investigating the local dimension of social forces and interactions could have implications for HIV-prevention. For instance, "where gay men go for their sexual pursuits, what they read, the kinds of things they do to socialize, the norms associated with sexual culture—appear, in some respects, to be shaped by regional pressures and interests. Useful health programming would depend on developing a finer understanding of these differences and similarities..." (Westhaver & Allen, 2006, p. 22). Given the emphasis in the NSSN study and other academic literature on understanding the local context of barebacking, one can conclude that national HIV campaigns can be helpful. But policies and programs should also consider small, local areas and particularly those outside of large urban centres.

In the early days of HIV/AIDS in Nova Scotia there were grassroots efforts in the gay community in response to the outbreak. These efforts were the starting point for what would later become various ASOs. As the organizations formalized and sought funding from government agencies they faced significant challenges due to competing interests and limited funding. Government funding invariably changed the movement because of the requirements attached to the money. Subsequent chapters reveal that funding not only provided support for ASOs, but also shaped the efforts and the way HIV messaging was delivered. Public health surveillance does not capture the local dynamics of HIV/AIDS. Though some research has taken place in Nova Scotia there remains a gap in our understanding of how local dynamics shape HIV messaging and prevention efforts.

Unprotected Anal Intercourse (UAI) and Barebacking

The previous section briefly described some of the history of HIV-prevention and HIV/AIDS organizations in Nova Scotia, and the research that has influenced current policies and programming. The purpose of the preceding discussion is to contextualize HIV-prevention and to more broadly portray the short history of policy and decision-making surrounding HIV and AIDS. While it can be assumed that the various HIV/AIDS organizations, and their policies, programs and members, all impact attitudes and behaviours toward HIV and gay men's sexual practices, one must also recognize the role of academic literature in contributing to these discourses. Reducing unprotected anal intercourse (UAI) or at least reducing the risk associated with this sexual practice is at the core of HIV-prevention and the research that attempts to measure the success or failure of these efforts.

The following section will describe the current academic literature that addresses the impasse between health promotion and gay men's sexual practices, particularly in relation to barebacking. This review will summarize the current discussions regarding barebacking, including reconciling a definition of *what* barebacking is, the prevalence of barebacking practices (based on the definitions) compared to all UAI, the current work within social theory that attempts to rationalize and guide health promotion, and the challenges that remain. Initially I focus on the definition of barebacking because the literature has not fully reconciled what it is. If we are to claim that barebacking is a problem among gay men then we must distinguish what it is in order to address it. I trace the major publications that focus on gay men and barebacking including a literature review on the topic by Berg (2009). I primarily focus on how barebacking is framed from a health perspective because there is a distinction between barebacking being seen as an individual act versus a sexual practice embedded in the social, cultural and political landscape of the day. In the latter sections of the review I look at how social theorists have analysed it with barebacking in relation to this project.

Barebacking and health promotion. The World Health Organization (WHO) provides the most widely accepted and adopted definition of health promotion in that it seeks to increase individual control over health and the determinants that improve the overall human condition (WHO, 1986, 2005). The basic tenets of health promotion and health equity are outlined in the foundational work of the Ottawa Charter for Health Promotion (WHO, 1986). The Ottawa Charter suggests that in order to strive for equity in health outcomes there are multiple layers within social structures that must be addressed (WHO, 1986). While the Ottawa Charter demonstrates the need for local and specific

health strategies, there is always an underlying power dynamic between the health providers and the recipients of health services (Peterkin & Risdon, 2003). In addition, it is important to recognize the impact of the power relations between health-care providers and recipients despite the premise of equity and social justice upon which health promotion in Canada is established. In specific reference to this study, health promotion faces a particularly poignant challenge in designing equitable HIV-prevention policies aimed at gay men (Berg, 2009; Carballo-Diéguez et al., 2009; Crossley, 2002; Numer, 2009; Rofes, 2002).

For some time, public health and health promotion have targeted gay men and other MSM in attempts to prevent new HIV infections (Berg, 2009; Carballo-Diéguez et al., 2009). With this in mind, the literature has acknowledged barebacking as being of concern for researchers and practitioners seeking to improve the health and well-being of these groups through health promotion. Although there is no single definition of barebacking, at its core, it is generally regarded as the act of knowingly engaging in unprotected anal intercourse (Adam, 2005, 2006c; Adam, Husbands, et al., 2008; Berg, 2009; Carballo-Dieguez & Bauermeister, 2004; Carballo-Diéguez et al., 2009; Crossley, 2004; Numer, 2009). The concept of barebacking is complex because the literature points to it as both a "practice" and an "identity" (Adam, Husbands, et al., 2008; Carballo-Diéguez et al., 2009; Numer, 2008, 2009; Numer & Gahagan, 2009; Parsons & Bimbi, 2007). In other words, barebacking may occur situationally and/or it can be a sexual identity embraced by individuals and/or communities.

The term barebacking became popularized in close tandem with the advent of anti-retroviral therapies (ARTs) that were developed in the mid-1990s. Originally, the

term meant "intentional unprotected anal sex among HIV-infected men" (Carballo-Diéguez et al., 2009, p. 52). But in 2003 it was subsequently redefined in *The Joy of Gay Sex* to simply mean any "unprotected anal intercourse," typically referring to gay men (Carballo-Dieguez & Bauermeister, 2004; Carballo-Diéguez et al., 2009; Gendin, 1997; Silverstein & Picano, 2004). Since the introduction of the term and subsequent attempts to redefine it, barebacking has undergone significant scrutiny by social theorists and health researchers who attempted to better understand this social sexual phenomenon. The chronology of the barebacking critique in this discussion illustrates the development of the critical social theories introduced to both explain the seeming emergence of barebacking and to develop health promotion strategies for HIV-prevention that aimed to reduce the prevalence of such practices.

The early efforts to understand barebacking practices did so through qualitative research projects that sought to give voice to the experiences of gay men and also through quantitative studies designed to measure the prevalence of barebacking with the hopes of gaining a more complete understanding of the causative agents of HIV transmission (P. Halkitis, Wilton, & Galatowitsch, 2005; P. N. Halkitis & Parsons, 2003; P. N. Halkitis, Parsons, & Wilton, 2003; Ridge, 2004). In many instances, these studies revealed that many gay men (approximately 40%) had practiced UAI in the past year, but a relatively small portion considered themselves to be barebackers. This finding suggests that there is some disconnect between practice and identity. In other words, there is a distinction between "what I do" (practice) and "who I am" (identity) and the resulting social construction of the "gay male" identity. The idea that barebacking practices and identities contribute to the social constructs of gay identity emerged in the early scholarly literature.

This literature also recognized that gay male identities were set in a socio-political landscape that was being influenced by public health efforts (C. Patton, 1988, 1990, 1996).

For well over a decade public health messaging aimed at gay men emphasized the need for condom use to prevent the transmission of HIV. As is the case with most public-health campaigns, it was assumed that awareness and education would lead to behaviour change and for a period of time it did. However, with no end to the HIV/AIDS epidemic in sight and with the advent of ARTs, some social and behavioural HIV research theorists believe that barebacking emerged as a form of defiance against and resistance to public health messaging (Crossley, 2002, 2004; Dowsett, Bollen, McInnes, Couch, & Edwards, 2001; Rofes, 2002; Underwood, 2003). This research began to make visible the impacts on the public-health rhetoric (Numer, 2009). Moreover, it shifted the discussion of barebacking from an individual experience, which might be targeted or altered through further mass education and awareness campaigns, to a more nuanced understanding of a sexual practice that is often impacted by and energized through a variety of social forces. This shift in the discussion on barebacking is a key point for this investigation, because public health is often less well equipped to manage conscious engagement with risk behaviours and relegates individuals who do so to the status of "irrational" (Crossley, 2002; Numer, 2009; Numer & Gahagan, 2009; Westhaver, 2005).

If the individual is not seen as a lone actor, but rather as a subject negotiating a number of competing discourses, including health promotion and eroticism, produced both by the mainstream media and health messaging, one can shift from blaming individuals for safer sex transgressions to engaging in a more productive discussion of

ways to promote the sexual health of gay men. This shift allows researchers to expand the problem from gay men to the social and cultural context in which they are situated. One feature of these critiques is that barebacking is recognized as “purposeful.” This removes it from being confused with other forms of UAI and adds other complex ingredients to the varied contexts of its discussion.

Recent claims in the literature on barebacking have suggested that including all forms of UAI within the category of “barebackers” or “barebacking” is not a useful means of referring to the term (Carballo-Dieguez & Bauermeister, 2004; Carballo-Diéguez et al., 2009; Gastaldo, Holmes, Lombardo, & O’Byrne, 2009; P. Halkitis et al., 2005; Parsons & Bimbi, 2007). Parsons and Bimbi (2007) suggest that unintentional UAI and intentional forms of UAI that incorporate risk/safety measures in an effort to avoid HIV transmission are two different categories that each requires a different analysis. Carballo-Diéguez et al. (2009) further explain that though some of the literature acknowledges the difference “bareback behaviour and identity are inconsistently operationalized terms that run the risk of being reified, creating confusion rather than scientific progress” (p. 52). Their claim suggests that by conflating barebacking practices and identities, the academic literature may be providing inaccurate information for those designing HIV-prevention interventions (Carballo-Diéguez et al., 2009).

This variability in the literature that examines the definition of barebacking points to the need for more nuanced understanding of barebacking and other forms of UAI. The rationale for this argument is that the literature, itself, is not merely an investigation or exploration of barebacking and gay culture, rather it actively contributes to the way the sexual experiences of gay men are known and understood (Adam, 2005; Adam,

Husbands, et al., 2008; Carballo-Diéguez et al., 2009; Parsons & Bimbi, 2007; Tomso, 2004). The literature itself names the lack of clarity as a challenge that may have unintended effects. The following continues to elaborate on the sexual behaviours that are referenced as barebacking.

To address the spectrum of UAI and barebacking among gay men, it is necessary to review the contexts within which men engage in unprotected anal intercourse while attempting to avoid HIV transmission (Crawford, Rodden, Kippax, & Van de Ven, 2001; Davis et al., 2006; Guzman et al., 2005; Ostrow et al., 2002). Recent literature has deemed these situations as "negotiated safety" or "negotiated risks" in which men consider specific practices to reduce the likelihood of HIV transmission. Calls for specific strategies to address the range of sexual practices among gay men have increased in recent years (Carballo-Diéguez et al., 2009). Specifically, men who bareback and thereby negotiate risk within a committed relationship, by serosorting or employing other means of harm reduction, may require more than a one-size-fits-all approach to HIV-prevention. In other words, it is recognized that while these groups of men are at some level of risk for HIV infection, there may be some overlap and divergence in the health-promotion strategies aimed at men who bareback and at the same time engage in various harm-reduction techniques (Adam, 2006b).

To more effectively address these and other concerns regarding the practices of UAI, and barebacking specifically, some researchers argue that a poststructural approach is beneficial to examining the ways these identities, or more accurately within this framework, subjectivities are manifested (Gastaldo et al., 2009; Holmes et al., 2006). Within a poststructural framework, Foucauldian concepts are often employed. These

conceptualizations apply to this study because it expands barebacking to discursive production of the experience rather than an individual identity or a lapse in judgement.

The literature that explores barebacking through a critical social theoretical lens has contested the notion that this sexual practice can be measured through individualized psychometric tests that are designed to measure "risk" factors only (Adam, 2005). Adam (2005) proposes that gay men may engage in UAI in "a variety of circumstances such as: a resolution to erectile difficulties experienced with condoms, through momentary lapses and trade-offs, out of personal turmoil and depression, or as a by-product of strategies of disclosure and intuiting safety" (p. 334). These possibilities expand some of the previous rationalizations for barebacking, which were sometimes described as a backlash or as defiance against public health messaging that seemingly encourages gay men to moralize their sexual behaviour through the safer sex practices (Crossley, 2002; Numer, 2009; Rofes, 2002).

A key point raised by Adam (2005) is that while some gay men may engage in barebacking as a means of defiance against the moralizing health discourse, in many instances, the public-health discourse has had the exact intended effect, given that many gay men claim "responsibility" for their serostatus. In other words, public-health efforts often rely on individuals to make choices that are in the best interests of their own health. The assumption is that knowledge and education about how to practice good health supersedes other motivating factors.

Adam (2005) expands on this by arguing that HIV-prevention messaging has largely relied on gay men to be responsible sexual actors who treat other gay men as HIV

positive. In doing so, this may create a condition in which sexual partners are not responsible for each other but only for their own safety, since protection is aimed at the self. In other words, prevention messaging has created a situation in which everyone must assume that their partners are HIV positive, so as to prevent infection.

Adam illustrates the tension between the seeming "neoliberal actor," who is the recipient of health messaging, versus the subject. Adam (2005) states,

> The neoliberal view constructs human actors as rational, adult, contract-making individuals in a free market of options. It does not account for the much more complex motivators and vulnerabilities that characterize real human interaction and it denies the vulnerabilities, emotions, and tough dilemmas faced by people in their everyday lives (p. 344).

This critique of the neo-liberal actor moves beyond focusing on the individual with various options and choices and marks a greater degree of complexity in the literature. This work refers to a number of competing discourses that coincide with the situational or individual influences on the practice of either UAI or barebacking at the moment of the sexual encounter. Adam (2005) further notes that

> ...even among barebackers who invoke neoliberal discourse most directly in the care of the self, there are clearly a host of competing discourses, drawn from romance, masculine adventure, gay solidarity, communitarianism, and so on, that can come to the fore, according to circumstance. In that sense, neoliberal discourse is not totalizing nor does it capture the subjectivity of these men in a

> fundamental way, but among some men it has become a modus vivendi and a leading resource for organizing relations with other men (p. 345).

The concept of competing discourses is presented in much of the recent literature regarding barebacking. Adam's work is important for examining the subject experience of gay men in sexual situations that involve barebacking. Many of his findings relate to the dynamics of gay culture including gender.

Race (2006) builds on the work of Adam (2005) and explores the role of gender in the poststructural paradigm. His findings reveal that heteronormativity has largely contributed to the prevalence of HIV/AIDS. Rooted in the sex/gender binary, heteronormativity naturalizes beliefs regarding men/women and masculine/feminine, which stigmatize certain sexualities and punish those who cross the boundaries of gender (Race, 2006). These social conditions have implications for barebacking because, beyond the various contexts and considerations the subject encounters, “gay men are led to interpret their sexual practice as intentional deviance regardless of HIV risk, and this leads to misrecognition of the preventive possibilities of their practice” (Race, 2006). The deviance Race describes is deeply embedded in gender discourses, both in relation to the behaviours of gay men and to HIV-prevention policies.

Race (2006, p. 100) suggests that Foucault “would maintain that the most important frame for understanding barebacking is not gender, understood in the categorical sense, but rather sexuality, understood as a regulatory system that works in and through gender, but that is not reducible to it and is frequently challenged unpredictably by it” (p. 102). The regulatory system of sexuality is maintained through

discourse, and barebacking as an identity and practice has become central to gay men's sexuality in the era of HIV. Race explains the malleability of the definition of barebacking (as previously illustrated) as a consequence of the mobility of the discourse over time and the production and reproduction of the term in the academic literature and within cultural contexts (2006). Though a phrase like "regulatory system of sexuality" may seem ubiquitous, it is found in social relations that occur in a very localized context. The ways in which barebacking discourses come to be known influences the way sex is practiced in local contexts.

The chronology of the literature points to the need for investigations that take into account the different locales of gender and gay men's sexual practice. In other words, to gain greater specificity and nuance to the discussion of this topic, the specific locations that produce barebacking discourse should be examined (Race, 2006). This finding has begun to guide the work undertaken in my investigation as it is set within a particular location and explores the dynamics of the social, cultural, political, and other factors that interact with gay men's experience of barebacking.

Holmes et al. (2006) review the popular analysis on sex and society introduced by Foucault in his later work on sadomasochism (S & M). The premise of this article builds on Foucault's work where he suggests that subjects engage in S & M in order to redefine the limits of their subjectivities. The authors assert that men who engage in barebacking are in a similar camp, as "raw sex" redefines the limit experience. Holmes et al. (2006) state that, "the subject becomes something new through the process of de-subjectification. The limit experience is attained, but simultaneously left behind; the line that veers from subjectivity and crashes through the walls of appropriate behaviour de-stratifies and may

become the new line for the subject" (p. 328). This article attempts to move beyond the rationalization of individual behaviour by bringing to light the complex constitution of subjectivities. In doing so, the Holmes et al. suggest that through repetition of breaking from the subject experience of gay men that once entailed consistent condom use, the subject experience has become redefined in that barebacking has become the new normal.

Consistent with much of this literature review, the authors cite the shortcomings of public-health messaging that aims to account for the subjects who fall outside the parameters of the rational individual who makes "responsible" health decisions (Holmes et al., 2006). This article returns to the premise established by previous research (Holmes et al., 2006; Numer, 2009), that barebacking is partly a result of the public-health discourse that has contributed to the production of gay men's subjectivities (Crossley, 2002; Dowsett, 1993; Rofes, 2002). The challenge with this critique of barebacking is that it often cites the public-health discourse and the shortcomings of health promotion, but it does not fully reconcile what, if any, messaging should be promoted. There remains a disconnect between the critiques of social theory and how it can be useful in forming public health policy and in particular, effective health promotion messages targeted at HIV-prevention among gay and MSM populations. I note this here because in subsequent chapters participants comment on how the lack of direction in the barebacking literature has left them guessing at how best to design and implement HIV-prevention campaigns.

Adam, Husbands, et al. (2008) illustrate the importance of critical social theories aimed at exploring the specific practices of barebacking and the contexts within which they present. For instance, they state that it is important to investigate

> ...[A] sociohistorical dimension to HIV that is typically missed in research grounded in biomedical individualism. Messages that catch on and are taken up in one time period can become stale, old-fashioned, or discredited in another. Rationales for unprotected sex can change, rendering the findings from research about "what works" dated as well. It is methodologically important to be able to track historically moving conditions that render once–effective messages obsolete and to document unanticipated cultural and generational processes that change or conflict with prevention programs (p. 422)

A further interpretation suggests that it is worthwhile to examine the broader forms of governance, such as that of government agencies, while taking into account the social changes that invariably take place over time (Adam, Husbands, et al., 2008). In addition, the local culture can be considered to more fully interpret the social conditions that inform gay men's everyday practices in the context of barebacking. Adam, Husbands, et al. (2008) suggest that there are particular cultural circuits in which many gay men establish sets of beliefs and, in turn, practices. The various profiles or "identities" the subjects may take on entail a set of scripted practices that, in some instances, may include barebacking (2008). Confounding the social categories described by Adam et al. is the idea that, in various ways, many of these identities are impacted by, influence, or are integrated or perhaps enmeshed in notions of masculinity (Adam, Husbands, et al., 2008).

Conclusion

The theoretical progression of the literature on barebacking points to a need for continued and further analysis within theoretical frameworks that can capture the

relationship between social and political climates and how gay men experience sex in the age of HIV. Strategies that simply focus on sexual encounters as singular events in which neoliberal actors must make the "best" choice for themselves simply do not resonate with the way gay men describe their experience in qualitative literature (Adam, 2005; Adam, Husbands, et al., 2008; Holmes, Gastaldo, O'Byrne, & Lombardo, 2008; Numer, 2008, 2009). Building on this recognition, the theoretical tenets of poststructuralism are employed to trace some of the ways we have come to know and understand gay men and their sexual practice in the wake of HIV/AIDS and the public health efforts that followed.

Chapter 3: Conceptual Framework

The literature suggests that there is a gap in the social sciences in health promotion, public health and HIV-prevention related to gay men. Despite calls for social science research that addresses this gap, biomedical and epidemiological research are favoured (Mykhalovskiy & Rosengarten, 2009). Berg (2009) suggests that we are at an impasse in the literature on barebacking and in HIV-prevention efforts aimed at reducing transmission. This impasse indicates that there must be a fundamental shift in the conceptualization of HIV-prevention and gay men's sexual health if the literature is to remain relevant. Some work noted in the literature review has begun to reconceptualize HIV-prevention and gay men outside of the neoliberal view and focus on the social, cultural, and historical dimensions of gay men's sexuality (Adam, 2005; Adam, Husbands, et al., 2008; Holmes et al., 2008; Holmes et al., 2006; Race, 2006). Building on the conceptualization of HIV-prevention and health promotion, more generally, as forms of discourse that contribute to subject positions and the impact of HIV discourse, this research employs a post-structural framework with an emphasis on the 'tools' proposed by Foucault.

To begin, I offer a brief explanation of my interpretation of the findings. Interpretation, like many of the terms translated from French for Foucault, does not have the exact same meaning in English. Foucault goes to great lengths to suggest that his methods are not interpretive, so much so that he dispels "the deep hidden meanings, the unreachable heights of truth, the murky interiors of consciousness" as "shams" (Dreyfus & Rabinow, 1982, p. 107). I use Foucault's methods in an attempt to abandon the historical notions of identities, as they are "masks, appeals to unity" (p. 107). The

interpretation I offer is one that looks at the same problem from a different point of view. Though the theoretical work is often dense, the interpretation of the topic is paying surface attention to the way things come to be. I do not attempt to delve into the hidden psyches of gay men to figure out why we risk contracting HIV through sexual contact. Instead, I suggest that the investigation is more a reading of the surface. Simply put, the secret is there is no secret. When I am interpreting the information presented in this study, it is with an understanding that this is not a search for truth, rather it is a reading of what lies on the surface because "underneath it all, everything is already interpretation" (Foucault, 1967, p. 189 as cited in Dreyfus and Rabinow, 1983). The work of the researcher from this perspective is to analyze the surface, recognizing the productive properties of the research itself, and avoiding a privileging of the discourse that the interpretation of the findings will produce.

This is not to say that the researcher has no role to play in the investigation. In the latter work of Foucault, he sees this as quite the opposite. That is, as he develops his tools, he sees the evolving role of the researcher. I see my role in a similar manner to Foucault: "involved in, and to a large extent produced by, the social practices he is studying" (Dreyfus & Rabinow, 1982, p. 103). As a researcher engaged in this method, I share involvement but am inclined to distance myself from it (Dreyfus & Rabinow, 1982). In some instances, a certain distance is useful when thinking about how I am situated in the very social practices under study. At various times I see myself as a production of the ideas I will later scrutinize. Gay identity, community and sense of self within these spheres are all the production that flow from the way meaning is made, meaning that is malleable in space and time. The project begins at a certain time and

place but the meanings under investigation will change through the passage of time and even by the discussions generated from this work. I attempt to locate some ways in which meaning is made with specificity to this time and place to understand how we are influenced by the productive power of HIV discourses.

This research has taken place during my tenure in Nova Scotia because I have been closely involved with the gay community and in particular on issues related to HIV/AIDS. My position as a gay man and gay rights activist, at this time and place, has allowed me to view the research in a way that may not have otherwise been considered. My particular vision of these issues is not a claim to truth. Rather, it is a claim to a way of seeing and interpreting the social and cultural practices. For Dreyfus and Rabinow, however, “cultural practices are more than discursive formations (or any theory) and … the seriousness of these discourses can only be understood as part of a society’s ongoing history” (p. 125). It is from this position that I outline my conceptual framework, one that sees the discourse on this topic as the point from which to understand the relevant cultural practices and from where I begin my investigation.

Discourse

In this thesis I employ a Foucauldian understanding of discourse as the basis for my investigative methodology and interpretation of my findings. Discourse, as it relates to this research, is defined as a “group of statements that constitutes a set of understandings about a topic or phenomenon at a given historical moment” (Nelson, 2008, p. 14). Discourse operates to make things knowable. It essentially provides a frame of reference from which to locate objects. These "objects" take shape in different ways,

depending on the location, the time and the ideas that pervade around the object at a given moment. In his earlier work, Foucault describes objects as the discursive formation of the topic at hand. In other words, as statements coalesce they form the discourse that makes objects comprehensible (Lemert & Gillan, 1982). In this sense, discourse can be understood as a productive operation. Objects become knowable through the statements made about them and the discourses that come to be dominant about the objects. Objects are seemingly stable definitions about what something is or is not. One example that comes to mind is the idea of gay culture in North America.

Gay male culture has emerged in the public sphere in the last half-century or more. Though sex between people of the same sex has always been present in human behaviour, the concept of a gay culture is a relatively new one. Dominating the idea of a gay culture is a highly sexualized energy that is located outside of mainstream or normal culture and one that is most observable at annual Pride events. Gay culture has largely come to be known as a male-dominated dance, and a drug- and alcohol-induced party that privileges the lean muscular body that is fashionably dressed in as little clothing as possible. Admittedly, this is my own evaluation of what I believe has come to dominate the idea of gay culture. It is an opinion that has emerged from having participated in these very aspects of gay culture. However, if I were to ask people, at random, to describe gay culture, I imagine that many of these themes would emerge. The discourse emerges out of this process because as images of gay culture are presented through various forms of media, such as talk and other modes of transmitting statements, the discursive formation of gay culture takes place. Certain discourses come to dominate; in this case, the discourse allows us to comprehend the objectified gay culture.

This is not to say that these dominant features represent *all* gay culture or that everyone believes it does. Rather, it is to suggest that these types of dominant ideas have the power to shape what is known about gay culture and are contextually situated. It is generally recognized that there is a great deal of diversity within gay culture, but this is secondary to the popular definition that has come to the fore. The object, gay culture, takes shape in society and all other statements or representations are either in agreement with or go against this dominant discourse.

The discourse, however, is more than productive, it is limiting. In other words, discourse can set the boundaries for what can and cannot be said. Foucault provides three stages to discursive formation, though it does not always happen as such: 1) setting the boundaries of the discourse; 2) authorizing a "knower" to speak about and legitimize the object; and 3) providing a framework or map for future statements (Mills, 1997, p. 51). This process is continually reiterated as statements are made about the objects, thus rendering the discourse itself a malleable process, though not without limits.

The limiting effects of discourse can be seen when they become dominant because they set the boundaries for what is acceptable or knowable about a topic. In some cases, certain statements are dismissed because they exist outside the mainstream culture; they become incomprehensible, insane or silenced (Dreyfus & Rabinow, 1982). Discourses that become dominant in a given place and time exercise a form of power. Nelson (2008) argues that "discourses congeal to form 'regimes of truth' – ways of viewing the world that become powerful and dominant, while their social and historical sites of production are obscured" (p. 15). This reinforces Foucault's position that there is no 'natural order' of things; the world has no intrinsic ways of knowing, but only the "ordering which we

impose on it through linguistic description of it" (Mills, 1997, p. 52). Discourses make comprehension both possible and impossible by virtue of their limitations (Dreyfus & Rabinow, 1982). This concept is exemplified in this research as certain statements in HIV discourse are privileged while others are unspeakable.

In subsequent chapters we can see how discourses that have come to dominate the way HIV/AIDS and gay men are understood also act to exclude other ways of knowing about this topic. This situation has been present since the early years of the HIV-AIDS epidemic. Whether HIV/AIDS is considered a "tragic illness" or "the wrath of god" depends on the discourse that achieves dominance at a given time and place and particularly within institutions. Discourses such as these can bring order to institutions and dictate how the objects of statements are understood. Thus, as the HIV discourses are discussed throughout this work, the reference is to the collection of statements that make HIV and the gay man as comprehensible or visible objects. These discourses are frequently homophobic and stigmatizing. This is because gay men are often objectified as being inherently promiscuous and personally responsible for the spread of HIV. This is not to say that "all people believe the discourse; there are critical, resistant discourses in circulation. It does mean that the discourse is powerfully operative in society, and that such forms of knowledge have consequences; they give rise to particular actions" (Nelson, 2008, p. 16). An example of how discourse can be powerfully operative in society can be seen in some of the effects of public health efforts.

The historic representations of gay men as sexual deviants, dirty, and diseased has resulted in the categorical referencing of Men Who Have Sex with Men (MSM) as a population for which there needs to be surveillance for Sexually Transmitted Infections

(STIs) and the findings of such surveillance becomes the basis for public health interventions. The point here is not whether MSMs should be monitored based on STI infections, rather such surveillance requires statements to be made about who the targeted group is, thus rendering the object of surveillance visible. This is not a right or wrong argument; it is an analysis of how institutional practices of public health, for example, have formed subject positions.

The Subject

The term “subjectivity” or “the subject positions” are used in this project to illustrate how discourse works to create categories of identity or subjective spaces for people to occupy. As previously mentioned, identities are fictional, they are “masks” that are used to make sense of the world (Dreyfus & Rabinow, 1982). The subject is “produced through discourses and is also historically and contextually specific” (Nelson, 2008, p. 17). Seeing gay men or MSM as subject positions rather than as individuals with certain predispositions moves the outcome of research on HIV-prevention from fixing or correcting the problems of gay men to examining the effects of dominant discourses on the subjectivities of gay men. This interpretation sees the practices and experiences of gay men as the place where discourse plays out in strategies instead of as behaviours that are motivated by some other deeper and more intrinsic properties.

As discourses vie for dominance the effects can be observed in the way people take on identities. This process is both a product of discourses and a reconstitution of them. Within HIV discourses, including public health messaging and resistance to it, related to gay men, the grappling for dominance can be seen in our attempts to reconcile

who we, as gay men, are as sexual beings. If we accept the premise that gay subjectivity is most prominently enmeshed with how individuals understands themselves as a sexual beings then HIV discourse must be deeply woven into the subject experience because of the way it has impacted and been associated with gay men.

To further this discussion, gay men frequently identify with some sub-group within which to frame their sexual identity. For instance, bears, twinks, otters, subs, and doms are a few of the many sexual sub-categories in use today. I suggest that these subject positions are often framed with HIV somewhere in the background. In many cases, particularly in the online world, statements such as "safe-only" or "bareback" or other similar sexually based descriptions provide a statement about who the subject is and where they fit within the HIV discourse relative to sexual identity and practice. Frequently, these statements are an attempt to stabilize identity, but these identities are not as stationary as they seem.

The varieties of sexual identities that emerge within gay culture are, in fact, subject positions that make subjects knowable through sexual experiences, which are a product of discourses. The identity category “barebacker” is of particular concern because it has emerged as a sexual identity within gay culture, one that is marked as a target for HIV-prevention efforts. With stable notions of identity in question, I draw on Foucault’s analysis to suggest that the “barebacker” is a fictional figure “constructed through the current discourse” (Nelson, 2008, p. 17). This is not to say that barebacking as a sexual practice does not exist; rather, it is to note that the practice constitutes an identity category that makes the object visible. The object, itself, is a product of the dominant discourse of gay male culture. In other words, as the statements about gay men having unprotected sex

have congealed, the identity category “barebacker” has been produced. This subject position provides not only a target for researchers and public health interested in HIV-prevention but also an object that can be seen and analyzed.

Barebacking not only appears in the sexual practices of gay men, but in the popular culture, academic literature and AIDS service organizations (ASOs). As an example of the limiting effects of discourse, however, that of barebacking is replaced with language that is more aligned with what is considered acceptable within public health spaces. One example is “unprotected anal intercourse” (UAI); it disembodies the practice of barebacking and focuses on the population as a whole. The discourse of barebacking in public health may be unrecognizable or lack legitimacy because it falls outside what is considered “normal” or the dominant discourses available within that space. This is an interesting twist in the discussion because while public health efforts may focus on the MSM population and the practice of UAI in surveillance and intervention, the object is rarely named in the same way in public health as it is in other spaces such as community agencies or online. In effect, this seems to remove the cultural and social context that surrounds this sexual practice and is a measure that seems to disembody this particular sexual experience. The subject position, however, does not exist without the bodies to exemplify and manifest their identity.

The Body

Foucault sees the body as the place wherein the systems of discourse and power relations come together and materialize. Without the body there is no power or subjectivity upon which to script the discourses; without the body there is no resistance

and therefore no power. Nelson (2008) notes “Foucault saw the body as the principal target of power and incites us to think about how power is enacted specifically to produce, affect, regulate, and rule the individual” (p. 17). This conceptual framework draws attention to the how the bodies of gay men are named, territorialized and surveilled in modernity.

Instead of seeing "gay man" as a sexual identity that people have intrinsically, this theoretical perspective places the analysis on the body as a product that is sexualized within a discursive framework. Within such a subject position there is room to “manoeuvre what Foucault calls ‘a field of possible options’” (Foucault, 1972, pp. 36-37 as cited in Dreyfus and Rabinow, 1983). The discourse allows for limited mobility within the sexual subjectivities of gay men, but the body is the site where dominant discourses are realised and/or contested or resisted. It is here that the esoteric discussions of discourse and power materialize; “it does not simply remain at the level of ideas or ideology” (Nelson, 2008, p. 18).

My research is not focused on the embodied experience of gay men in barebacking situations per se. Rather, I raise the issue of the body here and comment on it theoretically because it appears in some of the research findings wherein activists who are also gay men describe their experiences. My analysis in subsequent chapters will, at times, describe how the dominant discourses on the body come to the fore when these men talk about their experience as both activists and sexual subjects. The discussion on the body is limited because it only appears in these specific sections of the findings. Focusing further on the embodied experience would change this study, as the operations of power are observable through different mechanisms.

Power

Foucault's conceptualization of power is one of his most important contributions to social theory. He departs from many other philosophers by moving away from the notion that power is simply oppressive or repressive to an interpretation that sees power as omnipresent and an integral part of society. He instructs us to think about power beyond having power over someone or something. Foucault states:

> We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production (Foucault, 1977, p. 194).

This statement is very similar to the terms I used previously to describe how discourse operates. Discourse and power are closely bound though not the same.

Power is productive but it does not exist outside of social relations. We can see how discourse is formed and how power relations are produced by observing social relations situated within institutions. Foucault elaborates on this topic by suggesting that:

> Discourses are not once and for all subservient to power or raised up against it… We must make allowances for the complex and unstable process whereby a

> discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart (Foucault, 1981, pp. 100-101).

This distinction allows for Foucault's interpretation of power as both productive and "discreet" to be operative but not absolute. In other words, individuals or institutions do not possess power, but it is produced from all directions (Foucault, 1978). Tied closely to this is the productive nature of discourse in that discourse not only produces objects and subject positions, but also power relations. Examining discourse, however, provides the means through which we can interrupt the otherwise inherent the operations of power.

It is interesting to note that although Foucault takes a novel approach to explaining power, he suggests that methodologically, examining power itself is not how an investigation should take place. He takes this position because of his complex definition of power and its manifestation. Foucault's description of power suggests that there is no singular source from which it originates, rather unequal power relations are an historical effect of interactions. Though institutions are often marked as the origins of power, Foucault contends that it is discourse that forms and produces power relations that are propped up in the mechanisms of institutions (Dreyfus & Rabinow, 1982).

Though institutions provide the mechanisms through which power is put in operation, they are not the origins of power. As explained previously, power is aligned

with knowledge and what is knowable about an object. Power, in this sense, takes form through subjects that interact with each other. These interactions are constituted within society and thus change the nature of power from simply operating within an ephemeral space to operating within the broader social sphere. This way of thinking about power shifts the terminology from power, itself, to power relations because it is within social relations that power operates and takes shape.

So far, I have discussed power as it takes shape and operates in general terms. One of the ways to observe power in operation is in the "micro-practices" of subjects participating and interacting within institutions (Dreyfus & Rabinow, 1982). Dreyfus and Rabinow (1983) suggest that micro-practices take place in our everyday lives and are often unnoticed as mechanisms of power. These micro-practices include the way things are said, how the discourse and the constitution of subjectivities are formed, and how this takes place all around us in very subtle ways. Through institutional behaviour and seemingly innocuous habits, micro-practices work to frame the way things come to be known. An example of how discourse is formed through innocuous habits follows:

For the past five years I have taught a Human Sexuality class to over 3000 students. Each term I discuss love and attraction. And without giving any further context I casually mention that certain people are "10s" and others are not. I continue with the lecture and later return and ask the students what I meant earlier when referring to a "10." Without fail, the students always know what I am talking about: a person that meets idealized standards of beauty and attraction. As I progress through the discussion, I ask them how they know this, since "ten" is only a number. We note that simply providing the reference to any number on a scale of one to ten represented the degree of

attractiveness and that it is a common method of describing this in our society. We go on to discuss that without ever defining or really thinking about its implications, we establish a scaling system through which to rank and station people based primarily on physical attraction. Underpinning this system are threads of heterosexism, misogyny and other social forces that are not immediately visible. All of this is constituted through discourse and occurs in the everyday language of people. This system is a fast and effective means of ranking and stationing subjects into what our social norms dictate is their proper place or subject position. All of this is known without ever having to name it, I merely say a "10," and it is understood by all.

This example might further suggest that investigating the discourses and micro-practices that are embedded in everyday life can reveal the illusive operations of power. In most cases, people would not think about the domination effects that ranking people on a one-to-ten numerical scale might have, but it does. It is a way of objectifying the body and locating it within a knowable discourse. It is through these types of seemingly innocuous strategies that discourses come to dominate and power is manifested. Amidst the grappling for dominance and the struggles that subjects experience, this analysis helps us see that the “strategy is without a strategist” (Power, 2001, p. 17). In other words, though we can see the power at work by interrogating these everyday experiences, there is no one person who is guiding the strategy and attempting to bring these forces into absolute power over a people or society. Power simply is, and though we are all players in its operation, no one has control over the entire game.

It is from this understanding of power and its relation to the other concepts of the subject, the discourse and the body that this investigation takes place. There is one clear

institutional interest related to gay men and HIV, this is the public health interest in preventing HIV transmission. What may be unseen, however, is how the public health discourse takes shape and how it impacts the subjectivities of gay men. In his description of power, Foucault was never suggesting that it should not exist, nor did he think that social services had no place in society. He was, however, concerned with how the institutional practice of social services might have dominating effects (Foucault, 1977). Shifting from thinking of power as a negative consequence enables me to see public health and other HIV-prevention efforts as a discursive practice that has productive properties.

Implications

Some basic tenets of the theoretical framework for this thesis have been outlined above. Further explanation is provided in the methodology chapter and in the analysis of the findings. In this chapter, I have focused on four main concepts and their relevance to this investigation: discourse, subjectivity, the body, and power. These ideas are also deeply enmeshed with one another and provide the basis for how we come to know who we are as gay men and how this knowledge frames our experiences within sexual relations. If we see our sexual experiences within the social context, then these "practices" do not exist as independent acts that take place at one particular time in one particular place; rather, the locale of these practices is *the collective experience of gay men*. This is also the site wherein the effects and strategies of discourse and power can be observed. The chapter that follows presents a discussion of the methodology used in this investigation; it also explains how this investigation takes place from the perspective of the discourse on this topic.

Chapter 4: Methodology/Methods

This chapter details the research methodology and methods employed in this investigation. The methodology used is in a post-structural theoretical framework and is primarily focussed on the power relations embedded within the dominant HIV discourses as they relate to gay men (Weedon, 1999). From a post-structural paradigm, power is always relational and is enacted through a variety of techniques. This chapter begins with the research questions. It then outlines the methodology, study design, methods of data collection and analysis, and some ethical considerations.

Research Questions and Design

The research questions are aimed at investigating one overarching topic: **How HIV discourse in Nova Scotia is set within the discursive field of gay men's sexual subjectivities.** To guide this research, the following questions are posed:

1. How do HIV activists in the gay community talk about HIV in relation to public health and health promotion?
    a. What are the meanings that participants give to their experiences in the field of HIV?
    b. How do HIV/AIDS activists who are gay men talk about themselves as participants and recipients of health promotion and/or public health HIV-prevention messaging?
    c. What is the meaning of “barebacking” and how does it relate to gay men’s sexual practices in Nova Scotia?

2. How do HIV activists talk about the social and political climates of Nova Scotia that influence HIV work in terms of health promotion and public health?

Research design. This research is designed to explore the discursive field of HIV in Nova Scotia from the perspective of HIV/AIDS activists. From the outset, it was anticipated that the participants would have insight into how the social and political climate influences the development of HIV policies and programs. This investigation set out to address the above-outlined research questions through a post-structural discourse methodology. I begin by describing the methodological framework that guided the research. Some specific methods follow.

Methodology: Post-structural discourse analysis

In its broadest sense, discourse analysis is a study of language and discourse in various disciplines and social institutions (Luke, 1995). Luke (1995) further clarifies this notion, stating that: "drawing on post-structuralist discourse theory and critical linguistics, it focuses on how social relations, identity, knowledge, and power are constructed through written and spoken texts …" (p. 3). Discourse analysis provides a method for investigating the ways in which discourse is the means through which practices and experiences are constituted in social relations (Fairclough, 2003; Graham, 2011). This method enables me to investigate specific texts, while focusing on the "order of discourse," which interrogates enduring social structures and the resulting social practices (Fairclough, 2003, p. 3). "Reading" the text for discourses can illuminate both the intended messaging of health-promotion campaigns and some "unintended" messaging,

which also contributes to dominant discourses (Kippax & Kinder, 2002; Nettleton & Bunton, 1995; Stanczak, 2007).

The following builds on the work of Graham (2011), which details a discourse analysis that draws from the work of Foucault. Discourse analysis serves as theory and method because there is no purist "method" for doing Foucauldian-based work (Graham, 2011). This type of examination requires a theoretical orientation to situate the type of discourse under analysis. The definition of discourse may vary depending on the social theory employed. As outlined in the previous chapter, in this study discourse is closely bound to power and subjectivity. Foucault avoids prescribing a specific method and leaves the application of his 'tools' open for interpretation. Not only does this allow for interpretation, but it also addresses his critique of the way social science and academia create systems that produce power/knowledge relations. His lack of specificity in method occurs, in part, because he did not want to create the same conditions of subjugation he was examining.

Graham (2011) notes that "Foucault (1994, p. 288) himself disliked prescription stating, "I take care not to dictate how things should be" and wrote provocatively to disrupt equilibrium and certainty, so that "all those who speak for others or to others no longer know what to do" (p. 663). Foucault, however, does not render researchers unable to employ his theories in research by avoiding a specific methodology; rather, he creates a situation in which the very *truth* being sought after is called into question. Rather than attempting to create a new truth about gay men health, this research shifts from replacing one *truth* with another by exploring the effects of discourse (Graham, 2005).

“Doing” the discourse analysis. The challenge for post-structural researchers employing discourse analysis is to balance putting a theory to practice while avoiding a systematization of method. Graham (2011) argues that the purpose is not to propose a “true/false” reading of the texts; rather: “the objective is to explicate statements that function to place a discursive frame around a particular position; that is, statements which coagulate and form rhetorical constructions that present a particular reading of social texts” (p. 669). During the analysis of the "texts", which in this study were the interview transcripts, I looked for statements that were repeated and gave meaning to particular issues related to my research questions. Specifically, I interpreted and focused on statements being made that indicated a way of knowing about certain topics such as gay identity and Nova Scotian culture. Hook (2001, p. 525) indicates that for poststructural discourse analysis attending to these common statements makes visible “the underlying forms/conditions/criteria of reasonable knowledge on the basis of which truthful statements can be made”. In subsequent findings chapters I am concerned with the way topics related to the research questions are talked to see how collection of things that were said formed a way of knowing.

In addition to framing the analysis around the way things became known through discourses, I looked for areas in which competing discourses emerged. At times, I could see in the texts how certain institutional ideologies influenced how certain topics were understood. For example, one of the participants talked about his sexual practices as an activist and as a person living with HIV/AIDS (PHA). He noted that, at one point, the scientific literature advised against HIV-positive men having sex with other HIV-positive men without protection because of the potential for contracting a superbug. But, the

participant said he knew intrinsically that this was not correct. He also stated that he continued to have bareback sex with his "main squeeze" since they were both HIV positive. Regardless of the validity of the scientific literature, this participant found that despite being an activist and being thoroughly knowledgeable about the current HIV literature, he was not able to speak about HIV positive men, especially about himself, barebacking.

This example begins to illustrate how discourse has power over what can and cannot be said or rationalized. This creates a system of governance that is particularly observable in topics related to sex. Though more than forty years have passed since Foucault wrote about the modes of governance through discourse, his thoughts still ring true: the "areas where this web is most tightly woven today, where the danger spots are most numerous, are those dealing with politics and sexuality" (Foucault, 1971, p. 8).

Foucault argues that by giving meaning to objects, discourse creates a system of practices. The ability to recognize and describe objects forms discourse, and a system of practices is developed through this formation. Hook (2001) notes that the effect of discourse is to create a system that is virtually impossible to think outside of; when one does think outside the box, one is labelled as mad or incomprehensible. This theoretical notion became evident in the analysis when participants talked about spaces where they and other were able to speak about certain topics related to gay sex. By producing and limiting what can be known about gay men's sexual practices in certain spaces, discourse creates a system of practices based on the social setting. Breaking with this system or "thinking outside the box" becomes almost impossible. To apply this concept to the findings, I looked for instances in which participants talked about where and when they

felt able to speak on specific topics and how this had a regulatory effect on what could be known about the issue.

Discourse provides a framework for experience, while power works to ensure that certain things can and cannot be said and, if non-normative things are said, then they are isolated as irrational. Hook (2001) states: “Discourse analysis should, hence, busy itself not only with the search for a plenitude of meaning, but also with a search for the scarcity of meaning, with what *cannot* be said, with what is impossible or unreasonable within certain discursive locations” (p. 527). In the analysis that follows, there is an examination of what is permissible language and what topics are available for public and private consumption. Frequently, the topic of silence and silencing arises as a concern for participants. Early in the findings, it becomes apparent that what is said about HIV/AIDS is as equally important as what is not or cannot be said.

One of the key features of public health in operation is targeting specific populations at risk for particular diseases. Since HIV emerged, public health has attempted to target gay men (MSM) to control the disease and limit transmission. In recent years in various forms of public health, there has been an interest in isolating “higher risk” groups within the category of gay or MSM to increase the effectiveness of targeting campaigns. Classifying groups of people is not merely a practice of definition; it is a constitutive mechanism through which a discursive formation renders objects visible (Foucault, 1972). Through the isolation of such discourses and statements, it becomes possible to locate the ‘positivity’ (Foucault, 1972, p. 214) and reveal the formation of the power relations that are often embedded within institutions (Graham, 2005). Graham (2005) argues that “ [i]dentifying and following discursive traces leads one back to the knowledge-domain upon which the statement relies for its intelligibility, at the same time

revealing other artefacts or statements from that particular discursive formation, which together work to sustain the field from which they originate" (p. 671). The analysis that follows focuses on tracing discursive threads to interpret how objects are described and classified. Further, this analysis traces power/knowledge relationships to examine the domination effects that discourse may have.

Discourse analysis that draws on Foucault seeks to explain how discourse produces objects and therefore subjects and to gain an understanding of how "discourse shapes identities, beliefs, actions" (Graham, 2005, p. 671). The following analysis attempts to illustrate how groups not only understand themselves as a health problem (Scheurich, 1997) but "come to know and accept their *place*" (Graham, 2005, p. 672, emphasis in original).

Experience. Experience is discussed throughout because the methods of this study include individual interviews wherein participants discussed what has taken place in their lives and their view of history. Experience is frequently thought of as an individual conception. From a post-structural framework, however, experience both in the moment and the recollection of that moment is a production. This work employs Scott's (1991) analysis in which she discusses the historicizing of experience.

The concept of lived experience within qualitative research has often been privileged as a knowable *truth* (Van Manen, 1990). Scott (1991) rhetorically raises the following point: "When the evidence offered is the evidence of "experience," the claim for referentiality is further buttressed—what could be truer, after all, than a subject's own account of what he or she has lived through?" (p. 777). Critiquing the evidence of "experience," Scott proceeds to argue that it is a production of discourses and a

reproduction of dominant ideological systems, if left unquestioned, particularly for those who claim to have experience outside of mainstream historical accounts.

This understanding of experience will be employed, here, as seeing individual experience as a production of discourse enmeshed in power relations. The focus will be on the "processes of identity production, insisting on the discursive nature of "experience" and on the politics of its construction" (Scott, 1991, p. 797). The proceeding analysis attempts to see the situations participants describe as being embedded within the broader social, cultural, historical, and political systems that produce experience. This method follows Scott's analysis noting, "experience is at once always already an interpretation and something that needs to be interpreted. What counts as experience is neither self-evident nor straightforward; it is always contested, and always therefore political" (p. 797). My analysis draws from Scott's rendering of experience, which is so eloquently designed in her work.

I turn, now, from the more theoretical aspects of my methodology to the actual methods employed in this research project. The following describes how I collected data, including recruitment and the sampling strategy, the analysis of the data, some ethical issues, and some limitations that should be considered in this research.

Methods

Data collection. Data were collected through informal interviews with individuals who work or volunteer in the field of HIV/AIDS and are interested in gay men's sexual health. These interviews focused on the issues and circumstances related to HIV and gay men in Nova Scotia. It was anticipated that participants would be able to discuss the social conditions that surround the experience of gay men and sexual health, how health

policies have influenced and been influenced by these social conditions and political agendas. That all of these factors influenced the participants' experiences, proved to be the case, but the ability to comment on the different aspects of HIV work varied depending on the participants' position within the relevant institutions. For instance, responses of participants working in AIDS Service Organizations (ASOs) differed from those of individuals working in primary care. Though the perspectives were different, they informed multiple aspects of HIV work that might not have otherwise been considered. The interviews followed a similar format to the research questions listed above. Investigating the context of the development of HIV-prevention illustrates how health policy has influenced discourses that have entered the discursive field of gay men's sexual health and how this discursive field has been mediated through public policy.

Individual Interviews. Seventeen one-to-one in depth interviews occurred between September 2011 and February 2012. The format was face-to-face, informal, and the interviews took place at mutually agreed-upon times and places. Interviews were selected as the primary tool for data collection because the participants occupy a unique space within the HIV system. As activists and community members working in various agencies and boards, the participants embody a position within the discourse while being part of the formation process. In other words, they are either allies or members of the gay community doing HIV-related work that, in turn, influences the very community they inhabit.

Each interview lasted approximately 60 to 90 minutes and used an interview guide with open-ended questions (Appendix B). Occasionally, individual interviews drew on health promotion materials, including health policies and programs, and were based on

the participant's knowledge. These texts were helpful in eliciting the participants' knowledge and understanding of the policies and programs as well as the broader social structures embedded within these forms of discourse (Stanczak, 2007). Interviews were audio-recorded and transcribed verbatim so as to accurately capture the specific details of the interview, in keeping with a discourse analysis.

From a post-positivist perspective on interviewing, the data are not considered a "truth;" rather, the data are considered a form of discourse of which the researcher is a part (Thomas, 1997). Though interview guides were used, the language and discourses that emerged in the data are not considered "bounded or stable" because accounts are "persistently slippery, unstable, and ambiguous from person to person, from situation to situation, from time to time" (Thomas, 1997, p. 62). The usefulness of the data is to analyze discourse and the effects of power. I attempt to be conscious not to dismiss the "experience" of the participants because the ways experiences are formed and discussed in conversations are reflections and products of the very discourse under examination (Graham, 2011; Scott, 1991).

Sampling Strategy. In keeping with the tenets of a qualitative research tradition, this study sought to gain an in-depth understanding.

Patton (2002) suggests that the:

> …logic and power of purposeful sampling derive from the emphasis on in-depth understanding. This leads to selecting *information-rich* cases for study in depth. Information rich cases are those from which one can learn a great deal about

> issues of central importance to the purpose of the research, thus the term *purposeful* sampling" (p. 46).

Recruitment for this study occurred in three forms: 1) through poster advertisements in HIV/AIDS and LGBT-activist organizations; 2) through snowball sampling; and, 3) through direct sampling. Organizations included the AIDS Coalition of Nova Scotia; HIV/AIDS Commission; the Nova Scotia Rainbow Action Project; Hepatitis Outreach; the Halifax Sexual Health Centre; and PrideHealth. Participants had a history of working with policy and programming aimed at reducing HIV transmission among gay men. As such, this research is information-rich in nature due to its links with health policy, social conditions, and impacts on the sexual practices of gay men.

An increasing body of literature, both provincially and nationally, inform about context of the sexual health of gay men. In addition, significant attention has been given to the barebacking phenomenon within this population. Yet, efforts to reduce HIV transmission have not resulted in a decline in new infections. The key informants within the Nova Scotian context provide significant information to "illuminate the questions under study" and inform future health policies (M. Patton, 2002, p. 46). Each of the study's participants contributed to an understanding of the context of HIV from their varying perspectives. These insights are critical to the investigation because, "they take us, as readers, into the time and place of the observation so that we know what it was like to have been there" (M. Patton, 2002, p. 47).

These interviews provided an account of the historical context through which we can investigate the evolution of HIV-prevention discourse in Nova Scotia. Patton (2002)

further attests to the importance of gaining access to these experiences because it "means going into the field—into the real world of programs, organizations, neighbourhoods, street corners—and getting close enough to the people and circumstances there to capture what is happening" (p. 48). In this way, the participants provide insight into the unseen dimensions of the design and implementation of health policies and how these, in turn, influence the power relations surrounding the sexual health of gay men.

Snowball sampling is another purposeful research method because the selection of participants is not randomized. Rather, it is a guided attempt to access individuals who have specific information regarding the topic (Creswell, 2003). Once key individuals responded to poster solicitation, they were asked to seek out other participants in their networks who would have insight into or an interest in the topic of gay men's sexual health, particularly with respect to HIV-prevention. Most of the participants agreed to do so and contacted other individuals with relevant information or experience. This sampling method is also useful if the participants are well networked and would likely be in contact with other potential participants (Rice & Ezzy, 1999). After snowball sampling and poster recruitment slowed, I emailed potential participants in volunteer or paid employment positions related to HIV. The purpose of direct recruitment was to ensure that factors such as geography, race, age, and other factors were considered.

Community Activists. Community activists within the lesbian, gay, bisexual and transgender (LGBT) community have a long history of contributing to and influencing health policy and programming aimed at the reduction of HIV transmission among gay men (D'Emilio, 2002; Dowsett et al., 2001; Dowsett & McInnes, 1996; Rowe, 2008). Such activists are in a unique position to offer information and insight into the historical

context of HIV-prevention messaging. Given this situation, the sampling began through advertisements in activist organizations within Nova Scotia. It is somewhat unique that in health promotion gay men may be both the designers and recipients of public health messaging. Though this sample group was not limited to gay men, their contribution had the potential to be particularly useful for this investigation. Interviewing community activists provided me with insight into the discourses of gay men that may influence the design of health policy. In other words, these community activists advocate within the public health system for what they perceive addresses the sexual health needs of gay men. As leaders within the community, these men may in turn signify categorical representations of the gay male identity to policy developers and practitioners outside the LGBT community.

The participants had an age range of approximately mid-20s to late-60s and were located in Halifax or in northern areas of Nova Scotia, including Pictou County and Cape Breton. In the results I note generally where participants are geographically located. No participants came forward from the southern regions of the province. This may be attributed to the lack of ASOs or other agencies there that are directly involved in either LGBT issues or HIV/AIDS. The interviews took place in the participants' homes, offices in community agencies, or the researcher's office. Men and women were recruited for this project and most (but not all) of the men identified as gay.

Data Analysis. The analysis of the data took place throughout the study through formal and informal methods. During the interview process, I reflected on the ways in which different discourses emerged by taking notes during the interviews and on the transcripts, following the interviews. Some topics were added as discursive threads

emerged in the early interviews. For instance, in a number of early interviews, participants spoke of HIV as a "gay disease." This issue was raised in subsequent interviews with many of the participants in order to gauge their interest and opinions on the matter. It is explored in greater detail below.

Interviews were transcribed following each interview and notes were taken prior to coding. My notes were used to identify the common language that formed consistent threads. At the outset, I did not assume that these were necessarily dominant discourses. However, through the process I noted certain ways of speaking that allowed me to trace discursive threads. I used these notes as a starting point to code the transcripts.

Once the interviews were complete, all the transcripts were coded using Atlas-TI software. The coding was an iterative process in which the initial set of codes was derived from the field notes and subsequent codes were added as topics related to specific discourses emerged. The codebook was not designed to reflect the individual experiences of the participants; rather, it concentrates on how these experiences fit into the collective whole and contribute to the discursive field of gay men's sexual health and HIV. In keeping with the theoretical tenets and the research questions outlined above, during the coding process I looked to certain statements that silenced certain aspects of the HIV discourse or that produced certain ways of knowing about and understanding both HIV and gay men. I was particularly interested in how we came to know gay men as objects of analysis in Nova Scotia and how sexual practices might have become privileged or silenced. This was the basis upon which I developed the codebook.

When the codebook and the first round of coding were completed, the interviews were re-analyzed to ensure all data were analyzed using the complete codebook. The codes reflected the discursive threads that were used to analyze the data and write the

findings. In other words, based on the issues identified, the codes were developed from the interviews with the intent of following the specific discursive threads that derived from the data (e.g. identity, community, barebacking, etc.).

Ethical Issues. It is imperative to provide ethical safeguards for researching marginalised groups, particularly in relation to sexuality and sexual health practices. James and Platzer (1999) suggest, "research that recognizes that participation can make marginalized people very vulnerable and values the need for reflective and nonjudgmental attitudes amongst researchers is more likely to be empowering for participants" (p. 77). From an insider's perspective I am aware of the unique challenges that emerge when doing research with gay men. James and Platzer (1999) illustrate this advantage, stating "being native 'insiders,' part of the lesbian and gay culture, has given us certain advantages. We have an understanding of cultural issues, of language, of current debates, of history. It has enabled easy access to and a good rapport with a sample group of people who have been more trusting and less suspicious of us than they might have been of 'outsiders'" (p. 79). In this case, I was knowledgeable of all of these issues. The participants for this study were also lesbian, gay, bisexual, and transgendered, and identified and affiliated with LGBT community organizations, so it follows that they were comfortable with their sexual identity. Lastly, all possible measures were taken to ensure confidentiality. The data were stripped of the identifying characteristics that might disclose participant's identity.

In keeping with the Tri-Council Policy, ethical approval was sought from the Human Ethics Review Board at Dalhousie University. It is of critical import that the data and methods of collection of a potentially vulnerable population such as gay men be

safeguarded. Ethical issues are paramount when conducting research that requires data collection on humans. As previously noted, the interviews were conducted at a mutually agreed upon time and place between the researcher and the participant. Some of the participants chose to conduct the interviews in their homes, at work, or in the researcher's office. The interview format was informal and one-on-one. Participants were advised that their participation was voluntary, that all possible measures would be taken to ensure confidentiality, that they could withdraw at any time, and that any data collected would be destroyed if they chose. (No participants chose to withdraw or indicated any hardships during or after the interviews.) And since this topic has the potential to cause emotional distress, counselling resources were made available through the researcher upon request.

The interviews were digitally recorded to preserve accuracy. The recordings were transcribed by either the researcher or a paid interview transcriptionist, and stored on a password-protected computer drive. The transcriptionist signed a confidentiality form (see Appendix C). . "Hard" or paper copies of transcripts, consent forms (see Appendix A), and other identifying material are stored in a locked filing cabinet in the researcher's office. Electronic sensitive data is password protected.

Finally, as a gay man with the relevant professional background, I believe I was particularly well suited to carry out this research. I have insight into some of the common experiences of coming out and homophobia. As a counsellor, I am experienced in dealing with the kind of emotional stress that can occur from the recall of potentially traumatic experiences. Given my qualifications, I believe that the research was conducted in a safe and ethical manner.

Limitations. The limitations of this study relate mainly to recruitment across the various populations impacted by HIV/AIDS. One of the key groups from which participants did not come forward for this research was the black community. In 2006, an initiative was funded by the AIDS Commission of Nova Scotia to address issues related to the province's black communities and HIV/AIDS, but some of these activists have either moved on or did not choose to volunteer for the study. Significant efforts were made to include members from this community; however, no formal organization exists that deals primarily with African Canadians in Nova Scotian and HIV/AIDS. This undoubtedly contributes to the issue presented below wherein the definition of "gay community" is contested.

Frequently, initiatives to address "gay men" are challenged in academic literature for reifying the concept of the gay community in North America as primarily of the urban, white, middle-upper socioeconomic class (Bérubé, 2001; Rowe, 2008). To an extent, this study investigates the prevailing discourses that surround the gay male community, but a limitation is that it does not reflect the racial or ethnic diversity that actually exists within this group. It is anticipated that, based on the study design to investigate the dominant discourses, this limitation will be mediated. That is, the approach to investigating the discourse, rather than individual "lived experiences," focuses primarily on the productive powers of discourse that reference HIV and gay men. Thus, as the study progresses, it is anticipated that conclusions regarding the production of the gay male subject might provide insights into how this impacts subjects across various identity classifications.

The second limitation or acknowledgement is that the very act of writing and providing a perspective on the impacts of HIV on gay men's subjectivities is a constitutive process. Writing and speaking this research into existence contributes to the overall production of the very issue under examination—barebacking and HIV among gay men. It is anticipated, however, that the act of knowing and acknowledging will mitigate the governing effects of the present discourse.

Chapter 5: Findings – The Nova Scotian Context

The literature review in Chapter Two provided some historical information and a discussion of the primary AIDS Service Organizations (ASOs) and HIV policies related to HIV and gay men in Nova Scotia. This chapter aims to apply the theoretical tenets to everyday experiences of HIV activists working and living in this province. To more fully explore participants' understandings and impressions of the Nova Scotia experience as it relates to the research topic, the interviews often entailed discussions about the overall political or social climate here, as well as the specific personal experiences that likely formed their opinions. The following exploration of participants' ideas or impressions of HIV-prevention and gay men's sexual health in Nova Scotia is not designed to offer a definitive, singular *truth* about Nova Scotians in relation to this topic; rather, it intends to illustrate how normative ideas about culture and society can take shape in sexual subjectivities. At times normative forces come crashing into the ideas or events that challenge the existing, taken-for-granted beliefs. The result is that the normative discourses are disrupted, and new or counter discourses are created and ultimately produced in the experiences of the subjects who exist outside the dominant culture of Nova Scotians.

This study examines the HIV activists' experiences of working in the field of HIV/AIDS. Some participants identify as gay and recount various aspects of their lives and how this relates to their work. The reason for analyzing how HIV activists, in Nova Scotia, view the social and cultural conditions is that their impressions and methods of speaking on the topic influence the design and implementation of HIV policies and

programs. They also influence the day-to-day language that is adopted and reiterated within the contexts of HIV/AIDS work and HIV discourse.

In the first part of this chapter, I focus on the language and statements that are used to describe the Nova Scotia culture as it relates to gay men. Some of the statements are not necessarily unique to this region. Nevertheless, they provide guidance on how people, here, comprehend the dominant discourses related to gay men. The primary discursive thread that appears in this first section is a culture of homophobia and heterosexism in Nova Scotia, which is often overlooked under the guise of social progress and equality. This idea is often exemplified in participant's experience of coming out, particularly in relation to religious and government institutions. The effects of living in a small community compared to other major urban centres in Canada emerged as having an impact on the way gay identity is shaped and HIV is contextualized here. Following these threads, the middle section of the chapter focuses on the effects of silence in relation to various aspects of gay male identity, sexual practice and HIV/AIDS. In the concluding sections, I examine how participants experience the effects of silence and other aspects of Nova Scotian culture in their work and personal lives.

Gay Culture In The Maritimes

I use the term Maritimes because it reflects some of the cultural trends that emerge, but this project is limited to Nova Scotia. Gay culture in the Maritimes can be explored at great length. However, this section will focus only on a few key aspects that illustrate the above-named discursive threads. An example of the gay cultural experience in the Maritimes can be seen in one participant's coming out. Though coming out is not

unique to Nova Scotia, the language and local dynamic used to describe what can happen here is.

Coming out and coming in. In a descriptive book about various aspects of Maritime culture, Goodman (1988) discusses the gay existence by saying that, historically, being "gay" was generally accepted, so long as one was not too flamboyant or made too much of a spectacle. Although this book was written over twenty years ago, participants in this study described similar attitudes today, which were even more pronounced in rural areas. One participant recounts his story:

> *…well my immediate family were pretty accepting and you know there were other people around … that sort of idea that o.k. if you go public then people have this sort of conception of seeing people dancing on the streets at Pride, you know, pictures from San Francisco or New York or Toronto… being gay or lesbian, on the whole, I don't think was the issue; it was more, sometimes, the overt sexual expression in some respects… (William, 40s, Northern NS)*

The participant's family and the people in the local area had an impact on how he initially felt about his "gay identity." His early understanding of gay people was that they were excluded from the dominant culture.

The participant recounted his experience of growing up in a small town, in rural Nova Scotia. He said it was known that certain people were gay or lesbian, but there was an understanding that "flaunting" gayness or being "too gay" was unacceptable. The participant felt that this suggests that there is a taken-for-granted knowledge of appropriate gender and sexual identity that is common to most people. The fact that

examples of behaviours that fall outside the norm were taken from large cities in Canada and the United States reinforced this attitude for him. He saw himself situated within the larger landscape of sexual subjectivity, but localized through the experience of his relationships with his family and community.

Though this participant's situation is not unique, the specific ways gender and sexual identity are presented in different regions tend to be. In this participant's description, he mentions the region he grew up in and talks about how it was known that others were gay or lesbian, but they kept the fact they were gay to themselves. The dominant discourse about what it means to be out and publicly identifying as gay, in this region, is to be flamboyant and scantily dressed, like the people of San Francisco or other larger centres where gay people live. This participant was primarily describing his relationship with his mother. She communicated to him that her knowledge about being out and gay was contrary to the norms of their society. This can be interpreted as a way a particular society attempts to place a "normalizing" influence on gays and lesbians by stating what should or should not be expressed.

The interviews conducted during this study reveal that there was more than one situation in which an individual learned that being too flamboyant was not acceptable in mainstream culture. In a way, these attitudes set the limits of gay expression, particularly in rural areas where there is less of a sense of how a "gay community" exists. The pressure to avoid flamboyancy is a disciplinary tactic. The productive component of this interaction is the understanding that there are people who are gay, but as proper members of the community, they do not flaunt it.

The above excerpt illustrates that there is a premise of equality within which many cultures in Western modernity align. William states that it was known that there were gay people in rural communities and for most people there *"was no problem with it."* Foucault suggests that within a disciplinary society, power can be operationalized through "normalizing judgment" (Dreyfus & Rabinow, 1982, pp. 157-158). Under the guise of equality, there are "micro-penalties" for deviation from cultural norms. In this instance, sexual expressions like those observed in *"San Francisco or New York or Toronto"* would contravene what is acceptable behaviour. Seldom will someone be arrested in rural Nova Scotia for being too expressive of their sexual orientation, but they will often experience micro-penalties for these transgressions. One participant suggested that though he did not experience overt homophobia and heterosexism, other gay men were still fearful of being out in a rural community: "*... a lot of the fear lies within the heads of the gay community" (David, 60s, Northern, NS).*

David further talks about these fears originating from not wanting to be *"out,"* particularly in professional settings. Though there have been instances of violence, the participants in this study recall their own experiences and the experiences of others as being tied to other issues, these being the more micro-penalties. Dreyfus and Rabinow (1982) state that "this leads to an initial homogeneity from which the norm of conformity is drawn. But once the apparatus is put in motion, there is a finer and finer differentiation and individuation, which objectively separates and ranks individuals" (p. 158). These strategies not only seek to keep individuals in their proper place, through observation and surveillance, there is a ranking effect of normalizing judgment, particularly for those who violate sexual norms. This gives rise to the "apparatus" of heterosexism in the dominant

culture. The apparatus I am focused on, at this point, is the maintenance of heterosexuality as the norm.

The apparatus in this project is difficult to trace because there is no singular institution within which we can observe the structural ordering of power relations. There are institutions that support power relations, such as schools, churches, and other organizations, but not everyone in the community attends or accesses these spaces. The issue that comes to the fore is not one of a single institution propping up these power relations; rather, it is the broader culture of homophobia and heterosexism.

Heterosexism, itself, is not unique to Nova Scotian culture, but the way the apparatus operates to maintain its dominance or hegemony has a local, context-specific dynamic. Dominant discourses such as heterosexism produce resistance because people fall outside of these norms. Foucault suggests that we look to resistance to identify power and dominance (Dreyfus & Rabinow, 1982). One of the effects of normalization is the "separating and ranking" of individuals who fall outside of the mainstream culture. By naming individuals as different and designating their space outside the mainstream culture, the norm itself becomes recognizable. In other words, the dominant culture is knowable by knowing what it is not, in this case those who step outside of the norms of heterosexuality.

William notes that, *"if you go public, then people have this sort of conception."* The reference to "going public" illustrates the Western rite of passage for most gay and lesbian people, which is coming out. The coming out process is commonly known within gay and lesbian communities and there is an expectation that people will eventually come

out if they have not already done so. The term “coming out” was used by a number of participants, including one who described the challenges youth face: *“The coming out stories, my god they were like… holy fuck” (Richard, 50s, Halifax)*. Although it is understood that people can come out at any age (and often continue to come out through the life-course), discussions about coming out frequently referred to youth.

The coming out process or the public act of declaring one’s same-sex sexual attraction is more than a declaration of sexual identity. Coming out is also a declaration of stepping into the subject position of being gay. When Richard was describing young people's coming out stories by saying, *“holy fuck,”* he was commenting on the incredible challenges many youth face. However, these challenges are not the same for everyone who comes out as gay. In some cases, people will feel a sense of empowerment. The force at work, here, is not the dominant heterosexual culture that is oppressing gay people; rather, the power relations are complex as, by coming out, subjects can both face hardship and experience empowerment.

Regardless of the individual outcomes, the process of coming out is a way of becoming known or knowable as well as visible. The coming out process can also be understood as "coming in." The individual not only steps into the public as an object that is comprehensible for the community and the people that surround them, but they also delve further into the subject position as being out and gay. By naming this gay identity, the subject becomes part of the system. They also shape the very object of analysis because it is reiterated and changed through their public proclamation. There is an expectation that one was and likely always will be gay, but to come out identifies that person as an *out* gay individual. Coming out is the act of speaking the self into existence,

and it changes the object of which people speak. The subject becomes further enmeshed in the web of discourses that are so tightly woven around sexualities; these discourses are not stationary, but they do have a history.

Another participant talks about the importance of queer history, by stating, *"kids coming out in the last 5 or 10 years don't know that history" (Michael, 50s, Halifax)*. While it may be true that many youth cannot knowingly articulate the history of queer culture, I would argue *they are that history.*

By coming out, young people are stepping into this subject position of gay that they can only recognize because of the discursive field. Though the field may vary to some extent, young people understand what it means to be gay and how this identity category fits outside of the heterosexual norm. In taking on the identity, gay young people are a product of the historical artefacts of the gay identification. By becoming part of it, however, they simultaneously reproduce the very identity category. Collectively, the next iteration of the gay identity is slowly moulded and slightly altered as new subjects contribute to the very subjectivity they have stepped into.

Coming out is more than a public declaration of with whom a person has sex. It is a process of becoming part of the history that has produced the gay subject. The object is known and the subject is manifested, but power relations are continually in flow because this is not a linear process. Under the guise of Western social progress, individuals are seemingly free to come out and openly express their gay identity. The myth of equality is a critical component of Foucault's (1982) description of the power strategies in modernity: "[T]hey assert the right to be different and they underline everything which

makes individuals truly individual. On the other hand, they attack everything which separates the individual, breaks his links with others, splits up community life, forces the individual back on himself and ties him to his own identity in a constraining way" (p. 212). This freedom to come out in progressive societies can also be seen as a shift in the way power operates, as opposed to one group having power over another. I use the above quote to illustrate that the idea of individual identity and respect for difference still separates individuals from mainstream society. There is a sense that today in North America, we seem to be more at ease to come out and identify as gay. Nevertheless, doing so may bind us to the subject position we are stepping into. Our individuality and right to be different is forced back on us in the web of discourse about who we are. In a sense, we may be getting what we are asking for—the right to be who we are, and to be separate and different from mainstream heterosexuality. Recently, a Pride theme in Halifax was named "Free to Be." I wonder if that freedom might be a way that power relations in progressive societies can still support systems of dominance *"and, for this to pass relatively unnoticed"* (Graham, 2005, p. 671, emphasis in original).

Legislation in Canada and, specifically, in Nova Scotia that protects the rights of LGBT people has led to a broader discourse of an inclusive environment. This inclusion or acceptance comes under the premise of equality. Progressive societies are still disciplinary as the illusive nature of power finds other strategies through new means. One participant commented on the fact that many challenges remain despite the progress:

> *I'm not sure it's been any easier to be gay these days… you still see this high suicide rate amongst adolescent boys… given what's happened in my sixty years of existence and the "sentence of gayness"… I never thought it would ever*

happen… there's still self-loathing and the number of kids… look at the bullying, look at the suicides… I'm not sure it's any better… (*Charles, 60s, Halifax)*

From this participant's perspective, "progress" in terms of gay rights has not resulted in the egalitarian society he would have expected by now. He notes that, in some ways, there is less pressure for people to hide their sexual expression, but this has not resulted in less bullying, fewer suicides, or more general acceptance. In modernity, the *"sentence of gayness"* does not mean violent societies seeking to kill or harm (though homophobic violence still occurs); rather we are killing ourselves because the strategies that support heterosexual hegemony have turned our identities back on us. I say this because these social conditions are not necessarily new or unique, nor are the experiences of gay people with homophobia and heterosexism. What is relatively new is that this is all happening under the guise of a new sense of equality.

Often, I hear people who identify as either gay or straight asking why we need Pride these days. In this question there is an assumption that because we cannot see as many overt forms of homophobia, it does not exist. It seems that we have been accepted into mainstream culture. I will explore how this has impacted some of the ways we express ourselves, particularly in the sexual relationships recounted below. Regarding Nova Scotia culture, gay men who are not too flamboyant and who align with traditional heterosexual views of sexuality are accepted. At times, they are even part of the normalizing apparatus.

The power of the small community. The ideation of Nova Scotian culture takes many of its cues from rural areas. The songs and folklore that identify this place often

characterize it as an old culture that is formed around harsh weather, trying manual labour that includes fishing and coal mining, and a strong sense of camaraderie. There is an impression, here, that people are friendly and that communities are closely knit, traditional, and rooted in Judeo-Christian beliefs. One participant recalls his experience in rural Nova Scotia even before his public declaration of his sexual orientation:

> *I've been gay all my life and living in a rural community, tried to hide it. Got married twice to real women, trying to hide it and live in a small rural community and survive with the extent of homophobia and discrimination that runs rampant in small communities, you basically had to hide it. (David, 60s, Northern NS)*

David goes on to talk about leaving rural Nova Scotia to come out and live his life. It is not uncommon to hear that more people hide their non-heterosexual identity, but according to the participants in this study, these accounts are more pronounced in rural communities. Though David refers to them as *"small communities,"* it is the rural areas, in general, that strongly influence who and what Nova Scotia is. The power that rural communities have is not only in how they influence the shaping of non-urban areas within a dominant discourse of heterosexuality, but also in how they shape what is known about Nova Scotian culture as a whole.

Although this project is not aimed at investigating heterosexual hegemony or the coming out process, one aspect focuses on the way Nova Scotian culture impacts HIV discourse and gay men. This discussion is meant to set the stage for the discourses that are more specific to HIV because they occur within this place. An example is given by another participant who recalls his experience of living as a gay man in rural Nova Scotia:

'cause so often there's a certain attitude... some people say yes you find that more in rural [areas]... this is why people from Sydney will travel all the way here (Halifax) for an HIV test. (James, 50s, Halifax)

By living, seeing, and understanding situations like these, the participants bring their experiences of residing and working in Nova Scotia to their activist efforts. Though coming out is a near-universal concept for gay and lesbian people in Western culture, this does not preclude it from having a local dimension.

Religion. Some religious denominations have also played a role in maintaining the effects of homophobia. Also, religion is often influential in framing the way sex is discussed. The effects of religion resonate as a particular point of contention for HIV activists because the discursive language around HIV was produced not simply as a disease or an illness but as a moral transgression. One participant analyzes why the way HIV-related issues are dealt with in Nova Scotia is unique:

Nova Scotians are still afraid of it and they're afraid to talk about it. They're a little prudish… it centers around the fact that we have a huge amount of organized religion that does not want to talk about sex and drugs other than to talk about it as being a sin… I think that a lot of that has to do with people's morals and values and what they hold as word. (*Gary, 40s, Halifax)*

This participant suggested that sex is largely silenced through morals and values that are often embedded in religious doctrine. Though the effects of religion on sexual practices seem to be lessening in the broader culture, there remains an ideology that bases morals and values on principles that have been set forth in religious doctrine. In other

words, people may not be directly stating that their practices are reflections of Christianity, but the moral discourses that have been deeply embedded in Western society remain influential. Another participant noted the depth of Nova Scotia's religious identity in recounting his experience in working in HIV-prevention, "*...you know, with Nova Scotia, it's so, you know, we all have our pinafores on... so we're all with our little catechisms. So there was an issue of how far could you go" (Charles, 50s, Halifax).* From this excerpt, the participant recollects that the undercurrent of religion limited what could be publicly said about HIV-prevention.

Government. Institutional influences, like all social interactions, can shape or alter the dominant discourse. One participant recalls an initiative that took place in the early days of HIV/AIDS that had government support:

> *...they [the government] accepted the task force recommendation on AIDS education in schools... usually people think of Nova Scotia as sort of a conservative backwater but... we did a public opinion survey and it showed like only 25 or 30% said people with AIDS or gay teachers should be allowed in the classroom. When we did the survey nine or ten months later, those numbers had changed to almost 75% (Michael, 50s, Halifax).*

The reliability of these statistics can be questioned. But the participant's perception of how Nova Scotians responded may influence how he sees the culture here. In his account, he also mentioned that the task force produced a condom booklet, in 1990, which was considered particularly progressive in Nova Scotia. It might also be argued that this was a reflection of how behind the times the province was, because in many other places in

Canada, and elsewhere, condoms were not a new public health device used to respond to HIV or other sexual health concerns. These contradictions are seen throughout the interviews where, on the one hand, Nova Scotia is implicated for having been behind on many HIV- related issues, homophobia, and stigmatization, and yet, on the other, there are progressive examples, such as the AIDS Task Force, the provincial HIV/AIDS stragey, and the early establishment of the ASOs. Further, Michael notes the contradiction between the commonly held belief that Nova Scotians live in a *"conservative back-water"* community and the view that public opinion could be changed through activist approaches when the government legitimizes them.

Government health and social policies are entrenched in people's lives because the citizens cannot simply opt out of the political influence. When governments support various initiatives, and roll them out through selected institutions, the discourse that is produced from the initiative is mobilized to a wide array of people depending on the initiative. The irony in this story is the fact that the AIDS Task Force was formed because of the firing of Eric Smith (as discussed in Chapter 2). Mr. Smith was an elementary school teacher, in Nova Scotia, in the early 1980s. When his HIV status was disclosed by his physician's office, he was fired. Though later reinstated, he never taught again and the settlement included the formation of the AIDS Task Force. This case involved the Nova Scotia Department of Education and, therefore, the Nova Scotia government.

The injustice of firing Eric Smith as a schoolteacher produced a situation which would strategize to change the public discourse on HIV/AIDS. The government as a social institution can influence how discourse is produced. The AIDS Task Force ultimately became part of the government funded bureaucratic response. Along with the

Task Force, other organizations formed as grass-roots efforts (discussed in Chapter 2). They were formed out of effects from the stigma associated with HIV/AIDS. The actions of these organizations can be seen as more than a community response to oppression; they are forms of resistance to the early discourse on AIDS and gay men that viewed these men as being dirty, diseased, infectious, and disposable. As the effects of oppression become apparent, power changes tactics in progressive Western modernity. When it became apparent that government supported overt mechanisms of oppression (including failure to respond to the outbreak of the epidemic) against gay men afflicted with HIV/AIDS, the position changed and support for AIDS organizations was bolstered. Part of this support meant that ASOs became formalized and an increasing part of the discursive production in Nova Scotia.

The Nova Scotia Government, in its interactions with the gay community, made the various organizations part of the institutions that influenced HIV discourse. As community organizations became part of the government machinery, overt acts of oppression were lessened, thereby pacifying the active resistance against them. One participant comments that *"they couldn't speak out as readily and as easily because they were on the payroll kind of thing of the very organizations around that they might want to challenge" (Joseph, 50s, Halifax).* This transitioning from a grass-roots movement to formalization, as a part of the political machinery, illustrates how governmental power can operate.

Another participant describes what it is like to work with the government today, now that HIV/AIDS work is largely funded and overseen by various government officials:

> *"[I]f you are a heavy results-oriented, right-away type of person, [and] you need that gratification for what you're doing right now, this is not the place for you because you'll become angry and resentful and, you know, burned out." (William, 40s, Northern NS).*

William is describing a situation where community members are provided with a means within which to attempt to influence government opinion and initiatives related to HIV/AIDS. However, working within this setting largely frustrates the efforts of the community because of the slow pace of government operations. The irony of this situation is that the slow government response to HIV/AIDS during the initial outbreak was a major reason grass-roots efforts were initiated in the first place (Plumb, 2005). Decades hence, community responses to HIV/AIDS, initially presented as a means to give voice to the issue, became largely embedded within the bureaucratic HIV machinery. According to many of the participants in this study, this bureaucracy has worked to limit what can and cannot be said. The strategies of power change, and the community that once experienced overt oppression became part of the machinery.

Silence

Participants frequently commented on the impact of silence in relation to HIV/AIDS. A key aspect of Foucault's later work is the methods through which silence is maintained, or how some discourses were privileged while others were silenced. Downing (2008) discusses Foucault's analysis of the Victorian era in which he uses this period of history to illustrate how covering the "piano legs" was actually an extraordinarily detailed account of people's sexual practices (p. 88). Downing further

notes that the mistake was to simply focus on the covering rather than to examine how discourses of regulating sexuality in specific ways were being privileged. Drawing on this example, HIV/AIDS in Nova Scotia has been discussed in the public realm throughout the epidemic, but some discourses that fit within the cultural and political landscape of the day came to dominance, while other discourses were sidelined. For example, one participant states:

> *Well it [silence] was maintained, I would say, culturally, socially … culturally, it's maintained the way things are maintained in the Maritimes… it's about who you are, who you know, and using that in a way to silence others. So, it's sort of that very same small town, so it's done through gossip, it's done through behind-door communication, it's done through, you know, strategic meetings here or there, agreements being reached but not verbalized out loud… lots of people poke through that, lots of people who took a risk and said 'no we're really going to poke through it'… (Thomas, 40s, Halifax).*

In the first half of this quote, the participant suggests that silence is maintained in a small-town fashion in which things get done by what and who you know, while others who do not hold such privileged positions are silenced. The result is that individuals who hold privileged positions assume the right to speak and are seen as representatives of the gay and HIV communities. On the topic of silence and backroom deals, Thomas noted that there were certain people who were given prominence in both the HIV organizations and as consultants for the government. The way things were accomplished depended on the people who occupied positions from which they could make a difference. In this instance, it was those who were either gay and/or associated with HIV, so they fit the

persona of someone who could represent an acceptable form of difference. Being different but still accepted by the dominant culture requires those who are different to not be too extreme or too challenging.

The preference for dealing with people who did not *"poke through"* the standards of normalizing judgment also privileged the speakers. In an example, Thomas talks about a prominent figure who has nearly been erased from the history of HIV/AIDS in Nova Scotia because he: *"wasn't from the right family, grew up working class, lots of stories about him that just didn't fit the middle-of-the-road norm that make most people comfortable."* This example speaks to the privileging that came with adhering to societal norms. People who were welcomed into the backroom, to broker deals and to deal with the HIV epidemic, were those who promoted a discourse that did not disrupt the normalcy of heterosexual hegemony. This can be linked back to earlier sections of this chapter where it is noted in Nova Scotian culture that not being too flamboyant or too far outside of the mainstream culture allows people who fall outside the heterosexual norm to exist and sometimes reap some of the benefits of heterosexual privilege. Because people who were willing to work within the limits of the discourse of the day were given a voice within government and among other decision-makers, resistance became subsumed within the broader dominant positions. Though there was no single person orchestrating this way of doing things, repeated acts of including some and excluding others came to represent the discourse, some of which could be included and some that was disregarded because it was regarded as irrational or uncompromising.

People *"poke through"* normalizing judgment to change or speak back to domination effects. The example from Thomas's quote can be seen as a way of pushing

back against the dominant discourses. Thomas goes on to name the individuals who were widely accepted as HIV activists in the mainstream media in the world of HIV, but he then further discusses how other individuals had been largely silenced, in the history, because of their approach. In this way, Thomas' account references the constant reworking of the discursive field because there is a privileging even within the discourses of resistance. The mechanism of silence or of limiting discourse is not reserved for the formal HIV machinery; subjects outside of privileged positions experience the effects of limiting the discourse.

In one interview in Northern Nova Scotia, a participant comments on the operations of silence because, from his view, there was an erasure of identity:

> *… certain things that you don't talk about, which is both a contributing factor to more-so heterosexism than homophobia where, like, queer identities are erased because it's just something you don't talk about and it's something that you shouldn't see, it's something that shouldn't be in the public sphere. But, also, it leads to less direct homophobia because all the remarks are made behind someone's back, within a family (Ronald, 20s, Northern NS).*

What should or should not be seen or heard in the *"public sphere"* is another means through which individuals are separated and ranked. Subjects come to not only know their relegated space, but also accept this position even when they are able to *"poke through."* In many rural communities, there is a limitation on the available discourse because of the effects of silence. It is often after individuals have been exposed to alternative discourses

or *"queer identities"* that they come to see themselves as occupants of such subject positions.

In another example, a participant recalls his experience of growing up in a rural community. He talks about the effects of silence as:

> *...an old way of doing things ...the code of silence was very important... it's a way of life. You may ask a question to someone, and you know when they're lying, going to say, "Oh, I don't know anything about that," and they just kind of look the other way. That's how it works. You know not to say anymore. Or ask anymore (Mark, 40s, Halifax).*

The way this participant speaks about silence is particularly poignant in this case because he does not talk about being silenced or not being allowed to speak. Rather, Mark experiences silence as a code, a way of life. The code of silence, itself, is unspoken. Through a look or an innocuous statement, he learned not to say or ask any more about a topic. In his experience, ideas or questions that fall outside of the normal social order are not even named; they are simply silenced through a *look*. This is a very efficient way of normalizing. Without having to explain anything at all, what falls outside the public discourse is simply communicated. In this case, Mark understood without being provided a rationale for what could and could not be discussed.

The term "silence" was used repeatedly in the interviews to describe how things have and do get done in Nova Scotia. Silence is both productive and limiting. While certain discourses are left out of public discussion, the dominant discourses that come to the fore increase in viability when others are pushed further away from mainstream

culture. Earlier, I mentioned that it was important for activists wishing to gain access to governmental power to be seen as not too different. The preference for working with gay activists who fit the acceptable type of difference not only set the privileged type of activists that would enter government space, it also set the boundaries for what type of HIV activism would take place within those spaces. In the interviews, I often heard frustration over the loss of the grassroots nature of the HIV/AIDS movement, not just over the type of activism that was limited within government space, but over the movement or the idea that gay culture could no longer stand in opposition to the domination effects of heterosexuality. Rather, in the wake of HIV/AIDS, activists were, to an extent, compelled to become a part of the machinery in order to gain access to government funds.

The effect of silence is that it produces a dominant type of HIV discourse, one that is acceptable in mainstream Nova Scotian culture. The effects of the HIV discourse are that it not only sets the boundaries for what can be said about HIV, but it also has an impact on gay men's subjectivities because it has produced a certain image of gayness that is acceptable in mainstream culture. However, limiting the discourse does more than set the parameters through which subjects can express themselves; silence breeds fear, particularly in the field of HIV/AIDS.

Silencing the Poz Community. Silence in Nova Scotia extends beyond HIV strategies in the public realm; HIV-positive gay men (sometimes referred to as poz men as this is the terminology often used in the community) experience the effects very personally. The privileging of certain HIV discourses moves from a lack of public discussion among policy-makers about the nuances of gay sex to an experience that

occurs, in silence, for HIV-positive gay men. This distinction is made because the academic literature and the discussions, in this study, suggest that once gay men seroconvert, their experiences are more closely tied to gay subjectivities (Rowe, 2008). For some, there is a sense of empowerment through rejecting the stigmatizing aspects of HIV discourse. But for many, there is a silencing affect in which HIV-positive gay men feel that they do not know anyone else with HIV and, therefore, become isolated and sometimes hide their HIV status:

> *… in Nova Scotia, the silence is deadening around HIV… that nobody talks about it, nobody knows who else is positive, unless it's all hearsay. People are afraid that people are gossiping behind their back, and there are some men who just are like "fuck that shit, I'm not taking part in that." But for many men, that fear is so "there" because… they don't know anybody (Pat, 40s, Halifax).*

A thread that is presented here, in the activist's statement, is the *"silence is deadening."* This phrase has been used through much of the historic protests that happened in the early HIV/AIDS movement, because governments and health sectors failed to act when it was recognized that HIV/AIDS was somehow related to gay men. ACT UP [AIDS Coalition to Unleash Power], an HIV/AIDS activist group that grew out of the need to mobilize in the face of limited government action in the early years of the epidemic, coined the phrase and the image of Silence = Death (Edelman, 1994). From Pat's perspective, there is a sense that the privileging and silencing of discourses is not merely a preference for conservative ideologies around sexuality, but that there is also a positioning of power that determines, at an extreme, life and death, and at a minimum, a method through which HIV is transmitted.

Many gay men who are HIV positive remain at the fore of HIV/AIDS activism and have and continue to hold a unique point of view because of the way they experience both HIV and the gay community. Michael remarks, "*in Nova Scotia, certainly from the mid- to late-80s on to the mid-90s, gay men were at the forefront of developing the programs" (50s, Halifax).* While some men have come to publicly identify as HIV positive and take up this subject position, others are either silent or silenced in their diagnosis. In Nova Scotia, participants claim that they experience stigmatization through the above-described cultural mechanisms of silence, gossip, and ostracism.

An individual from an ASO commented on the impact of this phenomenon. She recalled one initiative in which people were asked to be photographed in an HIV campaign: '*Volunteers who had participated in pictures, being so terribly ostracized in their community, coming in very upset, demanding we take the campaign down" (Linda, 30s, Halifax).* Linda also stated that many of these men were not HIV positive, but that their appearing in photographs that depicted men with HIV caused this level of backlash. Others noted that this strong sense of stigmatization is bred by the silence surrounding the issue.

John discusses how this silence impacts gay men living with HIV/AIDS by saying, *"the fear, 'cause it's such a small province, of being rejected, if they do disclose, the fear of a loss of confidentiality, and the fear of trying to find a partner, so I think there were huge challenges" (John, 40s, Halifax)*. There is also a challenge in addressing the silence and fear because, in many cases, HIV activists talk about the difficulty of getting people to events to address the HIV stigma and other issues that are planned for the public. The silence and stigma associated becomes very challenging for people living

with the disease. John describes what it is like for people living with HIV/AIDS (PHAs), *"So, I think there were huge challenges as far as fear of discrimination... in other cities you can be more anonymous... Nova Scotia is such a small province and the gay community, in many ways, is small, it's just a whole different ball game..." (John, 40s, Halifax).* John and others in the study commented on the how being a small province translated into relatively conservative talk about sex. Another participant speaks about his experience of HIV, *"So, I was already aware of, for years, of the massive stigma and what that meant locally, and I had to live with that... we still have a hostile world, even within the gay community..." (Joseph, 50s, Halifax).* In Joseph's experience, he describes the HIV stigma as feeling the open hostility within the gay community, a problem that also exists in many other places, but is compounded, here, by the nature of the small community.

The way power operates is complex, as the top-down effect is one of silencing non-conservative talk about sex, and the bottom-up effect is how the "gay community" contributes to this social dynamic through gossip or reiteration of the HIV discourse. Some of the participants attempt to resist the effects of the HIV stigma by being more outspoken and by taking on an activist role. Even within these roles, however, there are times when activists are reminded of their position. One participant discusses how working in an HIV/AIDS organization impacts her: *"There's certain people who aren't comfortable interacting with me in a public forum because they don't want to have to explain why they know me" (Linda, 30s, Halifax).* In this instance, Linda is not only silenced, but she is shunned in certain social situations because of her association with

HIV. It is through these experiences that HIV and the subjects associated with it are recognized as something that should be treated with silence and secrecy.

This remains an important concept because “silence and secrecy are a shelter for power, anchoring its prohibitions, but they also loosen its hold and provide for relatively obscure areas of tolerance” (Foucault, 1981 as cited in Weedon, 1987, p. 111). Returning for a moment to Foucault's notion of power, it is not one-sided where it excludes certain individuals from society. Silence works to shelter power, but it also undermines the very prohibitions or discursive boundaries around HIV. In other words, the effects of silence are not absolute because we recognize silence when it is broken. This process of breaking silence can also be understood as breaking through the limits of the dominant discourses. This is a concept I will expand on in subsequent chapters.

This chapter has focused on how the discourse regarding the dominant Nova Scotia culture impacts what it means to be gay, using coming out as the primary example, and how silence operates to produce and limit the HIV discourse. The purpose of examining these two threads is to illustrate the context within which the following chapters are set. The subsequent chapters focus more specifically on how gay subjectivity is framed and the production of HIV discourse. Before proceeding to these chapters, however, I conclude this one by discussing the experiences of the activists as they describe various aspects of their personal lives. Though I will challenge the idea of personal versus professional life later, I conceptualize it this way to distinguish between what participants discussed as personal experiences versus something that impacts the community as a whole. The remainder of this chapter provides some of the common

discourses that emerged about who these participants are and how they talked about their experiences of working and living in Nova Scotia.

Experiences

The stories of the activists were accounts of their "lived experiences" as each person recalled their history. For this study, the idea of experience moved beyond the locale of the individual to the field of knowledge about gay identity and HIV because of the participants' roles as activists. Within their histories, the discourses about specific topics were produced and reproduced and make the history knowable. As Scott (1991) suggests,

> History is a chronology that makes experience visible, but in which categories appear as nonetheless ahistorical: desire, homosexuality, heterosexuality, femininity, masculinity, sex, and even sexual practices become so many fixed entities being played out over time, but not themselves historicized (p. 778).

HIV can be conceptualized along the same lines as a seemingly ahistorical entity. But in the accounts of *experience,* HIV is historicized through the subjects who speak their personal experiences into the discourse.

HIV is an historical artefact, produced through discourse, and most poignantly embodied in the Western world by gay men. Further, HIV has become so embedded in the subjectivities of gay men, that one participant comments: *"…some would consider it's just a rite of passage…I'm just going to accept that that's part of something that could happen to me because my life is gay" (Linda, 30s, Halifax).* HIV has become part of the experience of gay men, whether they seroconvert or not. In the architecture of our

subjectivity, HIV shapes part of our experience and identity as gay men. We can ignore it for a time, but it remains there as a risk, whether we, ourselves, are considered risky or not. Our friends, our lovers, our history is one that is deeply enmeshed with HIV/AIDS. Our history resonates with the similarities of Scott's historicizing of gay culture.

In Scott's (1991) article, she analyzes the experience of an historical account. The experience of this person is conceptualized not simply as an account of one time and place, but rather, a production of the discourse within a subject space. In other words, *experience* is not ahistorical, it is framed within an architecture that, itself, is historical but is experienced in the present. Scott (1991) suggests, "we need to attend to the historical processes that, through discourse, position subjects and produce their experiences. It is not individuals who have experience, but subjects who are constituted through experience" (p. 779). This statement reflects a post-structural position that questions the existence of a pre-discursive subject and places experience as a product of the discourse. Scott offers a view of history and experience that guides the following analysis of HIV activists in that their experiences are a production of the discourses and, at times, a form of resistance.

The activist experience. Some of the participants in this study noted that it was difficult to talk about certain aspects of their personal lives because of their role in HIV work. In many cases, they spoke of things they would reveal in public and others that they simply would not speak about. In some instances, their behaviours outside of their activist work contradicted prevention messaging. In what follows, I link the effects of silence on HIV activists to a transfer of responsibility for safer sex to the subject. It is somehow known to these participants that, in their role, they should not speak about their personal

transgressions regarding safer sex. Silencing these practices produces an experience in which subjects state that they are responsible for the possibility of HIV infection.

William discusses how the public and private discussions come together in the seemingly separate worlds of work life and personal life:

> *I certainly believed what I told people. Did I always practice what I preached? Not always. And you know, sometimes I went out there and I had unprotected sex. A couple of those times it was because I was under the influence and a couple of times it was because of the person I was with. I made a choice. That, at that point in time, having unprotected sex with this person was a level of risk I was willing to assume. (William, 40s, Northern HRM)*

The participant touches on a number of issues beyond the immediate experience of sex education or sexual activity. The first assumption that finds its rationality in the disciplines of medicine and public health is that the modern neoliberal actor will take responsibility for the self. Specifically, with accurate medical knowledge and the ability to make the appropriate choices according to medically sanctioned public health practices, the subject will choose to care for the self, so long as other mitigating factors such as mental health issues, substance use issues, and so on do not interfere with the rational decision-making process. The logical conclusion, from this premise, is that sexual health educators and HIV activists would be most diligent in practicing safer sex. William's comments suggest that the situation is more complex. Despite having accurate medical knowledge and the means to avoid risk, he claims to have made a choice otherwise. He further suggests that his choice is a matter of personal responsibility,

something he was *"willing to assume."* In his willingness to assume responsibility for his behaviours, William is also assuming responsibility for HIV infection, if that were to occur. Though that experience would seem like it happened in a particular instance, it is not ahistorical. William knows he was acting out and assuming a level of risk that is contrary to HIV-prevention messaging and, therefore, if HIV transmission were to occur, he as a neoliberal actor would be responsible. Choice, from this perspective, is a rational act absent of a history. It is rationality itself; however, that is the fiction. Rationality presupposes an underlying truth, an optimal way in which a subject should act, as if the preservation of the healthy body is the panacea of existence.

Adam (2005) counters this argument regarding HIV-prevention, suggesting that such thinking fails to account for the *experiences* of gay men. In doing so, he clarifies the contexts within which sexual-health decisions are made. As examples, he notes, "partner's erectile difficulties, momentary lapses and trade-offs, personal turmoil and depression, disclosure and intuiting safety, and indeed love" (Adam, 2005, p. 344). Building on this notion, if we move further into Scott's concept of *experience,* then even these circumstances are a product of the discourses that produce the subject.

If mere rationality underpins decision-making, then surely HIV activists and sexual health educators would be the model for the "condom code," which maintains that condoms should be used, all the time, in male to male penetrative anal sex (Race, 2006). Throughout this study, however, another discourse emerges wherein even among those with a great knowledge of "risk," few really maintain the "condom code" in private. The literature suggests that for years it has been obvious that gay men use an array of prevention techniques within the spectrum of harm reduction, regardless of whether they

are publicized or recommended by medical institutions (Kippax & Race, 2003). Nonetheless, the everyday understandings of harm reduction maintain that there is a level of choice involved.

Pleasure and desire. The choice of whether to engage in "risky" sex is a personal, individual one that may be consciously in defiance of the sanctioned sexual practices and, therefore, be responsible for the outcomes. The effects of the medical discourse on the responsibility of the subject to care for the objectified body are evident in the language this participant uses, the willingness to assume “levels” of risk and, in turn, the measured outcome of that risk. Yet, the risk according to this statement is assumed by the body and one might argue, according to Race’s (2008) queering of the language, *consumed*. Here, an excerpt from Race (2008) can be applied to this context because pleasure is often absent from this discussion and “To acknowledge pleasure here would seem to betray the self that medicine must contain in its effort to produce a properly objectified body, so pleasure is performatively banished from the clinic” (p. 2). Shifting from the formal clinic to health promotion, broadly, such discussions are indeed banished or silenced in the field of sex education because there is a desire to deliver sexual-health messaging as though it were absent from the body or at least presented through the “properly objectified” one.

Another component of William’s story (participant quoted above) is the acknowledgement of substance use as a component of decision-making. The participant denotes two circumstances within which unprotected anal intercourse took place, one under the influence and the other not. It is interesting that during the sexual encounters *“under the influence,”* the participant attributes the decision to his condition, by saying it was “because” he was under the influence. The *influence* was not just having a role in the

decision but, more decidedly, it is a direct result of the *influence* as if this were a separate mind and body. It raises the question, is the influenced mind/body the same as the non-influenced mind/body?

Race (2008) argues that it has been a longstanding practice, within some HIV-prevention and HIV literature, to vilify drugs and alcohol and to suggest that the influenced body may fall outside the scope of health promotion as this approach often relies on rational thinking. The claim is that by reducing alcohol and drug use among gay men, there would be a corresponding decline in the spread of HIV as men would simply make 'better choices'. Again, however, these arguments only address modifying desire and fail to take into account the depth of embodied pleasure. A participant illustrates the tension between pleasure and risk by saying: *"it's a double-edged sword and one side is saying oh yah that's more pleasurable, and the other side is saying oh but it's risky. And I think people know that it is a double-edged sword... it's what are they willing to risk" (James, 50s, Halifax).* William further discusses the challenge of promoting condoms:

> *…we always told people in safer-sex education that, you know, hey use a condom; it doesn't really feel that different. Bullshit, it does…I'd gone bareback and it just was a whole lot more enjoyable and the more you talk to other people, the more they felt the same way, people who had had that experience. So, how do you make that case to those people? (William, 40s, Northern NS)*

The situation, presented by the participant, illustrates the tension when it is known that condoms are currently regarded as the best protection against HIV transmission during anal sex, yet it is suggested that the use of condoms detracts from pleasure. There

is also a distinction that is made, here, between pleasure and desire. The participant is not talking about the desire to have bareback sex; rather, he is discussing the experience of pleasure during the barebacking experience and how this does not necessarily fit with some of the popular discourses in the “condoms only” approach. At times, sex educators who adhere to the condom mantra suggest that if a particular condom does not feel good or natural, there is a wide selection from which to choose. In other words, if one condom does not provide the desired sensations, they suggest one simply keep trying different brands. Perhaps implied in this approach is that there are more condom brands than there are instances of sexual engagements that require them.

It is also clear within the literature and in the participant’s comments that there is far more to the act of barebacking than physical pleasure. Barebacking and pleasure can both be conceptualized as discursive productions that come to the fore in the subject's experience. William notes that his feelings of pleasure were confirmed *“the more you talk to other people.”* Barebacking is continually shaped through repetition and moves from an individual act to a collective experience. In this excerpt, some of the tension in the HIV discourse is illustrated specifically in relation to barebacking because the pleasurable collective experience of barebacking resonates through the community of gay men, whereas proponents of prevention attempt to *“make the case”* that an equivalent level of pleasure can be achieved through safer sex. This participant and the collective experience suggest it is otherwise. However, the collective experience is, itself, a discursive production; when the subject position changes, so do the effects of the discourse. For gay men, an HIV diagnosis changes the subject position from that of being a gay man to that of being a gay man living with HIV or sometimes referred to as a poz man.

Poz activism. HIV/AIDS activism is a multifaceted movement. This is because the goal for many, working in the field, is reduction in both HIV transmission and stigmatization, while avoiding the governance of gay men's sexuality and sexual practice (Courtenay–Quirk, Wolitski, Parsons, & Gomez, 2006; C. Patton, 1988; Siegel, Lune, & Meyer, 1998). Instructing gay men to use condoms to avoid HIV transmission has been a primary tool throughout the epidemic, and gay men have certainly participated in this effort. Nevertheless, there has been some controversy, among HIV activists, as to whether other approaches to reducing the risk of infection are appropriate. These are harm-reduction methods and include serosorting, sexual positioning, withdrawal, HIV treatment, and more. Promoting these methods has caused some controversy because there is a belief that promoting harm reduction will result in reduced condom use. Moving away from a condoms-only approach to HIV-prevention represents a paradigm shift away from the more conventional modes of HIV-prevention.

In Nova Scotia, many of the HIV activists are gay men who have seroconverted. Participants noted that it is sometimes difficult to work and volunteer in the field of HIV because of the stigma that is often associated with the disease. This led one participant to describe the tension that these men sometimes experience when working on HIV-prevention:

> *…I mean a harm-reduction approach to sex and HIV-prevention is very emotional for gay men and it comes out in very emotional ways. If you're living with HIV and a) you've been infected, somewhere along the way and b) you may have infected other people and may or may not know it, that's huge. That's emotional. How do you step away from your own experiences in that? (Pat, 40s, Halifax)*

The feelings of responsibility for HIV are produced in the lives of gay men who have HIV. In the previous section, the discussion of responsibility was framed as a discursive production in that HIV risk is turned back to the individual to manage and care for themselves. For HIV positive activists, however, the effects of responsibility do not end if someone is infected; rather, they may be seen as having violated the norms of safer sex. HIV-positive activist men often carry the weight of the HIV-stigma discourse, which is produced in *"very emotional ways."* In this instance, it becomes apparent that health-promotion efforts that involve harm reduction are not simply prescriptions about methods to reduce risk when engaging in sex; rather it contributes to the way of gay men experience HIV. Earlier in this chapter coming into the subject position as gay was discussed. A similar pattern of experience is described here and in response to the participant's question at the end of this quote, people do not step away from their experience, they step into it. This can be seen as she describes the stigmatizing effects of HIV discourse towards gay men who have been infected.

As Pat describes how HIV-positive gay men may feel during the process of creating harm reduction messaging, one can sense the competing discourses and the controversy that ensues. On the one hand, it seems as though harm-reduction methods are useful technologies in the HIV-prevention toolbox, but on the other, reducing harm does not eliminate risk. With risk comes responsibility, and HIV-positive gay men often come to experience the effects (R. S. Lee, Kochman, & Sikkema, 2002). In forming HIV-prevention messaging, many of these men do not want others to experience the effects of HIV and therefore promote only the most effective methods of HIV-prevention, which are abstinence or condom use. This is not to say that HIV-positive men represent an

opposition to harm reduction; it is merely to suggest that promoting harm-reduction messaging can cause controversy because of the experience some have had with HIV.

There is another story in which some HIV-positive gay men have found ways to break through some of the HIV discourse. There is a sense of ownership that is described by one activist:

> *For myself, when I'm sexually active with my main squeeze, who's also an HIV-positive gay man, we don't use condoms and we don't want to use condoms. And despite, you know, the scare a couple of years ago about superinfection, I've been conscious from the beginning of the AIDS crisis about how gay men who continued to be sexually and politically active in a very conscious way, how they usually instinctively are on the right track long before any academic or any researcher started to find evidence… (Joseph, 40s, Halifax)*

As an HIV activist, Joseph is aware that his actions can be interpreted as both a sexual and a political statement. He consciously resists popular HIV discourse by not using condoms with other partners that are HIV positive. In doing so, he is suggesting that his actions do not exist in a singular moment; rather, they are a method to resist the dominant discourse. He further suggests that through their experience and their involvement in the HIV/AIDS movement gay men intuitively know which measures are appropriate and which are not in regulating sexual practice or reducing harm. Joseph knowingly shifts the discussion from individual practice to a collective experience by contesting the dominant discourse. For many gay men who are HIV/AIDS activists, their sexual acts are political because the issues they are advocating for or resisting are

enmeshed with their lives. Joseph sees his experience as being part of the collective; he sees it as a political act. He speaks to a discourse of resistance against the governing institutions of academia and medicine. He is knowable through discursive productions of gay, poz, activist, and sexually active, and his body is thus made political so long as he is known, both to himself and to others.

Entering into the public discussion about one's sexual acts is not without risk or repercussions: Gay men who are HIV/AIDS activists and HIV-positive undergo significant scrutiny for the political statements they make. Their personal lives become indistinguishable from their activist work. The challenge of working in HIV/AIDS advocacy is described by the following participant:

> *Once it was very personal, and it became even more personal when you become positive. I think being in a small province... provided a grand opportunity: ...we're small, we have fewer resources. So the opportunities are there. Which is also its down side... because it's so small, there's so few opportunities that if you burn your bridges, you're screwed. (Donald, 60s, Halifax)*

The discussion returns to the "small town" scenario outlined earlier in this chapter. The implications of a small-town characterization of Nova Scotia do not simply illustrate a way of living, but influence the way systems operate and the ways people engage with institutions. In this instance, Donald recognizes that his efforts must be measured. In a small town, things can get done, but there can be challenges.

One example of an issue that is contested within the community is confidentiality. Donald remarks, "*we are so super sensitive about stigma and confidentiality and risk that*

we sometimes shoot ourselves in the foot" (Donald, 60s, Halifax). Donald suggests that the stigma is associated with confidentiality and is *"part of our own making."* By keeping such strict guidelines on confidentiality, he believes that we are doing a disservice. He recognizes the need for confidentiality, but suggests that our history is actually impeding efforts at de-stigmatizing. By insisting on confidentiality measures, there may be an unintended expectation that HIV-positive men, themselves, are silenced. Donald recounts the context in which this became a major issue:

> *I don't know if it's whether we're hiding behind it or we're … it's almost like the legacy of Eric Smith is still … 'cause I hear it cited all the time and I cite it sometimes too… it was so dramatic, here, in Nova Scotia, that I think we sometimes replay that script over and over and over again, that it's kept us stuck back there and there are, and on an individual case, it's probably still very legitimate, but I think as a collective body, I think we could perhaps break out of that. (Donald, 60s, Halifax)*

The very public case of Eric Smith being fired as an elementary school teacher for his HIV status, in the 1980s, continues to appear in the public discussion. Though there are many other instances of HIV/AIDS discrimination, this one received the greatest attention and continues to remind HIV/AIDS activists and practitioners of the stigma that is still associated with HIV/AIDS. The script that Donald speaks of is not just a script; the Eric Smith story is a part of the discourse that is used to characterize how HIV/AIDS is understood in modern day Nova Scotia.

The phrase Donald uses at the end of his quote that the *"collective body"* could *"break out"* is an example of the how his experience is a part of the collective community. To break out is to break from the dominant discourse of the stigma of HIV both within and outside the community. It is not a simple task to influence and change both the experience and the dominant discourse that it is associated with. Breaking out is a risky affair. Perhaps we could suggest that all HIV-positive gay men come forward and form a collective body that speaks back to the discourses of stigma; however, the onus of responsibility, in this suggestion, is once again placed on the shoulders of these men. The repercussions can be significant as one participant recalled earlier how an HIV-awareness campaign had to be cancelled because the models were assumed to be HIV-positive, many of whom were not. They were so severely stigmatized within the gay community that they requested the campaign cease. Perhaps over time we will find greater mobility within the discourse of HIV and a reduced need for such strict confidentiality requirements. But the current collective body stands in contrast.

Physicians. The final perspective on the culture of Nova Scotia and the connection to HIV is the physician's experience working in the field. Amidst various controversies surrounding HIV/AIDS treatment over the years, doctors have nonetheless been an integral part of the movement. Specifically, there have been gay male physicians who had been deeply invested in the community during the epidemic. Though the experiences of the physicians were highly varied, especially before and after the introduction of highly active antiretroviral therapy (HAART), their experiences are presented here. The following participants discussed how the role of gay male physicians,

since the beginning of HIV/AIDS, has been extremely important but not without difficulty:

> *It certainly cut my social life in a way, you know. Mind you, I was very cautious in terms of making sure that I kept my practice different from my private life, which basically compromised, in this town, compromised your private life quite a bit… it's always difficult because they're people you know and like and you have to. You have a different relationship with them, you know them and you're really close to them, and then all of a sudden you're their doctor and you've got to let them die with you. Die with them. (Charles, 50s, Halifax)*

At the beginning of this quote, there is distinction made for the roles Charles played in his social and professional lives. The division of public life versus private life versus professional life was a common thread that appeared in the interviews of people working in HIV. Specifically, social gatherings within the gay community, meetings with other health organizations, places for meeting sexual or dating partners were all spaces which the HIV activists felt had changed for them. Perhaps, in too simple terms, one can point to a general aversion of sex and the HIV stigma as forces that relegate people who work in this field to the margins of these scenarios. Often anyone even associated with HIV, whether in work, volunteerism and/or by having HIV, was stigmatized. Despite the work people were doing on behalf of the community, people associated with HIV were seen as others. The othering process, however, is turned on itself because a person's serostatus may change. Charles experienced the relationship change, particularly in the early days of HIV/AIDS. He cared for his patients and experienced the death of people close to him

over and over again. His commitment to his patients and the community ultimately came at a cost.

For Charles, his division of public versus private life broke down over time. The personal was no longer distinguishable from the professional because ultimately death and suffering brought these worlds together. Charles describes the end result:

> *I burned out. I think it's a funny sort of thing. I think you survive, or I survived by getting totally engrossed in it to the point where you gave up the rest of your life. And that finally had its toll on you. They say keep a balance, I thought I kept a balance. I didn't though, when I think about it. I mean, it was so overwhelming the emotion, that you didn't want to, if you were constantly involved in it, you didn't have to deal with it emotionally. …and finally I just got, I blew. I just blew. It just happened all of a sudden and I was gone. Because you knew that you were, you knew you were getting fucked. You just knew and you weren't sleeping and you were becoming more irritable and you'd cry in between patients. I mean I remember a couple of patients would leave and I would just be back there bawling, then go out and get the next patient, you know. (Charles, 50s, Halifax)*

The description of this physician's experiences illustrates that, in certain circumstance, there are no clear distinctions in the division between a person's professional, personal, and social lives. The physician's experience makes HIV anything but ahistorical. He is part of the collective experience that makes HIV knowable to us today. Sadly, the end result for this doctor, whose practice consisted of most of the HIV patients in Halifax and much of Nova Scotia from the emergence of the epidemic, was

complete burnout. His excerpt speaks to the devastating toll the disease has taken not only on him personally, but on the entire community. This is one example of a person that dedicated his life to the HIV/AIDS movement; he notes that he was *"constantly involved in it."* Separating the personal and professional life is usually not possible in the HIV world. Other participants discussed events for the gay community at which they were avoided because they were associated with HIV/AIDS. Charles recalled other instances in which family members of his patients would not speak to him after the death of a loved one because he represented a reminder of their lost loved one. There has been and continues to be tremendous pressure on health care providers who work in the HIV/AIDS field.

In other instances, the distinction of personal, professional, and social lives is also enmeshed. Though it is less extreme in terms of the personal toll, in another excerpt a physician advised patients on a personal level:

> *I had a couple of guys who were HIV positive, very high profile in the city, and I said, "If I were in your shoes, I'd be going to Toronto, Montreal, and getting my care because it's such a small town…" Some guys may have had female partners, and I said, "You know, if I were you, I wouldn't get anything done here, and you've got the means… don't get your care here…" I probably had one or two guys that went and got all their care in Toronto, mostly to protect confidentiality. (John, 40s, Halifax)*

When John advised patients to go elsewhere for treatment, this may have been a good option for the individual. But there are significant implications to this, which are counter

to a progressive HIV/AIDS social movement. Informing higher profile patients to seek treatment elsewhere certainly reinforces the sociocultural condition of the HIV stigma to seek treatment outside of the province. This discussion is not meant to challenge these singular situations as many of the people may have benefitted greatly from receiving care in other areas of the country. However, it is prudent to point out the underlying social forces and the potentially unintentional consequences of the physician's recommendation. Suggesting that patients seek care elsewhere may contribute to the overall silence that surrounds HIV in Nova Scotia, particularly if patients have notoriety. Many of the participants in this study noted that one method of fighting the HIV stigma is for high profile people who are HIV positive to reveal their status and for others to show their support for HIV through public pronouncements and even through testing.

Amidst this discussion, it becomes apparent that there is a reason for fear and lack of trust in the medical system. Instances of breach of confidentiality and other mistreatment in Nova Scotia continue to reinforce the discourse of mistrust. In another instance, a physician recalls the following incident:

> *…when I came here in '97… I had a young guy who came to me… 20 something, maybe undergrad, not going to university, had a boyfriend or partner, they were living together, got quite ill, probably… in the hospital, when he was in hospital, he got diagnosed with HIV. Went back to his doctor who had delivered him, told his doctor he was HIV, doctor had to start to note. Fucking doctor phoned his parents and told his parents. Parents didn't know he was gay, didn't know he was HIV. And so the parents said what the hell is going on here? Parents were actually o.k. with it, my recall of it, but you know the young guy didn't trust*

anymore, and plus the physician said I don't know how to treat HIV, you should go and see --------, so they came to me, I was like what? …I said that's your confidentiality was breached, you should file a complaint to the College 'cause that's unacceptable. I still remember this young guy said, "Oh, you're from Upper Canada, you guys are way more aggressive, we don't do that here in Halifax." And I was just like, but probably I saw lots of breaches of confidentiality and it wasn't always willing to be addressed, and sometimes the guys, they don't want to be the poster child for this (John, 40s, Halifax).

The discussion reinforces the commonly held belief that confidentiality within the medical system remains an issue in Nova Scotia. While this particular incident happened over a decade ago, parameters regarding confidentiality were in place. We may never know how many additional instances were silenced in the public discourse. This participant's account, however, may point to the maintenance of overall mistrust between the gay community and the institution of medicine. Another key to this story are the instructions for the physician on how to operate in the Maritimes. The young man in this story knew the cultural code and the effects of social pressures. His discussion with the doctor was more than an anecdotal account; the discussion was a set of culturally prescribed instructions that were being reiterated and reproduced.

The young man from Halifax was instructing the doctor from *"Upper Canada"* on how things get done here in Nova Scotia. His comment is that *"you guys are way more aggressive,"* though it appears that the techniques of power are no less effective here. It appears that breaches of confidentiality are expected because everybody knows everyone through various networks. The result is mistrust that is exemplified in this one instance,

but is a common discourse between gay men and the institution of medicine. Though things may not happen aggressively or overtly, the effects are no less aggressive. Thus, nearly fifteen years hence, the physician remembered the words of the young man on how things happen in Nova Scotia; his *experience* was a production of the discourse that has produces a level of mistrust between some gay men and physicians.

The young man that John discusses in his interview knew that there was a way things get done in Nova Scotia that distinguished itself from Upper Canada and elsewhere. Regardless of the actual demographics of Halifax or Nova Scotia as a whole, the way things get done is in part a production of the discourses that emerge from the small town way of doing things described above. This way of thinking orders the dominant discourse of gay identity here and makes it somewhat unique. This is not to say that everyone believes it or that people take on this version of the subject position, but dominant discourse shapes culture and society and the common understanding of what it means to be gay. This idea of gay identity in Nova Scotia influences the way HIV work is experienced by the activists in this study because of the close association between gay men and HIV. The local context contributes to the shaping of who and what we are as gay men in the era of HIV.

This chapter has focused on how the cultural context of Nova Scotia interacts with gay men's subjectivities and HIV discourse. Beginning with an analysis of how homophobia and heterosexual hegemony contribute to the way the gay subject is framed here, the analysis sets the premise for key issues that will be carried through the findings. One key analytical tool is the ranking and stationing effects of dominant discourses. This concept will be used to demonstrate domination effects throughout. Another focus is

related to the ways identities are turned back on the subjects as they take on responsibility for the self and contribute to the power struggles that are involved in shaping norms associated with the gay community. These ideas frame the way the gay rights movement will be discussed in subsequent chapters.

In addition to the general ways the cultural context of Nova Scotia influences gay men's subjectivities, institutions such as the government and religion play a part. In many ways, the government sets the parameters for can and cannot be said about HIV in public spaces because they provide significant funding. To illustrate this point I examined how participants described moving HIV activism from a grass-roots movement to a part of the bureaucratic machinery. In some ways, getting the attention and funding we were requesting stifled our ability to mobilize overt activism. An important aspect of bringing HIV work into the machinery is that it privileged the type of gay men who aligned with mainstream culture, not too flamboyant or deviant. This privileging not only allowed certain types of people into position of power that met mainstream standards, it normalized what a proper HIV activist should be.

Continuing to build on how gay subjectivities are shaped in Nova Scotia, this chapter turns to more specific examples of how HIV work is involved in this production. The effects of silence are examined in the broader culture surrounding HIV as well as in the lives of the activists in this study. To conclude the chapter, I examined the experiences participants described associated with gay subjectivity and HIV work. They described a situation in which they were acutely aware of how competing discourses were involved in their lives. HIV positive activists' experiences are situated in a particularly challenging position as they signify the work they are engaged in. The concluding

sections of this chapter are spent illustrating how discourses come to the fore in the activist experience and influence their work particularly in relation to harm reduction.

Chapter 6: Findings – Gay Identity/Subjectivities

Since the beginning of the gay liberation movement in North America, gay identities have been contested as much as they have been employed as a tactic of political resistance. The liberationist effects of the gay-rights movement brought about greater social equality, but there are often unseen dimensions of any political movement that suggest equality is not evenly distributed (Epstein, 1996). HIV began to spread at the height of the sexual-liberation era. HIV emerged and changed the political landscape of the gay-rights movement in tandem with the right-wing backlash it encountered in North America and elsewhere (Epstein, 1996). The historical pathologizing of gay men through psychiatric and psychological measures (e.g., DSM) means had nearly become a part of the past, but HIV created a space wherein medicalizing of homosexuality was reinvigorated.

The effects of HIV/AIDS can be seen from a variety of perspectives, including those that suggest it created a central message around which gay communities could rally, while others note its devastating impacts and, in turn, how it influenced the production of gay subjectivities. Today, HIV is part of the subjectivities of gay men (Gastaldo et al., 2009; Holmes et al., 2008). HIV is central to the community and has taken on meaning and produced discourses that go well beyond any medical references to this disease. HIV has given rise to sanctions against some sexual acts, the provision of instructions for ways to act on the risks and responsibilities entailed in sexual relations, and is the site of resistance to these very instructions (Holmes & Warner, 2005; Kippax & Race, 2003). In what follows, activists discuss the impact of HIV on what it means to be a gay man. These perspectives and interpretations of how HIV impacts gay men have entered the

decision-making processes for HIV policies and programming, further contributing to the discursive field of gay men's subjectivities. The purpose of this chapter is to analyze how HIV/AIDS activists view and interpret the effects of HIV messaging. Though this is one focus, this thesis cannot fully extrapolate all of the discourses that frame the gay male subject; rather, the analysis will investigate the impact of HIV on the gay male subject within the context of HIV messaging in Nova Scotia.

HIV Messaging

Throughout the study, participants were asked how HIV/AIDS had impacted their perceptions of what it meant to be a gay man. The responses were varied, but many considered the early years of HIV/AIDS and connected this period to the present sexual practices of gay men. Many suggested that the efforts of the gay community during the initial outbreak and the years that followed set the stage for the way we, as gay men, know and understand ourselves today. The participants' roles in framing the gay male subject left some to ponder the long-term impacts of what they and the community as a whole produced. For instance, one participant talked about the dynamics of changing the perception of who we were:

> *…because we tackled it, head on, from the beginning, it's made it probably a lot easier to be an out gay person… And I think that got the respect of a lot of people in the larger community… That the gay community was all about this whole sex, you know the whole '70s free sex, free love type of thing… Are they the reality? …I don't think so, I think the number of gay men practicing unprotected sex is quite high and I don't think, I don't think the wider community really has the idea of how pervasive that is. (William, 40s, Northern NS)*

The participant explains the early response to HIV/AIDS in Nova Scotia as it galvanized the community to do education and raise awareness within and outside the gay community. He also notes that it legitimized the gay-rights movement beyond sexual liberation because, from his point of view, many people viewed the gay-rights movement as a hedonistic practice rather than a political one. In the above excerpt, the participant shifts from an analysis of the overall early response to the present day *"reality."* The use of the word "reality" implies that there are a truth and a non-truth that are not reconciled. From his perspective, the community accomplished the intended purpose of making people aware of the risks associated with HIV during the initial outbreak of HIV/AIDS. However, the methods of increasing awareness among gay men were not successful over time. The present day *"reality"* is unprotected sex, with the broader community unaware of the pervasiveness of HIV/AIDS. In addition, this excerpt is in direct response to the query regarding the impacts of HIV on what it means to be gay. In his response, the participant questions the broader public's perception of gay men and of being out. His response is, in part, a suggestion that gay subjectivity has been formed in part through general public opinion.

The experience of being a gay man is tied to the prevailing attitudes and beliefs of the broader social culture. Homophobia and heterosexism continue to be an issue in our society, but it has changed since the outbreak of HIV/AIDS. One participant comments on the early days of HIVAIDS, by saying:

> *...[W]e're still dealing with homophobia... but it was so intense then, in a different way than it is now. And I think everybody was afraid to say something 'cause they didn't know what to say... we started that targeted work, working with gay men... under the scenes, but not really talking about that publicly, right (Linda, 30s,*

Halifax).

Linda goes on to lament that things might have been different if early HIV-prevention measures took a positive approach to sex and also considered the issues of homophobia, stigmatization, and LGBT rights. She notes that early HIV-prevention measures, instead, contributed to homophobic discourse. In recalling these events, she also comments that this was, in part, due to public health funding that was directed toward promoting HIV-education campaigns to the broader public. Linda states that this changed what was being said about HIV. To meet the requirements of public health, many of the HIV messages did not include messages that were positive about sex or information about gay men's sex practices. She goes on to conclude that the effects of this early HIV messaging silenced any discussions on sex practices that fell outside the public health definitions of safer sex. The result of this type of HIV messaging was that it began to shape the dominant discourse about sex in the gay men's community.

The gay community. The early days of the HIV/AIDS movement were frequently described as a time of bonding and solidifying the gay community around the common goal mobilization of a social movement for survival. Others recalled the very complicated fights that took place within the community and the consequent fracturing. The urgency in the early days of HIV before the advent of Anti-Retroviral Therapies (ARTs) required that the gay community bond and join forces to mount a coordinated action-based agenda for greater attention to those who were impacted by the virus. As HIV demanded that some people come out of the closet to access care and treatment because of infection, in many ways, it solidified the notion of a community of gay people and formed a rallying point. Though the tactics around which people "rallied" differed, the gay community was engaged to combat the effects of HIV and the institutions that were failing to respond to

it. One participant recalls:

> *So you had the situation where you were fighting the government, you were fighting religious leaders; you were trying to provide care for people who were ill and dying. And it also brought the community together… You know, people could no longer look at us and say, you know, they're puss or deviants… as far as the gay community achieving its goals, I think it was the best possible thing that could have happened (Michael, 50s, Halifax).*

This excerpt is in direct response to the question, "How has HIV impacted what it means to be gay?" Similar to William, in the previous quote, this participant discusses the broader community of gay people in Halifax, which always raises an important question, "What is the gay community?" For Michael, there is a clear picture of the community of gay people who have fought and continue to fight battles against oppressive regimes, including governments and medical institutions.

In this interview, it was noticeable that Michael was being provocative in his statement that HIV was the best thing that could have happened to the gay community. He even went so far as to state that he had gotten in trouble for making such a claim. It is indeed a powerful one, but if we consider that the end game for Michael is a cohesive gay community, then it becomes apparent that HIV/AIDS initially had this effect. There is, however, a critique to be offered when considering the concept of "gay community." From a Foucauldian perspective, Francis (2012) argues that the cohesion of a gay identity in Canada is constitutive of a "truth" that enables the management of subjectivities. The political power of a gay community also opens the space for a counter-discourse against the structures of medicine and governments. From Michael's quote, one can hear his sense of accomplishment that the community came together, formed a new discourse

about their experience and changed people's perceptions of the "gay identity." In the latter portions of the excerpt from his interview, he states that *"people could no longer look at us and say, you know, they're puss or deviants."* In gaining legitimacy through political struggles, the "gay community" gained rights and raised awareness of the HIV/AIDS epidemic.

Often in historical accounts that involve various forms of oppression there is a struggle between those who have power and those who do not. When disciplinary tactics are employed, however, the struggles are not binary. In keeping with Foucault's analysis of power, the discourse does not work simply as one entity pushing against another; rather, there is a complex interworking that is, itself, not static. In this instance, the counter discourse of the gay-rights movement became the discourse upon which the gay identity and the "gay community" were framed. In other words, through time and repetition, the counter-discourse becomes the preferred discourse that creates a system in which subjects are resisting and creating subsequent counter-discourses. This phenomenon has been noted by a number of researchers (Crossley, 2002, 2004; Holmes et al., 2006; C. Patton, 1996; Rofes, 2002) in relation to the discursive field of HIV and gay men's sexual practice. The effects of a discourse and the process of reiterating or generating alternative discourses contributes to the discursive field of a seemingly knowable "gay community," yet this process of recognition becomes a form of governance. This suggests that Michael's comment, *"as far as the gay community… this was the best possible thing that could have happened,"* may mean that this was the best possible mechanism through which to produce a dominant discourse that reflected a desired gay identity. I note this here because the common bonds of a "gay community" may very well be resistance to oppression or subjugation, but the cohesion of the

community can be found in the binding effects of discourse. This productive power creates subject positions which are another means of constraint. Subjects are never fully reconciled within identity categories. Resistance becomes cyclical and the identity has, again, been turned on itself.

The discursive field of the gay community. Holmes et al. (2006) note from Foucault's work that the subjectivities are "always seeking lines of escape from governing agencies" (p. 320). The response to HIV/AIDS represents a paradox as it becomes the site of both resistance and restraint. For Michael (the above-quoted participant), HIV provided the rallying point from which to create an alternative discourse to homophobia and heteronormativity and a political basis upon which a cohesive 'gay community' is formed in Nova Scotia.

One product of a cohesive community according to dominant public health messaging, however, is a hegemonic discourse of gay male identity that includes safer-sex practices. It is not surprising that messages of safer sex and responsibility were promoted within the gay community as traditional public health measures that dealt with the crisis were inadequate (C. Patton, 1988). One participant recalls the interplay between gay rights, HIV activism, and the initial response by public health:

> *So, in the early days… you'd be pretty hard pressed to find a gay man doing HIV work who wasn't also a gay activist. So that dialogue was seamless… they already had an entire discourse about gay sex that they brought to it (Thomas, 40s, Halifax).*

In this excerpt, Thomas states that, while the HIV/AIDS response was unique, it incorporated a discursive field that had already been established through the gay-rights movement. His use of the word *"seamless"* illustrates how easily gay rights transitioned

to HIV activism. As previously mentioned, gay rights produces a system of subjectification within itself, thus the reformation of the gay-rights discourse to an HIV/AIDS discourse carries forward these notions of hegemony. As Thomas notes, one would seldom find a gay-rights activist who was not also an HIV activist in some capacity. According to his experience, the two became nearly synonymous with each other at the height of the crisis in that one could not be a gay-rights activist without also being an HIV activist.

Thomas further elaborates on the ways gay activists attempted to influence public health responses:

> *[So] very early on, while Public Health is saying, "Okay, we're going to use traditional public health measures to... corral them in, you know, you corral the virus, the bug, whatever it is, you quarantine, being the extreme end of it. But there's other ways that you corral people in, whether it's through legislation or whatever. And gay activists were like, no, that's not what you do and that's a really dumb thing to do. Because it's not going to work. In fact, you're only going to make it worse 'cause that's going to drive it further underground and people are going to take more risky activities (Thomas, 40s, Halifax).*

Thomas talks about public health initially proposing to corral people and the consequent resistance from the gay community. Though the public health proposal was to use traditional tactics to physically corral the virus and was soon generally abandoned, nonetheless, the corralling occurred through the subjectification of gay men. This subjectification comes about through shifts in the way power operates. As overt mechanisms were no longer useful, they were replaced with other forms of power that encouraged gay men to take care of themselves and be responsible citizens. One of the

effects of this type of HIV-prevention messaging over time was to bring safer sex to the fore as a dominant discourse among gay men. This shift saw the workings of power move from external forces such as public health entities seeking to control the spread of the virus through *"corralling"* to a community response to HIV and sex among gay men. In the latter case, we as gay men own the effects and have, indeed become part of the messaging that encourages safer sex. This effect is not "bad" per se, but it has the unintended consequence of driving activities that fall outside of the safer-sex mantra underground. Barebacking and other behaviours that were seen as risky became shrouded in secrecy within the community of gay men itself; this approach also contributed to the subjectification of what gay men should be.

Foucault famously crafts his argument about the effects of disciplinary power by stating that a disciplinary society is not synonymous with a disciplined one (Foucault, 1977; Holmes et al., 2006). This facet of Foucauldian theory provides the space through which the subject can embark on a process of de-subjectification and break through it. In other words, subjects are not merely constrained by the effects of the dominant discourses; rather, the boundaries that are drawn by subjectification also represent where resistance can take hold and new subjectivities can be formed. Holmes et al. (2006) argue that "bodies (individual and collective) are not passively disciplined and cannot be completely *mapped* (territorialized, inscribed) by disciplinary technologies, transgressing the prescribed limits 'brings out corporeal potentials that have remained unrealised' (or silenced) by these technologies of power" (Lyng, 2005, p. 43 & 326). Thomas illustrates this concept when he states that there was resistance to overt public-health measures in early HIV/AIDS efforts because it was thought that this would drive riskier sexual practices *"underground."* The underground he describes is silence and secrecy

surrounding sex practices that fall outside the safer sex mantra. One participant discusses how encouraging gay men to practice safer sex influenced other sex practices and the way they thought of themselves as sexual beings:

> *…I hear guys feel that it's gay men who are becoming too mainstream, trying to get married, and it's, gone are the days of leather and barebacking and slings and group sex because we've all got to be safe sex now and so it's impeded— the liberty or kind of the, an identity right, everything has become too safe and too mainstream. And the guys that now don't practice safe sex, some of them are feeling like they're being ostracized… (John, 40s, Halifax).*

In John's initial examples of the ways in which gay men's practices have become *"too mainstream,"* only one refers to riskier sexual behaviour: *"barebacking."* All of the other examples: marriage, leather, slings, and group sex can all be practiced under the umbrella of safer sex. However, they are referring to this as a loss for today's culture of gay male sexuality because of the mainstreaming and the push for safer sex. The implication is that the practices of leather, slings, and group sex lose their eroticism when safer sex is introduced. In other words, safer-sex discourse produces tensions in the sexual experience by contradicting desire, eroticism, and pleasure.

Though this study does not focus specifically on the first-hand accounts of gay men and barebacking, the tension noted here has been well documented in the literature (Adam, 2005, 2006c; Adam, Husbands, et al., 2008; Crossley, 2002, 2004; Gastaldo et al., 2009; Gil, 2007; Haig, 2006; P. N. Halkitis & Parsons, 2003; Holmes et al., 2008; Westhaver, 2005). The language both Thomas and John use to describe the effects of discourse illustrates some of the experiences gay men are producing. Thomas talks about driving practices *"underground,"* while John recounts gay men discussing *"impeding*

liberty" and *"ostracizing."* Both participants use very descriptive physical language to explain the effects of HIV-prevention discourse. From the interviews, the language used provides a reflection of their experiences in interacting with other people who identified with the *"mainstream"* gay identity, an identity category that included safer sex as a dominant way of thinking.

To draw on the work of Holmes et al. (2006), "riskier" sexual practices are more than a fulfillment of desire and the experience of pleasure. These practices may represent a process of de-subjectification or of simply breaking from the hegemonic discourses. Holmes et al. state: "…the subject becomes something new through the process of *de-subjectification*. The *limited experience* is attained, but simultaneously left behind; the line that veers from subjectivity and crashes through the walls of appropriate behaviour de-stratifies itself and may become the new line for the subject" (p. 327 emphasis in original).

The authors claim that, through barebacking and other means, subjects are able to break through the hegemonic discourses through a process of de-subjectification. In doing so, subjects take part in a process of redrawing the lines of subjectivity. In this example from Holmes et al., the limit experience or barebacking occurs so often that it moves from being a method of resistance to safer-sex discourse to part of the subjectivity of gay men. The practice of barebacking happens so often that it becomes part of who we are. In a sense, the lines of gay men's subjectivity have been redrawn to include barebacking. While Holmes et al. (2006) and other researchers have more broadly focused on the individual experiences of barebackers and gay men's sexual subjectivities; this research takes the perspectives of HIV activists who are part of the process of creating HIV-prevention programs and policies. The work of these participants becomes part of the

overall effort that is focused on HIV activism but often entails a gay-rights agenda.

One participant connects the practice of barebacking to gay male culture by saying that it is, *"...trying to recapture what it was before, it's trying to recapture the freedom of gay life before HIV cluttered, messed up our lives" (Donald, 60s, Halifax).* Here, Donald expresses his belief that gay men of his generation may bareback to recapture a foregone era. I see this connection as a way of breaking from the hegemonic discourses of safer sex. Saying that barebacking is a way of recapturing freedom suggests that Donald interprets barebacking, particularly among those in his generation, as a political act. Another participant states that, "*there were a number of gay men who talked about barebacking and having the right to bareback and having the right to make that choice" (Pat, 40s, Halifax).*

Both of these activists have heard and view the act of barebacking as something that is a product of the pressure to adhere to safer sex. Seeing barebacking as an act of resistance may challenge the notion that HIV was the best thing that could have happened to the community. In the short term, it may have brought cohesion, but some activists see barebacking today as a product of a community response that insisted on only safer-sex messaging.

Gay Rights: HIV Activism

One participant suggests that the community (the whole "gay community") itself has become less responsive to HIV issues in favour of more palatable activist agendas:

> *…one of the things that happened around '96, '98 was that communities in Halifax and across the country started to coalesce on singular issues… it became about marriage and adoption and it felt like… moving towards normalcy… but when we kind of deny the rest of the community, and that's what I feel has started*

to happen, right, so the local AIDS organization, well, they're a bunch of pot heads who are all going around having sex at the ... Well, it's not true… it's a bit of that internal homophobia that starts to happen, so we start to really dislike the other… (Steven, 40s, Northern NS).

In this excerpt, the participant discusses a number of issues that describe the energy and activism of the current gay community. A key issue is the shift from the HIV/AIDS activism that was earlier described by Thomas to a near-symbiotic existence in which gay rights and HIV activists were nearly one and the same to a very different situation today. HIV went from being the central issue that mobilized the gay community to both the disease and the people associated with it becoming stigmatized. This sea change of attitudes and beliefs about HIV shifted from one of sexual liberation and freedom to one of survival within the HIV/AIDS era.

The health crisis that brought one cohesive voice to the gay community became the issue that splinters the gay-rights agenda through a process of othering. Steven specifically describes this, above, when he states, "*we start to really dislike the other.*" Though he attributes this to internalized homophobia, one might argue that, in addition, this is part of the normalizing or mainstreaming of gay sex and other aspects of gay culture. Steven suggests that as marriage, adoption, and other issues became the priority for the gay-rights movement, HIV became increasingly stigmatized along with the people who worked in the field. According to Steven, the stigma that people associated with HIV organizations was rooted in illicit drugs and 'unsafe sex'.

Patton (1996) argues that the othering effect of gay people within the broader society "is totally subsumed by the elements that make them different, by their identification with that difference" (p. 19). This is a critical point because the process of

becoming identified as being different is a process of subjectification. Patton's work was published seventeen years prior to this study, but her analysis of safe-sex education and its impacts on the gay community are relevant because she illustrates the role (and failure) of safe-sex education and HIV in the process of the subjectification of gay men. At the conclusion of her text, she advocates *Fatal Advice: How Safe-Sex Education Went Wrong,* and notes that, in the coming years, "It is important to see the next phase of organizing as a political project of queer survival." She later recommends "linking the new organization with its gay liberationist roots—but also recognizing that gay and lesbian organizing has diversified and evolved" (p. 140).

Summarizing these statements, Patton argues that while AIDS activism and gay activism are not the same thing, they require a "hybrid" politic wherein they support each other. Subsequent to Patton's (1996) work, it can be argued that HIV/AIDS activism and the gay-rights agenda do not seem to support each other as they should. In fact, Steven suggests the opposite, which is a situation in which the normalizing/mainstreaming effects of the gay-rights agenda have been damaging to both the people living with HIV and those working in the field of HIV/AIDS.

Some participants describe their discomfort with the "mainstreaming" of gay identity and the shifting to heterosexual normalcy because it creates a central discourse that is not open to sexual diversity and may even be seen as adverse to sexual liberation. One participant states that "*…in a really, really simplistic way, I would say maybe reinforce that notion that it's all about sex" (Thomas, 40s, Halifax),* which seems to be an association that the broader political agenda is not comfortable with. Another participant suggests that:

> *... inherently, it does influence what it means to be gay… it continues a historical*

trend of pathologizing gay men… One of the huge challenges of trying to do prevention work is how do you talk about disease prevention without, inherently, people feeling that they're dirty and diseased. It's the stigma about sexuality, the stigma about having an STD, in particular… So many gay men are affected by this… AIDS within North America… what comes to mind is a gay man dying… (Joseph, 50s, Halifax).

Joseph acknowledges the challenge of reducing the stigma associated with HIV, while recognizing the historical impacts that the politics of HIV/AIDS inevitably had on gay men. How do HIV activists engage people without increasing stigma and making people feel dirty and diseased? Other participants talked about the wonderful job that was done in making the imagery that shows HIV-positive men, in various campaigns, in a positive light. Yet, they also stated that this may have had an unintended consequence in that many people now see HIV as a manageable illness while other participants who have been living with HIV state that "*it fucking sucks.*" The complexities that surround the methods of creating HIV materials are exacerbating at times, yet all of it contributes to the perception of HIV and, in turn, the perception of gay men through their historical association.

Joseph comments on a specific situation in which someone accesses the services his organization provides:

…I had a call from a guy in the Valley who's starting to come out. And he's already an adult… he wants to have sex, but he wants to know what's safe, because already in his mind if he's going to have sex, he has to be worried about AIDS… Now he's freaked out… I think lots of gay men might be in denial about how much AIDS and HIV have influenced their lives… I mean, for men of my

generation, I mean it's one of the defining aspects of our lives (Joseph, 50s, Halifax).

Illustrated in this excerpt is that even today, a *"man in the Valley"* knows that AIDS and gay men go together, but he does not know how to prevent it. Joseph suggests that this is evidence that gay men deny or are simply unaware of the tremendous impact HIV has on their lives, particularly those who did not experience the initial outbreak. He goes on to state that this is the *"defining aspect of our lives."* HIV has and will continue to influence what it means to be gay for generations to come. I sensed the intensity of Joseph's experience as he talks about how, even if other gay men in Halifax experience a fraction of what he has, it is still *"massive."* Amidst this deep description of experience, Joseph reflects that this is both an individual and collective impact. It is a statement that resonates with Patton's earlier description of the identity of difference. This experience is both individual and collective because the two are inseparable. One cannot be a gay man without a broader discourse of the gay subject.

Joseph further explores the concept of being both an individual and a part of a collective as he connects his experience with the broader community:

> *…the massive impact.. individually and collectively… Sometimes it shows up in how resistant people are to the messages… If it was a non-issue, there wouldn't be a reason for the resistance… to messages about using condoms or anything about safer sex, or anything about HIV-prevention… You then become the person, you then become the one who's ostracized or ignored or trivialized or, you know, has to be silenced... And the flip side of that for me is… further pathologizing gay men who have been defined as diseased for centuries... So, it's never simple (Joseph, 50s, Halifax).*

Governing discourse inherently creates resistance. Joseph states that there is, indeed, an issue with prevention because there is resistance. If prevention did not have a subjugating effect, there would be no resistance. There is tension within the way we understand ourselves as gay subjects. On the one hand, there is an implicit understanding that HIV is part of our history, but there is nonetheless resistance to incorporating safer sex into the community. There is tension in the experience of the discourse, but people are not publicly opposing safer-sex messaging. The resistance is underground, and part of the challenge to HIV work is that the target is not always obvious. In modernity, power is not always immediately visible. If safer sex did not meet resistance, the messaging would simply be adopted and subjects would properly care for the self. Instead, there is resistance. While the people doing prevention work play the part of safer-sex messaging, those who enact resistance are less clear. In some ways, those promoting safer sex come to signify the discourse they are encouraging. Joseph describes his experience as an activist as "*ostracizing, ignoring, trivializing, and silencing.*" These descriptions illustrate the power of the complexity of discursive effects. Further, Joseph does not statically represent prevention, but moves to resistance as he later describes some of his own experiences of barebacking with other HIV-positive gay men. In his words, *"it's never simple."*

Who are we?

The above discussion focused on the broader community of gay men and how HIV messaging has impacted the discourse related to them. Another component to this discussion is how various groups within the overarching category of "gay men" receive and interpret this messaging. One participant described how different generations experienced seroconversion and the impacts of prevention messaging:

The majority of young men who I've talked to, who are gay and who identify as being gay, have been diagnosed with HIV and it's just part of being gay… from their perspective… that's just what happens sometimes. That's just part of the experience… for some… they felt it was an inevitability. We all get that, and it's manageable… that messaging is definitely filtered down and… many other gay men don't feel like it's curable, but that it's manageable… I can still live (Pat, 40s, Halifax).

One message that a number of participants raised was the effect of positive messaging regarding an HIV-positive status. Many suggested that while this had the intended effect of portraying HIV as a chronic disease and reducing stigma, which was beneficial in some respects, it also had another effect in that HIV is perceived as less serious than it once was. With the advancement of medications HIV is certainly no longer a death sentence; many people regard it as a manageable, chronic disease. Despite this acknowledgement, numerous participants noted that HIV was still a very difficult illness to have because of the side effects of medications and other challenges, including stigma.

Pat talked about how generations feel the effects of HIV differently. She suggests that men who have lived through the entire epidemic have a different experience than younger gay men. While it is recognized that these two groups (younger, older) are not all-inclusive categories, the overall experience described by the participant when interacting with HIV-positive gay men suggests that there are discursive effects that produce experience. For younger gay men that are relatively newly diagnosed as HIV positive, Pat states that they regard this as "*just part of being gay"* and that this "*just happens sometimes."* There are two key points that I would like to focus on: one, that HIV is part of the subject experience, and two, that for some there is a degree of

inevitability to seroconversion. There is a marked difference between thinking *HIV could be contracted because condoms or harm-reduction measures have failed* to thinking *it is likely that HIV will be transmitted, based on subject experience*. These notions also fall outside the category of "bug chasers," which means those who have been described in the literature as individuals purposefully seeking out HIV infection (Grov & Parsons, 2006). There is a discourse that has emerged among some young men that HIV is going to happen, not because they want it to, but because it is the end result of resisting safer-sex discourse. If HIV is simply part of gay subjectivities then there must be a significant rethinking of the way we approach HIV-prevention.

Similar to the above findings, Gastaldo et al. (2009) note that simply not knowing any better or being irrational are not the reasons gay men engage in bareback sex, though mainstream public health uses these as the premise for HIV-prevention campaigns. Gastaldo et al. go even further to suggest that following mainstream public health edicts would be more irrational than engaging in "risky" sex. The issue becomes, if mainstream public health follows the premise of a rational neoliberal actor, employing either fear-based or educational approaches, these efforts are not addressing the experience of the gay male subject. In other words, if HIV is simply *part of being gay,* it is more than knowing that HIV is a potential risk factor in sexual behaviours, it is a way of existing and connecting with the broader understanding of gay men as a community and subject experience. It follows that if young gay men enter the gay world with the knowledge that HIV is part of who they are, then it does indeed *just happens sometimes.* That is to say that there will be a variety of sexual practices, some of which present the potential for contracting HIV.

Adam et al. (2008) show the role of various circuits or networks through which

men come to experience gay life. Within these networks, some are more likely to incorporate bareback sex and others use the idea of barebacking as the primary descriptor of the network (i.e. barebackers). Drawing from the existing literature and the data from this study, one might suggest that the circuits provide not only a way of connecting to other people through common sexual practices but also how people know HIV as part of the gay experience. The young men's reaction to HIV, which Pat describes above, is markedly different from the way older gay men react upon diagnosis:

> *…men who are newly diagnosed in their 50s and 60s… carry a level of shame for having gotten it… it's not even on the same page as the attitude of the young men that I see. It's very different because many of these men witnessed lots of their friends dying and they feel so much shame for having been diagnosed… the ways in which they perceive being gay… sexuality… sexual flexibility, sexual movement… accepted by family and friends… their experiences in discrimination and stigmatization are very different… And that has to be taken into account if we're going to do effective messaging… (Pat, 40s, Halifax).*

The way the subject becomes knowable is a product of the available discourse. The reactions that are classified by age group, in this excerpt, signify generational discourses. The expectation that older gay men should know better or that having seen the impact of HIV during the early years should influence them so strongly that safer sex should be automatic does not capture the complexity of the experiences described here. Knowledge of HIV, even first-hand experience, does not result in full adoption of safer sex. The difference, however, is the shame and guilt that results upon diagnosis. Two issues emerge, one that the discourse pushing against safer sex within the gay community is powerful, so much so that even people who have experienced the early days of HIV are

susceptible and, two, that having this first-hand knowledge implies greater psychological challenges because within the discourse of HIV among older gay men is the fact that they should have known better and that they, therefore, deserve it. There are no external agents forcing these messages upon us; this is one of the ways we take up HIV within our own community and surveil each other, and it is a reflection of the stigma that is reserved for people who seemingly should have known better. This is a convenient simplification, particularly for those who identify as HIV negative. This analysis is not to suggest that negative and positive gay men are at odds; rather, it is meant to illustrate the effects of the dominant discourse at the time of diagnosis, while keeping in mind that sex without condoms is common among gay men, but the point of diagnosis determines the impact of these discourses.

So who are we? We are subjects that become knowable as we come out at various stages of our lives and experience the gay male subject position as a product of the competing discourses that include HIV. The "generational discourse" is not based merely on age; it is a product of a discourse within the gay community that encourages gay men to practice safer sex. Their cumulative experience is often different from that of younger generations within the gay men's community because the discourse has shifted. Again, the purpose of this discussion is not to simplify the experience of older and younger gay men into all-inclusive categories (thereby reinforcing notions of hegemony and the dominance of discourse); rather, it is to trace the threads of seemingly disparate and competing discourses to further understand how these *experiences* are produced and reinforced.

To review, this chapter departed from the notion that equality is not evenly distributed, particularly in the area of gay rights. From the outset of the HIV/AIDS

pandemic, gay subjectivity shifted. The gay community found cohesion through HIV/AIDS activism and created a dominant discourse that entailed safer sex. Cohesion can also be seen as binding and subjects seek lines of escape from domination effects. Resistance can be cyclical and the hegemony of the gay community became the site of resistance for some. This can be seen in part through public health attempts at corralling. First, corralling occurred in the literal sense by trying to physically contain HIV/AIDS and subsequently through attempts to corral gay men's sexual practices. Both create resistance.

A symbiotic effect of safer sex messaging is that it became associated with a change in the focus of the gay rights movement to mainstream issues such as marriage and adoption. For some who do not see themselves represented in the dominant gay agenda, gay rights and safer sex messaging represent competing discourses to sexual liberation. The hybrid politic that Patton recommended years ago has not emerged. Rather, the gay community, at times, distances itself from HIV issues. HIV/AIDS activists sometimes see themselves as the site of resistance and are often ostracized as a result.

Bringing the chapter to a close, I turn to the question "Who are we?" to analyze how different people interpret gay subjectivity today in the wake of HIV. The most prominent notion that emerged was that some young men regard HIV not as a "risk factor", but as a part of who we are as gay men. That, in many cases, contracting HIV *just happens sometimes*. This is a very different description from that of the experiences of older gay men if they seroconvert. It appears as though the dominant discourse that older men who have lived through the epidemic should just know better than to bareback has had a profound and negative impact.

To this point, the analysis of the HIV discourse has centred on the production of discourse related to the gay male subject. In the following chapter, the discussion shifts to barebacking as the site of the specific discourses that are unique to the gay community. It is here where tensions within HIV-prevention messaging emerge. Barebacking has been reviewed in the literature and is now examined in regards to its various contexts and how this practice impacts HIV discourse.

Chapter 7: Findings—Barebacking

Barebacking has come to signify a tension within the subjectivities of gay men because of the desire to both engage in this practice and to avoid HIV transmission. In addition, barebacking has become a way in which gay men can be classified as "at risk" within the broader HIV-prevention public health discourse. Activist perspectives on barebacking provide the basis for the analysis of this sex practice as it conceptually shifts from an individual, isolated act to a discursive production. Specifically, what emerges in this process is the normalizing effects of both silence and rendering visible barebacking practices and identities in public and private spaces. The effect of silence is to draw the boundaries of discourse in these spaces, while at the same time, rendered visible in the discursive, prevention-focused spaces public health occupies. The following chapter begins by illustrating the tension from one participant who has been deeply involved in HIV work in Nova Scotia.

The Tension

> *We know what's really going on. We know men, both positive and negative, aren't using condoms, for a variety of activities and we know why. I mean anyone who's having sex, condoms fucking suck… (Pat, 40s, Halifax)*

There is litany of research articles published about why gay men do not use condoms during sex (Berg, 2009; Garcia, 2013; Mowlabocus, Harbottle, & Witzel, 2014; Prestage, Hurley, & Brown, 2013). However, there seem to be opposing discourses between the various health institutions (i.e. public health, primary care, etc.) and gay men over the type of sex gay men want to have. The former promotes 'condom or safer sex,' whereas the sex many gay men desire and eroticize about is 'condomless sex.' The irony of these

opposing discourses is that gay men and health institutions both want to avoid HIV transmission. While some might argue that there are, indeed, individuals who have purposefully seroconverted (i.e. bug chasers), it is safe to assume that most people do not want to contract HIV. Often, gay men are finding ways to avoid HIV infection and to bareback by employing harm reduction practices (Berg, 2009). In what follows I examine two threads of the barebacking discourse: 1) the effects of normalizing certain sexual behaviours, and 2) the sense that safer sex is associated with foregoing sexual liberation as a gay politic.

Sanctioned talk. Participants in this study frequently discussed how the discourse of 'safer' sex was regulated, based on the setting. Certain spaces seemed to regulate what could and could not be said. In a discussion with one of the participants he suggested that:

> *…[I]t's very, very difficult to talk about. And then the things that are sanctioned in terms of how it's talked about is if you're in a monogamous, long-term relationship… you can sit around in polite company and say that. And then the guys who are very open about their sex… which sort of leaves a lot of people in between… The other thing is… that maybe talking about sex isn't just talking about fucking... And so, again for good public health reasons, we start there with sex…but you still have another 23 hours to your day… (Thomas, 40s, Halifax).*

Thomas suggests that, in various circles, different types of sex are discussed within a range of social sanctioning. He talks about two seemingly opposing situations, one where monogamy and long-term relationships are valued in *"polite"* company and the other where people talk openly about their sexual practices. This characterization of the way sex practices are talked about suggests that the first perspective of monogamy and long-

term relationships is that they are not *"open."* But the effect is not one of silencing; rather, it is one of producing a preferred discourse, in certain spaces, about sex. The tension in the discourse is observed when Thomas notes there are *"a lot of people in between."* The two seemingly opposing discourses of gay sexuality, one that is conservative and based on monogamy and other that is open, leaves a lot of people in the middle. The middle ground can be translated into a space where an alternative to the two dominant discourses may be found. The tension that occurs in this middle space, however, is not limited to the social spaces wherein people discuss sex. Later in the discussion, he noted that for *"good public health reasons"* gay men have employed various harm-reduction techniques, when engaging in sexual intercourse to avoid HIV transmission. So, for Thomas, there was a connection between the social sexual practices of gay men and the institution of public health.

The types of gay men`s sex that are sanctioned are given space within the semi-public arenas for uptake within the mainstream gay culture. Some of this likely filters into the domain of health promotion as gay men are also involved in HIV-prevention. There is, however, a reciprocal relationship in that practices and discourses surrounding gay men's sex influences the public health response; the discourse surrounding HIV, in public health and medical treatment, gets taken up in the discourse and sexual practices of gay men. In other words, neither discourse— gay men's sex or HIV in the health field— has dominance over the other. The cycle of discursive productivity does not occur in isolation. Rather, institutional processes are involved in the production of the *experience.* Another participant suggests that discourses emerge over time. He uses the drug therapies

that are now available as an example. Charles recalls that the language of barebacking emerged with the advent of highly active antiretroviral therapies (HAART):

> *And you know there are men who won't have sex unless it's barebacking. I'm fascinated by that, that if you pull out a condom, they're gone. They're just gone…that's proved to be my experience. I mean, I'm sure that, it's funny 'cause that term didn't exist in the early days of AIDS. That's a term that's existed since we've had HAART therapy. I don't think BB happened before then. It was certainly never, never put on an ad or certainly never discussed. So, I think that's only happened since we've had some quasi-successful therapies. 'Cause you certainly never saw that in the early days (Charles, 40s, Halifax).*

The way barebacking has become knowable within the gay men's community is not a random evolution of desire and pleasure. Rather, one can trace the shift in practices and patterns to the development of HIV medications such as HAART in the mid-90s and, in turn, track how the way people talk about HIV has evolved. I note this, here, because it is important to keep in mind that discourses are sometimes influenced by factors that may not be immediately obvious. The advent of HAART is surely seen as a success in the treatment of HIV and the reduction in AIDS-related deaths (Attia et al., 2009). Along with the development of these therapies came the space for gay men to consider having sex without condoms. And as HIV treatments and technologies have advanced, a new discursive space has been made available, a space that was not present in the early days. The emergence and evolution of the barebacking discourse stands in contrast to the public health approach to HIV-prevention to the extent that the desire and practice of barebacking has caused some to see gay men as having underlying problems that cause

them to be self-destructive through this practice (Adam, 2005, 2006c; Stall, Friedman, & Catania, 2008).

Gay Men's Health. As has been previously stated, the advent of HAART has saved countless lives, yet the discourse that this has produced is a shift from viewing HIV as a death sentence to seeing it as a chronic condition (Chesney, 2013). It is possible that in the early days of HIV the focus on the sex practices of gay men left open the possibility for mobility within the discourse of barebacking. Previously, Thomas suggested that there are more than these incidental moments of sex and that gay men still exist throughout the remainder of the day when sex is not happening. His concern is that the broader issues of health are not being addressed. One participant even stated that *HIV has taken over that whole conversation for so many years, and in many ways that's increased the spread because gay men, it's not been inculturated into the gay men's, into gay culture, to take care of your health in really proactive ways (Pat, 40s, Halifax).* Taking this notion a step further, part of the failure of HIV-prevention may be associated with treating the sexualized body as being separate from the subject experience of gay men.

Referring to Thomas's discussion of the other *"23 hours"* in a day, the question as to how we address the whole person in HIV-prevention is raised. This idea is a very prevalent one and it emerged in a number of the interviews. For instance, one participant notes that in HIV-prevention: "*we have to look at the broader context of gay men's health. And what it means to be a gay man and that it's, so it's you know the HIV stuff is part of it, but it's not the only thing" (Donald, 60s, Halifax).* It is evidence that in the local context and the literature the focus is to seek to identify and improve the overall condition of gay men and to revitalize "gay men's health." This trend in the literature is presented

as a syndemics model and often notes the health disparities faced by gay men including increased rates of drug use, depression and so on (CATIE, 2010; Stall et al., 2008). By addressing the health disparities associated with gay men in a broader sense, it is thought that this should, then, lead to a reduction in the likelihood of HIV transmission (CATIE, 2010). This direction represents a shift in HIV-prevention strategies among gay men. It is a move from programs that focus on their sexual encounters and using condoms (or, in some cases, employing other harm-reduction tactics) to reducing the incidence of HIV by holistically addressing the health and well-being of gay men. To an extent, this trend de-emphasizes the practice of sex and refocuses on the communities and identities of gay men by beginning to take into consideration the other *"23 hours."*

It may be that underlying this perspective is the idea that there is something wrong with gay men; and barebacking is used as evidence. Here I offer a critique of this approach. Health disparities among gay men are often seen as a product of childhood trauma or abuse or other environmental factors that may have been damaging. The solution has often been seen as fixing gay men rather than addressing the broader determinants of health such as the social and cultural factors that brought about these negative experiences. One assumption of this approach to HIV-prevention is that barebacking is evidence of health problems stemming from substance abuse and depression. In contrast, other research has argued that if we see the competing discourses of barebacking and consider what public health is up against in terms of the eroticism and pleasure presented in porn and elsewhere, then it is not the health problems of gay men but the product of competing discourses that produces barebacking practices (Gastaldo et al., 2009). In other words, a deficit model of gay men's health may not produce a

reduction in the rates of HIV transmission because gay men may be acting logically if eroticism and pleasure are coming to the fore in barebacking discourse. From the syndemics approach, the logical end is that if we treat gay men holistically, then we can make them more normal in the everyday lives and in their sexual practice thus reducing the likelihood of HIV transmission. Emergent from this research is that there is resistance to the normalization of the gay experience as well as in the normalizing of gay sexual practices.

Community, Identity and Barebacking

Participants throughout this study refer to a distinction between gay men and MSM who do not identify as gay. The participants make this distinction, but there is some complexity as this differentiation attempts to distinguish between an act and an identity. The term MSM was introduced in the health literature as a way to speak about men who had sex with other men but who avoided the gay identity. To avoid the gay male identity, however, the subject must have a conceptualization of what it means to be gay and what it means to resist that subject position. One participant describes an example of dealing with someone who did not identify as gay but perceived himself to be at risk for HIV:

> *…[S]o these are guys that don't actually self-identify as gay men, but they are men who have had sex with men. And so and they'll ask and they'll say, I just heard someone earlier this week saying that "I was really drunk with my friend and I ended up putting my penis into him. And, you know, it was bareback, but it was only for two minutes, you know, what are my chances of getting HIV?" sort of thing… (James, 50s, Halifax).*

To an extent, HIV has forced some people into interact with gay identity, despite trying to avoid it. Since HIV is largely associated with gay men, the act of engaging in same-sex behaviour can create some tension among men who do not identify as gay. HIV brought gay male sexuality out of the proverbial bedroom by forcing it not only into the public space for discussion but also into the subjectivities of both men who identify as gay and those who do not. In a way, the desire of men to have sex with other men, whether people identify as gay or not, brings the politics of sexuality into the issue because these desire and sexual acts are never without meaning.

The politics of sexual liberation was at the forefront of the gay rights movement in North America, in the 1970s, prior to the emergence of AIDS (D'Emilio, 2002). The AIDS movement in North America not only entailed a reconfiguring of how gay men had sex in order to survive, but also reconstructed the gay male subject. The necessity of safer sex in the '80s and '90s changed what it meant to be gay as the discourse of sexual politics shifted from one of gay liberation to one of survival. In James's quote, the man who does not self-identify as gay knows that there is some risk associated with what he did but is unsure of what that exactly means. He goes on to comment on the specific acts in which gay men describe "topping", or the insertive partner in male to male anal sex, as a method of harm reduction when barebacking. Whether individuals participating in male same-sex sexual activities identify as a gay or not, there is still an effect of knowing that this is associated with the risk of contracting HIV. This contrasts with the 1970s' notions of gay sex being associated with sexual liberation. In a sense, sexual liberation has been traded for constraint in order to contain the spread of HIV.

Subsequently, buried within the safer-sex messaging, other sexual health messages were underpinned with the notion of sexual morality (Numer, 2009). These were, in part, a consequence of HIV-prevention discourse. John (quoted in the preceding chapter) encountered members of the gay community who felt remorse over the changes they had seen. They recalled the days of sex that were free from the constraints of HIV-prevention, particularly those in the early days of the AIDS crisis: *"Gone are the days of leather and barebacking."*

The data analysis in this thesis points out that power is never simply top-down, but a complex constellation of socio-political influences. This suggests that there is more happening here than the governing of gay men's sexual practice by health authorities. Often, gay men's resistance to the mainstreaming of gay sex or the gay identity is aimed at the discourse that emerges from the gay community itself. In analyzing John's above quote, the person he is talking to would not likely blame some ubiquitous health authority for the shift in gay men's sexual identity; rather, it is likely that the individual thinks of the gay community as a place where they no longer fit because of their preference in sexual practices. One might argue that this grinding against the discourse of the mainstream gay identity is only part of the story. This conflict is not over the actual sexual practice, rather, it seems to lie in the "*the things that are sanctioned in terms of how it's talked about" (Thomas, 40s, Halifax, stated earlier in this section).* In other words, the statement that Thomas makes about barebacking is that we know many gay men are engaging in this practice, but there is only space for talk about it within certain sanctioned places, e.g. in monogamous relationships, etc. Based on the participants' discussions and the rate of HIV transmission within the gay community, it appears that

there is a connection between barebacking and the silencing of this practice in the community. It seems that gay men are finding ways to have sex without condoms often through the employment of such hard-reduction practices as sexual positioning, serosorting, withdrawal, and more. It appears that to maintain the standards of morality that have come to the fore in the gay community, however, individuals either do not talk about it or are considered irrational for engaging in such practices.

Another suggestion that morality underpins the silencing of sexual practices is found in John's above statement about leather, barebacking, slings and group sex. By themselves, leather, slings and group sex are not necessarily "unsafe" practices. Yet the participant includes barebacking in this list of bygone expressions of sexual liberation. This may suggest that this is not just a discussion of safer sex. Rather, it is a discussion of the subversive sexual practices gay men have historically employed in their resistance to heterosexuality. From this excerpt, it seems that 'safer sex' entails not just condom use, but a rethinking of the sexual practices that have long been a symbol of gay-male culture.

One participant recalls his discussions with gay men who felt ostracized by the mainstreaming of gay-male culture: "*Guys who were saying, you know, we should be able to do whatever we want, we shouldn't have to, we're all being too gentrified into... moving to the center" (John, 40s, Halifax).*

Two competing discourses associated with the gay-male community that are central to this research are the discourse of safer sex, which includes a normalizing and, often, a moralizing of sexual behaviors, and another that is beholden to the sexual liberation that is a historical part of gay-male culture. The two concepts are not fully at

odds. But there is friction between the two as promoting safer sex ultimately attempts to govern certain aspects of sexual behaviour.

Identifying Barebacking. Sanctioning talk about barebacking does more than ostracize individuals within the gay community, it limits the discourse and separates and ranks individuals according to their position. The power of discourse operates beyond individuals by shaping subject positions. The following sections will examine the discursive thread of barebacking from the viewpoint of activists working in the community. Three key concepts emerge from these interviews: first, that barebacking discourse has a ranking effect among gay men; second, that HIV-positive gay men experience the stigma that is associated with the ranking effects; third, that the barebacking discourse presents specific challenges for HIV-prevention work in Nova Scotia.

In one discussion, a person who deals with the public's questions about HIV and barebacking talks about the meaning of barebacking:

> *…[I]t means lots of different things to lots of different people. I think, for some, it means we're in a relationship… for some, it's something that I do when I feel like I want to do it. I think, for some, it's something only dirty people do, or people who are doing something wrong do… it's something people don't want to talk about… there's really a lot of discomfort in disclosing that they've barebacked (Linda, 30s, Halifax).*

At the beginning, Linda notes that there are many different ways in which the concept of barebacking is seen and understood. It can range from a relationship

designation to an act of defiance to something other people do. This list of possibilities denotes some of the varieties of discourses that are used. The term *"dirty"* is at the end of the list. "Dirty" is often used to describe deviances from proscriptive norms of sexuality. It can be interpreted that dirty is the judgment passed upon others, while *"wrong"* designates deviance from moralistic principles. The calls that Linda discusses are often from people who are either closeted or outside of the immediate Halifax area. And despite not necessarily knowing the exact risks involved, these callers appear to intrinsically know that there is risk in both identifying as gay and in the sexual practices.

Often, without having ever entered gay space or things associated with the gay community, these callers know that there is a risk to admitting having barebacked, not only in terms of HIV transmission, but also in the social repercussions. Linda goes on to discuss the tensions:

> *It seems like it must be that misty line that people cross from their perspective in however they grade things, right. I think, from that periphery of the community, it's something people should never do, right. 'cause I think there's this higher intensity that it would just be aghast for someone to… I think, from a gay men's perspective, there's not enough focus on that as an option… I think there's that people even especially trying that out for the first time, they're afraid to even ask people about how to do it... terrified to ask someone (Linda, 30s, Halifax).*

The "*misty line"* Linda refers to, regarding sanctioned talk about barebacking, is associated with the level of risk. Often, monogamous couples are expected to engage in barebacking practices, but those who frequent bathhouses, cruising areas, Internet hook-up sites, and other venues, for casual sex are expected to stay silent about barebacking

practices. This follows the way *"they grade things."* Grading the extent of the sexual transgression is assessing risk. It is a method through which to understand and rank the individual according to their deviance from the safer-sex mantra. In other words, the act of barebacking constitutes and situates the subject as a sexual being that is ranked according to sex practices.

Linda states, however, that the view from the *"periphery of the community,"* the lower ranking, serves to splinter the concept of a community and also the dominant discourses that follow. What emerges are subgroups within the groups of gay men, those who purposefully identify with leather, barebacking, slings and group sex. Not all subjects can or will break from the dominant ideologies, particularly when they are not identifying as gay or are at the beginning of coming out. In these instances, people are left *"terrified to ask someone"* about barebacking and harm reduction. This fear is often associated with the ranking that takes place as subjects speak their position into existence. Based on the discussions with many of the participants, there is very limited space within the Nova Scotian context for people to talk about these practices. This closes the space for public dialogue, despite the fact that "*we know what's really going on" (Pat, 40s, Halifax).*

Linda offers another perspective on the space where talk of barebacking is sanctioned. In discussions of barebacking as an identity or practice for gay men, she responded by saying:

> *…[T]here are those that it's something they do, but they're not necessarily entirely wanting it to be all about who they are… there is a subset… individuals*

and groups that feel that it is some sort of intentional rite of passage for who they are… they may be the only ones that are open in public about how to do it. So, that's actually the only entry point that gay men have for that… if that's your only entry point, if you're thinking more broader about risk assessment, understanding, you know, what you can do and what kind of choices you personally want to make about your health and your sexual behaviors, that's pretty scary that there's no other options (Linda, 30s, Halifax).

The interesting turn in Linda's discussion is that the very people who are rejecting safer sex discourses are also creating a discourse of resistance. Within this space, there is not only room for an alternative discourse for those unwilling to engage in safer sex, but also a primer or set of instructions on "how to" conduct oneself. The participant makes the point that barebacking culture may be the only space within which there is open dialogue about how to potentially negotiate safety and use the body, particularly the "ass" (this is what she is referring to at the end of her quote), to engage in sex without condoms. This observation suggests a rethinking of how we engage safer-sex messaging in Nova Scotia. For an HIV activist working directly in the field, to offer this insight, speaks to the profound silence in the public domain regarding harm reduction.

The rethinking that this might require means that the system that ranks and orders the subject in the manner that is currently observed, and the discourse that is produced in HIV-prevention, will have to change. It requires us to think about HIV and people who engage in barebacking, not as the minority of irrational actors who cannot be reached, but as the majority of gay men who are indeed finding ways to have sex without condoms. Going even further, Linda states: *"[L]iking it also seems to be not necessarily something*

that's publicly discussed, unless it's in a really… brash kind of way. It has to be a particular social setting" (Linda, 30s, Halifax).

Liking anal sex (the reference is probably suggesting liking receptive unprotected anal sex) is silenced unless it is in a *particular social setting*. And the spaces for talking about it are either sanctioned or relegated to certain places. These are not usually formal physical spaces (though bathhouses may be one exception); they are spaces where gay men are able to connect with others who resist the discourse of safer sex.

Barebacking and HIV-positive gay men. The notion of networks of gay men having a system or rules of conduct within barebacking circles has been verified and discussed elsewhere in the literature (Adam, Husbands, et al., 2008). The need to reiterate this here is because these discussions often happens in larger urban centres where HIV is more prevalent and where there is more opportunity for a variety of networks and discourses to emerge. Within the Nova Scotia context, however, there is a limit to the number of gay "subcultures" one might find. This may also be the rationale for the fairly homogenous understanding of what the "gay community" is in this region. Another participant recalls his interaction with the gay community and the lack of research in the area of barebacking. He notes the various "circles" he interacts with:

> *So, I was already aware of, for years, of the massive stigma and what that meant locally, and I had to live with that… We have a shared experience, first of all, and we still have a hostile world even within the gay community… The meaning of having sex without condoms is one that I think gets far too little attention… Some of the literature around gay men's health speaks of it as something that needs to*

be addressed, but nobody's actually doing research looking at the particulars of what it means… I think it's massively significant… (Joseph, 40s, Halifax).

For Joseph, his entry into a *circle* of HIV positive gay men is about finding acceptance and a level of freedom from the stigma that exists for people within the gay community living with HIV. He also mentioned that they "*shared an experience,"* which refers to the impact seroconversion had on these men`s lives. Despite the fact that many people interact within the gay community because of the shared experience of coming out, and possibly because of rejection from various parts of mainstream society, there is stigma within the community for those who are HIV-positive. This is connected to the sanctioning of talk about barebacking, within the broader gay community, that not only silences the actual practices of many gay men but also stigmatizes those who seroconvert.

Though Joseph understands this as a *shared experience,* this can also be understood as a shared resistance to the dominant discourse of the gay community. HIV-positive men have come to represent resistance and a *subset* among gay men often embodies the splintering of the community. If we are to understand that the dominant discourse at the periphery of the gay community is that barebacking is something that you should never do, then HIV positive men are marked as examples of what happens when subjects break from this discourse. In a process of subjectification, they become the undesired and encounter a *hostile world* within the community that is, itself, subjectified.

From Joseph's interview, we learn that the meaning of barebacking comes to the fore as the point of focus. This may contribute an explanation of the hostility that is reserved for many HIV-positive men within the gay community. For subjects in this

position, this hostility becomes *massively significant* because it is the discourse of barebacking that puts both the friction and the divisions into operation.

Barebacking and Healthcare. The gay community is not the only source wherein the production of barebacking discourse is evident. The formal health care system is also a source of production because of its involvement in HIV-related issues. When a participant was asked whether barebacking was ever discussed among public health officials or even policy writers, she replied as follows:

> *It's not on a list of things that they offer, if they're going to talk about risky sex… I can't say I've ever really been at a table where having discussions about gay men's health or other things where we're actually talking about barebacking, i.e. the time we did the pamphlet, well, we heard things, we got a response, which actually, I felt that that was really galvanizing 'cause I think it allowed us to challenge people… (Linda, 30s, Halifax).*

Discussions on barebacking are limited in the public health sector and among other health officials in the province. If nothing else, the discussions on unprotected sex are likely simply discussions that look at such things as awareness or recent outbreaks, rather than the multiple layers of meaning that are inherently embedded within the sexual behaviours of gay men. One campaign that was launched within the last five years seemed to challenge the way people considered gay men's sexual practices. This campaign challenged people to begin thinking about barebacking and other higher-risk sexual behaviours. Though some applauded the effort, there was also concern that the issue was only being raised so recently. It appears that this is further evidence that Nova Scotia's approach to this topic in relation to gay men's health and HIV is, indeed,

“behind the times” (as mentioned in previous sections). The lack of public health attention to gay men’s sexual practices, namely barebacking, is likely a result of this issue being left outside of the immediate repertoire of responsibilities or awareness at this level. Other participants indicated that when compared to other health concerns in the province, barebacking is just not a *“hot-topic”* issue.

From a broader standpoint, the contradictions in the health and public sphere are that optimal sex is sex with a condom. But in their actual everyday sex practices and experiences, gay men are often looking for a way to have bareback sex without contracting HIV. The difference is that certain talk is sanctioned in certain spaces but not in others. What has emerged is another discourse in relation to condoms and their utility within these broader discussions.

Barebacking and evidence. One of the difficulties noted by participants regarding policy and programming is the gap in knowledge, outside of the major urban centres in Canada, of *how* HIV is transmitted. Some participants suggested that they were left to rely on anecdotal information or to simply use data from the urban areas to guess at these issues. This suggests that the approaches to HIV-prevention are based on common-sense assumptions that may actually be a production of the discursive field of gay men`s sexual practice within a given region. In Nova Scotia, there is scant literature that pinpoints the context within which HIV is transmitted. Commenting on these concerns, Joseph states:

> *You can’t do evidence-based work when nobody’s collecting the fucking evidence… every time I read that statement, evidence-based prevention work… Almost none of it is, it’s all bullshit because we don’t have the evidence. We can’t*

get the funding to collect the evidence… It's a joke; it's a cosmic joke. So, what does barebacking mean? (Joseph, 40s, Halifax)

Joseph is clearly frustrated with the lack of research on barebacking. His frustration is a result of having to work in the field of HIV-prevention without having the evidence or the research to guide his practice. This notion was echoed by many of the participants in this study. They noted that they were forced to rely on limited research and to implement programs modelled after those in other regions, both nationally and internationally. All of this frustration led Joseph to conclude that the task of being able to effectively work in HIV-prevention, in this region, is *a "cosmic joke."*

This discussion is not meant to fault those involved in attempting to design health messaging aimed at HIV reduction in Nova Scotia. Rather, it is to highlight the fact that these people are often working with limited resources and that this has a direct impact on what they are able to do and how their decisions are informed. This research also points out that the resources available for HIV-prevention outside of the major urban centres are limited.

To review, this chapter begins by illustrating some of the tensions in the discourses associated with barebacking. While the desire to avoid HIV transmission and still engaging in barebacking practices seems to set up opposing discourses, many people occupy the *space between* as one participant describes. To address this space, and perhaps push back against the dominance of barebacking, efforts have been made to reinvigorate the notion of gay men's health. This approach, however, may depart from the premise that gay men are simply an at risk group because of their subject position. This risk is identified by the prevalence of barebacking and the associated prevalence of HIV

transmission. A critique of this approach offers that if barebacking discourse has risen to the pinnacle of desire and pleasure then gay men may be acting rationally in seeking out bareback sex.

Following the thread that sexual practices do not merely occur in isolation but are produced as an effect of social conditions, gay sex is inherently tied to gay rights because political activism contributes to how we know and understand ourselves. The move of the gay rights agenda toward more heteronormative and mainstream issues such as marriage equality has pushed the dominant notions of gay identity toward the centre. Some of the participants in this study suggest that the process of mainstreaming gay identity has forced subjects who do not align with some of the norms of sexuality to the margins of the gay community. This marginalizing is an effect of ranking and stationing people according to their sexual practices.

At first glance, barebacking seems to be a behaviour that public health and health promotion can focus on in their efforts to reduce HIV transmission through evidence-based work. But as the literature on barebacking and the findings presented here suggest, this is not a straightforward assumption. The barebacking discourse is not completely stable and cannot simply be reduced to convincing gay men to wear condoms. Further, the depth of meaning associated with raw sex has evolved significantly during the decades of HIV/AIDS. As barebacking discourse evolves within the gay male community, the public health and health promotion response must become more nuanced to account for this change.

Chapter 8: Findings – Public Health

"How do we sell condoms for free?" (Joseph, 50s, Halifax)

As indicated in the previous chapters, some participants described HIV as part of being a gay man and a degree of inevitability to contracting the disease. While this is not the opinion of all gay men, it is a statement that reflects the opinion of some younger gay men who have seroconverted. In contrast, opposing discourses come from public health as it is responsible for stopping the spread of communicable diseases. In the context of HIV, public health tracks the spread of HIV through epidemiology that is largely based on HIV-positive test results. It develops its response to the disease from these data and also from the basic clinical, social and behavioural research that occurs within and outside of Canada. Both formal public health agencies and less formal health organizations or groups that present HIV messaging to the public have an impact on the discursive field of HIV. In other words, the tactics of public health influence the way the public receives HIV messaging and conceptualizes the disease.

Public health in a broad sense is tasked with interrupting or influencing discourses that counter those that emerge within the gay men's community that promote bareback sex as an experience of sexual expression free of physical and psychological barriers. From a philosophical standpoint, one may question whether public health should interfere with free and natural expressions of sex and desire. A poststructuralist might posit that subjects are never completely 'free' to express sex and desire because they are often acting somewhat in complicity or defiance in relation to the dominant discourses. Even as one manages to break through the constraints of discourse, the discourse is articulated or

reiterated in this very process. The production of gay men's sexual subjectivities leaves the institution of public health in a precarious position. The answer to the question should public health and health promotion attempt to influence gay men's sexual subjectivities and, in turn their sexual practices, is yes. I offer this answer because public health *does* contribute to the discursive fields of gay men's subjectivities whether it is through the production of HIV messages or through silence(ing).

Beginning by returning to the idea that there are competing discourses between safer-sex and barebacking, this chapter intends to use public health to exemplify the tension that was explored in the previous chapter on barebacking. Key issues emerged from the data that illustrate how public health efforts have contributed to the way HIV and gay men are understood in Nova Scotia. Some of these efforts came from national strategies while others were determined locally (Nova Scotia Advisory Committee on AIDS, 2003). Regardless of the origin, these efforts were often given priority through funding initiatives and taken up in the local context.

Competing discourses: Public health and barebacking

Generally speaking, many researchers and activists view HIV-prevention efforts aimed at reducing HIV transmission among gay men in Canada as a failure (Gastaldo et al., 2009). As previously noted in the review of the epidemiology of HIV in Canada, rates of new infections among gay men are not declining despite the new HIV-prevention technologies that should, theoretically, reduce infection rates according to biomedical paradigms (Adam, 2011). This, along with the increasing incidence of syphilis, suggests

that barebacking is increasing as a sexual practice among gay men (Gastaldo et al., 2009). It seems as though the discourse of barebacking is achieving dominance among gay men.

HIV-prevention messaging serves to offer alternative discourses to barebacking. The volume of barebacking discourse, whether presented in pornography, talk, websites, or otherwise, greatly outweighs the messages of safer sex and harm reduction. This is not a new concept as the literature notes various references to the increased eroticisation of barebacking and even describes it as the “forbidden desire” (Berg, 2009; Crossley, 2004; Holmes et al., 2008; Holmes et al., 2006; Holmes & Warner, 2005; Numer, 2009; Race, 2006; Ridge, 2004). It has also been documented, within this literature, that the very act of forbidding not only increases the desire for the forbidden object but also the pleasure associated with it. HIV-prevention efforts must, somehow, convince gay men that the benefits of safer sex or even harm reduction techniques outweigh the pleasure of barebacking.

Many of the participants in this study note that, predominantly, bareback sex is one of the most desired and pleasurable sexual experiences for gay men. The effects of the barebacking discourses among gay men are powerful, sustaining and reiterated to fit within the changing culture. But despite these iterations, the desire and pleasure associated with bareback sex remains relatively constant. Within the significant qualitative literature that explores barebacking among gay men, one never hears people talking about the erotic nature of catching semen in a latex barrier; rather, the talk is almost always about the desire for someone to “cum inside” their partner(s) or to share semen (Berg, 2009; Carballo-Dieguez & Bauermeister, 2004; Crossley, 2004; Dowsett, Williams, Ventuneac, & Carballo-Dieguez, 2008; Holmes et al., 2008; Ridge, 2004).

Barebacking discourse is very powerful because it draws on sex which, as we have discussed is not only a pleasurable act, but also a way in which the gay male subject is constituted. Public health meanwhile is tasked with developing HIV-prevention efforts that are acceptable in public space and counter barebacking discourse (Adam, 2006a).

In much of gay culture, porn, erotic talk, hook-up sites and the actual experiences of bareback sex are both rewarded and rewarding. Regardless of the origins of bareback eroticism, the prevalence in gay men's culture sets up seemingly opposing discourses between the pleasure and desire of bareback sex against the often-desexualized public health efforts to promote condom use. It is not surprising that one author notes that "nothing kills a hot fantasy faster than serious talk about sex" (Underwood, 2003, p. 17). If safer sex is viewed as oppositional to barebacking then it is also positioned against pleasure and desire. Given the challenges associated with developing HIV-prevention efforts and the amount of time that has passed since this epidemic first emerged, there seems to be little interest in even addressing it, especially outside of large urban centres.

Government: public health. Assessing how funding is allocated is one of the most basic methods of analyzing political and social will within the Canadian health care system (Lasry, Richter, & Lutscher, 2009). The language of public health, however, attempts to depoliticize this sector's role. For instance, the Public Health Agency of Canada's mission is "to promote and protect the health of Canadians through leadership, partnership, innovation and action in public health" (PHAC, 2013, p. 1). Through the population health model, public health has a clear mandate to maintain and promote the health of citizens.

Provincially, the Nova Scotia Department of Public Health defines itself as "the art and science of improving and protecting health and preventing illness, injury and diseases through the organized efforts of society" (NSPH, 2013, p. 1). At first glance, public health as an institution seems a noble cause, one that is dedicated to the welfare of the citizens. However, this agency is not without controversy. Even within the definition of this particular public health agency, the reference to "society" raises the question, what society? Ultimately, the institution has organizing powers that, when exercised, serve to shape society by producing subjects that have taken up and reproduced public health discourse. In terms of HIV, public health is concerned with determining incidence, tracing cases and ultimately reducing HIV transmission primarily through prevention-oriented messaging.

The underlying ethos of public health is a humanistic one that presupposes universal good health within the "one health" rhetoric or the ability to achieve the healthy body (K. Lee & Brumme, 2012). Foucault questions the universality of humanism with a "suspicion" that suggests there are greater freedoms to be obtained. He notes this because humanism relies on the concept of an ideal subject in which liberal democracies work to encourage its members to achieve such subjectivity. In doing so, societies inherently employ power strategies that have domination effects to achieve such ends. Foucault holds the basis of humanism suspect because it relies on the "Other:" the sick, the perverted, the insane, to achieve the mantra of good health (Downing, 2008; Foucault, 1986). Foucault clarifies this by noting that this is not a case of good versus evil or a simple oppression, but rather, a game of strategy:

> I see nothing wrong in the practice of a person who, knowing more than others in a specific game of truth, tells those others what to do, teaches them, and transmits knowledge and techniques to them. The problem in such practices where power—which is not a bad thing—must inevitably come into play is knowing how to avoid the kind of domination effects… (Foucault, 1997, p. 289).

Foucault's broad analysis of liberal democracies and humanism can be applied to public health. It is not the public health attempts to prevent HIV that are at issue here; rather, it is the domination effects that may occur in the process. It is from this perspective that the following discussion on the effects of Nova Scotia's public health sector and the broader operations of governmental power in the field of HIV in this province ensues.

Public health response. There are many components to the overall responses to HIV/AIDS within the government and the community. The commitment of both can frequently be seen in the allocation funds. As progress has been made in working and dealing with governments on HIV, community organizations that provide HIV programs have come to rely on government-agency funding. The following excerpt illustrates how one HIV activist saw the role of government and public health in HIV-prevention among gay men.

> *…[G]ay men just kind of kept falling to the wayside… What I saw was an ever-decreasing amount of attention paid to gay men within HIV work… I just see it as, fundamentally, part of a homophobic discourse… it's o.k. if they're dead… Like there isn't a year in Canada where the largest number of new HIV infections, isn't*

gay men… smart people, who have access to all this material… you keep making the same decisions… (Thomas, 40s, Halifax).

Thomas draws his conclusions because, given the statistics and rates of increase in HIV transmission among gay men, there does not seem to be any other rationale. He states that in Nova Scotia there is a lack of focus on gay men in HIV-prevention and this commentary was repeated by participants in this study, whether they identified as gay or not. Thomas comes to the conclusion that this must be *"part of a homophobic discourse"* that does not mind if gay men die. This is also evidence of the shift that has occurred within the gay community, ASOs and public health.

Early social movements to mobilize in the face of the impact HIV/AIDS had on the lives of gay men were largely successful in raising awareness and addressing government's failure to respond. The government's lack of action in the early days of HIV/AIDS represented a more obvious form of institutional power. Activists banned together in the fight for more attention, including more funding, for HIV/AIDS treatment, care and support (Lorway, 1999). Over times, however, the government did respond and public health began to address HIV/AIDS. In this case, when overt power was resisted it did not merely disappear; rather, it changed the way it operated. Achieving some of the goals of the HIV movement undermined the cohesion of the gay community. In other words, government's investment in HIV-prevention and treatment took away the issues many activists were fighting against. This was replaced with a bureaucracy that showed a slowly decreasing interest in gay men and HIV and a doing away with AIDS exceptionalism (Smith & Whiteside, 2010).

Various participants noted the overall lack of dedicated funding as a major issue in HIV work. In one instance, Thomas was asked to elaborate on this point by describing the effects of funding shortages. Here, he provides further details that are gleaned from his insight into the effects of the discourse on HIV-prevention. When the question was raised as to the systemic silence, the lack of attention to HIV-prevention among gay men and how it impacted the community, a participant responded:

> *…[S]o you need people to say," okay, we want to do this, that's where the community groups come in and that's their role and public health has a role there as well. Public health in Nova Scotia doesn't do a lot of programming, so… it's just this devastating, I think absolutely brutal under-servicing… which leads to a whole range of health implications and outcomes (Thomas, 40s, Halifax).*

This participant uses powerful language to describe the implications of the lack of HIV-prevention programmes in Nova Scotia. Repeatedly, he uses *"brutal"* and *"devastating"* to describe the conditions. However, the same energy or even urgency is not evident within either the gay community or public health messaging. In fact, it seems as if there is little attention paid to HIV in the Maritimes. Some participants attribute this to the lack of programming associated with public health. Others attribute it to a lack of funding and a lack of urgency within the community.

According to some participants, the lack of HIV programming by the public health sector in Nova Scotia places an increased burden on AIDS service organizations (ASOs) as communities turn to them to provide these services. While it was clear from the interviews that the participants did not want to create strife or divisions among the various institutions, there was a sense that HIV was no longer a priority for either the

provincial or federal governments. The government and, specifically, public health's lack of attention to HIV in Nova Scotia has had far-reaching consequences. While demands are increasing, funding cuts have reduced the number of people and services available. All the while, a participant notes that, in recent years, ASOs have been unable to vocalize their concerns to government: *"There's no forum for us to do that, especially from a provincial perspective. And then I don't feel that there's anything coming down from the province that's formalizing gay men's health as a priority" (Linda, 30s, Halifax)*.

Participants suggested that the distancing of community organizations from government and formal public health institutions has prevented the formation of a concerted effort to reduce HIV transmission and the stigma that surrounds this disease. This can be seen in the way HIV has been silenced in certain spaces, particularly within government. Early efforts created situations within which ASOs became part of government bureaucracy. But subsequently, the forum within which ASOs could speak about these issues became less available to them, while the effects of government priorities still shaped the way ASOs operated. One of the most interesting and challenging debates that emerged in the interviews was the effect of the normalizing or mainstreaming of HIV as a disease, in general, as opposed to it being considered a gay male disease.

A Gay Disease? The concept of "ownership" of medical conditions has been a contentious one (Singer, Castillo, Davison, & Flores, 1990). This is because of the potential for discrimination against and the marginalization of various minority groups. Amidst the potential negative consequences of labelling a group of people or associating them with a disease (particularly a communicable disease) is the opportunity to engage prevention measures. From a public health perspective, this has been one of the most

difficult facets of dealing with HIV from within the gay community. One participant describes how public health did attempt to "normalize" messaging related to HIV/AIDS in order to engage the general public and, from a public health perspective, to reduce the stigma:

> *…[W]e could have done other things, had we had more support around homophobia, gay men's rights, LGB community stuff, it would have been a different world then… There was this public health outcry… both at a provincial level and a federal level, to fund programs that were public based. And to create messages about "it's not a gay disease." AIDS isn't a gay disease… it's not a gay disease, everything said it's not a gay disease (Linda, 30s, Halifax).*

In this excerpt, both provincial and federal government health agencies were attempting to change the perception of HIV through funding programs that would change HIV discourse, making it accessible to everyone. In other words, the attempts to de-stigmatize HIV/AIDS as a gay disease also created messaging that was socially/culturally acceptable outside of gay communities. In doing so, the government was changing its focus toward the delivery of a more palatable message while failing to address homophobia. In another discussion, Pat describes the government's influence on messaging as a method of "sanitization:"

> *So, as the bureaucratization has developed, the kinds of messaging has changed… definitely become more sleek, more "accessible" to a broader population, the whole move from "HIV is not a gay disease," absolutely sanitized messaging... How do we bring that back so it's not so sanitized…? Sometimes the messaging…*

isn't okay, from a political perspective. And then not wanting to further stigmatize… not wanting to further increase the stereotypes… (Pat, 40s, Halifax).

One of the main points this research attempts to make clear is that HIV messaging, in whatever form it takes, is part of the production of gay men's sexual subjectivities. In this instance, the assumption that HIV messaging must take different forms for different audiences coalesces the gay men's community into a sexualized one. In contrast, creating acceptable messaging to the *"broader population"* similarly assumes that the general public is less sexualized than the gay male community is or that it is not sexualized at all. This points to the dominating discourse that surrounds the general public as one of a desexualized heterosexuality that must be deferred to by public health messaging. Thus, "normalizing" for public consumption also entails sanitizing the HIV-related language and images.

Normalizing and sanitizing HIV messaging so that it is acceptable for public consumption has the effect of influencing the discursive field of gay men's sexual subjectivities in a way that promotes not only public "health" but public morality. In other words, the aim of public health to redefine HIV as a non-gay disease, and to purposefully fund programs and projects to this effect, also tailored messaging that was "*okay from a political perspective" (Pat)*. These efforts are not just a matter of cleaning up language so that the general public can read HIV-prevention or anti-stigma messages in the public space; it is reclaiming a disease that has historically been the cohesive force within the gay community (see previous section on NS Culture).

According to participants, in recent years, public health efforts aimed at HIV/AIDS have shifted away from gay men, particularly outside major urban centres.

This has impacted the gay community because the common goal of mobilizing HIV-prevention efforts, in the early days of HIV, served to bind the community and resist overt operations of power. As the strategy shifted, the effects of homophobic discourse are manifested in less obvious ways. Another participant sees the current mechanism of power as an effect of hetero-normativity:

> *…[I]n heterosexual communities, there's enough of a ready-made abhorrence around sexuality… like this [HIV] is another reason not to have sex outside of marriage. This is a reason not to pick up a guy at a bar… but in gay men's culture, sex and sexuality have been celebrated and it's been such a huge part of who we are. Like, really, we define ourselves by who we have sex with. So, if you have a message that interrupts that, what happens? (Steven, 40s, Northern NS)*

"What happens" is that promoting messaging that distances gay subjectivities from HIV creates an alternative discourse, which suggests that to have or to get HIV is to have engaged in a moral or ethical behaviour that is contrary to good health and HIV-prevention messages, both of which have been adopted within the dominant discourse of the gay male community. As one participant noted, the challenge now is to combat the public perception that it's *"not so much that it's a gay disease but it's a bad person's disease" (Ronald, 20s, Northern NS).* This statement demonstrates an interesting turn in many HIV-prevention efforts in the shift away from gay men to other "new" foci. Contrary to many other health conditions, and even communicable diseases, HIV is stigmatized for either having been the result of unacceptable sex practices or of illicit drug use (Oyserman & Swim, 2001; Parker & Aggleton, 2003).

The effects of tailoring the messaging to a "non-gay disease" is only partly associated with moralizing gay men's sex. Purposefully creating and funding a counter-discourse to the one that sees HIV as a gay disease also serves as a solvent to the discourse of cohesion that once solidified a purpose for the entire gay community. Repeatedly, through this investigation, participants recalled the days of rallies, of in-your-face activism, of dying with friends and lovers and wondering what it would take to get that kind of energy and momentum back. Simply stated, it cannot come back as it once was within the gay community because HIV is no longer a *gay disease*. Today, even displaying HIV and gay propaganda together can be a point of contention. One participant commented on a recent Pride event: *"…we had, just this year, we put out a promo ad with our walk and we did an AIDS ribbon and a Pride rainbow and we actually got a response from someone saying we fought for so many years to remove ourselves from that ribbon…" (Linda, 30s, Halifax).*

While we cannot attribute the attitude of the entire gay community to Linda's experience with this one person, we must consider this as an indicator that HIV meets resistance from within the gay community. One consequence of separating *gay* from HIV has been the unwillingness to mobilize the gay community to advocate for HIV-prevention and services. The reaction to the AIDS ribbon is a product of HIV stigma and attempts to dissociate the gay community from HIV.

Returning to the idea that some younger gay men felt that HIV was *"just part of being gay,"* here, another participant gives an example in which there is resistance to this association, i.e. *"removing ourselves from that ribbon."* One possible explanation for this tension is the perception of the public and private spaces within which these events have

occurred. The younger gay men were describing their experience in a private setting to an outreach worker, whereas the backlash was to having the red ribbon combined with the rainbow in the public forum of a Halifax Pride event. Another explanation is that this was a result of the normalizing effects of HIV as a mainstream disease. Linda simply states that this *"broader public message did a disservice to gay men's health…"*

Emerging from this discussion is the idea that there is no single "truth" or best practice for addressing HIV-prevention within the gay community. One senses the tensions in the discursive threads that historically exist in conceptualizing HIV as a gay disease. Some argue that, technically, anyone can get HIV, so it is not a gay disease, while others note that framing the discourse surrounding HIV has the potential to impact the future of the disease.

Damned if you do… While it is understood that it is a challenge to allocate scarce resources within a small province, it must also be recognized that the way resources are distributed is a method of privileging some messages and of silencing others. Within almost all facets of HIV work today, including public health, funding is the primary issue with which researchers, community organizations and recipients of HIV services are concerned. Often, various agencies ensure that, because of funding concerns, initiatives match political and social will, at least within some margin. This influences all levels of HIV services, including research, public health efforts, treatment and community-based efforts. Community organizations as not-for-profit organizations must be conscious of their image because they frequently rely on donations. The issue of funding is important for this discussion because it can be seen that the funds allocated to normalizing HIV have, over time, influenced how we understand ourselves as gay men.

Despite the effects of the normalization or mainstreaming of HIV, to an extent, some activists who have worked in the area of HIV and gay men still seem to take ownership of the disease. Steven remarks, *"even if it [HIV] really radically shifts and it does become more prevalent in the heterosexual community… for me, it's always going to be a gay disease" (Steven, 40s, Northern NS)*. This sentiment may be evident within an individual's experience; however, there seems to be an institutional effect that adds complexity. In a discussion of today's HIV efforts, one participant notes his sense of loss:

> *We've lost ownership of it… HIV work has become business, whether it's prevention, whether it's treatment, whether it's fundraising, or whatever. I think, maybe in smaller communities, it's retained some of the grassroots aspect of it. But we've, yah, instead of the gay community or the infected person running the show or leading the show, we're blogging as consultants or not consultants, we're consulted with (Donald, 60s, Halifax).*

In the above excerpt, Donald introduces another layer upon which to analyze the effects of the mainstreaming of HIV/AIDS discourse. The sense that HIV was a gay disease gave the activists something to work and live for. They bound themselves to the movement because the movement was about who they were. Working in the field of HIV was paramount to advocating for the gay community because the two were symbiotic. This explains why, earlier in this thesis, Thomas notes that if you were doing gay rights, you were also doing HIV activism and vice versa. Efforts to distance the movement from gay men also lessens the responsibility gay men feel for working in the field. HIV became part of government institutions and not-for-profit organizations. And many perceived this

as a loss of ownership despite feeling as though HIV would always be part of who they were.

Participants noted that many gay men have moved out of prominent activist roles. This is particularly so for those living with HIV. They also stated that this was a result of burnout, over-commitment, a lack of funding dedicated to HIV and gay men, and more. The movement has gone from advocating on behalf of ourselves to being consulted with on our own disease. Donald's sense of loss of ownership follows the pattern of the dominant HIV discourse that is both part of and disavowed within the community of gay men. While some have fought for HIV research, treatment and services, others have fought to have HIV removed from the way the gay community is understood.

On the surface, the mainstreaming of HIV was intended to provide information to the broader public and to reduce the stigma associated with HIV infection. The interviews revealed that, in large part, Nova Scotia was never ready to confront anal sex among gay men or even to enter into a public discussion about sex. As a result, even a recent HIV-prevention campaign that was targeted at the gay community and barebacking met with resistance. Researchers, public health officials and other people working in the field frequently employ targeting as a method to promote messaging and reduce transmission. One participant describes these efforts by saying, *"so the fund developers will say 'yes AIDS is everyone's disease…,' but then the programming that we do is really targeted or it's so generic it doesn't make any sense at all" (Steven, 40s, Halifax).* If targeted efforts are utilized, they only reach populations that are "at risk," including gay men, while the broader HIV messages are so ubiquitous they do not even make sense.

One explanation for targeting sex practices is to place HIV-prevention messages aimed at gay men only in venues known to be frequented by such clientele. In the case of recent syphilis outbreaks among gay men, public health officials consulted HIV activists and individuals who were broadly working in the area of queer health. This same discussion emerged in which there was concern that *"the straight community might be offended, and you know we don't want to label gay men as being whores and sluts" (John, 40s, Halifax).* Targeting HIV-prevention messaging is a mechanism that contributes to the way gay men are understood. But a common concern is that, by targeting gay men, the messaging will label them as *"whores and sluts."* Public health officials and people from the community do not want to either offend the targeted community or to contribute to the public's understanding of them in a negative way. Oddly enough, no one is challenging the assumption that gay men having sex with multiple partners is a bad thing.

The way the gay men's community is conceptualized and the way sex practices within the community are understood has changed through the HIV/AIDS epidemic. Having multiple sex partners is not something that is readily accepted within the dominant culture. Within and outside the community, people do not want to say that gay men have a greater likelihood of having multiple casual sex partners. This represented a shift because here the dominant culture prior to HIV/AIDS often entailed multiple sex partners. This shift has also been tied to a move toward hetero-normativity and has been part of the recent gay rights movement. As gay rights have sought access to heterosexual institutions, such as marriage, models of fidelity and closed, monogamous relationships have become valued. A movement that once positioned itself as sexual liberation has

become part of the system of constraint. HIV is largely responsible for this shift because sexual practices became a concern for the institution of medicine, including public health. There was direct evidence that promiscuity led to illness and death. Constraint was placed on gay sex and a new discourse emerged that positioned fidelity and abstinence and the resulting absence of disease as the proper object. The effect has been a limiting of HIV-prevention discourse. Public health and community members now work together to produce sexual-health messaging that avoids naming gay men as promiscuous. These limits constrain and make promiscuity unspeakable in the public domain. Safer-sex messaging has become so broad in public spaces that it silences discussions about people who engage with multiple partners and has largely become ubiquitous.

Public health has been challenged with creating HIV-prevention messages that are not stigmatizing and that represent a politic and morality that are acceptable by the provincial government. This is a difficult dilemma because targeting is employed to reduce the stigma that labels gay men as promiscuous or diseased, but it is also hiding or sanitizing forms of sexual practice that fall outside of the heteronormative culture. The analysis leads to the last participant's excerpt on whether HIV should be identified, within the queer community, as a gay disease. Near the conclusion of the interviews, I queried one activist, who has worked in HIV/AIDS from the beginning in Nova Scotia, about whether HIV is a gay disease. He states:

> *You know, from a prevention point of view… it's not isolated to gay, but once you start diluting the message, then people see "oh, it's not just a gay disease, so I'm not as much at risk." And they are… One time we were saying "Okay, you're stigmatizing the gays…" Now we're getting the other argument that not enough*

money is being spent on gay health, on gay men for prevention… So it's like you're damned if you do and you're damned if you don't … (Donald, 60s, Halifax).

The challenges that emerge are not a reason to do nothing or to create messages that are safe for public consumption. One possible change that can occur within the Nova Scotian context is the creation of a system within which public health can act independently of the political powers of the day. This recommendation is put forward because, without removing public health from the scrutiny of politicians, these normalizing effects will continue to be promoted. In other words, sanitizing health messaging to coincide with the political and social will of the day ensures that proper objects are promoted based on a humanistic ideal and subjects are produced ensuring good health based on the dominant discourse of heteronormative sexual morality. Along with a rethinking of the public health model related to HIV, there must also be a challenge to the general notion that naming gay men as promiscuous is negative. As long as sexual liberation for gay men is associated with barebacking, the tension between the discourses of safer sex and pleasure will continue to produce subjects who desire barebacking more than HIV avoidance.

One of the interesting aspects of drawing on a Foucauldian poststructural frame for this analysis is the limits of discourse. A recurrent topic, in this dissertation, is the effects of silencing and the privileging of the language and the discourses. Foucault notes that, at any given time and among all people, any utterance can produce a new discourse (Foucault, 1971). Foucault goes on to explain that, despite the *ability* to utter anything, people do not; most subjects speak in repetition, thereby reifying the relevant discourses (Mills, 1997). A great deal of his work is dedicated to explaining how power relations

influence and shape discourse. A line of enquiry that emerges, in this research, is the way public health speaks about gay men's sexual practice in the context of prevention and treatment. This questioning follows Foucault's thinking in the "Order of Discourse" where he suggests that one means of exclusion or discursive limit is how institutions regulate the discourse on subjects that are considered taboo within Western cultures (Mills, 1997). It can be argued that the way in which public health is willing/able to talk about gay men, sex practices and HIV will reflect the discursive limits in the public space.

One of the ways of sanctioning or providing legitimacy to knowledge is to medicalize the terminology (Race, 2008). Some participants noted that within public health, and other formalized health settings, it is easier to talk about taboo subjects if they are given medical labels and spoken about in benign terms. Erasing pleasure, eroticism and desire from sex, which is one of the most sought after experiences humans seek, is an ineffective way to engage public health efforts. A participant that frequently works in the field of sex education broadly commented on his experience with public health in Nova Scotia:

> *Public Health, they will say "Well, when you insert a penis in someone's bum or when you insert a penis without a condom in someone's vagina," I mean, I just simply say, you know, "when you shove a cock up someone's ass or when you shove a cock up someone's pussy…" I might even say, "listen, when you have a cock shoved up your cunt, I just, I don't hold anything back… (David, 60s, Northern NS).*

The language used by this participant would certainly elicit some reaction in public domains, particularly in an official meeting in the health sector. There are two threads to

examine here: the first is to question the sanctioned space and the second, the effects of language.

Within the public domain "explicit" discussions of sex are often simply not permitted even when they are relevant to the issue, which in this case is HIV-prevention. "Insertive partner" is the language often used in the academic literature and medical contexts to describe the person *"inserting a penis"* as David describes it. His preference is to state the more common usage that may occur in private domains, *"shoving a cock up someone's ass."* One can critique the effects as speaking different languages, or in academic terms, privileging certain discourses in sanctioned spaces. It becomes a question of whether the way public health employs language speaks to the private experience of having sex. The second component is whether using everyday language is actually more useful in designing and implementing HIV-related programming.

The use of language such as *"fucking"* or *"have a cock shoved up your cunt"* (though in this case cunt is referring to a male rectum) has been privileged by participants in this study as a more appropriate way of talking about sex whether in meetings or in public communications about HIV, especially when targeting gay men. It is often difficult for public health to speak in this manner in the public sphere. For instance, one participant poses questions about this very topic wondering whether explicit talk is useful:

> *What is the impact in saying "fucking?" What is the impact of, you know, let's talk about anal and oral sex, versus blow jobs… there's also a fear within public health that it's going to be too risqué because we don't, in Nova Scotia, we don't talk about sex, let alone blow jobs, let alone ass fucking, you know. Topping and bottoming isn't even often part of their dialogue… (Pat, 40s, Halifax).*

This is a direct reference to the above-discussed discursive limits in a specific time and culture. There remains a reticence to talk about the use of *explicit* words to address specific sex acts. The main challenge from the participant`s perspective is that the conversation about language cannot happen because people in positions of regulating the exchange of public health information in the public domain are unwilling to have these conversations. Mills (1997) suggests that this "is simply a discursive and institutional limitation, which becomes habitual within particular cultures at certain periods. Once a subject is tabooed, that status begins to feel self-evident" (p. 65). The last sentence of this quote is of particular importance, because as institutions either sanction or prohibit certain discussions, by labelling topics or language as "taboo," it *feels* taboo when taken up and reiterated by people in everyday communication.

The process of *tabooing* reinforces the culture, within the Nova Scotian context, that limits people's ability to talk openly about some aspects of sex in public domains and likely in some private domains. It can be safely assumed that this discomfort with talking about sex, generally, can have an even greater impact on the tabooing of gay sex as this type of sex falls outside the heteronormative space. Thus, as Pat notes, when it comes to something like sexual positioning (top/bottom) within gay-male anal sex, this is simply not discussed despite the known impact this can have on HIV transmission. This same participant notes that, in recent years, public health in Nova Scotia has made some effort toward a "sex-positive" approach to sexually transmitted infection (STI) prevention:

> *I'm seeing a real movement around Public Health's acknowledgement around having to talk about sex in positive ways and having to stop judging sexual acts… An acknowledgement that public health has to lead the discussion on sex and if*

they're going to lead a discussion on sex, it has to be… a sex-positive perspective… (Pat, 40s, Halifax).

The participant goes on to talk about public health sex-positive approaches in dealing with syphilis or chlamydia. But these discussions can be covered in a very general approach to sexual health, rather than discussing the details of gay sex. This distinction is made because, at present, from this participant's perspective, gay sex seems to be the limit of the discourse for public health in Nova Scotia. In other words, public health is more at ease in candidly discussing mainstream heterosexual sex, but not in discussing other forms of sex.

More recently, there seems to have been a greater ability for public health officials to talk about sex in a positive way. However, this is not equally distributed across the varieties of sexual practices. Further, one participant was specifically asked how public health officials, community activists and other groups talk about unprotected anal intercourse among gay men (using the more formal language that is preferred within medical models) and the response was "*it's probably only 30% of them that are actually capable and willing to do it" (Linda, 30s, Halifax)*. In this instance, the discussion is directly related to the medical terminology used to describe the sexual practices of gay men that may increase the likelihood of HIV transmission. And even with this type of language, the participant suggests that only 30% who have sexual health as part of their mandate are either willing or able to talk about it. This question was raised because the term "barebacking" is well understood among gay men and is characterized as far more sexy or alluring than a medical term. This suggests that the way the institution of public

health and medicine prefer to speak about gay men's sex can be distinguished from the way gay men experience sex.

Participants were then asked whether they believed barebacking to be part of the language of public health officials or policy makers. Two different participants noted the following:

> *It's not on a list of things that they offer if they're going to talk about risky sex… I can't say I've ever really been at a table where having discussions about gay men's health, or other things, where we're actually talking about barebacking… (Linda, 30s, Halifax).*
>
> --
>
> *…And certainly, on a public health level, people know it's happening. They don't say "barebacking," they say, "unprotected sex." From a policy level… they're not calling it barebacking (Pat, 40s, Halifax).*

In this instance, the language illustrates the translation, from public health as a governing body, that is terming the type of sex as "unprotected anal intercourse" because it fits with disease transmission. But the issue of HIV-prevention within the community of gay men is increasingly recognized as an area that goes well beyond the moment of transmission.

As previously noted, in the sections on the impact of HIV on gay subjectivities, sex is an integral part of the discursive constitution of the gay male subject. If, from a public health perspective, sex is simply regarded a "risk," it can translate into an understanding of gay men, and particularly those living with HIV, as a 'risk.' The

language and approach of public health must go beyond a risk-aversion approach because attempting to stop people from barebacking may strike at the *experience* of being gay. In the case of barebacking (and likely other forms of prohibited sex) among gay men, breaking through limits of experience is a process of achieving the next level of pleasure and eroticism (Holmes et al., 2008; Holmes et al., 2006; Holmes & Warner, 2005). This logic is reflected in a recent article by Gastaldo et al. (2009) in which the rationale for barebacking is directly linked to public health: "Men may simply engage in unprotected sex because, from the perspective of their understandings, legitimations, and rationales about risk and safety, it would be more irrational to follow mainstream public health dictates than to engage in unprotected sexual contact(s)" (403). The argument is that by using an approach that is limited to avoiding "risk" at the moment of contact or avoiding "UAI," set up against all of the desires, pleasures and eroticism embedded and embodied in gay male culture, it is not only unlikely to succeed but would go against rationality—the very rationality that is expected to propel gay men away from "risk."

From the community perspective, one participant suggests that the way to change is to question the very basis upon which public health and other prevention proponents are acting:

> *I think changing our perception of what the goal of prevention campaigns is would be really important. You know what are we trying to achieve? We're not going to, it's not going to go away, it's not going to disappear. So what is our goal? (Pat, 40s, Halifax)*

Pat goes on to state that there must be some cohesion between the various institutions that engage in HIV, including medicine, the community, governments and public health

to redefine what the goal of prevention actually is. Many of the participants spoke of harm reduction, as the main method within which HIV-prevention must operate, as simply saying, “use a condom,” while avoiding any further discussion is not a rationale method of preventing the spread of the disease among gay men.

Though public health is concerned with reducing the transmission of HIV, policies and programmes often have unseen or unnoticed effects (Adam, 2005). Mainstreaming public health messaging to reduce stigma is a worthwhile initiative. But the way this impacts the gay men’s community was not immediately recognizable. The insight many HIV/AIDS activists lend to the subject says that there is no clear direction for gay men and HIV from a public health and health promotion perspective. There is a recognition that these issues are complex, but the business of HIV and the tendency to *consult* with the community seems to have not only diluted the prevention messaging of HIV, but also rendered the movement impotent. In other words, if HIV is not really part of who we are anymore, how can we be expected to mobilize around the cause?

Chapter 9: Conclusion

This thesis has attempted to illuminate some of the often-unseen dimensions of HIV, the effects they have had on the sexual subjectivities of gay men in Nova Scotia, and how HIV discourse impacts health policy in this province. This research began by reviewing the literature on barebacking and gay men to formulate the primary research question: how has HIV discourse impacted the sexual subjectivities of gay men in Nova Scotia? The project then focused on interviewing HIV activists in the province to answer this question. The research findings were presented based on a poststructural discourse analysis methodology. Tracing the most poignant discursive threads that emerged from the interviews with activists has facilitated an examination of this issue across various domains including the culture of Nova Scotia, the way gay men are conceptualized, how barebacking is an important issue for gay men and HIV-prevention, and the role of public health in HIV work aimed at gay men. The following will summarize the key findings from each of these areas with the aim of informing future public health and health-promotion efforts aimed at HIV policies, programs, and other related issues.

This research began with an analysis of HIV and gay men's sexual practices in Nova Scotia. An historical investigation of the circumstances of gay men and HIV/AIDS, in this province, moved this thesis to questions of how gay men's sexual subjectivities are influenced by HIV in Nova Scotia. Subsequently, in examining the concept of barebacking, it addresses the question of how HIV activists in the gay community talk about this disease. Finally, the dissertation concludes by discussing the role of public health and health promotion in HIV work in Nova Scotia as these policies relate to gay men's sexual subjectivities.

Nova Scotia

Nova Scotia provides a unique set of historical circumstances and social contexts in which gay men practice their sexuality in the age of HIV/AIDS. These contexts also influence the ways in which HIV/AIDS activists and those concerned with HIV-prevention for gay men must work. In its broadest sense, Nova Scotia's mainstream culture is often reticent to talk about issues related to sex and sexuality, even though there is a unique history of activism around issues related to HIV/AIDS, in this province. Given the reticence to talk about sex broadly, that which falls outside social norms is particularly controversial. In this sense, gay culture is also a form of resistance to the heterosexual hegemony of mainstream society. In the early days, the HIV/AIDS movement became the "rallying-point" for the entire gay community as governments and health officials failed to respond to the needs of gay men in relation to HIV/AIDS. Despite these efforts, over time, the HIV/AIDS movement stalled because it became part of the bureaucracy. This situation contributed to the silencing of the HIV discourse within the gay men's community, especially for those living with HIV/AIDS.

The experiences of HIV/AIDS activists in the community emerged as a key feature in this work because it demonstrates how HIV discourses comes to the fore in the lives of the participants. Many of the participants saw themselves as both the designers and recipients of health promotion policies and programs aimed at HIV-prevention and stigma reduction. Emergent from this study is that even among the most educated in the area of HIV-prevention, knowledge does not necessarily result in safer sex practices. Sexual encounters are not a momentary event, but an experience produced through the history of gay identity and the discourse related to gay sex.

A key finding for health promotion and public health, within policies and programs, is that they need to acknowledge pleasure and desire in relation to HIV-prevention and gay men's sexual relations. Although this may seem to fall outside the domain of "health," if the concept is reconceptualised and drawn out of the disciplinary silos, it offers the possibility of engaging sexual "risk," while considering sexual pleasure. The work of Race (2008) is taken up to raise the subject of pleasure and for health care policies to consider pleasure in its harm-reduction approaches.

Finally, the experience of the activists reaches beyond simply engaging with HIV-prevention and treatment. These activists are rarely considered as inhabiting a contested position in which they may be living with HIV, while at the same time attempting to stop its spread. These are tensions that are lived and breathed by some of these activists; their experiences and challenges are acknowledged and examined in this thesis. In addition, the tireless efforts of some physicians who were also activists and advocates for the community of gay men impacted by this disease have often gone unnoticed. Their stories are presented here to provide a depth of understanding about the context.

Gay Identities/Subjectivities

The *experience* of being gay men in North America is tied to both the sexual liberation and the HIV/AIDS movements. The process of investigating what it means to be a gay man and how gay subjectivity is produced requires an analysis of gay liberation and the effects of HIV thereon. This study illustrates how the modern "gay identity" is invariably part of HIV discourses. The terminology within this conceptual framework shifts from "gay identity" to gay subjectivities to signify how identity itself is a "mask to

unity" (Dreyfus & Rabinow, 1982). The unity created by the gay identity is the discursive production of a "gay community." This community became the response to HIV and, for a time, HIV became the cohesion that bound together the concept and experience of the gay community.

The collective response to HIV/AIDS prevention produces a dominant discourse of safer sex within the gay men's community. The tension within the subjectivities of gay men is produced through the pleasure associated with and the desire to have bareback sex. Though many gay men engage in bareback sex, often through harm-reduction practices, including relationships, sexual positioning, serosorting and more, for the most part, this practice remains largely silenced within the mainstream gay culture in Nova Scotia. Though the mainstream messaging of safer sex, popularized through community efforts and public health messaging, became part of the dominant discourse, one can observe that a disciplinary society is not synonymous with a disciplined one (Holmes et al., 2006). In other words, though the disciplinary effects are in place to regulate gay men's sexual practice, the result will not be complete compliance with the safer sex mantra.

One participant reveals that HIV-prevention creates resistance; he describes the experience as *ostracizing, ignoring, trivializing, and silencing*. The opposing discourses of HIV-prevention and barebacking illustrate a tension within the experience of gay men. The tension is mostly simply stated as the desire to avoid HIV transmission while engaging in bareback sex. The result of this tension is the unease within the community of gay men and the question as to whether the subjectivities of these gay men are primarily driven by safer sex or by bareback sex. In recent years, bareback sex has also come to represent sexual liberation, which is another aspect of the gay political movement.

The perspectives of some young gay men who have seroconverted were also presented. In their discussion with an outreach worker, many of these men noted that HIV was just part of being gay. This revelation is raised in many of the subsequent discussions regarding barebacking and public health because it suggests that HIV is part of the sexual subjectivities of gay men. In other words, the response to HIV by some gay men is that it is *who we are* and therefore a process of *becoming gay*. Though many gay men would disagree, for some, this is the subject perspective.

Barebacking

The topic of barebacking is explored to further interrogate how the tension between safer sex and anal sex without condoms is addressed in Nova Scotia. At the outset of this part of the research, there emerged the idea that there is a sanctioning of discussion about barebacking within certain circles. What can and cannot be said regarding this topic is relegated to certain spaces, and often these spaces do not include public health.

In recent years, HIV-prevention efforts have moved away from singularly focusing on barebacking toward a holistic approach to gay men's health. The issue that arises, here, is that focusing on gay men as a whole, rather than on the broader determinants of health that influence their health outcomes, infers that there is something wrong with gay men. Barebacking and the prevalence of HIV among gay men are often treated as evidence that gay men have underlying problems that are producing risk behaviours.

Another key finding, here, is that the type of sex gay men have also serves as a mechanism to rank and station them within the broader gay community. There are social repercussions for discussing types of sex, such as barebacking, that fall outside the dominant discourse. In contrast to this, however, is another view that the alternative communities of men who engage in barebacking sometimes serve as the only entry point to learning how to safely use the "ass" in sexual relations among men. The analysis suggests that not only is the effect of the discourse not one-sided, but that the community of men who identify as barebackers may serve to provide a service to men who are entering this community and who are silenced elsewhere. In other words, because there is reticence to talk about anal sex and harm reduction, some men find that barebacking communities are the best entry point for learning how to have gay sex.

The analysis then turns to gay men who are HIV positive and how barebacking represents a shared experience among them. Poz gay men who are engaging in barebacking practices, in some form, often incur stigma because they contracted the virus that makes their sexual practice known. These men are marked as transgressors of the safer-sex and HIV-prevention discourse because of their seroconversion.

Finally, when one activist discusses what barebacking means, he speaks of his frustration with HIV research. He says he cannot know what barebacking means because no one is collecting the information he needs from the gay community. And without evidence-based work, he finds himself unable to devise and implement effective HIV-prevention strategies.

Public Health

Public health efforts are left in a precarious position as the discourse produced from these efforts must interfere with the increasing prevalence and acceptance of a bareback-sex discourse within the gay community. Though this scenario is true for many public health efforts aimed at HIV-prevention and gay men, in Nova Scotia, the history and experience of HIV-prevention is both similar to those elsewhere and unique. One of the key aspects of the local culture has been the dismal response from the formal public health agency. It has only been in recent years, however, that the agency is tasked with delivering prevention programming, and the lack of funding has left most of the efforts to be coordinated and conducted by AIDS Service Organizations (ASOs). One participant suggests that this lack of response to gay men and HIV is simply part of the long-standing *"homophobic discourse."*

The concept of HIV as a "gay disease" is contested both within and outside the gay community. For some activists, gay community ownership of HIV/AIDS is essential to the delivery of effective and meaningful programming for gay men. For a number of years, however, public health funding has focused on mainstreaming HIV and reconceptualising it outside of the gay community to the broader population. The effects of mainstreaming HIV has yet to fully address the underlying stigmatizing effects of living with HIV. It also explains, in part, why the mainstream gay community has distanced itself from the disease. In one instance, when asked whether HIV should, again, be labelled as a gay disease, a participant notes that you're *damned if you do and damned if you don't.*

Finally, the way public health and other officials talk about and reproduce the discourse of HIV has an impact on the way this disease is understood within the gay

community and the broader culture of Nova Scotia. Avoiding candid discussions regarding gay sex and silencing the general topic of sex in terms of it being an *experience* has the effect of producing some discourses and limiting others. Attempting to simply medicalize sex, specifically the language that is permitted in formal settings, including health care, creates an impossible situation for public health and health promotion because pleasure and desire are removed from the sexual *experience*.

Health Promotion

The findings of this study show that health promotion efforts need to bring a critical perspective to HIV-prevention. It is anticipated that this study will contribute to an understanding of how HIV policies and programs become part of the sexual subjectivities of gay men and, in turn, part of their sexual *experience.* The task for health promotion in the field of HIV is to bring forward a critical social-science perspective that disrupts the taken-for-granted beliefs about the gay community and HIV.

Though this research did not set out to create a set of proscriptive recommendations that would, in turn, create a new system of conventionality, the findings can be considered within health policy and program development. I would suggest that our efforts to design and produce HIV prevention and stigma reduction campaigns should be viewed as part of the production of gay men's sexual subjectivities. The effects of seeing HIV messaging this way may not predict the impacts on gay men's understanding of themselves, but it can help to mitigate the domination effects that can occur. It is anticipated that expanding and producing multiple sources of knowledge about gay men can help us understand how we are part of the discursive production. This can be applied

across the domains of HIV prevention stigma reduction efforts to include pubic health, health care providers and others involved in these efforts.

So what is left for a social scientist researching in the field of HIV-prevention and health promotion aimed at gay men? The answer remains as complex as the virus itself. Nevertheless, I offer some thoughts on the how I will proceed in my future work: The truth about gay men's health must be questioned. One of the current directions of HIV-prevention is to address gay men's health overall, with the assumption that by producing a better subject, HIV will diminish. This logic assumes that the object is knowable, that the identity of gay men is inherently flawed, and that the incidence of HIV is evidence of this assumption. By questioning the truth of gay men's health and the fiction of identity, perhaps we can interrupt the assumed fact of the inevitability of HIV infection. The situation must be viewed as a struggle in the strategies that we as gay men constitute and animate, rather than an inherent problem within gay men that must be corrected.

In my view, we must change what it is we are struggling against. As long as safer sex and condom use represent a limiting of pleasure and the suppression of sexual liberation for gay men, it will be the object against which we, as gay men, travail. The questions we are asking about bareback sex and the strategies to change this behaviour must be seen as having constitutive effects. The methods of health promotion and public health used to corral the virus contribute to the production of subject positions. If we are to change the way discourse is shaped and the subject position of gay men is experienced, we must work toward shaping discourses that do not vie for dominance and oppose each other in these strategy games.

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APPENDIX A

PARTICIPANT CONSENT FORM

Health Promotion and Barebacking: A Discourse Analysis of Community Activists Perspectives on HIV Prevention

PRINCIPAL INVESTIGATOR:

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Ph: (902) 494-7809
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STUDY FUNDING PROVIDED BY:

INTRODUCTION

We invite you to take part in a research study being conducted by Matthew Numer, a doctoral candidate in the Interdisciplinary PhD program at Dalhousie University. Dr. Jacqueline Gahagan, a Professor in the School of Health and Human Performance, is supervising the research. Your participation in this study is entirely voluntary and you may withdraw from the study at any time. You are being asked to take part in an interview face-to-face interview. The study is described below and information is provided about the potential risks and discomforts that you might experience. You should discuss any questions or concerns that you have with Matthew Numer, the principal investigator.

PURPOSE OF THE STUDY

The purpose of the proposed study is to gain a better understanding about how HIV prevention strategies influence the overall sexual health of gay men.

WHO CAN PARTICIPATE IN THIS STUDY

You are eligible to participate in this study if you have been an HIV/AIDS activist in Nova Scotia for at least 5 years and are currently working with an organization that deals with HIV/AIDS in some capacity.

STUDY DESIGN

This research study is a qualitative project aimed at investigating the impacts of HIV prevention on gay men's identities and sexual health practices. It is anticipated that approximately 30-40 HIV/AIDS community activists will participate in this study. In general, participants will be asked to describe social and political factors that may influence how HIV prevention is developed and delivered and how this impacts the sexual health of gay men. Once the interviews have taken place, the data will be transcribed verbatim and analyzed by the researcher. The analysis will be focused on the language activists use to describe gay men's sexual practices and including the language that is developed in HIV prevention. The results of this study will seek to inform future HIV prevention policies and programs in Nova Scotia and elsewhere.

WHO WILL BE CONDUCTING THE RESEARCH

Matthew Numer is the Principal Investigator for this study. Dr. Jacqueline Gahagan will oversee the research activities. A thesis committee will guide the research process, and consists of the research supervisor, Dr. Marion Brown, School of Social Work at Dalhousie University, and Dr. Susan Atkinson, Department of Family Medicine at Dalhousie University, and Russell Westhaver in the School of Sociology and Criminology at Saint Mary's University. The Principal Investigators will conduct the interviews, analyze the data, and write research reports (including a thesis). The research supervisor will oversee all of these activities and provide guidance.

WHAT YOU WILL BE ASKED TO DO

As the interview will need to be audio-recorded and transcribed, consenting to be audio-recorded during your interviews is a pre-requisite for participation. However, at any time during the interview, you may request that the audio-recorder be turned off and, if you wish, all data collected during the interview, including hand-written notes and the audio

recording will be destroyed. The individual interview will last approximately 60-90 minutes, and will explore questions regarding your experience and perspectives on HIV prevention in Nova Scotia. At the completion of the interview you will be asked to provide consent for direct quotations from your interview to be used. You are not required to allow the use of direct quotes however, should you give permission all personally identifying information will be removed from the quote and you will not be identified. You will also be provided with an opportunity to identify any information that you disclosed which you do not permit to be directly quoted.

POSSIBLE RISKS AND DISCOMFORTS

It is possible that you may become emotionally or psychologically distressed as a result of participating in this study. Talking about the past and present context of HIV prevention may be uncomfortable. Given this, you do not have to answer any questions that you do not wish to answer. Should you become distressed following the interview the interviewer can arrange for support services to be accessed if the participant deems appropriate. If at any time you feel upset and would like to take a break from the interview, please inform the interviewer.

WITHDRAWAL FROM THE STUDY

There is no pressure to complete the interview and it can be ended at any time at your request. Your participation in this study is completely voluntary and should you decide to not to answer any question(s), or end the interview, you may do so without question or consequence. If you choose to withdraw from the study, all data including the audio recording and any hand-written notes will be destroyed.

POSSIBLE BENEFITS

It is unlikely that you will directly benefit from participating in this study. You may experience a positive outcome from having a non-judgmental and supportive space to discuss your experiences. Your participation may benefit others as the information you provide may help to create new knowledge in relation to HIV prevention and gay men's sexual health. This knowledge may be used to assist health professionals in creating HIV prevention strategies, policies and programs.

COMPENSATION/REIMBURSEMENT

There is no compensation for participation in this study.

CONFIDENTIALITY & ANONYMITY

While full anonymity in this study is not possible, measures will be taken to ensure that you will not be identifiable to others as a participant in this study. In the transcripts, your name will be replaced by a pseudonym and other specific identifiable references such as places of employment will be deleted or changed so that you are not personally identifiable. Moreover, the responses you provide will be kept strictly confidential and in no way will it be possible to link you to your responses. The digital recording of this interview will be transferred to a password protected USB flash drive and downloaded by the transcriptionist onto a password-protected computer. Your name will not be used in any transcripts or reports, including when direct quotations are used. All personally identifying information will be removed from the transcripts, or a pseudonym may be

used. For example, if you mention the name of your family doctor it will be removed from the transcript and may be replaced with “doctor.” Once the document is complete the audio recording will be deleted from the transcriptionist’s computer and a number assigned to the transcript. This number is only used to differentiate between the interviews during data analysis and in no way will it provide a means to link the transcript to you. All transcripts of your interview will be kept in a secure location in a locked office within the School of Health and Human Performance, at Dalhousie University. All materials will be stored for a period of 5 years after publication, at which time they will be destroyed. This consent form, and any other forms that contain personal information such as your name, will be stored in a locked filing cabinet, in a secure office at Dalhousie University. Any forms containing your name will be kept geographically separate from the transcripts and will never be used to identify you.

LIMITS OF CONFIDENTIALITY

During the interview, if you discuss the abuse of someone under the age of 16, or an adult in need of protection, that the interviewer is required by law to report this information to the proper authorities. In this instance, confidentiality will be breached.

QUESTIONS

If you have any questions about this study, its purpose or procedures, please contact the Principal Investigator, at (902) 494-1153 or via email at matthew.numer@dal.ca. You may also contact the research supervisor, Dr. Jacqueline Gahagan, at (902) 494-1155, or via email at Jacqueline.Gahagan@dal.ca

PROBLEMS OR CONCERNS

If you have concerns about any aspect of this study or your involvement, you may contact Catherine Connors, Director of Dalhousie University’s Office of Human Research Ethics Administration at (902) 494-1462, or via email at catherine.connors@dal.ca**. Please note that collect calls are always accepted.**

Participant Consent Form - Signature Page

Health Promotion and Barebacking: A Discourse Analysis of Community Activists Perspectives on HIV Prevention

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However, I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

By signing this form you are agreeing to the following statements.

- I have read and understood this form.
- I understand that my participation is voluntary and that I may withdraw at any time without consequence.
- I consent to be audio-recorded
- I would like to receive a copy of the results of this study.
- I consent to be contacted by the researcher to review key themes from my interview and to provide feedback.

Participant Name:________________________________

Participant Signature:_____________________________ Date:___________________

Interviewer Name:_______________________________

Interviewer Signature:____________________________ Date:_________________

Please provide a mailing address or email address in the space provided below if you would like to receive a copy of the study results, or if you are willing to be contacted to review a summary the key themes from your interview and provide feedback to the principal investigator.

APPENDIX B

Interview Guide

1. How do HIV activists in the gay community talk about HIV prevention and health promotion and public health policies past and present?

   Probes:
   a. How would you describe your experiences in working on HIV prevention in general?
   b. In general, would you describe HIV prevention efforts in NS as positive or negative? How so?

2. How do HIV/AIDS activists who are gay men talk about themselves as participants and recipients of health promotion and/or public health HIV prevention messaging?

   Probes
   a. Can you describe the role of gay men in developing HIV prevention strategies?
   b. Can you describe the any varying viewpoints between public health and community activists?

3. What is the meaning of barebacking and how does it relate to gay men's sexual practice in Nova Scotia?

   Probes
   a. Can you describe how Unprotected Anal Intercourse (UAI) is discussed among public health officials, community activists and other groups?
   b. Can you discuss whether barebacking is viewed as an *identity* (something I am) or a *practice* (something I do)?

4. How do HIV activists talk about the social and political climates of Nova Scotia that influence HIV prevention policies and programs in terms of health promotion and public health?

   Probes
   a. How were policies, programs or other health promotion or public health initiatives influenced by the social or political implications?
   b. Can you describe any instances in which messages were "sanitized" or changed because they were sexually descriptive?

5. How is HIV prevention messaging influence what it means to be a gay man?

   Probes
   a. How is health messaging aimed at HIV prevention viewed in the gay community?

b. How does HIV and gender influence gay identity?
c. How does gender influence roles and sexual expectations among gay men?

APPENDIX C

Transcriptionist Confidentiality Agreement

You have been hired to transcribe interviews for Matthew Numer, Principal Investigator, for the research project at Dalhousie University entitled, *Health Promotion and Barebacking: A Discourse Analysis of Community Activists Perspectives on HIV Prevention.* Given the ethical guidelines of this study, please read and sign the form below, signifying that you are willing to enter into a confidentiality agreement with respect to the data collected in this study.

The audio-recordings may contain personally identifying information about the participant, such as the names participants. You are to remove all identifiers in the transcript in order to protect the confidentiality of the participant. In addition, you will be required to remove all identifying information such as place names, or names of friends, and to provide an appropriate designation. For example, if a specific rural town is named, you would remove it and indicate 'rural area." If transcription occurs outside the School of Health and Human Performance, you will ensure that all records, transcripts, and recordings ne kept confidential (i.e. materials are never left unattended or are secured when not being used). By signing below, you agree not to reveal any information about what is contained on the audio-recordings or in the written transcripts. Furthermore, you agree not to discuss anything regarding the participants or the data collected in this study with anyone other than the Principal Investigator.

If you have any questions or concerns regarding this contract or the confidential nature of this study, please contact the Principal Investigator, Matthew Numer at (902) 494-1153 or via email at matthew.numer@dal.ca.

By signing below you are indicating that you have read and understand the above agreement and that you will follow all of the specified conditions.

Name: ____

Contact Telephone: ___________________________________

Contact E-mail: ______________________________________

Signature: ____

Date: ____