

**CULTURING TALK ABOUT HIV/AIDS IN IRELAND**

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## SUMMARY

This Thesis is concerned with the ways in which discourses about HIV and AIDS are generated in Ireland and how they are cultured within the various practicums in which they are generated. I discuss this in relation to three practicums: the practicum of microbiological science as taught to undergraduate students, the practicum of public health and health promotion, and the practicum of gay men's saunas. I trace the ways in which these practicums are interrelated and how knowledge about HIV and AIDS is generated and given meaning within each practicum and between practicums. Starting with the production of a scientific discourse of HIV and AIDS, I examine the production of epidemiological knowledge through statistical representations of HIV and AIDS in the population, and look at how these statistical representations are used to target strategic interventions among particular groups. I detail the origins of the gay community and their response to AIDS and HIV as well as their relations with government in attempting to introduce HIV prevention strategies among gay men. This includes a discussion of various representations used in HIV prevention materials produced both by the gay community and by the Department of Health and regional Health Boards.

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## Introduction

### White Towels in the Corridors of Possibility

*It is the only lighted doorway you see when you look down this small laneway near the heart of Dublin's Temple Bar area. The light illuminates a sign with the logo and the name of the sauna written across it. As you push through the door, you enter a small vestibule, with a glass-fronted booth, inside which is a friendly boy in a white boilersuit. If you look a little lost or apprehensive, you might be asked if you've ever been here before, and if you're aware that this is a gay sauna. Mind you, most guys know where they are when they get here. You hand over your money and the boy gets you to sign your name on list. Above yours are several other signatures though almost all are blurred and illegible. You might have time to notice in the background a television monitor which shows the views from several cameras both inside and outside the building. You are given a towel and a key on a plastic bracelet on which is printed a number corresponding to the locker you've been allocated, and the boy in the boilersuit buzzes you through a second door into the building. When you've located your locker, you strip off, and bundle your clothes into the locker. Sometimes, a condom is put in the locker for your use, sometimes with a sachet of lubricant. When you're ready, you lock the locker, remove your key, wrap the towel around your waist and set off into the building.*

*This particular building has five floors, and everywhere there are men parading in their towels. Women are excluded from this space, and the assumption is that the men who are here are all here looking for sex. On the ground floor, there are two locker rooms and a brightly-lit coffee bar*

*and lounge area: there are newspapers to read and two television screens to look at, usually showing RTE or MTV. There's even a Playstation in one corner if you're interested, and there's the buzz of quiet conversation between men in towels or between the men and staff members. The next floor up has two toilet cubicles with frosted-glass doors which allow much of what happens within to be observed from outside. In addition to toilets and wash-hand basins, both cubicles are equipped with stainless steel douches, and there are dispensers with sterilising wipes for the toilet seat. There is also a third locker room on this floor. The next floor up is referred to as the "wet floor." Here there is a toilet (with a 'proper' door on it), a stand-up tanning booth, a sauna, a jacuzzi, a steam room, showers and several cubicles. The cubicles contain nothing more than padded benches and an ashtray and bin. One of the things you might notice at this stage is that the lighting changes depending on where you are. The jacuzzi is lit from above with strong lights and, along with the mirroring and the play of light on the foaming water, it has a sense of this being a very public and open space. The cubicles have dimmer switches which allow you to adjust the lighting to suit your own needs. The light in the actual sauna is dim and reddish coming from underneath the benches where guys sit, their towels either discarded or draped anomalously over shoulders or thighs. In the steam room, there is no light other than what comes in through the frosted glass of the door. At one side of the room, there is an opening into an inner area that doesn't benefit from this light at all: this is one of the many darkrooms. Here men stand or walk around in pitch darkness and sex may take place here. On this floor there is a more-or-less constant sound of splashing water, and the patter of wet feet on tiles, or the slap of wet towels on wet flesh, and the loud noise of the jacuzzi's motor. There is also an assortment of smells, from the chlorine of the jacuzzi, to the hot wood smell of the sauna, and the woodgreen liniment smell of the steam room.*

*On the next floor up from this, you notice the light is much dimmer. It's also a lot hotter and has a different set of smells. Here there are more communal showers though more dimly lit than the ones downstairs, and, off the shower area, is a room which, though not completely dark, is used for sexual encounters. Further along is a cruising area: you can walk in a circle around a central block of cubicles with doors on either side of you. Some of the cubicles have the doors shut, and others are open; some are empty, others have guys inside, many with their towels off, groping themselves and looking out the doors for something they might fancy or something that might fancy them, all the time waiting for the moment when their moment comes. Some of these cubicles are equipped with television monitors showing gay porn movies, others have large areas of the wall mirrored, and one (with its own en suite facilities) can be booked. This area is one of the*

*busiest and most popular in the sauna. Eyes and hands are active here. Men make the most of peripheral vision, looking in one direction but watching each other out of the corners of their eyes. There is little in the way of chat amongst cruising men, though you can usually hear the conversations that take place in the cubicles. At the end of one corridor is yet another video monitor showing gay porn movies. There are also floor-to-ceiling mirrors at the ends of two of the corridors, increasing the sense of space and the number of bodies, and allowing for greater surveillance of the parade of passing bodies, your own and others'. The air is full of the smell of bodies, sweat and sex, and also the smell of "poppers", amyl nitrite sniffed out of small brown bottles that causes a rush of blood and which is used to heighten sexual arousal. From all around come the sounds of sexually active bodies, whether from people in cubicles or characters in the videos. The sights and sounds and smells of sex are all around.*

*On the final floor, you reach the apex of this gay sauna. Here, the only light comes from two television screens placed opposite each other, showing gay porn. The lack of light is added to by the black walls and benches, and the heat is often oppressively stifling. Here, through a narrow doorway and round a turn at the end of a short corridor, you find the largest darkroom in the building, almost as big as the cruising area on the floor below. Here you literally cannot see your hand in front of your face, or anyone else's hands, or anything at all. The humid stifling of the air is added to by the rich, thick smell of bodies and poppers, the sounds of breathing and sighing, and the immediacy of groaning, moaning, writhing bodies. You inch your way into the darkness through the bodies of men on all sides and sometimes underfoot. From the moment you enter, other bodies are smelling your body, feeling you, kissing and licking you, groping you. All in complete darkness.*

#### "IN(TER)VENTIONS"

The experience of the so-called 'gay saunas' in Dublin opens up a number of questions which this thesis aims to address. They are sites of interaction of many complex factors and they have recently become the focus of hitherto unknown attention that has opened them up to the gaze of those who never knew such places existed. An important part of this is the issue of identity: not simply the identity of the men themselves, or whether they identify themselves or are identified by others as gay or bisexual or men who have sex with men, but the discursive production of identity through the invention of oppositions and differences which I see as being part of the work of HIV prevention.

This thesis is concerned with the ways in which HIV and AIDS are used to produce discourses of distinction and justifications for particular interventions. I have concentrated my research on three main areas of interest and the relations between these areas. Each of them (microbiology; epidemiology, public health, and gay men's health initiatives; and the saunas themselves) is concerned with HIV and AIDS, and each represents a socially organised reality centred on producing knowledge about HIV and AIDS. These sites are concerned with pedagogy, with learning and teaching, and with the many ways in which we learn and teach:

We wish to think of pedagogy in terms of all the myriad ways in which we learn and are taught to position ourselves within regimes of truth through which we understand our gendered, heterosexualized, racialized and classed world; the punishments for transgressions as well as the rewards for conformity. [Epstein & Sears 1999: 2]

My aim is to examine the particular representations of HIV/AIDS in these different practicums, how these practicums relate to one another, and the uses of representations of HIV and AIDS in generating in(ter)ventions (see Sears 1999).

Emily Martin (1994) uses the word 'practicum' to describe the processes through which configurations or patternings of the world come about:

"Practicums" involve learning about new concepts of the ideal and fit person, often in noninstitutional settings. I mean to imply learning, but learning that is often less formally structured than it would be in a school. As often as not, the practicums that I discuss seem to us already to be an ordinary, mundane part of daily life, not a special exercise in a special class that we attend. Even where practicums are used inside an institution, such as a corporation, the complex combination of physical and psychological experiences evoked often means that the "teachers" are not exactly in control of the outcome. I also mean to imply learning that is embedded in some sort of complex physical-mental experience. [Martin 1994: 15]

Most of the sites I studied were themselves directly involved in training and education, though an important part of many of them was also this "less formally structured" learning which Martin mentions. No-one teaches classes in how to operate within a gay sauna, yet the men who use saunas must learn to use them correctly, most often through observation of others and practice.

My research follows some of the ideas about multi-sited ethnography outlined by George Marcus (1995). Rather than concentrating on an ethnographic study of an individual site concerned with HIV and AIDS, I have attempted to follow the metaphors, stories and contestations around the production of knowledge about HIV and AIDS across several sites. Each of these is both a location (site) in which HIV and AIDS are talked about and in which knowledge about HIV and AIDS is produced, and each has a particular view (sight) of HIV and AIDS, influenced by the particular culture of that site or practicum. My thesis, then, can be seen as a multi-sited, multi-sighted ethnography of HIV and AIDS.

The microbiological site is of interest in that it is the primary site of the production of scientific knowledge about HIV. As a participant-observer, I attended lectures in the various subdisciplines of bacteriology, virology, immunology, and medical microbiology with third year undergraduate students, and also sat in on laboratory practicals in bacteriology (there being no practicals for the other subjects). The principle aim was to observe how HIV is represented at this level, how science operates as a site of knowledge-making, and to attempt to understand the construction of scientific knowledge about HIV. The related discipline of epidemiology provides a link from the microbiological world to the social world, and studying the production of epidemiological statistics on HIV infection in Ireland allowed me to see further how HIV is represented in particular ways, and also how it is used to represent particular people or groups of people in particular ways. These statistics in turn are used as the basis for much of the intervention work which is the aim of public health initiatives. Public health represents an important site of intervention in the health of populations. The ways in which knowledge and information about HIV and AIDS are produced and disseminated for public consumption make this one of the primary sites of representations of HIV and AIDS.

I have focused on gay men's HIV prevention campaigns and their relations to other, more broadly-based public health campaigns for two reasons. One is that Irish statistics on HIV infection and AIDS indicate higher populations of infected among intravenous drug users than gay men. This situation is reproduced in few Western countries (Spain and Italy being the only others in the wider European context) and has resulted in a greater emphasis being placed on service provision for intravenous drug users than gay men. The experience of other countries (for instance the United States, Britain and Australia) is quite the opposite, with much larger populations of gay men than intravenous drug users infected, and thus the emphasis both in the

media and in terms of HIV prevention campaigns has been quite different. In Ireland, the emphasis on intravenous drug users and the provision of information and services for them sidelined the issue of homosexual transmission to some extent, and it is only since 1992 and the publication of the National AIDS Strategy Committee's first report that a concerted effort has been made by the Department of Health, the regional Health Boards and the gay community together to provide services and information for gay men. This partnership was further enhanced in 1996 by the publication of a report which stressed the need for such a concerted effort (see GLEN/Nexus 1996). These more recent and concerted campaigns, though building on previous ones, offer a good insight into the ways in which these three practicum relate to one another. This leads to the second reason for my interest in the gay men's HIV prevention campaigns, which is that, unlike intravenous drug users, gay men are seen to be a community, and much of the effort of HIV prevention has been directed at developing this community. This involves questions of the relations between community and health, which are not quite so apparent in the case of intravenous drug users. Part of this has to do with the particular inscription of gay sexual relations as being a transmission route for HIV infection, and the saunas, which are unique to gay sex, are heavily implicated in such transmission.

Each of these sites is concerned with a type of *invention*, which is not to suggest that they are in some way artificial or inauthentic so much as that they offer a particular view of reality, a type of sight that is particular and peculiar to that site. Microbiological science invents a particular view of nature, one that is brought to light in laboratories through the use of ocular technologies such as petri dish cultures and the microscope, and thereby invents a particular knowledge about the human body and the relation of nature and culture. Public health invents a particular view of social individuals, bringing them to light in health statistics through the use of the ocular technologies of epidemiology, thereby creating a particular knowledge about the relation of the health of individuals and society. Saunas invent a particular view of desire, bringing it to light in commercialised spaces which make sexually available men visible to one another in a knowing and organised way, thereby creating a particular knowledge about the possibility of male sexual relations.

Each of these sites/sights develops its knowledge as inseparable from *intervention*. Microbiological scientific knowledge intervenes to protect culture from inundation by nature; public health intervenes to protect the health of the general population from inundation by disease; and saunas intervene in the mundane reality of the everyday world to provide a relief

from that world in the form of oases of organised sexual possibility. Each represents a carefully managed, constructed, bounded and regulated site/sight, but each also offers itself as being transparent. The 'white coat' of the science laboratory is symbolic of the transparency of science, its objective bias, and its basis in empirical knowledge generated through controlled and repeatable scientific experiments. It also represents the rule-boundedness of science as a practice, with its particular approaches and technologies which have to be inculcated into the prospective scientist. The 'white paper' of public health is symbolic of the best interests of society, formulated on the basis of a proffered ability to see into the health of the population and to organise interventions to protect that health. It is also symbolic of the boundedness of public health policy: that it operates within a certain sphere of influence to regulate the health of the general population. The 'white towel' of the saunas is symbolic of the sexual availability of individual men, hiding the commercial construction of this desire in the appearance of a multiplicity of possibilities available to the men who go there. It is also symbolic of the boundedness of the men in towels: that they are bound by certain regulations, rules, and codes of behaviour which all understand, and on the basis of which the organisation of the saunas is possible.

What is at stake in this is the 'politics of knowledge.' Each of the sites may separate itself through the creation of specific boundaries around its own knowledge production, yet each presupposes the others. The microbiological site would be impossible without epidemiology and public health. It also assumes that its laboratory knowledge can be deployed in assessing and controlling the risk of infection by the virus in places and populations like the saunas. Producing knowledge within the microbiological site, bounded by rules and regulations that control the production of knowledge, presupposes areas in which this knowledge has other meanings. Likewise, epidemiology and public health rely on the knowledge generated at the level of the microbiological site in order to further their own productions of knowledge about disease in the population. The saunas are a site for the understanding of how disease is transmitted and also a site where public health and epidemiology can put their knowledge into effect.

Each of the sites produces knowledge about HIV in different ways and with different uses for that knowledge. Each knowledge is a description of HIV but as Wittgenstein puts it "what we call *"descriptions"* are instruments for particular uses" (Wittgenstein 1967: § 291) and each knowledge about HIV and AIDS has a particular use. The politics of knowledge is about the contestation over these knowledges and these uses:

To engage in the politics of knowledge, individuals and groups must be able to present themselves as credible representatives of social interests and engage in the framing of reality through techniques of representation. They must be able to mobilize a constituency by framing or translating issues and interests in ways that attract adherents. And they must succeed in constructing enabling identities with relatively well-defined boundaries. Different actors will seek to frame AIDS, or construct knowledge, or assert their claims to expertise in quite different ways depending in part on their interests, their social locations, and the organizations to which they belong. By means of these framings, credible knowledge is both assembled and taken apart. [Epstein 1996: 25]

This thesis concerns the ways in which HIV and AIDS are figured in, and are used to figure, these different sites/sights. This figuring concerns both the ways in which HIV and AIDS are represented, and the ways in which they are used to represent. My aim is to examine the discursive nature of HIV/AIDS in each of these areas, but also how HIV/AIDS itself becomes a boundary object, having different uses and significances depending on where and by whom it is employed.

To introduce the thesis and its main points, I wish to explore further the phenomenon of gay saunas in Dublin. The word 'gay' is difficult to apply as an adjective in the case of the saunas, and indeed most other 'gay' venues, since most do not discriminate between gay and non-gay. The saunas themselves have no policies which require proof of gayness for entry; one sauna has a sign inside the door saying "Sauna and Leisure Club for Gay, Bi-Sexual and Other Interesting Men." The difficulty of what exactly 'gay' denotes has cropped up in the course of HIV prevention work over the past decade. Where information could be directed at 'gay' men, it was felt that 'bisexual' men were not 'receptive' to this information because they did not identify themselves *as* (and sometimes did not identify themselves *with*) gay men. Likewise, information which addressed itself to 'gay and bisexual' men was thought to be missing the mark when it came to men who engaged in homosexual activities but who did not see themselves as gay or bisexual. The problem can be seen as one of "interpellation," the way in which an audience feels that a given message is beckoning to them, addressing them directly rather than anyone else. Since there were some men who engaged in homosexual activities but did not appear to be interpellated by messages directed at gay and bisexual men, the term "(other) men who have sex with men" was introduced. It has now become something of an identity category in its own right, with these men being identified as MSMs (Men who have Sex with Men). Despite the fact that both gay and bisexual men are, or can be, men who have sex with men, MSM has become

another category of person. Thus, sexual health information publications, like the Gay Health Network's *Play Safe, Play Sexy* booklet, address themselves to "gay, bisexual and other men who have sex with men" (Gay Health Network 1999). 'Gay' and 'bisexual' must then be seen as having some other common denominator(s) other than simply sex with other men. This can be a matter of identification: that gays and bisexuals identify themselves as such and identify with others of the same kind in communities, social venues, or otherwise, though this is not always the case, as a distinction between 'scene and non-scene gays' (those who participate in the gay social and political 'scene' and those who do not) also exists.

### WHO'S IN THE DARK?

Here, I want to explore some of the complexity of the saunas, their relations between 'inside' and 'outside,' and their social organisation. What goes on in saunas is the object of knowledge for both science and public health, and the saunas represent a point of intervention for both. Knowing what goes on in saunas and attempting to regulate them present certain difficulties for both science and public health. Both science and public health imagine saunas as dark and mysterious places, where sauna-goers engage in dangerous practices that spread disease. The saunas also represent a site for possible intervention. Closing them down might only spread their particular danger elsewhere, to places less susceptible to control. As "learning centres" the saunas provide an opportunity to both science and public health, as well as to the gay community.

Saunas (or "bathhouses" as they are termed in the United States and some other countries) have been the subject of representations by social scientists in recent years (see for example Weinberg & Williams 1975, Delph 1978, and Elwood & Williams 1999). They are an important part of gay community life, and of the history of gay communities and homosexual sex relations (see for example Rumaker 1979, and Chauncey 1994). Dublin saunas have several times been the focus of often lurid reporting in the popular press (as when a priest died of a heart attack in one sauna, and when a fire swept through another), and they remained largely dark and mysterious places until the publication of Karl Hayden's report on the pilot HIV prevention project in saunas in 1998 (Hayden 1998). This report brought the saunas to light as places which were social as well as sexual, sites of desire and potentially of education as well as sites of disease. Foucault claims that

Sexual desire is considered more intense for men and therefore in greater need of release; so, along with brothels, one saw the emergence of baths where men could meet and have sex with each other. The Roman baths were exactly this, a place for *heterosexuals* to engage in sexual acts. [Foucault 1982-3: 15, my emphasis]

The ambiguity of sexuality which is identified by Foucault in claiming that these were places for heterosexuals to engage in sexual acts, touches on the difficulty of identifying saunas as 'gay.' The exclusion of heterosexual sex from saunas does not, necessarily, exclude heterosexual men from being there and engaging in other-than-heterosexual sex. Foucault speaks later of the rushed and anonymous nature of homosexual contacts as being the product of interdiction:

Homosexuals were not allowed to elaborate a system of courtship because the cultural expression necessary for such an elaboration was denied. The wink on the street, the split-second decision to get it on, the speed with which homosexual relations are consummated: all these are products of an interdiction. [ibid.: 18]

Though saunas, in institutionalising and commercialising the opportunities for such unelaborated contacts, may be represented as being the "products of an interdiction" they have continued in popularity despite more liberal attitudes to homosexuality and the lifting of legal interdictions against same-sex relations. Nonetheless, interdictions remain. In a state where Catholicism has dominated as a religion and as a moral code, the Church's continuing interdiction against homosexual practices and inclination is not without influence. Despite this, the number of saunas has grown rather than diminished since the decriminalisation of homosexuality, suggesting that they have less to do with interdiction than with other factors. It may well be, as Gary Dowsett notes in connection with "beats" (public spaces where men engage in sexual activities) in Australia, that saunas,

...are not only sites of endless promise, but also signifiers of and venues for exploring the elsewhere unattainable or unavailable, of pursuing the fantastic. [Dowsett 1996: 147]

This pursuit of the fantastic is an important element in the attraction of the saunas. They offer the possibility of sexual intimacy without social intimacy, the possibility for having one's fantasies fulfilled (in whole or in part), and the possibility of numerous sexual or sensual encounters in a short space of time, but all within a carefully organised and controlled environment. This marks the saunas as different from the 'outside' world, but the world 'inside' the saunas is not one in which the individual can exist indefinitely. Saunas achieve their sense of possibility in relation to,

and against the background of, the mundane world outside (see Delph 1978: 162-3). In this sense, the two are fundamentally linked: the saunas are attractive because they offer possibilities that do not exist outside of them; but the outside is also a relief from the impossibility of only existing in a sensual world.

Important in this is the constant reiteration of the identity (or rather the lack of identity) of the men who go there. In almost every mention of the saunas in gay HIV prevention reports and documents, the fact that many of the men attending saunas do not identify themselves as gay is seen as being important for the progress of HIV prevention. Whilst these documents make clear that there may be complex reasons for this, it is to this non-identification that they constantly draw attention. Perhaps here is the real problem of the saunas: not only is non-identification part of what makes the saunas what they are, but non-identification or ambiguity around identification also threatens the possibility for control. As Bersani (1988) puts it in his essay, "Is the Rectum a Grave?":

Phallocentrism is exactly that: not primarily the denial of power to women (although it has obviously also led to that, everywhere and at all times), but above all the denial of the *value* of powerlessness in both men and women. I don't mean the value of gentleness, or nonaggressiveness, or even of passivity, but rather of a more radical disintegration and humiliation of the self. [Bersani 1988: 217]

If phallocentric control is aimed at denying the value of powerlessness, the saunas allow the opportunity for evading that control, but only within the limited and regulated environment which itself is only a temporary relief from control.

Gay saunas form a significant part of gay life in Dublin. While there are only two gay bars in the city, there are four saunas, and though the saunas (because of size restrictions limiting the number of men who can be accommodated at any one time) may have fewer numbers of visitors than the pubs and clubs, they represent a significant outlet for gay men. The saunas can be represented as "erotic oases" (Delph 1978: 59ff), but as such they are not cut off from the outside world. The worlds 'inside' and 'outside' the saunas are interconnected. The saunas provide a relief from the mundane flatness of the everyday world, and the everyday world provides a backdrop to erotic experience (Delph 1978: 162-3).

In recent years the saunas have become the focus of HIV prevention campaigns, hence my initial interest in them. Compared to ten years ago when there were two small saunas in Dublin, there are now four saunas, with a correspondingly larger and constantly increasing number of men using them than ever before, and a consequent increase in interest in them from public health quarters. This interest has manifested itself in terms of proposals for and reports on HIV prevention initiatives in the saunas, as well as in newspaper reports and sociological studies. These works (and this work also) have attempted in various ways to 'throw some light on' the saunas, or 'to bring to light' aspects of sauna sex. Against this enlightening is the darkness of the saunas. This is not just the physical and literal darkness of the darkrooms as part of the saunas, but the metaphorical and figurative understandings of the dark and of darkness. Just as 'sauna' is a synecdoche for the places which contain not just saunas but other facilities as well, so too the darkness of the darkrooms spreads silently and synecdochically to represent the entire sauna. Darkrooms are common to all the saunas, and, quite possibly, the saunas would not be so attractive without darkrooms or similar spaces. The literal meaning of 'absence of light' which applies to the darkrooms is expanded to the figurative absence of enlightenment, the lack of knowledge, the inability to see or be seen, the obscurity of meaning, and even the religious connotation of being impenetrable to the light of God and therefore sinful, covering the entirety of the sauna. The saunas can thus be represented, for instance, as 'pits of disease,' as dark, mysterious, and dangerous places.

The account I have given is of one particular sauna, probably the most popular in Dublin. The other three have many of the same features but also differ significantly. All have locker rooms, showers, toilets, saunas or steam rooms, video rooms, dark rooms, and cubicles. One of the others also has a "dungeon" with cubicles equipped with harnesses and slings. This sauna also has a maze, a room with mirrored walls and ceiling, and cubicles with 'glory holes' (holes cut in the walls allowing for the penis to be pushed through from one cubicle into another yet ensuring that neither occupant can see the other). It also hosts "fetish nights" twice a month, intended for those who wish to wear something other than a towel. This sauna also tends to show videos which are oriented towards fetish: videos showing leather, combat, and rubber wear, with SM action scenes. Another sauna also has a cinema which is open to non-sauna goers. All the saunas have attachments to other businesses, ranging from shops and pubs to bed and breakfast accomodation.

There is also an important relation between location and clientele. Two of the saunas are located on the north side of the river Liffey, and two on the south side. One of the northside saunas is

attached to a pub which has a reputation for rougher elements, men and women who, by and large, are from the northside of the city, speak with strong Dublin accents, dress in tracksuits and trainers with a penchant for heavy gold jewellery. The associated sauna tends to attract a similar clientele, and, as it is located on the quays and not far from the Phoenix Park (one of the main public cruising areas), also has a reputation for being frequented by prostitutes. The biggest sauna is located on the southside of the river near the heart of Temple Bar, and attracts a more middle class, southside clientele, as well as visitors. This kind of class and background distinction is visible also in the two gay bars in Dublin. The one on the northside caters mainly for “tracksuits” while the one on the southside has a strict “no sportswear” dress policy. This is ostensibly meant to refer to sports footwear but implicitly is aimed at excluding the stereotypical northsider. There are also differences in the size of the saunas and the cost of admission which also have a bearing on who goes there and why.

### WHAT GOES ON IN THE DARK?

So why do men go to gay saunas? The facilities provided (sauna, jacuzzi, steam room and so on) are not merely a ‘front’ for sexual encounters: these facilities are used and may be an important factor in why men go there. Staff from gay bars and clubs often use the saunas’ facilities before or after work to relax and refresh themselves, getting in free or at discounted rates. Office workers make use of the lunchtime opening hours and early evening, and particular days (like pension or dole days) bring an influx of associated clientele. Others may make use of the saunas as a place to go for remunerated sex, either meeting clients elsewhere and going to the sauna for sex, or cruising the saunas for paying clients. The latter practice is particularly frowned upon by the management of saunas, as, on the one hand, a harassment of clients, and, on the other hand, as putting the saunas themselves at risk of being identified as brothels. Especially at weekends, the saunas provide a cheap alternative to rented accommodation in the city centre, though again this is not liked by management. Cubicles often carry signs reading “Cubicles are for cruising not for snoozing,” or “These cubicles are checked every hour on the hour” in an attempt to dissuade people from using them for sleep. The fact that most of the saunas also have food and non-alcoholic beverages available is a further attraction to overnighters, as well as other men who might have been drinking and who wish to drive home, or who have been clubbing and who want somewhere to relax or chill out before heading for home.

Perhaps the most significant factor in why men go there has to do with the lack of identification. You do not have to be gay to go there. You do not need to identify yourself as gay in order to go there. The one question you are least likely to hear asked is "Are you gay?" This adds to the sense of saunas as 'safe' places to go. They are usually discrete from the outside, offering little indication of what is inside. Some of the men I spoke to cited this and/or a contempt for explicitly gay venues as the main reason they liked saunas. Many of what used to be strictly gay pubs and clubs have now become more mixed but this has not happened in the saunas. That makes them attractive for men who want to associate only with other men who are interested in men. The lack of identification extends to other areas as well. Once inside, it matters little what or who you are outside. Most of the external material markers of social standing or relations are left behind in the locker. The towel then becomes a universalising uniform and the darkness of dark rooms can hide a multiplicity of other markers such as age, weight and good looks, the very things that often count most in social interactions in pubs and clubs. That said, the bodies in saunas are 'whole' bodies. Since most of them involve stairs and narrow spaces, it would be difficult for persons with disability to maneuver, and the architecture largely precludes this.

The saunas have also generated no small amount of sex tourism in Dublin. Their central locations, long opening hours (well after most pubs and clubs have closed for the night), relative cheapness and comfort, all make them attractive to the visitor. The fact that there are no saunas in Northern Ireland and that the journey south by train or car is quite cheap makes the saunas and other gay venues attractive to visitors from the north. Visitors to England (in particular, to Manchester and London) have told me that the saunas there are nothing like the ones here. In England there are rules prohibiting sexual acts in cubicles, and the saunas are sometimes subject to police raids. One friend told me that he visited two different saunas in London and found that one showed only softcore porn videos and the other no videos at all. The relative ease of travel to Dublin from England, good currency exchange rates, common language, the frequency of rugby and other sporting events, are also factors in attracting large numbers of English visitors. Most of the saunas are regular advertisers in the Irish gay community press, but some also advertise in national evening newspapers and in other publications such as *Buy and Sell* and *In Dublin* which have a wide circulation in the country. There is one sauna in Cork, but otherwise there are none on the rest of the island outside of Dublin, and again this gives rise to large numbers of non-Dublin visitors, especially on long-weekends or occasions like gay Pride or Mardi Gras.

Dublin Mardi Gras was organised by the gay business community and took place on weekends when there was a bank holiday in England. Modeled on Manchester Mardi Gras, the first Dublin Mardi Gras welcomed people to “the first non-stop, party kickin’, fairy flirtin’, macho movin’, dance and groovin’, easy steamin’ (what?/party/celebration?) in this the fair city.” Out of twenty-nine ‘events’ listed in the first year’s programme, thirteen took place in saunas, with one sauna offering “free shots all day” on three of the five days of Mardi Gras. Funds raised during Mardi Gras were distributed to various charities, principally AIDS charities, and the programme leaflet carried information numbers for various helplines and STD clinics as well as information on safe sex. That Mardi Gras was a tourist event is clear from its being advertised in the English gay press, being run on an English bank holiday weekend and even from the “End of Mardi Gras pre-flight drinks party” event held at one venue on the last day of Mardi Gras. The prospect of an influx of tourists from outside Ireland also drew hopeful Irish men to Dublin, and the same thing can be seen on weekends of international rugby or soccer games. On the Sunday afternoon of one such rugby-international weekend, I overheard one Irish man complain to a staff member in one of the saunas that “there weren’t half enough French over for the game” and that he had yet to shag one.

“Shagging” is not the only thing that men go to saunas to do. Whilst the “trading off of sperm” (Michaels 1997: 57) might be of interest to many when they go there, it is not always the only interest, and is not always or necessarily achievable. As I have already noted, the saunas have coffee/juice bars which are a favourite place for men to gather to chat or watch some (non-porn) television. Much of the conversation is between clients and staff and often concerns non-sexual matters, often prompted by items on television. I have met some men who find this homosocial atmosphere particularly pleasant, often favourably comparing its relative peacefulness with the noise, smokiness and crowded atmosphere of pubs and clubs. In most saunas, you will not be served at the coffee bar unless you are wearing your towel, or are dressed and about to leave. Beyond this level of homosociality, there is also a level of homoeroticism which does not always or necessarily lead to sexual engagement with another man. Some guys I met came in to saunas after work or after a few pints in order to watch porn videos (to which they did not otherwise have access) or just to look at other men walking about half-naked or having sex with each other without becoming involved themselves.

Undoubtedly, these men are a minority, and most men go to saunas looking for sex. Yet the kind and extent of the sex is as varied as the men who go there. I recall one man who walked around

one of the saunas one night, naked except for a towel over his shoulders and a pair of brand-new trainers, who was looking for other men to masturbate and ejaculate on his trainers. In one of the saunas there is a semi-dark darkroom which is popular with men who like to masturbate whilst watching other men having sex. This sometimes turns into mutual masturbation with another or others. Some men cultivate a somewhat disengaged demeanour, not cruising around but often sitting in a particular place and inviting other men to come to them. This disengagement often extends to the kind of sex they are seeking: usually, they are looking for another man to give them oral sex or to masturbate them but nothing more than that. One guy, who happened to have a rather large erection, had several men queuing up to fellate him, and gave each guy a minute or two of sucking before pushing him away and allowing the next in line to go down on him. Many acts of sex take place in the semi-dark of the sauna or steam-room, but it is rare for men to engage in penetrative sex in such “public” areas. This is usually reserved for the darkrooms or the cubicles, though on busy nights (when finding a free cubicle at the right time can be difficult) men will get it on almost anywhere. There is little doubt that unsafe sex also happens in saunas, though the extent or type of unsafe sex is not at all clear, and beyond that lies the question of why men have unsafe sex. Referring to studies which showed that a majority of men practiced *safe* sex in bathhouses, Elwood and Williams go on to say

While these studies demonstrate that men who frequent bathhouses do engage in sexual behaviors that carry a risk of HIV infection, nevertheless, they do not illuminate why risky sexual activities transpire or are avoided in this setting. The perceptions of bathhouses as sexual settings by the men who frequent them largely determines the behaviors in which these men engage. As a specific setting, a bathhouse has its own socially constructed rules of conduct that directly influence the behavior that occurs. Thus, the physical environment of bathhouses, the meanings patrons attach to the establishments and the sexual behaviors that occur there, and the behavioral expectations of patrons all influence an individual’s behavior while in a bathhouse. [Elwood & Williams 1998: 26]

Knowing that unsafe sex happens and that infection comes from the saunas is only the beginning of understanding what goes on in them.

This understanding of “public” and “private” space is important in sauna life. Irish saunas tend to be relatively modest. I have heard of saunas in America and in England where it would be considered strange for a man to walk about with his towel on, but in Dublin (with the exclusion of the “fetish nights” in one particular sauna) wearing your towel whilst cruising around is the general rule. A guy who walks around without a towel on is likely to attract few if any other men

and is more likely to be frowned upon. Likewise, “publicly” displaying an erection is unlikely to gain interest, though revealing an erection in the sauna or steam room (both of which are dimly lit) is often a sure come-on to someone else. As I have noted, acts of penetrative sex tend to be reserved for “behind closed doors” or for the darkrooms, but even mutual masturbation tends to be done furtively under towels unless in the security of the dark or dimly lit areas.

A sense of security is an important factor in understanding saunas. On the one hand, they are safe spaces, safe from the deprecations of a homophobic world, safe from harassment by the Garda, safe from public gaze, and safe from the violence or threat of violence which many of the men perceive as being associated with other public cruising areas such as parks and public toilets. I was present on one occasion when, at about three o’clock in the morning, two Gardai came in the front door of one of the saunas. They had seen a man coming in and wanted to know what the place was. The staff member on duty told them it was a sauna and fitness centre, and, in response to further questioning, said there was no drink on sale there. The Gardai left within a minute and never entered further into the building than the front lobby. Staff are also usually careful to screen men coming into the sauna. If they do not recognise the man as a regular, they will often ask them if they have ever been there before and if they are aware that this is a gay sauna. Anything other than a straightforward ‘yes’ will raise suspicion. Also, staff are wary of groups of men entering the sauna together, and do not allow in men who clearly have too much drink taken. They also try to ensure that the premises are not being used by prostitutes.

If, in this sense, the saunas offer a space free from unwonted intrusion, they also offer a space that preserves the individual’s life from intrusion. Encounters in saunas happen, as it were, on neutral ground. Neither participant has to allow or accept the other’s intrusion into his personal life. He does not have to bring the other into his car or home, or reveal anything of his social position or circumstances, unless he chooses to do so. This darkening or obscuring of self can be seen as being a self-protective mechanism, maintaining a certain social distance in the moment of greatest physical intimacy. As I have already mentioned, these spaces are also free from any requirement to reveal personal social arrangements. Men who come here may be married and have otherwise heterosexual lifestyles in the outside world, but do not have to reveal any of this to the men they encounter in the sauna. They may be gay and have partners outside, but again this does not have to be revealed. Who these men are in the world outside does not necessarily form part of who they are while they are in the saunas, and this is a kind of safety that is often particularly appealing. From another perspective, the saunas offer a kind of safety to the Garda: whatever the

Garda know about what goes on in saunas, they are obviously not unaware of them, and possibly tolerate them as offering men an alternative to cruising public spaces like toilets and parks where the men will cause public nuisance. That the saunas are outside the public gaze makes them tolerable for the Garda.

The saunas offer other comforts and safeties too. Clients do not have to bring anything with them that might identify them as sauna users. Unlike someone using a gym, clients do not need to bring towels or other clothing or equipment with them to the sauna. They do not need to bring condoms or lubricant, or even soap or shower gel, since all this is provided by the sauna. There are no membership cards, and complimentary admission passes often given out to regulars carry no information other than the name and address of the sauna, making them quite innocuous. Some of the saunas run customer loyalty schemes, but often these involve a customer loyalty number which is given at the front desk rather than a card or any other identification. Most of the saunas have video surveillance inside and outside the building which also adds to a sense of security. There is also the comfort of having facilities like showers, toilets, cubicles and coffee bars available, as well as condoms and lubricant. The different spaces available in the saunas allow men to decide where and with whom they want to have sex, unlike cruising parks or toilets where no such security is available. If men want to have sex in private or semi-publicly, if they want to be voyeurs or exhibitionists, all these possibilities are available to them in saunas. Given the relatively long opening hours (on average, saunas are open from one o'clock in the afternoon until three or four in the morning, with longer hours at weekends) men can also choose when they want to go. Unlike pubs, which usually open at lunchtime and close at half past eleven (or later if they have licence extensions), and dance clubs, which do not usually open until eleven or twelve at night and close around two or half past two in the morning, the saunas are regularly open fourteen or fifteen hours a day and sometimes even twenty-four hours a day at weekends.

These long opening hours mean that the saunas are available to different groups of clientele who can fit the saunas into their schedules, so that the saunas clearly have "temporal peaks of activity" (Delph 1978: 64), particular times when they are more active than others, or when particular types of clients predominate. There are some who go there at lunchtime or early afternoon, but who would not normally go there later in the day or at night. Office workers and professionals who are in the city during the day but who might live in the suburbs can thus avail of the saunas without breaking a routine or having to be in the city late at night. There are also various 'times' within the saunas. Men who go there before pub closing time will often be waiting to see who

comes in after the pubs close. Likewise, the early hours of the morning bring an influx of men who have been at dance clubs, but between then and lunchtime that day there are unlikely to be many more new entrants. These different waves of men at different times often reflect other factors. The younger guys will probably go to both the pubs and clubs, and therefore do not tend to show up in the saunas early in the night. Older men who are less interested in dance clubs will turn up mostly when the pubs close. Some men (young and old) prefer to go on days or nights when the saunas are less crowded, avoiding Thursday, Friday and Saturday nights. Sunday afternoon and evening are popular with regulars, and it is often on Sundays that free passes are given out to these regulars, so they get in free again on Monday or Tuesday.

### POSSIBILITY IN THE DARK

Timing, timeliness and timelessness are also features of the saunas. In the effort to get off with another man, timing is of importance. If you have not gotten off with someone by the time the last wave of men has arrived in from the clubs, then you are unlikely to get off with anyone that night. Chances are that the guy you want to get off with is also looking for someone, and you have to try and get to him before he finds or is found by someone else. You might well be attracted to a particular man, but if he is seen emerging from a cubicle (indicating that perhaps he has just had sex with someone else) then you may be less interested: even if he were available to you, it would now be 'after' someone else. I have been told that men often look at things like towels as indicators of previous sexual encounters. If a man is seen walking around in a wet towel, chances are he has just had a shower after sex and is therefore less interesting. Most men make it their business not to walk around in wet towels anyway, as fresh ones are always available from the staff, and certainly this idea of not looking as if you have just had sex or a shower is important to some of the men at least. Likewise the timing of arrival is important: whilst it might seem desirable to arrive when the sauna is already crowded, it is not an effective strategy for most regular users as they know that there will be less chance of finding an empty cubicle to use for a sexual encounter. There is nothing worse in a sauna than finding and successfully attracting the guy you want and then having to walk all over the building looking for an empty cubicle and not finding one. Cruising itself is one of the major attractions of the saunas and is largely a matter of timing: placing yourself in the right place at the right time to 'encounter' the guy you want so that you can make your approach to him, or wait for him to make some advance towards you. This is often a careful choreography of time and space on which the sexual encounter to follow will depend, and this choreography involves many elements of the saunas. Speaking about

homosexual sex in public areas in Australia, Gary Dowsett describes this choreography as an important part of sexual skilling:

The sexual *skilling* that occurs in such encounters starts with the sex acts themselves. It is about the physical possibilities of the body; what hands, mouths, penises, and anuses can achieve. A second level of skilling occurs in learning the *choreography* of sexual encounters. By choreography is meant the subtle and nuanced movement of bodies in sexual encounters: the stalking of partners, the shifting of attention from the general possibility of sex to the specific opportunity for sex, the inviting glance, the suggestive movements of bodies, the first contact, the sequencing of exploring bodies, and so on. Beyond those sensate discoveries it involves a familiarity with the context, the local sexual economy; a recognition of sites for sex as being not limited to their defined purposes and subject to certain rules of conduct. [Dowsett 1996: 143-4]

The repeated episodal nature of many of the encounters also produces a kind of timelessness. For those men who are interested in multiple encounters, the time between episodes of sex have a kind of presentness. Both the last sexual encounter and the next one to come are “not now” and this moment in time is an often frantic search for another moment. These men cruise around out of time, waiting for the moment when their moment comes. There may be a desire to prolong encounters just in order to avoid these interregnums of presentness. The saunas are not without clocks that tell real time, but these are often used to calculate periods of interest: how long since your last encounter, how long to the next expected influx of men from pubs or clubs, how long before you must leave or before the sauna closes. On a simple level, the idea that time flies when you’re having fun and drags when you are not also applies here. The time when you might have to sit and watch videos or drink coffee waiting for someone interesting to turn up may seem to drag endlessly, like that period in early morning when most of the cubicles are busy and there are few men cruising, and you have not yet found anyone (or are unlikely to find anyone) and yet it is still too early to leave. There is often that feeling of having to stay to get your money’s worth, whatever that might mean, and the reluctance to leave until you have exhausted every last possibility of getting that. In that situation, it often seems as if it is too early to leave. This is particularly noticeable in the later hours, about two or two and a half hours before closing: everything starts to get a little more desperate. Delph notices something similar in relation to gay bars :

If cruising is unsuccessful during the evening, closing hour’s pressures bring home the real possibility of leaving alone (a dramatic loss of status). As the hour

hurries on, movement throughout the bar increases. Visual dialogues become aggressive, almost hostile. "Wanting hours" often result in hastily arranged matches, or intensifying levels of tension. All is lost, however, when white lights blaze on and reveal the "nakedness" of the individual. Tired red eyes, haggard from drinking and irritated from smoke, look about at glaring reality. Flooded out, erotic contours collapse. The clientele rapidly fade away. [Delph 1978: 127]

The constant muzak also adds a sense of timelessness. Though the type of music might change during the night, it continues relentlessly and is often used by staff to ensure that people do not fall asleep in the cubicles. This often means playing loud, fast, repetitive dance music early in the mornings, just at the time when men might be likely to be dozing off in the cubicles. Sleep deprivation (especially after a night of drinking and dancing) can have strange effects on one's sense of time. Likewise, the lighting is maintained until closing time, so that there is no sense of whether it's day or night outside. Only at closing time are the lights turned on fully and the building itself takes on a different aspect, one that is no longer conducive to sexual encounter. As Delph notes, the white lights bring with them a glaring reality, and the sauna seems, as Tóibín (1978: 98) puts it, "forlorn, full of dead energy":

Sometimes during the day I experienced a pressing need to go to the sauna. As soon as I woke I felt a fierce sexual compulsion. And once I began to think about it I knew that I would soon sneak into the other world and I would find moments of pure satisfaction there. I lay in bed saving myself up for what was to come. The sauna opened at one o'clock. But I waited. I was never the first there. I would not have liked that: empty, the place would have seemed forlorn, full of dead energy. Others always beat me to it, people, maybe, whose needs were greater than mine, or who had a shorter break from work. By one thirty or two, there were enough men wearing towels around their waists and a look of studied nonchalance on their faces to fill those corridors with possibility.  
[Tóibín 1997: 98]

I have already mentioned some of the factors involved in sexual encounters as a choreography of time and space. Most encounters are initiated without verbal communication, and silence is generally the rule within the saunas. This does not mean that there is no talking, or that talking is always frowned on, but rather that silence is part of the safety I have already mentioned, part of the ability to preserve yourself from the intrusion of others at the same time as one is closest and most personal with them. The coffee bars are the usual sites of conversations, often between clients and staff. Especially with regulars, staff, who have to survive the long hours too, are often happy to pass the time in conversation. Elsewhere, where sexual encounters have been initiated and conducted without verbal communication, it is the moment when the sexual encounter seems

at an end that men will ask each others' names and perhaps generate some more social relation, even if only fleetingly. Some of the men I spoke to enjoyed the general silence of these encounters but said they liked to talk afterwards, and one guy said he thought it would be bad manners to have sex with a guy and not at least ask his name afterwards. There may be perfectly good reasons for this silence: as Dowsett notes in his discussion of casual sexual relations, "Talking can be so dangerous: it jeopardizes anonymity, it beckons intimacy" (Dowsett 1996: 123). Though Dowsett is referring to casual sex in general, and not specifically to sauna sex, there may still be important elements in what he says that have meaning within the saunas:

This so-called anonymous or impersonal sex is anything but emotionally cold and un-involving. The sexual satisfaction is not simply a direct product of orgasm, although that counts for a fair bit. Such encounters are sexually fulfilling for both partners. Each is sexually validated by their success in performing well physically and emotionally. The moment is a highly charged one, and the elaboration of the ritual carefully draws on previous experiences and recognized processes and elements. But the frisson derives from the overall event not just the sex. The possibility of such complex satisfactions becomes a central feature of such sexual adventuring. [ibid.: 146]

Even at this stage, preserving oneself from the intrusions of others is not entirely done away with. Some of the regulars have names by which they call themselves and by which they are known in the saunas which are not their real names. In this way, the line between inside and outside can be preserved without offensively refusing to tell someone your name.

Negotiation within the sexual encounter often preserves this literal silence whilst at the same time ensuring that individuals achieve the sexual experience they want. Weinberg and Williams see this as a form of experimentation, governed by certain rules:

A rule of experimentation exists whereby one partner explores the other with his fingers, which the latter removes from those areas he does not want stimulated or penetrated. We have also observed one partner's attempting to motion the other into a particular position, as well as mutual repositioning. Communication is usually restricted to body language, especially in the orgy room, where talking is uncommon. In the private rooms, a limited amount of talking is more likely, and sexual requests are sometimes verbalized. [Weinberg & Williams 1975: 130]

Offensiveness is carefully avoided in the communication between prospective sexual partners. Unlike pubs and clubs, the extent of the investment in an approach and initial come on is minimal. If you see someone you want to get off with, the choreography can be as simple or as

extensive as you wish. It might range from holding a stare, to winking, to casting your eyes in the direction of an empty cubicle. It might involve a physical gesture, from 'accidentally' brushing against a man to deliberately touching him. Often these things are done in such a way that neither man can take offence. If the chasing guy does not find his gesture reciprocated in some way, he has made little investment and may give up chasing that particular guy and divert his attention to another. Rejecting the advances of another is also simple, either by ignoring the proffered gesture, or by offering a gesture to indicate disinterest. Rarely does anyone have to exchange words in the way one might in a club or pub. Men generally cruise around saunas singly, so the chaser is not intruding between the desired man and his mates, and is not going to be embarrassed in front of the desired man or his mates. On occasion I have seen painful rejections, sometimes without a word and sometimes with quite final words, but the general principle of ease of encounter and ease of rejection or acceptance remains one of the features of sauna sex. How this is learnt is difficult to say. My own first time in a sauna was with a friend of mine as guide, and what concerned me most was how I would reject unwonted advances (!). My friend, who had been to the saunas regularly, said "Just make it clear you're not interested, and do it nicely."

Rejection required no elaborate excuses or deceptions: a simple "Sorry" would suffice if anything needed to be said. Observing how others did this helped, and only a few times did I ever have to resort to the most offensive rejections which involved saying to someone very loudly that I was not interested. This was only ever with really insistent chasers, and was less an attempt by me to make it clear I was not interested, than to embarrass them sufficiently to stay away. For the most part, it is easy enough to tell when someone, at a distance, is expressing interest, and avoiding that person makes it clear that you are not interested. As Weinberg and Williams note,

Abrasive interaction is often experienced as demoralizing or degrading. Thus, ideal conditions include a genial atmosphere – e.g., the masking of rejection, and nonabrasiveness in the solicitation, acceptance/nonacceptance, sexual process, and departure. [Weinberg & Williams 1975: 126]

The saunas offer a carefully constructed social reality, bounded by rules and regulations, and by a constructed difference between 'inside' and 'outside,' which creates the possibility for sexual encounters with minimal risk of social embarrassment. This "known, shared, and organized reality" (ibid.: 130) is identified by Weinberg and Williams as one of the most important features of the saunas. Rejection at a distance is easier and to some extent less painful than rejection after a long chase. As much as anything else, the choreography of sexual encounter is a matter of

investment: you put time and effort into getting what you want, and the earlier the rejection the less time and energy is wasted. This is not to say that casual sex in saunas is without risks: having one's sexual desire acknowledged by others is important, and rejection can be painful. Each approach is a careful coordination to ensure that such risk and such pain are minimised, and this minimisation is part of the choreography of sexual encounters (see Dowsett 1996: 147-8).

### ACCOUTREMENTS OF THE SAUNA

There is no communication code in saunas comparable to say the 'handkerchief code' which was popular in seventies America. Where you wear your locker key and how you wear your towel may provide information for the knowing but are not generally known 'codes' and so are likely to be missed. Simpler inferences can be drawn from how a towel is worn, however. Usually, the towel is tied such that the opening is to the front, but having the opening to the back may convey information about sexual preferences. The towels in most saunas are wide enough so that when wrapped around the waist they hang to about the knee, but some men will double the towel over so that it just covers the backside and crotch, thus allowing greater ease of access to these areas of the body. Towels can be used either to disguise an erection or to accentuate one, depending on the desired effect. As I have already noted, wearing a towel is practically *de rigueur* in Dublin saunas, and those who choose to carry the towel in their hands or drape it over their shoulders when cruising the sauna are often considered to be somewhat desperate. The towel makes for some element of discretion which, when flaunted, is looked on askance. There are, of course, places and times when the towel must be removed. Using showers or jacuzzis requires the removal of the towel, and even using the sauna or steam rooms allows for the acceptable removal of the towel, or its being draped revealingly over thighs. Some men sit with the towel under them in the saunas. Towels also usually come off for sexual encounters, though sometimes in more public areas men will masturbate one another under their towels rather than lose them altogether.

Towels, then, can serve a number of purposes within the sauna. They are uniform dress but how they are worn can be significant. They are used to dry off after showers, jacuzzi, sauna and steam room, but are also used to mop up ejaculate, clean lube and anything else off penis or anus after sex and to dry off sweat. Having a clean towel on is often important and fresh ones are always available from the staff. Maintaining this supply of freshly laundered towels, particularly on weekend nights when the saunas are particularly busy, is one of the larger expenses of sauna owners, and managing towels within the sauna is one of the main tasks of the staff. Bins are

provided in locker rooms and elsewhere for discarded towels, and staff regularly check the building to pick up towels that are discarded elsewhere. Towels can sometimes be badly soiled and staff usually handle them with care wearing rubber gloves. This is an acknowledgment of the towels as being fomites, as instrumental in the spread of disease. Towels soiled by blood or sweat or semen pose their own threat, but towels can also carry body and pubic lice and scabies, though in saunas these are more likely to be transmitted from one man to another through close physical contact. Ideas about the proximity and spread of disease vary from man to man in saunas. One man I met told me he never used the bars of soap provided in the showers and always used the soap dispensers as the soap-bars could carry disease from one person to another.

Shower, sauna and locker room scenes are often a feature of gay porn videos making these videos somewhat reflexive when viewed in the sauna environment. In one, a younger man and a somewhat older man are sitting opposite each other in a steam room. The older man asks the younger "Even suck on a big ole cock?" to which the younger man replies "Yeah, sure, hasn't everyone?" "Well, why don't you come over here, get on your knees and suck my big cock?" and the sex starts accompanied by monotonous electronic music and inane dialogue ("Yeah, suck my big cock; yeah, lick those balls; yeah, fuck my ass" and so on). The men in the videos (by and large) have one thing in common with the men in the saunas who watch them: rarely is the word 'gay' (or worse, homosexual) mentioned. The men in the videos are not presented as gay or homosexual or heterosexual or anything else. They are simply men who have sex with men. Likewise, there is never any mention of disease or illness in videos. All the men are presented as whole and healthy, usually young, tanned and well built, though some video production companies specialise in 'alternative' videos depicting hairier men, shaved men, and younger or older men, as well as different types of sex. I have already mentioned one sauna which hosts "fetish" nights intended for men who are interested in costumed sex (wearing leather, rubber, jock straps, speedos and so on) and this sauna usually shows videos featuring this kind of costume sex, with SM scenes in which men are bound or gagged or whipped or engage in acts with urine and faeces. Stock props in such videos are leather harnesses, chains, jock straps, dildoes, and other tools of the trade. Other saunas show more typically American and European porn, largely with white models and less exotic sexual practices.

Managing the videos is again an important part of the saunas. The video tapes are often three-hour tapes with two or maybe three separate videos on them. This means they only have to be changed every three hours rather than every hour or hour and twenty minutes. It also means that,

in the re-recording process to produce these three hour versions, some of the notices placed by the video companies are omitted. Apart from the notices which warn about illegal duplication and public performance, both of which rules are being breached already, there are often other notices. On American videos, there are notices about compliance with age regulations (“proof on file” notices which state that all the models are over eighteen years of age and that proof of age is held on file at the offices of the production company). There are also notices to say that the videos comply with regulations requiring the use of condoms in porn videos: these require stating when the videos were made and notice that the productions after a certain date comply with the condom regulations. Sometimes there is also a ‘fantasy’ notice, like the following:

The following video fantasy is being presented as a viable alternative to actual sexual contact with another person(s). This is presented solely as a visual fantasy. Some of the precautions taken by the producers in the preparation of this visual fantasy may have been omitted for editorial considerations but have been used continuously throughout the production of this video.

The role of fantasy in the meanings which sauna goers attach to the saunas and to sex in the saunas is important. For Elwood and Williams (1998), the saunas might be used in the sense advocated by the fantasy statement above: that is, that men could use them as a performance stage:

...the fantasy aspect of men who frequent bathhouses merits additional study. Although this meaning of the bathhouse setting was not expressed by many of the men we interviewed, it does perhaps contain an avenue for effective HIV intervention...Teaching men that bathhouses can be used as stages for safe sexual behaviors could serve to reduce the risk of HIV infection. Furthermore, such safer sexual behaviors as performance may fit with a consumeristic view of sex, where the emphasis is on sexual fulfillment and not intimacy. [Elwood & Williams 1998: 41-2]

This goes beyond the fantasy elements of the porn videos to the kinds of sexual fantasies which may accompany sexual relations in dark rooms. The extent to which such videos influence or direct the behaviour of men in saunas would be difficult to determine. What is clear is that videos are important, even if only as something to do or somewhere for men to congregate while waiting for sexual encounters. This is evidenced by the annoyance of most clients when the video tapes finish and are not replaced or replayed quickly by the staff. Clients, especially regulars, have no hesitation in complaining about the lack of videos, the repetition of the same videos all the time, or even the playing of the same videos on two channels at once, since most saunas have two

video channels so there are alternative videos available at the same time. On week nights when trade might be slow, I have heard regular clients request certain video favourites, and the staff themselves often put on the videos they like best rather than showing random videos. Watching videos provide a temporary respite from cruising but also facilitate cruising and contact between men, as well as being instrumental in sexual arousal for many men. Almost certainly, the saunas would not function in quite the same way nor would they be so attractive without the videos. At least one sauna showed “safer sex” videos, produced by groups concerned about transmission of HIV, which depict safer sex practices explicitly (that is, both explicit sex, and explicit presentation of wearing and use of condoms and lube).

Condoms and water-based lubricant are usually distributed through the lockers, so that each client finds one condom and one sachet of lube in his locker on arrival. If a client requires more than that during his stay in the sauna, these are available on request from the staff. The provision of condoms and lube is an acknowledgement that sex does take place on the premises, but is also an attempt to regulate that sex. They are appropriate to the saunas in a way that would be totally inappropriate, for instance, in a regular sauna or fitness centre where sex is not part of what is on offer. This kind of regulation is an improvement in terms of access to condoms over the previous situation where condoms were only available on request, though one sauna had condoms freely available in a mini-shopping cart at the coffee bar and men could just dip in and take what they wanted. Providing condoms and lube in the required numbers is obviously an expensive part of running a sauna, and they also generate a great deal of dirt around the buildings. The floors of the dark rooms in particular are often littered with the packaging and the remains of condoms and sachets of lube, and these have to be cleaned up by members of staff, often during the night as well as at the end of the night. Also available in most of the saunas is amyl nitrite, commonly called “poppers.” Inhaled through the nose during sexual performance, it causes a rush of blood and is used to heighten sexual arousal. It is not usually harmful, and the effects (except for a slight headache) wear off after a few minutes, but if used by men who may be susceptible to heart disease or used in conjunction with heat and alcohol, amyl nitrite can be dangerous. It is used quite commonly in saunas, and can be purchased on the premises. The smell (something like the smell of rotten socks crossed with the smell of cellulose dope) is often pervasive, especially around the cubicles and in the dark rooms.

Saunas are profit-making business ventures, commercial enterprises which provide a service for clients in return for payments which generate profits for the owners. In the provision and

management of services (from towels to condoms, lube, porn videos, hot water, and even coffee and tea) they are meeting the needs of clients and creating an environment which is conducive to sexual encounter. Management pay a great deal of attention to the needs or expressed desires of their clients and the saunas as facilities are almost always adding something new or refurbishing or expanding something to keep the customers coming. All the saunas have relations with other businesses, either directly, where a sauna and another business are owned by the same person or company, or indirectly, through special arrangements. One sex shop, for instance, gives out free passes to its associated sauna with purchases over a certain amount. The sauna owners are businessmen with all that that implies, particularly in terms of making a profit. Some of the owners are themselves gay and have been providing commercial services for gays for some time. Though they are legitimate businesses, they seem to exist in grey areas in terms of health and safety regulations, especially where the provision of food is concerned.

Likewise, the staff are an important feature of the saunas. Staff who do well are able to manage their duties as well as getting to know the regulars and encouraging first-timers to come again. The staff themselves are not allowed to have sex with the clients on the premises, though they often make use of the other facilities before or after their shifts. Some are also trained in CPR and first aid, and they have to be able to deal with clients who are drunk or rowdy or with those who, like prostitutes, might be imposing on other clients. Some have also been trained in safer sex awareness workshops organised by gay health groups and the sauna management, though talking to clients about safer sex is thought by some of the staff I spoke to as being an interference and something they felt was not their duty or even part of their job. It is also important to think of the staff not just in terms of their work but also in terms of how this engages with the rest of their lives. A couple of staff that I met were interested in careers as fitness instructors and were using the work at the saunas as a way into that career. Others merely saw it as a job, and had plans of moving on to something else as soon as the opportunity arose. Many of the men who work in saunas are themselves gay, yet little consideration is given to this. Because the saunas are most often open late at night and on the weekends, that is, at the time most gay men are out socialising, sauna workers often have limited opportunities for socialising. Those who are well known as working in the saunas often get men coming up to them, albeit sauna regulars, looking for free passes, or buying drinks in the hope of getting into the sauna free if that worker happens to be on duty. The sauna staff themselves often get free or cut price admission to other venues when they have the time to visit them. Staff from gay venues are often known to each other and often socialise together given their unsociable working hours. It is also a job that some of them are

reluctant to tell friends, family and especially potential partners about. One of them introduced himself to me as working in a fitness centre, though it was not long before I heard, from someone else, that he worked in one of the saunas.

Part of the job for staff is cleaning and maintaining the darkrooms. The walls, floors, ceilings, benches and radiators on this floor are all painted black which further intensifies the darkness. The corridor leading from the television room into the darkroom is approximately two-and-a-half feet wide and is only dimly lit by the light from a television screen in the outside room. Narrow as it is, it does not allow two men to walk past each other face-to-face; at least one of them would have to turn partly side-on for the other to pass by. The darkroom itself extends to the right at the end of this corridor. The room is approximately four feet wide, but part of the space is taken up by a bench (about two feet deep and one-and-a-half feet high) which runs the length of the wall on the left-hand side. Also, since this is the top of the building, the roof slopes over the bench, reducing the ceiling height and thereby increasing the heat and smells. The small amount of room between the bench on the right-hand side and the wall on the left means that passers-by have to touch against the bodies of those who are sitting on the bench or standing against the wall. Those sitting and standing reach out to those coming through, touching and groping them as they pass. Men tend to remove the towels from their waist as they enter the darkroom, putting it around the shoulders or neck in order to be free to experience the tactile sensations better. This room is about ten or twelve feet long, and at the other end is another corridor to the right, shorter than the first, and leading, to the right, into a small dark room, dimly lit by the light from the television outside, it being close to the first entrance. This arrangement allows clients to cruise the darkroom in a circle before exiting or repeating the journey. The intimacy of the space allows for the constant tactile experience of other bodies. Bear in mind that this space is entirely dark for the most part, requiring that men grope their way along quite slowly from one end to the other. I have had the unnerving experience of entering this darkroom, standing for a few seconds to let my eyes adjust to the dark, and then becoming conscious of the fact that there is someone sitting to my left who starts feeling up my leg under my towel, and another man standing right beside me on my right who I became aware of when I felt his breath on my shoulder. The small amount of light that penetrates from the corridor allows those within, whose eyes are adjusted to the dark, to see the men who enter (albeit dimly or in outline). Another sauna has a different darkroom, approached down a similar corridor which turns left, left and left again to bring you into the darkroom. This darkroom is about nine feet square and has benches along each side-wall.

One of the staff described to me the job of cleaning the darkroom. Bringing a mop and dustpan and brush, this staff member would first shout into the dark that he was about to turn on the lights. Men would scurry out often quite indignantly adjusting their towels. Once the lights were on, he would go in and sweep up the used condoms, wrappers and sachets of lube from the floor, then mop it clean with disinfectant. If the benches were wet or soiled they too would be cleaned. Then the lights would be turned out and men would start to return to the darkness. Not everyone who uses saunas uses the darkrooms. I knew a good many men who were regular sauna goers and who claimed never to have been in a dark room, yet they are doubtless a significant feature of the saunas and every sauna has at least one. Neither of the two gay bars in Dublin have backrooms (a feature of continental and American gay bars which are dark rooms off the main pub area) and it is difficult to imagine that such backrooms would be tolerated by the Garda, so the dark rooms at the saunas remain the only thing of their kind available to Irish men. They are often orgy areas, with numerous men engaged in sexual acts together, but some men I spoke to said they did not like that feature of the dark rooms and that they enjoyed them for the excitement of encounter with bodies you could not see and which could not see you. The experience of the dark room is difficult to describe. Being small and cramped, they are hot and full of the smells of bodies and bodily products, mingled with whiffs of amyl nitrite. All around are the sounds of sex, but it is the absence of light and of the possibility of seeing anything that makes them interesting for most men. This is perhaps the ultimate possibility of fantasy since each man can imagine both himself and others as being whatever he likes. In the absence of sight, the other senses seem heightened.

The excitement of tactile contact with other bodies in an atmosphere devoid of light and sight is perhaps confirmation of Foucault's sense of the dark as safe and secure:

Full lighting and the eye of a supervisor capture better than darkness, which ultimately protected. Visibility is a trap. [Foucault 1979: 200]

This darkness, then, is one of the essential requirements of the saunas. It is not that the entire sauna has to be dark, but a sauna without darkrooms or without darker areas would clearly not succeed. The dark is protective, offering levels of safety and comfort in which men can pursue sexual encounters. The dark offers the possibility of erotic tension, excitement, and fantasy. It offers the possibility of concealing aspects of the self and of emphasising others, particularly emphasising the erotic or sexual self. The darkness is a relief from the light of the outside world, but can only be sustained for a relatively short period of time before return to 'reality.' These two worlds, of dark and light, are interdependent, each a relief from the other, each connected to the

other such that one cannot exist without the other. Both are socially organised, rule-bound and regulated: the saunas, just as the 'outside' world, has its rules and regulations, implicit and explicit, written and unwritten. These are codes of behaviour that allow the saunas to work towards desired ends.

## OUTLINE OF WORK

This thesis covers various sites of HIV invention and intervention from the laboratories of scientific experimentation to the "laboratories of sexual experimentation" (see Foucault cited by Dollimore 1999: 298). The sites are concerned with HIV and AIDS, but also with "the linkage of power, knowledge and order" (Epstein 1996: 2-3). These sites are arranged vertically, and part of the work has been to explore the relations of hierarchy, professionalisation and dependency which seem implicit in such vertical arrangements. For instance, the history of homosexuality, as I show in Chapter Two, begins with the (psycho)pathologisation of homosexuality, and gay politics comes to life as a struggle against this kind of medicalised inscription. Given that kind of recent history (and the history of 'gay' is only thirty years old), what are the implications for gay organisations who now work with medical authorities in HIV prevention? The question of co-optation raises the difficulties of 'insider' becoming 'outsiders,' the degrees to which gay men, for instance, take on (both in the sense of challenging and in the sense of adopting) the culture of the dominant medical and scientific world in order to deal with the problems of HIV and AIDS (Epstein 1996: 351).

The issue of boundaries is also an important part of this thesis. HIV and AIDS have become powerful tools in the demarcation of boundaries between people, and between groups of people. Part of the business of science is "boundary work" (see Gieryn 1983), the construction of boundaries between what is science and what is not science, between "expert" and "layperson," and between different scientific sub-disciplines, but it is important to consider these boundaries as themselves being constructions or inventions. It is no more possible for a scientist to exclude him- or herself from the world in which science laboratories exist, conduct research, find funding and deliver results, than it is for a man in the saunas to exclude himself entirely from the world beyond the saunas. These worlds interact constantly, changing each other and developing each other in an interaction which is productive. Gay men become experts on HIV transmission and the operation of the immune system and the complexities of combination therapies just as public health officials and epidemiologists become experts on gay men's sexual health.

If these sites create boundaries, there are certain things that translate across these boundaries, though they translate in particular ways. HIV and AIDS have become such “boundary objects:”

Boundary objects both inhabit several intersecting worlds...*and* satisfy the informational requirements of each of them. Boundary objects are objects which are both plastic enough to adapt to local needs and constraints of the several parties employing them, yet robust enough to maintain a common identity across sites. They are weakly structured in common use, and become strongly structured in individual-site use. They have different meanings in different social worlds but their structure is common enough to more than one world to make them recognizable, a means of translation. [Star & Griesemer, quoted in Fujimura 1992: 173]

As Epstein (1996) points out, “phenomena such as a virus, a medication, or a clinical experiment...may have the status of “boundary objects”” (18), and differing social and cultural worlds in which this boundary object participates are related as a field:

Each participating social world can be treated as distinct, at least for analytical purposes, yet somehow out of their intersection there emerges a *field* that generates knowledge about AIDS. [ibid.]

AIDS and HIV form powerful boundary objects, with different meanings in different social worlds, but with a common enough structure to be used as a means of translation between one world and another. So, too, the metaphors and models with which the microbiological sciences are replete act as boundary objects, as do concepts such as ‘health,’ ‘risk,’ and ‘self.’

Within and between these sites, HIV and AIDS are framed in particular ways, but are also used to frame. HIV and AIDS are framed in particular ways, but are also used to frame. They become powerful metaphors of mystery and otherness: “...the metaphors of mystery and otherness produce the desire for control which is in turn fulfilled and justified by the metaphors of otherness and mystery” (Treichler 1999: 101). In this way they can be used to frame representations of others: the saunas, gay men, intravenous drug users, and so on. This is achieved by a process of “condensation” (Waldby 1996: 36), “compression and centralisation” (ibid.: 96), or “flattening” (Patton 383). The object of this strategy is reduced to its association with HIV or AIDS but this is also a dividing strategy: inventing something simultaneously invents its other through a process of exclusion. The resulting boundary is fragile, permeable, and therefore threatened. It is this threat that justifies intervention, intervention to maintain the border on one hand but also to make

the other the same as self. The contestations around such boundaries are an important part of the politics of knowledge around HIV and AIDS.

My research was spread over two years, during which each of the main sites was covered as far as possible by participating in each practicum. In microbiology, I sat in on first and third year undergraduate lectures and laboratory practicals in microbiological subjects. These lectures covered bacteriology, immunology, virology, and medical microbiology, over a period of four months. Over the two years, I established contacts with many of the gay organisations involved in HIV prevention. I participated in HIV prevention work as an outreach worker for a period, distributing safer-sex information booklets and condom packs at gay venues, and sat in on the first meetings of a new group aimed at providing peer education for gay men. I also attended safer-sex workshops organised by one of the groups. Over a period of a year, I visited each of the four gay saunas in Dublin, visiting two of them on a regular basis, and made contacts with both sauna-goers and staff. Throughout the two years I took opportunities to meet and talk with individuals from regional Health Boards and the Department of Health, discussing issues related to HIV and AIDS as they were perceived by those working within the statutory sector.

Conducting this research as a gay man was not without its difficulties. Given the small size of the gay community in Dublin, many of the venues in which I conducted research were venues I otherwise attended socially as a gay man, and some of those engaged in HIV prevention work were men I knew before I started the research. Attending the saunas regularly gave me something of a reputation which made it difficult to conduct my own social life at the same time as undertaking research. Many of those engaged in HIV prevention work were interested in my research and the possibility that it might be of use to them in the designing and planning of HIV interventions, particularly in the saunas, but most tended to view it as 'academic' and probably of no use to them. Nonetheless, there were many discussions, often over drinks, where I had the opportunity to listen and participate in talk about HIV interventions, and these gave me the opportunity to observe how the HIV prevention workers themselves viewed their work. I hope, too, that some of my comments on sauna interventions in particular were of use to those who are now engaged in yet another intervention.

Conducting sex research is fraught at the best of times (see Udry 1993, and Henriksson 1995). The predominant influence of the medical professions on the evolution of ethical considerations makes it difficult for sex researchers to undertake participant observation, though different

possibilities have been explored by some researchers (see Bolton 1992). Ralph Bolton has been an advocate participation in sexual encounters as an important means of establishing the kinds of sex and the relative safety of the sex that men have in places like saunas. These kinds of ethical considerations, which create boundaries between researchers and subjects, also apply in HIV prevention work. In safer-sex workshops and in training for HIV prevention work, a great deal of emphasis is placed on 'understanding your boundaries.' This includes both an understanding of professional relations between workers and clients, as well as an understanding of one's own limits. 'Understanding your boundaries' is part of a two-way protection strategy, ensuring that workers can make clear distinctions between work and play, between professional and personal commitments, as well as establishing the limits of the relations between workers and clients. Having sex with clients is almost universally against the rules, yet it begs the question of the extent to which HIV interventions in places like saunas can be undertaken when the workers (even if they are present in the saunas) remain outside of what the men themselves are doing.

The issue of work such as this being viewed as 'academic' by those engaged in the practical aspects of HIV prevention interventions is important to this thesis. Much of the work which has contributed to our understandings of the "epidemic of signification" which is AIDS (see Treichler 1999c) concentrates on textual analysis, examining the varieties of signification around HIV and AIDS. This work too uses a great deal of text-based material (for instance, epidemiological statistics and HIV prevention education booklets and posters) as data for examination. However, I have attempted to move beyond the text base to locate these significations in the lives of those who produce these materials and those who are the intended audience for the material. In this sense, I have used both cultural studies approaches and anthropological approaches (such as ethnography and participant observation) in an attempt to achieve a better understanding of talk about HIV and AIDS.

The advent of HIV and AIDS in Ireland coincided with a number of contestations over sex, health, religion, social policy, and morality which are discussed in the chapters that follow and which form the background to much of the discussion of talk about HIV and AIDS in Ireland. Being gay is no longer criminal in Ireland, and there is an equal age of consent for sexual relations for both heterosexuals and homosexuals, a situation which does not exist universally even where homosexual acts are not criminal offences. Nonetheless, the Catholic Church still regards homosexuality as an "objective disorder," and regards homosexual acts as sinful. Despite, or perhaps because of, the effects of increasing liberalisation and globalisation on Ireland, there

are many who regard homosexuality as wrong, and see HIV and AIDS as providing a justification for this belief. The many changes which have taken place in Irish society (some of which are discussed in the following chapters) do not mean that contestation over notions of 'identity,' 'protection,' and 'risk' are not taking place on a daily basis in Irish society. Considering the sites and sights of HIV and AIDS allows some opportunity to view these wider contestations.

The remainder of the thesis attempts to demonstrate this by looking at the ways in which HIV and AIDS are talked about in Ireland. This talk is not only the uses of language: as Fox (1993) uses it, talk also encompasses discourse analysis, and the implications of discourse for power, knowledge and control. He offers the following as themes in what he terms "health-talk":

1 A concern to explore discourse and discursive formations in terms not of the grand designs which they are supposed to constitute (in modern social theory), but with the 'small designs': the movements of difference and deferral which enable them to serve their authors. Exploration of these small designs involves the activity of *deconstruction*.

2 A concern with the constitution of subjectivity through discourse, knowledge and power. In place of the unitary, prior, essential subject, there is a fragmented subject, constituted in difference. Power is evaluated not as a negative constrained action, but as a positive, constitutive activity, contested and resisted.

3 A scepticism about the commonsensical notions of social structuring, organization and continuity of the world.

4 A concern with the repressed and the unconscious, and with the relationship between desire and discourse.

5 A concern with intertextuality (the 'play of texts' upon each other), and a reflexiveness over the production of my own text. [Fox 1993: 19]

The production of knowledge is also centrally concerned with the dissemination and communication of that knowledge. In an article on the communication challenge posed by AIDS, Ling notes the following:

An often-quoted Chinese expression for crisis, composed of two ideograms – *Wei*, meaning danger, and *Ji*, opportunity – aptly describes the AIDS situation. [Ling 1989: 255]

For those engaged in the politics of knowledge around HIV and AIDS this danger-opportunity plays an important part in developing credible knowledge. HIV and AIDS have presented us with both dangers and opportunities. What I try to examine here is how these dangers and

opportunities are also rooted in culture, in the cultural production of knowledge and in the cultures of knowledge dissemination. As Crimp puts it:

...cultural conventions rigidly dictate what can and will be said about AIDS. And these cultural conventions exist everywhere the epidemic is constructed: in newspaper stories and magazine articles, in television documentaries and fiction films, in political debate and health-care policy, in scientific research, in art, in activism, and in sexuality. The way AIDS is understood is in large measure predetermined by the forms these discourses take. [Crimp 1988: 245]

This should not imply that new discourses are impossible, or that the cultural conventions associated with a particular field (say, science) cannot be used to good effect in another field (say, activism). This thesis traces the interactions of various actors in cultural fields, their contestations over credible knowledge about HIV and AIDS, and the dissemination of that knowledge.

This thesis starts with an examination of the relations between cultures and communications, looking at the way in which knowledge about HIV and AIDS is constructed, how it reflects the concerns of the practicum in which it is produced, and how it is disseminated. Chapter Two looks at the relationship between disease and communities, and how ideas about health, risk, protection, identity, and community are represented in terms of HIV and AIDS. Chapter Three looks at the ways in which these several issues come together in the saunas and in HIV interventions in the saunas. Chapter Four is an examination of the production of HIV prevention messages, both by the gay community and by public health organisations, examining in particular the cultural conventions which frame the production of such materials. The final chapter looks at silence and the uses of silence in all this talk.

## Chapter One

### Cultures of Communications: White Coat, White Paper, White Towel

In this chapter, I want to look at the cultural practices of the various practicums, and how those cultural practices influence the production of knowledge. As sites of learning, each concerned not just with the production of knowledge but also with its transmission. Communication is central to the microbiological understanding of HIV. HIV is 'transmitted' from one person to another, 'communicated' through particular practices. When the virus reproduces within a cell, it 'transmits' its genetic code to its progeny. As a retrovirus, it turns its own RNA into DNA through the use of an enzyme, reverse transcriptase, in order to reproduce its RNA, and this process of 'reading' and 'writing' is notoriously unreliable, resulting in frequent mutations of the virus and making it all the more difficult for the immune system to 'read' the presence of the virus. Epidemiology, producing its knowledge through statistics, also needs to communicate these statistical representations of the world and make them meaningful. This also means communicating particular knowledge about those who are constituted as the subjects of statistical representations.

#### WHITE COATS: THE PRACTICE OF PRACTICE

It was with some trepidation that I joined my fellow biology students in the corridor outside the teaching laboratories. I was pretty sure the lecturer whose course I had been sitting would have forgotten that I would be there. As my fellow students chatted in the corridor, they put on their white coats, and I wondered what would be done about mine, given that at that moment I did not

have one. One of the students told me I would not be allowed in the labs without a white coat, and that the supervisors were very strict on students turning up without white coats. I told her I was worried about going into the labs anyway, and she reassured me that I had nothing to worry about: after all, I was not going to be doing any of the experiments and I was not going to be sitting a test. A test? Yes, there was a ten-minute test at the beginning of the labs session on a course I was not doing. I realised I could not intrude on such a test, and that, instead of entering the lab with my student colleagues, I would have to wait outside until the test was finished.

And so it happened: while my friends went into the lab, I was left standing in the corridor with a girl who had injured her finger and who was waiting to present her injury to the head demonstrator in order to be excused from labs for that week. Finally, the test was over and the head demonstrator, Catherine, came out to deal with the injured girl. Just as Catherine was about to duck back into the lab, I presented myself and told her I was from the Department of Anthropology, and that Dr Roberts was expecting me. She asked me what it was about, saying that Dr Roberts was starting a lab session and was very busy. I told her I was supposed to be sitting in on the lab. She asked me again which department I was from and, evidently confused, went into the lab and spoke to Dr Roberts. I pressed my face to the little glass panel in the door, in the hope that he might at least recognise my face from lectures, and sure enough he looked over towards me and signaled me to come in. Dr Roberts introduced me to Catherine (though he could not remember my name or which department I was from or why I was there, information that I willingly surrendered), and he asked Catherine to look after me. I followed her to the preparation labs where she pointed to a coat rack with a load of white coats on it, told me to find one that fitted me and to put it on and come back into the lab. It occurred to me that I did not know what she meant by 'fit:' should it be tight or loose, or should it be open or closed at the neck? The 'fit' seemed to me to be related to the purpose of the coat, and I had no idea what that purpose was in my case. It seemed as if it were simply 'the rule' and accordingly I chose a loose fitting open-necked coat and put it on and went back into the lab.

The session had started without me, and Dr Roberts was going through the details of the experiments, all of which were in a manual, a copy of which one of the other demonstrators gave me. I took out my notebook and started to make notes of what was going on. A few minutes later, Catherine came back to me and asked what it was exactly that I wanted to do in the lab. I told her I merely wanted to observe the students as they conducted the experiments. She told me she couldn't have me walking around the lab, as that would be dangerous, and asked if I wanted to sit

at one of the benches with the students. I said that would suit me fine, and she asked if there were any particular students I wanted to sit with. I picked out a group of students I knew, and she hailed one of the demonstrators and asked her to give me a stool at the bench. I happened to know this demonstrator, Mary, and she took me down to the bench, joking that she couldn't believe I had actually managed to get into the lab. I told her I was a bit nervous about being there and she reassured me that there was nothing to fear; after all, I wouldn't be touching anything, would I? When we got to the bench, she gave me goggles and a pair of latex gloves and told me to put them on. The last time I had worn latex gloves had been at a safer sex workshop a group of us had practiced "latex love" using gloves, dental dams, dildoes, condoms and lots of lube. Feeling a little more at home, I donned the gloves and goggles and sat down with my notebook and pen.

Though the students at the bench knew me from seeing me in lectures, I still felt conscious of my anomalousness in the lab. The students would say things to each other quietly and then look to see if I had any reaction, or if I were writing it down. By the second and third lab sessions, however, I had become familiar to them, and during the practical work they would even ask me if I knew what they were supposed to do with such and such a thing, or if I had heard some instruction the demonstrators had given. Silence tended to be the rule, with little conversation other than the issuing of instructions by demonstrators and the students, who worked in pairs, talking through the procedures with each other. There was, of course, a certain amount of banter between students or groups of students, slugging matches or mini-competitions to see who could finish what first or get out of the lab first. One such incident took place during the preparations for two experiments which were being conducted almost simultaneously. One experiment involved getting a finished product to a spectrometer and reading the results there, and the other involved the preparation of a culture of bacteriophage-infected bacteria. The latter involved removing bacteriophage from a test-tube using a hypodermic syringe, and both the lecturer and the demonstrators had given several warnings about care when using the hypodermics. As they proceeded, one of the students leaned across to the pair on the other side of the bench, pointing his hypodermic at them and, in a mock Dublin accent, threatened something to the effect that "if youse go near that spec before us, I'll fuckin' stab ya." Everyone laughed at this, and then looked at me as if expecting a reprimand. I laughed too.

These kinds of mocking and joking, often shared (if tentatively) with the demonstrators could be seen as little resistances to the fairly strictly enforced uniformity in the labs, of which the white coat was one example. Everyone, as I knew, had to wear one but this uniformity did not prevent

individualisation either. Many had their white coats decorated in one way or another, with their names or the names of bands or pop groups they admired. One student, a member of the college drama group, had been using his lab coat in a play and had got it covered in stage-blood which would not come out. When another student made a joke about the "blood," one of the demonstrators replied very coolly that he didn't find the "blood" funny at all, and that the student shouldn't have been allowed to wear a dirty white coat.

There was a kind of enforced stillness in the lab which I had not anticipated. Only the demonstrators and lecturer moved around. At every session, everyone went to their allocated places (as I learnt to do) and stayed in that area for the duration of the session. Anything they needed was brought to them by the demonstrators. The air in the lab smelt strange, and this was added to by smells arising from the experiments themselves, everything from the smell of chloroform to the smell of melting agar. Burning bunsens heated this air until it was stifling. The students had the issue of safety impressed on them over and over again, getting warnings about the proper and careful handling and use of equipment and materials. Some of the students were quite nervous in conducting the experiments while others were jokey and relaxed about it. Everything in the lab sessions was rushed with students being kept to a speeding schedule by demonstrators who barked out instructions and walked around making sure everyone was doing what they should be doing and nothing else.

The oddest part of all this for me was that none of the experiments ever seemed to work out as they were supposed to according to the manual and the instruction we had in lectures. At one stage, we conducted a "synthetic epidemic," every stage of which had to be carefully monitored. Despite this monitoring, there was enough confusion in the results the following week to make it impossible to accurately tell who had started the epidemic at each bench, the object of the exercise. At the end of the bacteriology lectures, the lecturer had reminded everyone that we would be following up on what had been covered in lectures during the three practicals that were to follow. "You'll be doing practicals next week and I assure you you will be doing experiments that will work," he said, adding, with a smile, "promises, promises" at which the students started laughing. It was clear that experiments never quite worked the way they were supposed to, and that both students and lecturers anticipated this to some extent at least. Nonetheless, the practicals themselves were not very lighthearted, and students had to hand up their lab notebooks from week to week to be assessed on their practice. During practicals they were carefully supervised at every stage of the experiments, and the supervisors were there to ensure that proper lab procedure

was being followed at all times, particularly in relation to matters of 'good housekeeping:' the handling, use and disposal of laboratory materials and equipment. What struck me as being most important about these practical sessions was their practicality: this was the practice of practice. The students were here not necessarily to obtain the correct or expected results but to experience experiment under the correct practical conditions. As one of the women said to me, "Next year we'll be expected to do this for real, and it won't be funny then."

Fear of contamination was very much part of the labs and therefore maintenance of proper boundaries was paramount at all times. The bacteriology lectures which had preceded the labs had made evident the dangerous nature of some of the materials we would be dealing with. Much of the introduction to each of the lab sessions was what Dr Roberts referred to as "a bit of housekeeping," namely ensuring that no-one became contaminated by anything they were using and that no-one suffered any injury while in the lab. In preparing for an experiment which was to demonstrate the omnipresence of bacteria and fungi in the environment, Dr Roberts told the students they could use any surfaces in the lab as a source of bacteria but absolutely not to use bodily fluids of any kind, adding, more jocularly, that he didn't want anyone nipping out to the toilets looking for specimens. Keeping what is appropriate to the labs in the labs, and keeping what is inappropriate outside was an important part of the practice of lab practicals. A similar concern for the proper maintenance of boundaries is made clear in the "Laboratory Rules for Microbiology" in the manual which each student had:

- 1 Do not smoke or allow any material to go to your mouth.
- 2 Do not inhale culture material or reagents.
- 3 Do not allow culture material or reagents to contact your skin.
- 4 Notify supervisor of deep cuts on your hands before practical.
- 5 Notify supervisor of any spillage of cultural material or reagents. Do not Clean it up yourself.
- 6 You are required to wear a lab coat.
- 7 Do not discard culture material. Leave for disposal by autoclaving except where you are otherwise instructed.
- 8 Do not use alcohol as a disinfectant near a flame.
- 9 Wash your hands before leaving the laboratory.
- 10 Do not open dishes or tubes without instruction to do so.
- 11 Discard all slide and coverslips into disinfectant. The organisms you will handle are usually fairly safe but should be handled by means of normal laboratory procedures.

These "normal laboratory procedures" are intended to maintain the barrier between the inside of the lab and the outside. What comes in from outside and what goes out from inside are carefully

regulated. The most emphatic regulation is of those links between inside and outside: the students themselves. Not only does what is in the lab threaten contamination of those who come into it, but those who come into it also threaten to contaminate the lab and its materials. Good “housekeeping” is about the maintenance of boundaries between worlds and the white coat, symbolic of this boundary-maintenance, has become a metonym for science itself. Science has demarcated for itself the worlds between which it maintains boundaries.

The vision of “nature unveiled by science” goes back to Bacon and the Enlightenment. Nature is revealed before the penetrating gaze of her true master, science. The master, of course, must keep his clothes on, for fear of contamination on one hand but also as symbolic of the civilised, the cultivated, on the other: only the enlightened have his power over nature. Nature is hidden, something which requires unveiling: it is not apparent to everyone, and the hidden is, by its nature, dangerous: it is the light of truth that fights against the dark of deception. This makes science, as a dividing practice, a penetrative practice and a panoptic practice. The gaze of science penetrates, dividing the dark from the light, driving back the dark and bringing the formerly hidden to light. Nature is a hidden world which science renders susceptible to its gaze, and this hidden world is full of hidden purposes which are simultaneously revealed. In that sense, nature is not passively ‘hidden’ but actively ‘hiding’ from view. Thus science gives meaning to the meaningless, purpose to the purposeless, agency to the non-agentive. In what is clearly a gendered division of nature and culture, nature is made passive before the scientific gaze, but this passiveness cloaks agency. Agency, the ascription of hidden purpose and meaning, gives science its justification for the penetration.

This is clear in the way that the microbiological sciences represent the microbial world. In the lectures, I was surprised by the constant repetition of what biology itself recognises as a teleological fallacy. One dictionary of biological terms describes “teleology” as:

the doctrine of final causes, the invalid view that evolutionary developments are due to the purpose or design that is served by them; similar type of explanation applied to biological or cellular process, or animal behaviour, which presupposes an impossible awareness of a particular goal. [Lawrence 1995: 587]

Despite such an awareness, developments were constantly attributed such purpose during lectures I attended. Thus mutations of a virus like HIV were constantly described in terms such as “a clever defence mechanism” or “a trick that HIV uses to evade the immune system.” Whilst these

metaphorical constructions or anthropomorphisations might be useful models for thinking about the microbial world, they also provide a particular view of that world, and often the fact that they are just models or metaphors is ignored. The importance of seeing, and of the social and cultural context of seeing, in the construction and use of metaphorical models is also important and again often ignored. Jonathan Miller contends that "...seeing is not all there is to believing; belief determines the significance of what is seen" (Miller 1978: 187). Referring to the differences between Galen's model of the heart as a furnace and Harvey's model of the heart as a pump, Miller claims the difference was one of "metaphorical equipment" (ibid.). Galen could not have seen it as a pump since pumps of that kind did not exist in his time. The significance of what was seen by each of them is altered by the different social context, each providing different metaphorical possibilities which alter the way of seeing:

Good visibility, then, may be a helpful condition for making discoveries, but it is neither necessary nor sufficient. If someone already knows what he is looking for, he may recognise it even when the visibility is appalling; but if he has no preconceptions of what to look for, he may misconstrue or completely ignore what he is looking at. [ibid. 222]

That the social and cultural context provide these metaphors and models is evident in many of the metaphors and models used in science, particularly in the biological sciences. The mechanical world has been of great significance in this respect:

By mechanising his practical world, man inadvertently paved the way to the mechanisation of his theoretical world. The success of modern biology is not altogether due to the technology with which we pursue it; the number of technical images we now have for thinking about it play an almost equally important part. An American scientist once said that the steam engine had given more to science than science had to the steam engine, and the same applies to telephone exchanges, automatic gun-turrets, ballistic missiles and computers. Whatever these devices were designed to do, they have incidentally provided conjectural models for explaining the functions of the human body. [ibid.: 182]

However we look at it, our metaphors of systems based on things like steam engines and telephone exchanges is changing. It is such a system metaphor that is used in thinking about, and indeed representing, the immune system, and if the metaphor is unsuitable, the viewer may be blind to what is going on, or what is going on may be incomprehensible to her. Tomio Tada (1997) has questioned the use of a simple mechanistic system for viewing the immune system. He outlines the criteria by which the "system" is usually defined as being

1. It is composed of many different components or elements; 2. components have mutual relations coordinated to function as a whole; and 3. the system functions for a specific purpose. [Tada 1997: 6]

What Tada suggests as an alternative model is a “supersystem” which he sees as being characterised by several “self-referring” concepts, namely:

It is a system that engenders itself by generation of its diverse components from a single progenitor, creating a dynamic self-regulating system. The generation of its components is mostly by stochastic process followed by selection and adaptation, the consequence of its self-organization. The supersystem thus generated has individuality and is capable of deciding its own behaviour in response to environmental and internal stimuli by referring to its own established behavioral pattern. Unlike mechanistic systems that are constructed by assembling existing elements for a particular purpose, the supersystem is generated and operated without a given purpose. [ibid.: 2]

This altered model has implications for one of the fundamental presuppositions about the immune system: the distinction between self and non-self. As it is represented, the immune system self is the self of the body containing the immune system. For Tada, the immune supersystem is its own self:

The immune system can make self-nonsel self discrimination that enables the body to protect itself from microbial organisms in the environment. However, I think that the immune system has not evolved for such a practical purpose. It could only be a by-product of the purposeless evolution of the immune supersystem. Once the immune system had chosen the principles of the supersystem to establish the self, it is unavoidable that it will be intolerant to nonself microorganisms. The defense mechanisms seen in the invertebrate may be quite sufficient and safe for protection. As it evolved as a supersystem, however, the immune system has become a quite dangerous and harmful life system, providing ample opportunity for errors and undesirable results, e.g. autoimmunity and allergy. [ibid.: 7]

If teleological fallacy ascribes purpose where there is only purposelessness then it also risks obscuring the view. The reality of the model overtakes the model of reality. Purpose, what something is for, is the dictator here. As Miller puts it, “Things tend to look like what we know they are for – and if we don’t know what they do, we often find it hard to say how they look” (Miller 1978: 210). Judith Williamson extends this to thinking about the HIV virus:

Nothing could be more meaningless than a virus. It has no point, no purpose, no plan; it is part of no scheme, carries no inherent significance. And yet nothing is harder for us to confront than the complete absence of meaning. By its very definition, meaninglessness cannot be articulated within our social language, which is also a system of meaning: impossible to include, as an absence, it is also impossible to exclude – for meaninglessness isn't just the opposite of meaning, it is the end of meaning, and threatens the fragile structures by which we make sense of the world. [Williamson 1989: 69]

Science, then, is a meaning-making structure and ascribes meaning to the meaningless. It produces the meaningful. Such ascriptions of meaning and agency are made using the metaphors of war, so the agentive virus (defending itself and tricking the immune system) offers a self-justification for intervention. This extends to the role of science itself: if there is an uncontained nature that threatens contamination, then science is the proper defence against this. Science represents nature as hidden, as having hidden purpose and meaning, and this hiddenness justifies the (violent and violating) penetration of science.

What is it that hides nature? What is the “veil” that must be removed in order for nature to stand naked before science? I suggest that the veil is culture, and that science sees its role as abstracting nature from culture, and, further, as demonstrating the interrelationship of nature and culture. Science, then, ascribes a double nature to culture. There is culture *in* which nature is contained and culture *by* which nature is contained. The former is threatening and the latter is threatened. Culture, binarily opposed to nature, is therefore both threatening and threatened, dangerous and in danger. This justifies scientific intervention on two fronts: intervention into culture, effected through the penetrative gaze, in search of nature, and intervention into the world of culture, where science effects the containment of the threat of uncontained nature. Science alone can achieve this, representing itself as uncontaminated and uncontaminatable both by nature and culture. Science's division of the worlds of culture and nature creates a permeable boundary, one that justifies constant policing. Science posits itself as alone having full and proper knowledge of the world of nature, and as having a responsibility to communicate that knowledge as a form of self-preservation.

This can be seen in the way in which HIV was dealt with in lectures in virology with third year students. The lecturer started with a little of the history of HIV but could remember the name of only one of the scientists credited with the discovery of HIV: he glossed this with the comment that “it's of no consequence anyway,” and proceeded to discuss what was, ostensibly, the various potential transmission routes for HIV:

This was in the early eighties when homosexual men were found to have this disease. Transmission of the virus is usually through blood, in the past through blood transfusion, through sexual contact where the virus is found in semen or vaginal secretions. In what ways can it be transmitted by blood? Blood transfusions and blood products. You've probably heard about the French cases where the Minister for Health was taken to court for failing in his duty to screen blood used in the transfusion service. We don't have that problem any more, at least the first world is okay, but some other countries are not. Obviously, needle-sharing is a big problem, with many of the drug-sharing community but that goes for all needles. I strongly advise you to resist the idea of getting tattoos. In the case of dentists or surgeons who might inject themselves by dealing with patients who are HIV. There are a lot of precautions that can be taken but many of the heroin addicts don't give a damn, and that is still the biggest problem. One of the big problems with gay men in particular is that they practice anal sex which is a much easier way of transmitting the virus than heterosexual sex. In the past at least the gay community was more aware of this and simply using condoms is effective, but there are a large number of homosexuals who are infected. The sad cases are children being infected because of their mothers. Another HIV positive individual might be inclined not to get pregnant but drug users or other such women do get pregnant and this results in infection of the unfortunate foetus through perinatal, intrauterine, peripartum or breast-milk transmission of the virus. I don't want you to think that heterosexual sex is free of infection. As regards perinatal transmission, the best way to ensure that it stops is by HIV positive women not getting pregnant.

This series of statements contains a good many demonstrations of the work of science as a dividing practice. HIV is here presented as unproblematic on several levels. We *know* what *it* is and we *know* how *it* is transmitted. Science has named it, recovered it from meaninglessness and ascribed meaning to it. Yet the naming process is a clear example of the culture of science itself, of the refutation of science as being un-self-interested. The argument over the naming of HIV was not simply a matter of scientific nomenclature, but rather an unseemly wrangle over rights and prestige. (Full accounts of this can be had in Connor & Kingman 1988, Shilts 1987, and Epstein 1996) The lecturer's forgetting the name of one of the co-discoverers, and his dismissal of this as being "of no consequence," denies science its historicity, its self-interests and its culture. The history of HIV is rendered meaningless, the only meaning being that ascribed to it here and now. HIV does not have a meaning within science, but only in nature and culture.

That this is so is clear from the representational strategy used to 'describe' potential routes of transmission. The descriptions become both prescriptions and proscriptions. Describing how the virus is transmitted prescribes methods of avoidance and proscribes certain behaviours as potentially transmissible. Needle-sharing, tattooing, unprotected anal sex, pregnancy for women

who are HIV positive are all proscribed, and protected sex, avoidance of pregnancy by HIV positive mothers and avoidance of needle-sharing are all prescribed. These things are unproblematically offered on the basis of scientific rationales: engaging in proscribed behaviours results in transmission of HIV, following the proffered prescriptions offers the possibility of avoiding HIV, and this because science knows how HIV is transmitted.

Part of this representational strategy is a “flattening” of culture. The meaning of cultural practices such as needle-sharing or drug-taking, pregnancy, and sex is rendered meaningless in the face of the only possible consideration which is containing the risk of HIV transmission. Why people might do these things, and the meanings they give these things, are superfluous to prescription and proscription, and, by implication, to description itself. The potentially infectible (those who engage in these practices) are flattened to their potential for infection: only homosexuals engage in anal sex and homosexuals only engage in anal sex. Persons with HIV are likewise “flattened” to their disease only: their social, cultural, political, economic and even religious environments are of no consequence here since they add nothing to the meaning of HIV or its containment. What matters (the meaning of HIV) is the representation of these people as synonymous with their disease. The infected threaten infection.

Behind this too is a responsabilisation of the infected and uninfected alike. Both infected and uninfected have a responsibility to avoid transmission of the virus by following the proffered prescriptions. The infected, through the lack of such responsibility, are responsible for their own illness, and their continuing lack of such responsibility threatens others with infection. This results in a division of responsibility: some (who continue with proscribed behaviours) are responsible for their own disease and for the transmission of infection to others, and some of these others (particularly the “unfortunate” babies of HIV positive mothers) are not responsible for their own infection. Responsibility is then a matter of choice: some choose to be irresponsible and to infect others, and some of the others have no choice in the matter of their infection. Some of the infected, then, are innocent and some blameworthy. It should be clear, then, that microbiological science is not without moral imperatives, that its interventions in the world of culture are themselves cultured by particular hegemonic worldviews. Science reflects the dominant norms of society, reinforcing them by ascribing the possibility of pathology to deviance from those norms.

There is also a de-problematizing of knowledge. Knowing about HIV and its transmission is the work of science, and science communicates this knowledge to society. After that, it becomes a matter of choice. Other factors which might influence choice are flattened out of this representation. Optimum health (here represented as the avoidance of potentially fatal disease) is the only possible (rational) choice and must dominate. Likewise communication is also deproblematized. The knowledge that science produces is represented as being value-free, given science's position outside of nature and culture. Science's dual penetration means it can produce knowledge free of cultural factors which can then be disseminated for the protection of society. This is the so-called "hypodermic needle" model for health communication (see Tulloch & Lupton 1997: 14). This 'inoculation' of information is effected by recourse to other disciplines that have grown from medical microbiology: namely, epidemiology and health promotion.

### WHITE PAPER: TARGETING PRACTICE

Epidemiology continues the practices of microbiology and extends them in powerful ways. In particular, epidemiology, and the public health interventions which result from it, is concerned with sets of boundaries. These are boundaries between groups of persons, like the healthy and the ill, or the susceptible or non-susceptible, and also between particular realms of experience, like the public and the private. The remainder of this chapter is concerned with these boundaries and with the construction of what is included and excluded, what is inside and outside the boundary.

If microbiology flattens in order to clarify, epidemiology's representational strategies work in the same way. As Waldby notes:

...the knowledge practices of epidemiology allow the state of a large number of bodies to be presented to the eye in a synoptic form. I would argue, following Latour (1990), that the social power of epidemiology, or at least its amenability to use for biopolitical ends, derives from these features of compression and centralisation... The point of distilled and abstracted information which is the end result of data collection practices like epidemiology, Latour argues, is precisely the increased power such formats provide their interpreters in summarising an extensive domain. [Waldby 1996: 96]

Indeed, it is not just the power provided in summarising, but the extension of that power into these extensive domains. The ocular technologies of epidemiology, if not literally extended into the bedroom or the saunas, are at least extended to the collection of data from clinics and hospitals which allows inferences to be drawn about what is going on in bedrooms, behind the

closed doors of cubicles and in darkrooms in saunas. What were private acts between individuals undertaken outside of the glare of the public eye, come to light and public notice in the statistics produced by epidemiological survey. If microbiological sciences know how the virus works and posit transmission routes for the virus, epidemiology translates this knowledge into an enumeration of population: the infected. The infected are not uniform in their infection, and the patterns of infection result in their categorisation. At present, the Irish statistics for HIV are broken down into the following categories:

- Intravenous Drug Users (Male, Female, and Unknown)
- Children at risk
- Homosexuals
- Haemophiliacs
- Haemophiliac Contacts
- Hospital Staff/Occupational Hazard/Needlestick
  - \* Transfusion
  - \* Blood donors (specimens referred by the Blood Transfusion Service Board)
  - \* Organ Donors
  - \* Visa Requests
  - \* Insurance
  - \* Prisoners
- Hetero/Risk Unspecified

Notes following this breakdown state:

This does not include specimens tested in unlinked anonymous surveillance programme.

Note: The above figures which are produced by the Virus Reference Laboratory relate to categories of persons as identified either by patients themselves or by their clinicians.

\* Categorised by site reason rather than risk.

Statistics for "Cases of AIDS" lists the following categories:

- Homo/Bisexual
- I.V. Drug Users
- Homo-Bisexual/I.V. Drug Users
- Haemophiliacs
- Heterosexuals
- Babies born to IV drug users
- Other children
- Undetermined
- Transfusion recipient

The differences between the categories produced in each of these sets of statistics is the result of separate reporting systems set up at different times to monitor HIV and AIDS. Apart from raising a question as to the relation between the categories used in the two sets of statistics (which makes it look, for instance, as though there are no HIV positive bisexuals but that there are Homo/bisexuals who have AIDS), this also raises the questions of the use of such a representation. Following Waldby's citation of Latour above, I suggest that the use of such a representation is in the power it gives in the biopolitical field: that is, the imagining of the statistical world of HIV in Ireland increases the justifications for intervention in certain areas rather than others, and for the targeting of certain populations rather than others, and the privileging of certain populations over others. Waldby identifies this in the use of Homo/Bisexual as a classificatory category in HIV/AIDS statistics:

If a man says he has sex with both men and women, the grouping 'homosexual/bisexual' implies that his sexual identity *for the purposes of establishing HIV transmission* is homosexual.

This insistent classification of the male bisexual with the male homosexual is symptomatic of AIDS biomedicine's drive to protect the status of the heterosexual male body, to ensure that the category 'male heterosexual' is not contaminated by the infectious ambiguities of masculine bisexuality. All other possible forms of sexual contact must be eliminated before a man will be classified as HIV seropositive due to 'heterosexual contact.' [Waldby 1996: 132]

In the presentation of the Irish statistics, the fact that 'Heterosexual' and 'Risk Unspecified' are conflated perhaps adds to this sense of heterosexual transmission as being in some way 'undetermined' or 'unspecific.' Heterosexual transmission is presented as being almost as mysterious as 'undetermined' or 'unspecific.' This makes it more evident that it is the particular cultural practices of the 'other' classifications that makes them susceptible to HIV infection. As Nina Glick Schiller and her colleagues note:

The reification of social categories as 'risk groups,' and the tendency to distance these groups from the 'general population,' have contributed to the complacency and denial of the reality of risk of infection among members of this 'general population,' even those whose geographical location and (heterosexual) behaviour places them at elevated risk. [Glick Schiller et al 1994: 1344]

They conclude by saying:

Stereotyping and reification provide a misleading backdrop for policy formation. This tendency to distance the 'general population' from 'risk groups' has acted as

cross-purposes to public health goals, facilitating public definitions of the HIV epidemic as a problem which concerns others, not oneself and one's own 'group.'  
[ibid.]

In an earlier article, Glick Schiller (1992) discusses the hegemonic construction of culture in AIDS research in the United States. She notes that there is nothing new in locating disease in populations perceived at different:

An age-old paradigm of the contagious cultural other both delegates the origin of disease to the cultural other, who is seen as different and immoral, and holds that the disease is highly contagious so that the "other" must be separated from the body politic.

While these ideas can be found broadly within the society, they become formulated, codified, sanctified, and incorporated into the systematized "knowledge" of the era by those concerned with maintaining social order and discipline. [Glick Schiller 1992: 239]

Glick Schiller quotes comments made by Deborah Stone in an article on "Preventing Chronic Disease" where Stone says:

...risk factors and designations of high-risk groups do not grow immediately and automatically out of epidemiological research. They are created in a social context that involves judgment, persuasion, bargaining and political maneuvering. This larger social context also shapes decisions about what is considered a risk factor, [and] how broadly categories are drawn. [Quoted in Glick Schiller 1992: 240]

Emphasising risk groups rather than mode of transmission means that who is infected takes precedence over how they become infected, thus distorting the representation of transmission within the population and mis-representing the infected populations:

The risk categories used in the HIV/AIDS statistics may distort the nature of the transmission of the virus in that IV drug users may have become infected through sexual transmission rather than through unsafe injecting behaviour. [O'Gorman 1999: 6, note 4]

This particular representation is as old as AIDS itself which, in one of its early acronyms, was referred to as GRID, Gay Related Immune Deficiency, emphasising *who* was affected/infected rather than what the effects (and modes of transmission) of the disease were. This mis-representation makes it clear that epidemiological statistics are not so much reflective of as productive of the reality of HIV and AIDS in the population, and raises questions for the types of interventions which are based on the use of such inventions of transmission.

Again there is a process involved in the production of epidemiological knowledge. Abstracting from the technology of the HIV antibody test (on which the statistics are based) it produces groups of the always already marginalised, whose 'culture' can be seen to be the cause of their predisposition to HIV infection. This 'culture' is reified, such that all intravenous drug-users or all homosexuals engage in or are predisposed to practices which render them susceptible to HIV infection. This production is exclusive in that it privileges certain groups as being harder to infect and deprivileges others as being easier to infect. Even the layout of the statistical categories (which is arranged neither alphabetically nor in terms of higher/lower numbers on HIV positives) places "Hetero/Risk Unspecified" at the bottom, as if it were the group least likely to be infected, or with the lowest incidence of infection. It also marks it as the group that is most desirable, the group which is most privileged, the group to which others should aspire.

This can be seen in the 'naturalising' tendencies of epidemiology. As Frankenberg notes:

Because most people are concerned more with the threat of illness than with health, the notion of risk has become part of our thinking about the prevention of disease – the chances of health being thought of mainly as low risk of illness. We do not speak of our vulnerability to health and epidemiologists rarely study the characteristics of the healthy – though this is likely to become a more rewarding exercise as subtler indices of health are developed. [Frankenberg 1994: 1328-9]

Statistics make the unhealthy naturally more visible in their lack of health, but has the added effect of making the healthy less visible. Since what tends to visibilise the unhealthy are the reified cultural practices which effect their disease, the culture of the healthy becomes less visible as well. The healthy are thus privileged, possessed of knowledge but also of (proper) behaviours which keep them (all the time) free from infection. The healthy, in this sense, are, or at least see themselves as being, free of culture. Culture is what the 'other' has:

In practice, the emphasis on difference results in a peculiar ratio: as the "other" becomes more culturally visible, the "self" becomes correspondingly less so... [The] more power one has, the less culture one enjoys, and the more culture one has, the less power one wields. If "they" have an explicit monopoly on authentic culture, "we" have an unspoken one on institutional power. [Rosaldo 1993: 202]

The association between culture and pathology leaves the privileged group with a sense of natural security: it is 'their' culture which makes 'them' diseased and since 'I' do not have culture (since 'I' am normal) 'I' cannot become diseased. It also strengthens the notion that depathologisation

(the removal of disease) is about de-culturing: if only 'they' stopped their practices, 'they' would no longer be diseased. As Crawford puts it:

'High-risk' and its pathological consequences are ascribed to individuals who, unlike the privileged, are 'locked' into 'cycles' of deviance and self-destruction. 'Their' very existence as 'self-inflicting' agents becomes a screen for the projection of a putatively self-reproducing social world. The imagined distinction serves the socially sanctioned identity of health, responsibility and privilege and the reassuring belief in their mutual reinforcement. The otherness of the sick or the high-risk individual is, in short, a boundary maintaining device that serves multiple agendas. [Crawford 1994: 1359]

It is not difficult to see how statistics which apparently reflect the reality of HIV/AIDS in the population start to reflect the structure of institutional power. The always already marginalised are flattened in their representation such that it is particular practices of theirs which are the cause of their susceptibility to HIV/AIDS. It is the unknowing who become objects of knowledge and subjects of power. This can be seen as the function of epidemiology:

It provides forms of expert knowledge in formats which draw together far flung processes of health and illness in a central location, which summarise large numbers of bodies in simple formulae and standardised terms, and which does so in ways which translate the technical discourse of medical research into terms that are legible and useful to bureaucracies. [Waldby 1996: 98]

The projection of otherness onto others (or rather the projection of otherness onto the always already othered) results in a greater fragility of the projector. What is at stake is a fear of regression, of the loss of control over self. Loss of control is projected onto other, externalising it, such that the self is always controlled and the other is always out of control. It is this lack of control that makes others sick, and this lack of control threatens to make me sick. It is a fear that the boundary between self and other is not secure, a fear of contagion:

The 'epidemic of signification' is a fear of a particular kind of contagion, a fear that the boundaries which distinguish self from other cannot be maintained. The mark inflicted by AIDS, other sexually transmitted diseases, and to a certain extent, all serious affliction is an inscription of otherness. The visible component of this otherness is the *external* object of abjection – the 'homosexual,' the 'addict,' the 'prostitute,' or, simply, the seriously ill. The dynamic force of otherness, however, is the projection of an *internal* other – experiences not permitted the recognition accorded by identity. I am speaking about vulnerabilities – particularly about disease, psychic disintegration, and death – but also about desires, dependencies, addictions, and a range of experiences that are either excluded from legitimate selfhood or only tenuously integrated within it. [Crawford 1994: 1355]

The unhealthy other in the person of an HIV 'carrier' is conflated with the other within in the form of compromised immunity. Without immunity the self is overrun by other. The fantasy is one of ultimate loss of control and loss of self. [ibid.: 1358]

HIV/AIDS statistics, then, do not simply 'image' the incidence of disease in 'the population' but rather 'imagine' the ways in which the always already marginalised and excluded make themselves susceptible to disease through specific cultural practices that are diagnostic of this group. These 'imaginings' of the diseased are coupled with the need for protection of the privileged, and the reinforcement of the norms and standards of the privileged. The 'imagined' HIV/AIDS groups are produced as targets of interventions aimed at normalisation, responsabilisation and health. This reflects the proper concern of public health: the protection from risk of the general population, and the identification of those at risk. The production of statistics which form the basis for interventions amongst these cultural others is a visibilisation of public health's concern with disease, and a reassurance to the culture-free self that the threatening other is being dealt with. In producing this visibility, the statistical imaging of 'danger' also maintains a kind of "organised insecurity" (see Dion 1997: 175), a 'healthy anxiety' which keeps the self vigilant and surveillant by reminding individuals that there is danger out there. "The enemy" then becomes a useful tool in the constitution of self as self and the maintenance of a boundary between self and others:

...the "enemy" is a projected space of untameable darkness, murky chaos, and unspeakable excess of unfathomable "Otherness." This production of "Otherness" is how societies constitute themselves as domesticated, self-identical, and knowable sites. [Dion 1997: 175]

The constitution and maintenance of this order of things requires that "the "enemy" must be invented, vanquished, and the reincarnated" (ibid.).

#### WHITE TOWEL: MULTIPLE, CASUAL, ANONYMOUS, SEXUAL ENCOUNTERS

The projection of otherness onto the other is not merely the projection of fear (since the normal is always threatened by the pathological) but also a projection of desire. It is as if, in that Hobbesian sense, the privileged have given up something in order to become civilised, and, whilst it engenders fear, the return of the repressed in this sense is also somehow desired. Indeed, it is a

desire for desire. If we consider the men in saunas in the light of this discussion of culture and communication, it is evident that they are a particularly important site for such HIV prevention intervention, and also that they point up certain anomalies in the ease with which boundaries are created and policed.

One of the descriptions of what goes on in the saunas concerns “multiple, casual, anonymous, sexual encounters.” As McCoy & Inciardi put it:

Characteristic of *all* the gay baths was a commercialization of frequent, anonymous, high-risk sexual activity in which epidemics of venereal disease, hepatitis, and enteric disorders thrived. [McCoy & Inciardi 1995:71, emphasis in the original]

In the gay baths and sex clubs, there is high-risk sex with numerous, anonymous sex partners. Virtually all visitors to the bathhouses are gay and bisexual men and are at high risk for HIV and AIDS through unprotected sex. And because the majority of those who engage in risky sex in the baths are frequent callers at these establishments, the potential for encountering an HIV-positive sex partner is considerable. [ibid.: 87]

McCoy and Inciardi’s book is written from the perspective of epidemiology, but is aimed at concerned heterosexuals in the United States. The title of the book and of the preface contain the word “spread” but it is used by the authors in a way that suggests not “transmission” but the “spread” of infection from “others” to heterosexuals:

Elsewhere in the world, especially in the developing nations, heterosexual spread is the major route of transmission. [ibid.: vii]

If “spread” is not exactly a recognised epidemiological transmission route (in the way that sexual or blood-to-blood contact might be) we can see how their use of “frequent” and “numerous” has epidemiological consequences, as does their use of “anonymous.”

Though in one sense multiple, casual, anonymous, sexual encounters does describe the experience of the saunas, it also does a lot more. Firstly, as was noted earlier, such a description divides sauna goers off from others who may appear to be like them. It does this by positing qualitative and quantitative differences between two groups of people. It is as if “multiple, casual, anonymous, sexual encounters” do not occur any where else, either in the world of gay sexual encounters or in the world of heterosexual encounters.

The second thing such a description does is to reinforce a medico-moral view of this kind of behaviour. "Multiple," in terms of epidemiology and the science of viral transmission, means multiple opportunities for infection. Since gay sex is reified in terms of anal sex and since men can be both receptive and insertive, the possibilities for infection are greatly increased by multiple partnerings, but it is primarily the receptive sexual partner who is at risk. The phallogocentric inscription of this position as "passive" is significant here:

While anal sex requires both an insertive and a receptive partner, it is the position of 'passivity', of the reception of the penis and semen of 'others' which is nominated as the deadly act. It is the permeability of the gay male body, rather than its phallic or penetrative capacities, which place it on the side of contagion.

The rigid boundary of the immunocompetent body helps to naturalise an association between sexually receptive bodies and HIV infection. The establishment of boundary is equated with the successful enculturation of the body, its sealing off from dangerous associations with the natural world. Orificial, permeable bodies are on the other hand bodies which are associated with the encroachment of nature upon culture. [Waldby 1996: 77]

"Multiple" is not just placed in opposition to something that might be 'singular,' but also has resonances with the norm of monogamy:

The other issue about the saunas as opposed to the clubs is that there's a bigger opportunity for multiple partners within the saunas than there is, say, with somebody meeting somebody in a club and then going home. What usually happens in that situation is somebody meets one partner, they go home and they have sex. In the saunas, if somebody goes to the saunas, in reality the numbers of partners are as many as those that walk through the door, so it could be two hundred or three hundred people in the course of the night. Obviously that's a bit ridiculous, somebody having that many sexual partners in one evening is a bit extreme, but there are opportunities for people to have half a dozen, a dozen sexual partners in the course of a night depending on their particular sexual interest. Somebody who is particularly anally receptive may have a dozen partners in the course of a night. So that's the kind of thing that's involved. So there is a bigger opportunity, and I think also part of it has to do with the fact that the saunas are viewed in a particular way, and that is that they are just there for sex, people don't tend to think of the pubs as a venue for sex. So saunas have a different interpretation put on them by the community I suppose and that's why it's important to tackle them and to go in and do something with them. [HIV prevention worker]

Despite the fact that men following safe sex guidelines need not worry about the multiplicity of partners, multiplicity is still an issue in safer sex. The anally receptive man who has half a dozen or a dozen encounters in one night, can, effectively, only be infected once. It is not the multiplicity that matters, but rather the one time that it is infective. Where multiplicity does matter is in its association with promiscuity:

At the outset of the AIDS crisis, in the early 1980s, the tabloid press angrily denounced, even as it recorded in salacious detail, the numbers of sexual partners gay men were alleged to have in a day, a month or a year. [Dollimore 1999: 294]

Before AIDS, homosexual promiscuity was often regarded as epitomizing an impossibility of desire unique to the homosexual by virtue of his or her supposed immaturity and inauthenticity. [Guy] Hocquenghem, writing in 1972, had remarked the tendency to think of homosexual promiscuity as indicative of 'the fundamental instability of the homosexual condition, the search for a dream partner through a series of brief, unsatisfactory affairs'. In the context of AIDS, there were some for whom this specifically gay version of desire's impossibility became intensified into a death-driven futility. [ibid.: 295]

For some, like Crimp, promiscuity still offers possibilities, regardless of AIDS. He contends that promiscuity taught gay men not just about pleasures but about the multiplicity of pleasures.

It is that psychic preparation, that experimentation, that conscious work on our own sexualities that has allowed many of us to change our sexual behaviours – something that brutal "behaviour therapies" tried unsuccessfully for over a century to force us to do – quickly and very dramatically... All those who contend that gay male promiscuity is merely sexual compulsion resulting from fear of intimacy are now faced with very strong evidence against their prejudices. For if compulsion were so easily overcome or redirected, it would hardly deserve the name. Gay male promiscuity should be seen instead as a positive model of how sexual pleasures might be pursued by and granted to everyone if those pleasures were not confined within the narrow limits of institutionalized sexuality. [Crimp 1988: 253]

"Multiplicity" then can be read as an epidemiological concern, but also as a concern which has built into it a morality which translates "multiple" as "promiscuous." Promiscuity is a signifier of the lack of control: the inability to control desire, or control the body. Promiscuity inscribes desire as uncontained, and therefore contagious and contaminating. This too can be seen in the reiteration of "anonymity" and "casualness" as epidemiological concerns. "Anonymity" posits these encounters as particularly difficult for epidemiological exploration. In epidemiological terms, contact tracing is the means by which the chain HIV infection is made visible in the community. Yet in Ireland, HIV is not a reportable or a notifiable disease. This results in a curious anomaly. Where certain STDs (like syphilis, for example) are reportable, with the consequent requirement for contact tracing, HIV is not, and contact tracing can only be done on a voluntary basis. This voluntary contact tracing is encouraged by counsellors involved in HIV test counselling, but there is no legal requirement or obligation on the part of the person who tests positive for HIV to either reveal their sexual or other partners, or reveal their status to those

partners. In epidemiology, one person who is identified as HIV positive could lead to other contacts who in turn might be HIV positive, thus revealing the extent of the infection. It is this chain of infection which epidemiology must break in order to prevent transmission. Contact tracing is only possible if and when the identified HIV positive person knows who they have had sex with and is willing to reveal that information. If, as is often the case in the saunas, the contact was anonymous, or if all that was exchanged was first names, then contact tracing becomes impossible. Contact tracing, however, also carries elements of a morality, which "casualness" also emphasises.

"Anonymous" and "casual" come to imply a lack of concern, of proper responsibility for those with whom one engages on the most intimate level. "Casualness" is usually thought of in connection with the relations between two or more men, but it might be important to think of it in other ways as well, for instance "as a particular sex practice and not just as a description of partner choice" (Dowsett 1996: 146). Thinking of casual sex as a sexual practice rather than in terms of social relations between men may add something to the understanding of the appeal of casual sex: that it is not simply a matter of not knowing who you are doing it with, but rather that it is a kind of sex which, no more or no less than anal sex or oral sex or any other kind of sex, appeals to some and does not appeal to others, that some enjoy and others do not.

Insisting on the dangers of anonymity and casualness is part of the responsabilisation of the individual and also implies both their responsibility for their own infection and their responsibility for the infection of others. Responsibility for infection re-turns quite easily into moral responsibility for intimate sexual relations which the anonymity and casualness of sauna sex negate. Anonymity also negates one of the principles of governmentality: that the individual has a name by which s/he is identified and identifiable, a name which effectively confers individuality on her/him. Anonymity in the saunas is an escape or subversion of that governmentality, and is particularly offensive to the arms of the government engaged in the production of epidemiological statistics and contact tracing. There is another aspect to this which I have not heard mentioned by those who are engaged with the clinics and other centres where testing and contact tracing are conducted. They claim that what most of the men presenting with infections have in common is that they use the saunas. It may well be that this is the case, but it is also possible that the saunas are being used by the men involved as a way of avoiding the responsibility of contact tracing and thereby maintaining the anonymity of those with whom they have had sexual relations. Because the saunas are represented as being centres of infection, the men themselves may use them as the reported site of infection rather than admit that this

happened in their own homes or elsewhere: that is, it may be easier to admit that infection was the result of an anonymous encounter in a sauna, than to admit that one conducts intimate anonymous sexual relations in one's own home or somewhere else, as, for instance with a prostitute in a park.

This again has to do with the inscription of these sites with particular moral resonances. The home is a particularly sanctified place, one where intimacy might take place, but only with the most intimate of people. One does not, in this moral inscription, invite complete strangers into your home for sex. The same thing goes for the parks and prostitutes: sex in public spaces is a public order offence, and the men may fear prosecution as a result (since contact tracing is a direct involvement with the state and its functionaries) despite what counsellors and others advise. This also applies to having sex with a prostitute, which also has implications for the sexual identity of the man involved as being someone who had to pay to have sex, an identity that may be cast as being particularly degraded. Contact tracing obliges the positive individual opening a social and statutory contact with others who were previously only sexual contacts. Avoiding this moral inscription is easily done by naming the saunas as the site of infection. After all, these are public spaces, no-one is breaking the law by being there, and "everyone knows" what goes on there and the "codes" of silence and anonymity that operate in them. Granted, this is a psychologisation of the thinking of the men involved, but I have met men who, attending clinics for infections other than HIV, name the saunas as the site of infection regardless of where or with whom the infection occurred. In this way, the statistics produce the saunas as sites of infection, and the men re-produce this.

Contact tracing is one of the essential requirements of proper epidemiological intervention against disease spread in populations. There has been some tension in public health circles in Ireland between those who see this necessity as paramount and those who see the confidentiality and anonymity of the HIV positive individual as being paramount. This came to a head in March 1998 with a workshop addressing the question "Should HIV be made a Notifiable Disease?" The conclusion of the workshop was 'No.'

The Report of the workshop was examined by the National AIDS Strategy Committee which agreed that making HIV a notifiable disease might lead people to being more reluctant to being tested [sic], so other strategies such as the introduction of HIV Case Based Reporting should be investigated. [NASC 2000: 19]

Though Case Based Reporting does not make a difference to contact tracing as such, it should provide a better epidemiological pictures of HIV in Ireland.

Thus the boundaries between public and private become complicated and contradictory where HIV and AIDS are involved. Both HIV and AIDS are matters of great concern to public health, yet, unlike other sexually transmitted diseases, neither is notifiable or reportable. Guarantees of confidentiality and anonymity which keep the status of the individual private also mitigate to some extent against the public prevention of infection. A site like the saunas offers further complications. Whilst they are at least quasi-public spaces, inasmuch as there are no restrictions on the kind of men who can enter them and they advertise their facilities publicly in gay and other publications, they remain quasi-private in that they seem little regulated by public health officials, even where the serving of food is concerned. Whilst they appear open to the gaze of the Garda, that gaze does not seem to extend far beyond the front door. Private acts of sex between anonymous men in the dark and protective environment of the saunas happen as a result of a commercial contract between owners and the men. The shared knowledge and expectations of the men when they enter allows for the 'public' display of private parts and sexual acts. For some, it is the voyeuristic and exhibitionistic possibilities that are attractive, and both of these assume an audience. Even some of the toilets, with their frosted glass doors, allow for the privacy of the toilets to be penetrated. Yet the men who go to saunas are members of the public and private citizens. All this makes the relation between private sexual acts and public health fraught with difficulty.

## CONCLUSION

Communicating pictures of disease prevalence and the susceptibility of certain persons or groups of persons through statistical information reinforces the discourses of distinction between healthy self and diseased other. Communication itself, however, is also part of the issue. Interventions aimed at preventing the communication *of* disease require the proliferation of communication *about* disease to effect prevention. Increasing risk consciousness means identifying the risky practice as well as offering the possibilities of risk management. Ling (1989) has identified communication itself as part of the problem. Ling, a former director of information and education at the WHO and director of information and communication at UNICEF, suggests that "words and images, transmitted by mass media, are helping to shape habits and lifestyles that affect health" and argues that "many of the lifestyle diseases are therefore communicable via

information media” (Ling 1989: 253). He quotes Tan Shri Chong, president of the 36<sup>th</sup> World Health Assembly, as saying that “Lifestyles are not longer conditioned by climate and [traditional] culture. They are initiated as fast as communications speed information from one country to another” (ibid.) adding that Tan had effectively identified a “new type of contagious disease”:

In addition to the bacteria/viral and vector-borne communicable diseases, lifestyle illnesses had become the new communicable diseases – transmitted through the information media. Such infections may take a little longer to take hold, but they are no less infectious and no less deadly than the others. [ibid.: 254]

AIDS, he believes, must be added to the list of lifestyle illnesses (which already includes cancer, heart disease, alcohol and drug abuse) since though HIV is “the villain, the transmission of AIDS is largely a matter of lifestyle” (ibid.). The media and the images and information they communicate are agents of contagion. Behind this is a fear that communication of images and information leads to individuals indulging in dangerous practices, adopting lifestyles which are productive of particular diseases. Though he makes no explicit call for censorship as such, Ling clearly indicates that the desirability of certain lifestyles is part of their communication, and that this desirability poses a threat to health. This indicates a kind of double bind in health communications themselves: warning of the risk of certain practices (or lifestyles) may make them attractive to some who, it may be, were not previously aware they even existed.

If this appears a little far-fetched, it is perhaps worth noting that the information media have played some role in the spread of disease. A Reuters report in the Business This Week section of the *Irish Times* (27<sup>th</sup> August 1999: 10) claimed

Health officials tracking an outbreak of syphilis cases have followed the virus into cyberspace, identifying an Internet chat room as ground zero for infection.

Jeffrey Klausner, director of the sexually transmitted disease unit at the San Francisco Department of Health, said investigators quizzing the last seven homosexual men reporting syphilis infections were surprised to find that all seven found their most recent sexual contacts through a chat room on America Online [giving the name of the chat room].

The outbreak rang alarm bells for Klausner, who noted that venereal diseases like syphilis can boost a person’s vulnerability to HIV, the virus which causes AIDS.

“The challenge for us has been to contact, notify and inform individuals (when) we only have their Internet screen handles,” Klausner said.

The report also noted that America Online had declined to alter its privacy policy in order to reveal the identities of the chat room regulars.

The microbiological sciences are concerned, amongst other things, with the identification of transmission routes for viral and other infectious diseases, bringing to light the ways in which bacteria and viruses enter the body and cause disease. These sciences produce particular views of the body and its relations with the environment, particularly the microbial environment, and it produces these views through the use of ocular technologies centred in the bounded environment of the laboratory. Epidemiology is concerned, amongst other things, with the identification of persons or groups of persons amongst whom transmission occurs, bringing to light groups of persons who are seen to be vulnerable or susceptible, and bringing to light the practices through which the bacteria and viruses are transmitted. Public health relies on this knowledge in order to communicate the dangers and risks posed to health by these diseases, and to offer risk management strategies for those who are seen as being vulnerable or susceptible. Knowledge of the communication of disease and communication of knowledge about disease are interrelated and reflective of one another.

## Chapter Two

### Disease and Community: Protection, Risk, Identity, and Knowledge

Having examined the production of knowledge in the microbiological sciences and in epidemiology and public health, I want to turn in this chapter to the contestations over knowledge generated by the increasing visibility of the gay community in Ireland in recent years. As a community, gay men have been involved in the politics of knowledge since the advent of the gay liberation movement in the late nineteen-sixties in America. The medical profession of the time, and for nearly one hundred years before, had 'known' that homosexuality was a pathology. Against this, gay men presented their own knowledge of themselves as embodying a healthy sexuality, a lifestyle as opposed to a (pathological) 'death'-style. The appearance of AIDS not long after this assertion of self brought further contestation over the relationship between gayness and pathology, but the well-organised gay community, in Ireland no less than in America, met this challenge, and further extended its political will into the state and scientific realms.

In 1985, Gay Health Action was established in response to the growing awareness of AIDS as a problem in Ireland. It saw its work as being

to provide information on AIDS and related issues, not only to the gay community, but to the media, the medical profession, health workers, Trade Unions, and the general public. [Quoted in Duffy 1993: 24]

For the five years it existed, it provided information on AIDS and HIV to anyone who wanted it, but in particular to gay men. Initially, it was the only organisation in Ireland producing and distributing information on AIDS. Also in 1985, the Blood Transfusion Service Board introduced testing of blood products for HIV, and Cáirde, an organisation providing support and assistance for those with AIDS, was established. The first government campaign on AIDS was undertaken in 1987. Though the work of Gay Health Action was funded primarily by donations and fundraising in the gay community, it also, at least initially, received funding from the Health Education Bureau of the Department of Health, until

further funding was vetoed by the Department of Health because their legal advice was that information relating to gay sexual practices would be contrary to the criminal law. This was extreme duplicitousness as the Government was defending those very same laws in the European Court of Human Rights on the basis that they were not being implemented. While the Department of Health could not allow itself to support a gay mens [sic] health project the Department of Labour was, under trade union influence, funding a social employment scheme for Gay Health Action. [Rose 1994: 22]

In 1996, three years after the decriminalisation of homosexuality, the Gay and Lesbian Equality Network (GLEN) in association with Nexus Research produced a report titled *HIV Prevention Strategies and the Gay Community* (GLEN/Nexus 1996) which had been commissioned and funded by the Department of Health. From the point of view of GLEN, it was a welcome opportunity to extend further the very successful work which it had already done in the area of gay and lesbian equality and to extend contact between government and the gay community. The Department of Health wanted to see HIV prevention initiatives taken by the gay community and was offering funding for such initiatives. The report, which is over one hundred pages long, represents one of the most substantial pieces of cooperation between the gay community and the institutions of government, and subsequent action on the recommendations of the report included a bolstering of the gay community through government funding such as had not been seen before. Effectively, the report became the basis for government social policy in relation to the gay community.

The report presents itself as being “Phase One Report – A Baseline Study” indicating that it was the result of one phase of action and had expectations of there being further action to be taken. That further action was the establishment of Gay HIV Strategies (GHS), funded by the Department of Health directly, and which aimed “to radically improve HIV prevention work for

gay men by facilitating new programmes, resources and linkages” according to an initial press release/flier. The project director, Kieran Rose, is quoted on the flier as saying

This is a major step forward and provides a key opportunity to develop effective HIV prevention strategies based on a partnership between the gay community, and the statutory sector and the wider community and voluntary sector. The community development sector has a vital role to play and we hope to work closely with all community organisations to develop practical initiatives.

Community development has indeed played a large role in the strategies that were developed by GHS. Much of the funding has gone into supporting these voluntary groups and encouraging them to extend their roles to include HIV prevention initiatives, as well as into the establishment of new groups dealing with HIV prevention. More than anything else, Gay HIV Strategies has become one of the most powerful gay community organisations itself, a role it has largely taken over from GLEN. Though set up initially as a one-year project, it still exists and still commands a great deal of funding from the Department of Health and Children, and acts as one of the major representatives of the gay community in its relations with the institutions of government.

Probably the most significant factors in the many changes which might have influenced the movement of the Department of Health from vetoing funding in the Eighties to providing large amounts of funding in the nineties not only have to do with changes in the law criminalising homosexuality but also with changes in the perception of public health as a result of AIDS. This is not simply a change that took place in Ireland over the period, but rather reflects many changes in the approaches to public health and, in particular, to changes in the health promotion. In this chapter, I want to trace these changes, resulting in what has come to be called the ‘new public health,’ as the background to social change and gay politics in Ireland. The increasing visibility of the gay community brought with it new responsibilities but has also resulted in new understandings of the gay community on the part of government, as well as changing the way in which science is done.

### “STOP IT, YOU’RE MAKING ME SICK!”

In the report, *HIV Prevention Strategies and the Gay Community*, the authors conducted an extensive literature review, covering major texts dealing with HIV and AIDS and its impact on the gay community and their relations with health service provision and social context. One of the

works cited as a basic text is Dennis Altman's *Power and Community: Organisational and Cultural Responses to AIDS* (1994). The report quotes from Altman:

The redefinition of public health, sometimes described by the term 'new public health,' achieved official status with the adoption in 1986 by an international conference of thirty countries of what has become known as the Ottawa Charter. This declaration is committed to a policy of 'health for all,' stressing the importance of primary healthcare, of the promotion of healthy lifestyles, and of prevention and health promotion. Most significant for our purposes [is] its focus on the creation of supportive environments and the enabling of communities. [Quoted in GLEN/Nexus 1996: 29].

This statement covers what remain the most important features of 'new public health' which I want to discuss here. I want to start by looking at the social, political and economic environments in which the Ottawa Charter originates, especially as they affect gay men.

Perhaps the most significant movements to be considered are those arising in the 1950s and 1960s in America, where various groups (women, racial and ethnic groups among them) organised themselves with the objectives of fighting discrimination and obtaining rights. Rights, which formed much of the basis of modern democratic politics, start to become exclusive, with varieties of groups demanding rights which are specific to them. In America in the fifties and sixties, groups like the Mattachine Society, the North American Council of Homophile Organisations, and the Society for Individual Rights worked towards a greater acceptance of homosexuality. A significant moment was that point where the 'homophile' organisations (as they were known) became "gay":

"Gay" was used increasingly to refer to a total life-style and a way of thinking about oneself and others. Not unlike the change in usage from "Negro" to "black," and from "lady" to "woman," "gay" was intended to deemphasize the one-dimensional image imposed by traditional and particularly medical definitions. In many regards, "homosexual" could be seen as itself as oppressive term that grew out of a need to defend rather than assert one's human rights. [Conrad & Schneider 1980: 202]

The riots at a Greenwich Village gay bar in June 1969 led to the establishment of the Gay Liberation Front and the Gay Activist Alliance, signaling even by their names a shift from the politics of toleration to more militant action. The Gay Liberation Front was avowedly militant (indeed radical and revolutionary) while the Gay Activist Alliance sought (albeit in a more active

way) political and social changes from within the system. According to Conrad and Schneider, the Gay Liberation Front

...argued that the condition of homosexuals in American society was part of a general exploitative relationship between American economic and political interests and "the people." They insisted that only by drawing the various groups supporting "people's liberation" together – gay people, black people, prisoners, women, third-world people – could true freedom be won. [ibid.: 202-3 ]

On the other hand, the Gay Activist Alliance sought specific rights, as outlined in their constitution:

The right to our own feelings...to feel attracted to the beauty of members of our own sex and to embrace these feelings as truly our own, free from any question or challenge whatsoever by any other person, institution or moral authority. The right to love...to express our feelings in action...provided only that the action be freely chosen by all the persons concerned. The right to our own bodies...to treat and express our bodies as we will, to nurture them, to display them, to embellish them...independent of any external control whatsoever. The right to be persons...freely to express our own individuality under the governance of laws justly made and executed, and to be the bearers of social and political rights...guaranteed by the Constitution of the United States and the Bill of Rights...and grounded in the fact of our common humanity. [Quoted in ibid.: 203]

These two approaches – the militant and the rights-oriented – were contesting the accepted wisdom of the medical profession that homosexuality was a psycho-pathology. Not only was this a direct opposition to the view of the medical profession (in particular of the powerful American Psychiatric Association (APA), where homosexuality was defined as pathological) but it was also an attack on the very right of the medical profession to create knowledge about pathology. The larger question being posed was Who gets to decide who is sick, and how? The gay liberation movement challenged the commonsensical notion that "disease is first and foremost what the medical profession says it is" (Conrad & Schneider 1980: 208). In particular, the liberation movement targeted aversion therapy, "a popular form of behaviour control used in the clinical treatment of homosexuals" (ibid.: 204).

The efforts of the gay liberation movement were directed both against the inscription of homosexuality as pathology and against the interventions used to treat diagnosed homosexuals. It countered the posited relation between disease and cure, saying, on the one hand, that it was not a disease so cure was impossible, and, on the other, that because cure was ineffective it could not

be a disease. It became a struggle over the “politics of nomenclature” ( *ibid.*: 206) but the attack was not simply about ‘calling’ homosexuality a disease. It was also about the effects of such a pathologisation, about the view that society as a whole took of homosexuals, and about the rights to private sexual experience. At stake was the prerogative of the professions to divide the normal and the pathological. Both gay activists and some psychiatrists within the APA questioned the basis of the pathologisation: was it simply an effort at social control, or was it actually a sickness? The social and political effects of the labeling ‘homosexual’ were manifestly ‘sickening,’ inviting homophobic attacks, discrimination, and prejudice. The pathological labeling also had the effect of de-politicising homosexuality by medicalising it. In this logic, homosexuality was not a public matter of rights or social and political acceptance, but simply a private matter of treatment. Gay activist Ronald Gold wittily summed up the problem in the title of his paper to an APA panel in 1973: “Stop It, You’re Making Me Sick!” Until this nomenclature was changed, the struggle for gay rights and liberation could go nowhere. The “zapping” and “liberation” strategies used by the liberation movement against the APA were to be resurrected years later by AIDS activists in their encounters with the medical profession and others, at a time when the ‘politics of nomenclature’ again became significant.

Following the “liberation” of a session at the APA’s annual meeting in 1970, homosexuals were invited to participate in a panel (titled “Life-Styles of Nonpatient Homosexuals”) at the annual meeting the following year. By 1974, the APA had changed its diagnostic manual, eliminating homosexuality *per se* as a pathology. This de-pathologisation was hailed by gays as a major step in liberation, but there were dissenting views. Thomas Szasz, himself no supporter of psychiatry but a supporter of gay liberation, said:

I think the homosexual community is making a big mistake by hailing the APA’s new stance...as a real step forward in civil liberties. It’s nothing of the sort. It’s just another case of co-optation...[The APA] have merely relented on where they draw the boundaries around homosexuality. [Quoted in *ibid.*: 209]

Szasz’s point is valid: homosexuality had been a pathology, and had been de-pathologised. Gayness as a lifestyle came into its own with this de-pathologisation, and opened the way for progress towards rights. Yet this was done on the APA’s terms, and could just as easily be undone, raising questions about the role of medical professionals in the definition of what illness is. This goes back to the question of the representation of the normal and the pathological, and the consequences of this division. If homosexuality had been abnormal, did that make gayness

normal? If heterosexuality had been privileged as normal, and was now joined by de-pathologised gayness, what consequences did that have for the perceived opposition between heterosexuality and homosexuality? The distance from normal (in the terms of an organisation like the APA) and normal in the wider social environment was still great. There was also the question of what gayness was: if it arose out of an opposition to homosexuality, a name coined in the nineteenth century as a denote a particular psychopathology, did gayness have any existence outside of psychiatry?

For the moment at least, these questions remained unanswered. Government responses to the growth of rights-oriented campaigns raised other issues. There was a gradual devolution from 'population' to 'populations' or communities in many Western democracies. This was accompanied by decentralisation of power which is seen as being part of the shift from modern to postmodern society, or from the societies of power to the societies of control (Deleuze 1992). It is also a shift from the organisation of environments of enclosure under societies of control to more modulated controls:

Enclosures are *molds*, distinct castings, but controls are a *modulation*, like a self-deforming cast that will continuously change from one moment to the other, or like a sieve whose mesh will transmute from point to point. [ibid.: 4]

Important to this also is what Deleuze refers to as the shift from individuals to dividuals: "The disciplinary man was a discontinuous producer of energy, but the man of control is undulatory, in orbit, in a continuous network" (ibid.: 6).

The mid-1970s also see major upheavals in western capitalist governments. The post-oil crisis economic slump was followed by the election of conservative governments. The major concern of these governments was 'balancing the books' which was largely achieved by radical cuts in certain areas of government spending (often education and health). The change in governments' attitudes to spending has been referred to as the "contracting culture." As public spending was cut, governments emphasised the role of the private sector in filling the gap. Funding for infrastructural projects like roads, for instance, could come in part from government and part from private enterprise, with private enterprise benefiting from any generated profits (as from toll roads). Big budget departments, like health, were forced to make cut backs in services, and demanded the same 'balancing of the books' of the institutions and services it funded. Ward closures, and the consequent build-up of waiting lists, were common, as were delays in providing

funding for new equipment and infrastructural developments. Alongside this, government and its departments became consumers. Where before, public service workers were employed directly by the state, with 'jobs for life' and pensions after retirement, now the government employed on the basis of short term contracts, and developed the use of private enterprise to provide services on a contractual basis. This movement was easily undertaken in Ireland where the Catholic notion of "subsidiarity" had already kept certain health and welfare issues out of direct control and influence from government. As Smyth notes:

The Irish health system still reflects the Catholic social principle of subsidiarity whereby the Church maintains the desirability of leaving as many functions as possible to bodies lesser than the state including families, community associations and other professional and vocational organisations. [Smyth 1998: 664]

This move can be seen in prisons and hospitals, where full-time state employees were being replaced by private sector service providers on short-term contracts. Government pulled back from service provision, privatising formerly state-owned companies and businesses.

This 'contracting culture' comes into its own in the early eighties, just as AIDS emerges in the Western world. The fact that the first reported cases of (then nameless) AIDS appeared among gay men in America led to an initial focus on gay lifestyle as somehow predisposing gay men to this disease. Co-factorial theories (the 'immune overload' theory, the idea that poppers were somehow implicated in AIDS, and even that this was simply 'God's wrath') were overtaken by monocausal theories with the discovery of HIV. This did little to change the perception in many quarters that AIDS was a 'gay' disease, and this perception delayed many initiatives which might have saved lives in the early days of AIDS. The fact that AIDS had 'appeared' among gay men, a group already inscribed in many negative ways (as sinful, as sick, as criminal), seemed to justify thinking about AIDS as deserved by or inherent in gays.

AIDS is not a gay disease, but in the US it affected gay men first and, thus far, has affected us in greater proportion. But AIDS probably did *not* affect gay men first, even in the US. What is now called AIDS was first *seen* in middle-class gay men in America, in part because of our access to medical care. Retrospectively, however, it appears that IV drug users – whether gay or straight – were dying of AIDS in New York City throughout the '70s and early '80s, but a class-based and racist health care system failed to notice, and an epidemiology equally skewed by class and racial bias failed to begin to look *until 1987*. [Crimp 1988: 249, emphasis in the original]

Nonetheless, the perception was that gay men were the ones affected by AIDS, and amongst the plethora of acronyms floating around at the early days of the epidemic were CAIDS (Community Acquired Immune Deficiency Syndrome) and ACIDS (Acquired Community Immune Deficiency Syndrome), where 'community' indicated 'gay community' (see Shilts 1988: 138). These existed in addition to GRID (Gay Related Immune Deficiency) until the acronym AIDS was finally settled on in July 1982 just thirteen months after the publication of a paper that had noted unusual immune deficiencies among gay men (ibid.: 171). Gays, only recently de-medicalised by psychiatrists, were being re-pathologised in terms of AIDS. Not only that but acronyms like CAIDS and ACIDS directly implicated community in new disease. This also applied to the other groups in which AIDS was first noted, Haitians, heroin-injectors, and even haemophiliacs, though the latter were presented as being 'innocent' or 'blameless' victims of AIDS. Early diagnoses of AIDS in these non-homosexual groups led to searches for gay connections, and only when these failed was it generally accepted by the medical and scientific community that AIDS was not simply a 'gay' disease. The fact that "AIDS" became accepted as the name for this new disease rather than CAIDS or GRID did little to diminish the perception that *AIDS* was a gay disease.

Despite this, popular perceptions of AIDS as a gay disease were widespread and this 'gaying' of AIDS led to several problems. There was increased homophobia, now made more justifiable since homosexuals were diseased with AIDS; funding to support people with AIDS, particularly the large numbers of gay men in the United States, came largely from gay fundraising initiatives, and was slow to come from central and regional government who were reluctant (especially given the moral and economic conservatism of governments like those in Britain and America at the time) to be seen to be helping those who had brought this on themselves. Weeks et al (1996) quote from a volunteer with one such organisation:

In the early days when the epidemic first came around it was the gay community that fought back for their own survival...Maybe if they hadn't been so quick to mobilise themselves they wouldn't have been left to themselves. [Weeks et al 1996: 161]

Falling back on self-help at this point was difficult, especially in terms of raising funds, but the organisations and groups that endured through this became the representative gay organisations in relation to HIV and AIDS, and were to pose powerful challenges to the government as well as to the medical and scientific establishments in the years to come. The de-gaying of AIDS was undertaken by many groups affected by AIDS who claimed that AIDS was not simply a matter

for gay men but was rather a matter of public health. By the late eighties, most Western governments had taken this on board, less because of a need to act to help gays or drug users or Haitians who were affected than because haemophiliacs could not be construed as 'blameworthy' and commanded a great deal of sympathy from the general public. Added to this, and much discussed at the time, was the projection of mounting health costs in dealing with the infected and the ill. The fact that, despite the isolation of the aetiological agent, there seemed to be little prospect of either a vaccine or other preventive therapy, or of drugs to deal with the virus in the body, also increased the sense that prevention was the best way forward.

The de-gaying of AIDS, though it was effective in progressing the provision of services for those affected and the provision of preventive information to a wide audience, had the unanticipated effect making it harder for gay groups to get funding from state agencies. AIDS was not specifically a gay problem and funding for specialist gay initiatives was thought to be unnecessary. This led to what some have seen as being the 're-gaying' of AIDS, making the case that AIDS is a gay issue and of specific relevance to gays, therefore justifying funding for specifically gay initiatives to prevent the spread of HIV infection. This could be seen as the re-AIDSing of gayness, restoring a connection between gayness and AIDS, and building gayness around issues of health and especially around the issue of HIV and AIDS. This to-and-from pathologisation of homosexuality, de-pathologisation of gayness, re-pathologisation of gayness in terms of AIDS, the gaying of AIDS, the de-gaying of AIDS, and the re-gaying of AIDS, can be seen as a continual (indeed continuing) struggle over what Conrad and Schneider term the "politics of nomenclature." The associations made between determinations of disease and determinations of identity have changed several times in the space of thirty years.

At the same time as AIDS is emerging in the Western world, 'new public health' is rising to importance, achieving status with the Ottawa Charter in 1986. At the centre of 'new public health' is a distancing of government from major institutional infrastructure like hospitals, and an increased emphasis on health promotion. By the early nineties, this emphasis was being embodied in strategies produced by the Department of Health. *A Health Promotion Strategy: making the healthier choice the easier choice*, produced by the Department of Health in 1995, offers the following statement of ideal health promotion:

Health promotion at an individual level involves educational processes enabling people to acquire information and skills that will help them in making good decisions in relation to their health. At a community, regional and national level

it involves the development of appropriate policies, structures and support systems so that the healthier choice becomes the easier one to make. [Department of Health 1995: 2]

It is clear in this that health promotion is a multi-level approach, requiring the interaction of individuals, communities, and regional and national institutions, yet it is also clear that someone has to take the decisions as to what is healthy and healthier, and this opens up the question of just what health is in the late nineties.

Crawford in his paper argues

...that 'health' is a key concept in the fashioning of identity for the modern and contemporary middle class and that the 'unhealthy' come to be represented as the other of this self. 'Healthy' and 'unhealthy,' however, must be understood both in their biological meanings and in their implicit metaphorical meanings. The 'unhealthy,' 'contagious,' 'sexually deviant,' and 'addicted-minority' other – all condensed in the negative symbolism of AIDS – have become images which are mobilized as part of a cultural politics of reconstructing the self in conformity with intensified mandates for self-control. The expulsion of 'unhealthy' meanings from the self, an act of patrolling the borders of identity, finds its projected physical location in the figure of the person with HIV-AIDS. [Crawford 1994: 1347]

If we consider the health promotion statement of the Department of Health given above in terms of Crawford's sense of health as an identity-producing divider, the ideal of 'health for all' looks less like a mandate to free society of illness than like an ideal form of social control and the imposition of conformity. 'Health' has become *the* common sense of the end of the twentieth century in the Western world, and offers a way forward from the problems posed by rights-based campaigns. 'Medicalising' offers a depoliticised approach to political problems, dividing the problem itself between the individual and larger institutions, such that the individual must bear part of the responsibility for the problem, with the larger institutions taking another part. This responsabilisation thus requires internalisation of certain ideals on the part of individuals and the acceptance by individuals of the role they have to play in achieving those ideals, and environmental change to make such internalisation and acceptance easier. If we think of it, briefly, in terms of a phenomenon such as homophobia, it requires that individuals who feel they have been subject to homophobia see its effects as something they must deal with (usually through increased self-esteem) on an individual level. At a community level, the gay community pursues changes in the environment (at regional and national level) to ensure that homophobia is eliminated. The aim of health promotion, then, is to achieve lifestyle changes on the part of

individuals and the provision of supportive environments for such changes on the part of community, regional and national institutions. Along with this, though somewhat less noticeable, is the continuing acceptance of the metaphor of health as the basis for this kind of change. Health has become a dominant norm and a powerful instrument of social change.

That there is a morality operative in this is clear also in the Department's statement. Healthier choices are "good decisions in relation to...health" where good is neither defined nor clearly related to anything in particular (good for whom, good in what way?). The same goes for the notion of "appropriate policies, structures and support systems:" appropriate for whom and in what way? Who decides what is appropriate? If it seems that the solutions have all already been formulated by expert authorities, the gay community changes that, demanding a say in questions of appropriateness and intervention in health issues that affect it. I will examine these questions in more detail below, but for the moment I want to examine the emergence of gay community in Ireland and its relations with the institutions of state, and the role of HIV and AIDS in its development.

#### KNOWLEDGE, IDENTITY & LEGALITY

One of Oscar Wilde's more infamous phrase was "the love that dare not speak its name." It was another designation of

...the crime *inter Christianos non nominandum*, and it was so designated not only because it was conceived of as something lurid, shameful, and repellent, but also because it was, and is, conceived simultaneously as something so attractive that even to name or represent it is to risk the possibility of tempting some innocent into a fate too horrible – or too seductive – to imagine. [Edelman 1994: 87]

Much of the movement of gay liberation in Ireland has been an effort to get the unspeakable spoken about. Alongside sinful and criminally proscribed acts such as abortion, divorce, and contraception, homosexuality was not something that could easily be debated in Ireland. Unlike the United States where the acknowledged authorities on homosexuality were the medical professionals, in Ireland the acknowledged authority was the Catholic Church, and with a large population of Catholics, representatives of the people in government towed the Catholic line in relation to much social and welfare policy from the founding of the State.

When Wilde was committed for trial in England in the eighteen nineties, he was charged with two offences, one of which was "...the commission of acts of gross indecency...contrary to the Criminal Law Amendment Act, 1885, section 11" (Hyde 1976: 234). Section 11 itself reads:

Any male person who, in public or private, commits, or is a party to the commission of, or procures or attempts to procure the commission by any male person of, any act of gross indecency with another male person, shall be guilty of a misdemeanour, and, being convicted thereof, shall be liable, at the discretion of the Court, to be imprisoned for any term not exceeding two years with or without hard labour. [Quoted in Ellmann 1988: 409]

Wilde's biographer, Richard Ellmann adds to this a story that "When it was pointed out to Queen Victoria that women were not mentioned, she is reported to have said, 'No woman would do that!'" (ibid.). This story has some currency, as indicated by a different version related by Paula Treichler in her essay "AIDS, Africa and Cultural Theory":

I was curious about how prostitute was officially defined in AIDS research and prevention. This turned out to be a fairly complicated question, involving not only diverse languages but a disjuncture between legal and lived reality that reminded me of Queen Victoria's supposed insistence that reference to lesbianism be deleted from an 1885 bill criminalizing homosexuality on the grounds that women were incapable of such perversion. [Treichler 1999:217]

Section 11 was an amendment to the Bill, inserted under the part concerning the "Protection of Women and Girls" and became known in England as the "Labouchere amendment", or, more popularly, as the "blackmailer's charter" since it led to the proliferation of blackmail against homosexuals. It is interesting to note that the word "homosexual", which was gaining currency by 1885, is not used, and acts of lesbianism are not covered by this or any other legislation. As Hug comments, on a failed attempt to introduce a bill on lesbianism in the Britain in 1921,

The argument was that the measure would make women aware that such acts exist when the vast majority were innocent of such horrible thoughts. In effect, lesbianism was censured by silence rather than by an explicit condemnation. [Hug 1999: 204]

This is perhaps another case of not naming the crime for fear of its seductions. In addition to the 1885 Act, there were also the provisions against buggery in the 1861 Offences Against the Person Act. The 1861 Act was a reform of previous legislation which had been introduced earlier by an Irish House of Commons:

The criminalisation of sexual relationships between men was introduced into Ireland as part of the process of colonisation with the introduction of common law and also by 'An Act for the Punishment of the Vice of Buggery' passed by the Irish House of Commons in 1634. [Rose 1994: 74]

Both the 1861 and 1885 Acts extended to Ireland, then under direct rule from the British Parliament at Westminster, and both remained on the statute book after Ireland became a Free State and the North and South of the country were partitioned in 1921. The campaign to change these laws began in 1974 with the founding of the Irish Gay Rights Movement by David Norris, who also later chaired the Committee for Homosexual Law Reform. In 1977, Dr Noël Browne, an independent Senator and a former Minister for Health, called for a debate on homosexuality, abortion and divorce. Browne was a controversial figure, having resigned as Minister for Health in 1951 in a controversy that many saw as laying bare the relations between the Roman Catholic Church and the State in relation to social policy. His call for a debate was ignored, and the argument over homosexuality shifted from the Dáil to the courts. In 1977, Norris, with Mary Robinson as Senior Counsel, brought a case in the High Court alleging that the laws in relation to homosexuality were unconstitutional. According to Rose (1994: 35), Norris' intention was "to end the conspiracy of silence," but the court found against him in its judgment of 1980, a judgment that was confirmed by a 3 to 2 majority verdict after he appealed it to the Supreme Court in 1983. As one of the Supreme Court judges commented,

I regard the State as having an interest in the general moral well-being of the community and as being entitled, where it is practicable to do so, to discourage conduct which is morally wrong and harmful to a way of life and to values which the State wishes to protect. [Quoted in Hug 1999: 214]

This same judge also stated that

The legislature would be perfectly entitled to have regard to the difference between the sexes and to treat sexual conduct or gross indecency between males as requiring prohibition because of the social problem which it creates, while at the same time looking at sexual conduct between females as being not only different but as posing no such social problem. [ibid.]

The behaviour of the Courts in this seemed to many at the time to be slightly anomalous. Though the only job of the Courts was to rule on whether or not the law could be deemed unconstitutional, many thought that the Courts would have taken into consideration a recent

ruling in the European Court of Human Rights which had found these same laws to be in contravention of the Convention on Human Rights. The case had been taken by Jeffrey Dudgeon from Northern Ireland. As with the Republic, the 1861 and 1885 Acts remained on the statute book in Northern Ireland after partition. The 1967 reform of the laws in England, which legalised homosexuality, had not extended to Northern Ireland which at that time had its own Parliament at Stormont. Dudgeon had won his case in Europe in 1981, and the British government, which had reimposed direct rule of Northern Ireland by that time, extended its 1967 legislation to Northern Ireland as well. Norris and the Irish Gay Rights Movement had joined forces with Dudgeon and the Northern Ireland Gay Rights Association in funding Dudgeon's case in Europe. With no sign that the Irish government saw any connection between the ruling on the law in Northern Ireland and its own laws, attention shifted from the Irish courts to the European courts and Norris took his case to Europe in 1983. The European Commission on Human Rights ruled in favour of Norris' case, but the Irish government refused to accept the ruling, and the case was sent to the European Court of Human Rights, where the government took as its defence the apparently contradictory position that "the laws were not implemented but that they were necessary" (Rose 1994: 39). In 1988, the Court ruled in Norris' favour.

The Irish government, however, was not in any hurry to act on the ruling. In fact, it took another five years to make any change, by which time the climate had changed considerably. AIDS played no small role in this. The first AIDS cases in Ireland had been identified in 1982 but the first government campaign did not happen until 1987. As Smyth claims:

The government's failure to respond to the initial cases of AIDS in the gay community, for example, was attributed to an institutional homophobia which succeeded in presenting these events as an external threat that did not affect the "general population". The onset on infection among IVDUs was regarded as equally marginal. Indeed, it required the advent of heterosexual incidence to persuade the government both to recognise the Irish dimension to HIV/AIDS and to countenance positive actions like the restricted availability of condoms.  
[Smyth 1998: 671]

In the meantime, as I have already noted, Gay Health Action had been established in 1985 and continued its work until it disbanded in 1990, but the experience and connections established in the initial campaign against AIDS proved useful when it came to the issue of legislative reform. AIDS, however, also became useful to those who were now campaigning against any such reform. Groups like Family Solidarity, which had been set up in 1984, in the wake of the abortion

referendum, were not slow to point out the link between homosexuality and AIDS, as indicated by one spokesman who claimed that

...it would be an act of gross irresponsibility for the Government to do this [legalise homosexual acts], particularly during an AIDS crisis, encouraging as it does the main sexual act by which the HIV virus is transmitted. [Quoted in Hug 1999: 222]

Other groups, like the Irish Council for Civil Liberties, fought against this kind of inscription of homosexuality as being in itself a sickness or as being linked to sickness:

The model of homosexuality as a disease has sadly received new life since the advent of AIDS. AIDS is not, of course, a 'gay disease', but wide misreporting in the press has given that impression. In truth, gay men are just one of a number of groups at somewhat greater risk of HIV infection... There have been suggestions that gay male sexuality should remain illegal in order to prevent the spread of AIDS, though there is compelling evidence to suggest that the threat of criminal prosecution actually harms the public health effort by driving disease underground, where it is more difficult to study and contain, and by impeding the flow of information about prevention from public health experts to the population at risk. This dominating issue of illegality has badly distorted the Irish experience of the fight to contain the HIV virus. [ICCL 1990:40]

By 1993, no legislation had yet been introduced and Norris was threatening further action at a European level that had the potential of being very embarrassing to the government which promised legislation in the near future. The organisation primarily responsible for the campaign for law reform at this stage was the Gay and Lesbian Equality Network (GLEN), and they had already had a number of successes that made the government position less and less tenable. In 1987, GLEN had been part of a review within the Irish Congress of Trade Unions (ICTU) which produced "Lesbian and Gay Rights in the Workplace: Guidelines for Negotiators". In 1988, the Minister for Finance, Ray McSharry introduced the "Civil Service Policy on AIDS in the Workplace" which prohibited discrimination on the basis of sexual orientation, sero-positivity or AIDS. In 1989, the Law Reform Commission, a statutory agency dealing with law reform, recommends legislation be introduced and that there should be a common age of consent. Both GLEN and GHA had been involved in making submissions to the Law Reform Commission's review seminar. Also in 1989, the Prohibition of Incitement to Hatred Act was passed, and even went so far as to include sexual orientation not just as a provision within the Act but also in the Act's very title, An Act to Prohibit Incitement to Hatred on account of Race, Religion, Nationality or Sexual Orientation. So by 1989, the government had already protected from

incitement to hatred a classification of person still criminalised under other legislation, and protected them from discrimination within the Civil Service, but discriminated against them when it came to funding for HIV prevention campaigns through the Department of Health.

The anomalies did not stop there. When legislation was finally introduced, as the Criminal Law (Sexual Offences) Bill 1993, David Norris, who by that time had been elected a Senator in the upper house of the Dáil, said he felt he could not vote for the legislation because, *inter alia*, “I do not find it flattering to be continually lumped in with prostitutes, drug abusers and child molesters” (quoted in Hug 1999: 227). Norris was referring to the fact that the same legislation contained provisions criminalising prostitution and making kerb-crawling an offence among other things. Perhaps not surprisingly, the word homosexuality, which did not appear in the legislation being repealed, did not appear in the Bill either. The government had a large majority in the Dáil and intended to impose the whip to ensure passage of the legislation. The main opposition party at the time, Fine Gael, faced off dissent within its own ranks by tabling amendments which took all the available time to debate and ensured that their dissenters got no time to introduce their own amendments. One Fine Gael deputy, Brendan McGahon, wanted to vote against what he referred to as a “wanker’s charter” perhaps with an unironic reference to the Labouchere Amendment (the “blackmailer’s charter”) which this legislation would repeal. An independent deputy called for a vote on the Bill, but, since no-one supported his call, the Bill was deemed to have passed the House without a vote.

Thus, legislation which criminalised certain acts, but did not mention homosexuality, was taken on by the Irish State, without ever debating or voting on it, and was used by the Government as a reason for refusing to fund HIV prevention at the same time as the Government was claiming the legislation was not being enforced, and is finally repealed by an Act which does not mention homosexuality and which passed the Dáil without a vote. Most importantly, the government was seen to be under pressure from Europe, and acted in the face of a number of opinion polls which showed that as much as 60% of the population did not want homosexuality decriminalised (Hug 1999: 226).

Throughout all this, the campaign by Norris for a vindication of his personal rights was accompanied by the campaigning of GLEN for recognition of gay rights more widely. What GLEN achieved was a certain credibility for itself as the legitimate representative of particular social interests. In interacting with government, politicians, political parties, workers’

organisations and NGOs concerned with issues such as poverty and civil liberties, as well as through its own networking with other organisations pursuing social liberalisation and change, GLEN developed as a group of powerful and astute lobbyists. Through television, radio and press these lobbyists became the visible face of gayness in Ireland, taking homosexuality out of the dark and into the light, breaking the silence that had been imposed on it. Through their contacts with the media they built up a public relations profile that won over many middle-class educated people. In this way they were able to mobilise a constituency of support and empathy, framing the reality of gayness through representations which appealed to people much like themselves. By contesting the accepted authority of Church and State to frame them in particular representational strategies (as immoral, sinful, sick, criminal), they created their own representations of gayness, identities that interpellated sufficiently with their audiences (whether in government or in various organisations) to naturalise gayness. From here on, it was not the Church, the government, the Irish or the European courts who would control representations of or produce knowledge about gay men in Ireland: gay men were doing it for themselves.

#### CONDOMS: FROM EVIL TO PROPHYLAXIS

This period was an important one in the development of Irish social policy, a period which saw much debating of what Hug (1999) calls the “politics of sexual morality in Ireland.” Gay organisations like GLEN often joined with other groups involved in campaigns to change social legislation affecting sexuality, and in turn received support from these other groups. One of the issues on which groups campaigned long and hard, and which again was affected by HIV and AIDS, was the campaign to legalise contraception.

The debate on contraception had been on-going for some time in Ireland before the advent of AIDS and HIV. Hug traces what she refers to as “the construction of an Irish, Catholic morality” which led successive governments to introduce social policy legislation in line with Catholic morality. The *Report of the Committee on Evil Literature* in 1926 led to the inclusion in the Censorship of Publications Act, 1929, of clauses which made illegal any publication promoting contraceptives. The Carrigan Committee (1930-31) recommended that the sale of contraceptives be banned except in exceptional circumstances, but Section 17 of the Criminal Law Amendment Act, 1935, which was based on these recommendations, simply banned the sale and importation of contraceptives. This complete ban did not prevent the use of contraceptives entirely: the

contraceptive pill was available in Ireland from the early sixties, but only under prescription, and only as a menstrual cycle regulator.

By the late sixties, the Catholic Church had reiterated its policy through the Pope's encyclical *Humane Vitae*, but Irish people were defying the law on a daily basis, even openly importing condoms and other contraceptives into the Republic from Northern Ireland or from England. Fertility guidance clinics had opened, and one state-supported maternity hospital, the Rotunda, had a family planning clinic. Nonetheless, an attempt in 1972 by TDs Noël Browne and John O'Connell to have a Criminal Law Amendment Bill, drafted by Senator Mary Robinson, debated "created an uproar [among government TDs] at the mere mention of the word contraception" (Hug 1999: 95). In December of the same year, the Supreme Court ruled in the McGee case that the ban on the importation of contraceptives was unconstitutional, though only importation for personal use, and with no mention of anything to do with advertisements or publications on contraception. Just before this, in November 1973, Mary Robinson had tried again to get a Family Planning Bill debated in the Seanad, which was different from her earlier attempt in that the shift from Criminal Law Amendment to Family Planning marked a shift in responsibility for contraception from the Minister for Justice to the Minister for Health. On the day that Bill was defeated, the government introduced its own Control of Importation, Sale and Manufacture of Contraceptives Bill, 1974, which was later defeated in a vote where even the Taoiseach and the Minister for Education voted against the government Bill. A further attempt by Robinson also met with defeat and the task of drafting another government Bill fell to incoming Health Minister Charles Haughey.

The Family Planning Bill, 1979, promised, in Haughey's own words "an Irish solution to an Irish problem" (Dáil Debates 28<sup>th</sup> February 1979: col. 335). Information would be available through the Health Boards, and contraceptives would be available only on prescription and only for "*bona fide*" family planning or for medical reasons. The Act came into force in November 1980, but family planning clinics and the Well Woman Centres continued to sell condoms without prescription. In 1982, the President of the Irish Family Planning Association, "was fined £200...for giving condoms to a patient at the weekend when chemists' [sic] were closed. The fine was later lifted, but the judge said, 'anyone without condoms at the weekend will have to wait until Monday.'" (Hug 1999: 116). This almost risible attitude towards contraception was, however, only a milder version of what was becoming an increasingly vocal reaction against

creeping social reform. In 1983, Family Solidarity, a group pledged to protect the family, was founded. In a statement to the Irish Times, they said:

Family planning for people who are not forming a family is merely a licence to fornicate and we think this is a threat to the family. The age limit is irrelevant. It doesn't matter. If you have unmarried people of 18 who are not prepared to make the commitment of marriage then we take the view that they have no right to sexual indulgence. [Irish Times 14<sup>th</sup> December 1984]

In 1985, Minister for Health Barry Desmond, who had been involved with the Family Planning clinics, introduced the Health (Family Planning) (Amendment) Bill in an attempt to bring the law into line with the daily reality. Under this Act non-medical contraceptives, including condoms, could be sold without prescription to persons aged over 18 but only through chemists, family planning clinics, maternity hospitals and VD clinics. In 1991, the Irish Family Planning Association was fined for selling condoms at the Virgin Megastore in Dublin, and by this time, the government was again under pressure to amend the law. Now it was AIDS that drove the argument about the availability of condoms, with a move from condoms as contraceptives to condoms as prophylactics. According to Hug (p. 122), 20-25% of chemists sold condoms in 1985, 45% by 1986, 70% by 1987, and about 80% by 1988:

The Department of Health granted nine licences to import 18 million condoms in 1988; in 1989, the figure was 51 million owing to the increase in the demand caused by the AIDS campaign organised that year by the government. [Hug 1999: 122-3]

The new government, under Taoiseach Charles Haughey, started addressing the situation, but without much enthusiasm. After three successive Ministers for Health, Dr John O'Connell introduced the Health (Family Planning) Amendment Bill, 1992, which dealt only with condoms, lowering the minimum age for purchase to 17, in line with the heterosexual age of consent, and allowing for the sale of condoms in additional outlets, but excluding schools, youth and sports centres, and vending machines. In the Seanad debate, David Norris, a prominent gay rights activist, commented on how this was nothing to do with family planning, but rather, for some people, about not having a family, and for others, about protecting themselves from disease (Hug 1999: 129). Finally, in 1993, yet another Health (Family Planning) (Amendment) Act was passed. In this Act, condoms are no longer classed as contraceptives, and could be sold even through vending machines (though they were still banned from secondary schools and the Minister could

ban them elsewhere), and could be bought with no minimum age limit. The act also allowed for advertising of condoms, in line with the Minister's national AIDS campaign which promoted condom use as protection against AIDS through an advertising campaign. As Hug comments:

It could be argued that the smooth adoption of this law was not entirely due to the so-called sea-change in Irish society, but that the AIDS threat and its spread accelerated the process. After all, condoms are not considered as contraceptives, but as essential devices to protect public health, and as such are available everywhere to everybody. [Hug 130-1]

This account gives little impression of the complexity of the debate, or the passions it generated, but should make clear that ostensibly straightforward issues such as the availability of condoms as prophylactics are not at all straightforward in the Irish situation. It demonstrates the generation of signifiacnce around objects such as condoms, and the transformative effect which HIV and AIDS have had on thinking about them in Ireland. It should also make it clear that the complex interaction of politics, morality, health, justice and sexuality, though it has changed in recent years, still grips Irish thinking. In the language in which the history of contraception is couched – from committees on evil literature and censorship of publications to criminal law amendments to and health acts; from fertility guidance to family planning to contraception; and from contraceptives to condoms to prophylactics; and in the shift from Department of Justice to Department of Health – we can see again a politics of nomenclature which, through continual contestation over a long number of years, finally gave the say in private sexual acts to those who matter most: the people who were having the sex.

### THE LIMITS OF HEALTH

'Health' has become one of the most important metaphors of the late twentieth century, an important factor in which is its ability to act as a boundary object. Different groups of interests (like the state and statutory organisations, voluntary and non-governmental organisations, and individuals) can come together over the issue of health, yet each group can use it meaningfully in its own context. It facilitates the translation of the social and political concerns of groups like the gay community into a language that is understandable to other sectors such as government institutions and the medical and scientific professions. It is also 'inefficient' enough to allow for latitude on all sides. 'Health' represents a concern on all sides, and can be used to represent the

concerns of all sides. For the gay community, the most pressing health concern was HIV and AIDS.

In the *HIV Prevention Strategies and the Gay Community* report published in 1996, the consensus achieved to date was presented as providing a framework within which the gay community's needs could be met under the rubric on health:

There is now widespread recognition of the need for, and great opportunity to develop, a more effective and specific HIV prevention strategy for gay men. The granting of full legal equality to gay people in the law reform of 1993, the existing and proposed anti-discrimination legislation, the wide legal availability of condoms and the equality and partnership commitments of the Department of Health and the government, provide a public policy framework to develop the necessary partnership between the statutory sector and the gay community. [GLEN/Nexus 1996: v]

The report makes clear what it sees as the objective of local and national HIV prevention campaigns, and how health promotion is to be part of this:

The objective is to re-mobilise all gay community organisations and all gay people to re-focus on HIV prevention work as a priority and as a life enhancing responsibility – what others have described as building a 'safer-sex movement'.

There is also widespread international agreement that health promotion, and especially HIV prevention programmes, must include measures to promote the self-esteem of gay men and to develop the gay community organisations which are in the front-line of such health promotion work for gay men...It is difficult to have an effective safer-sex education programme without a general health promotion programme and it is not realistic to expect to have a successful health promotion strategy if we ignore the other immediate social problems which people face. There is no simple answer to the complex issue of health promotion, especially in relation to sexual relationships which respond to powerful feelings of love, desire and longing. [GLEN/Nexus 1996: vi]

These statements show just how useful a translator 'health' is. HIV prevention starts out as the object, but is quickly attached to the issues of self-esteem, then community organisation, then general health promotion, then social problems. Rather than starting out with the issue of sexual relations (the point it finishes on), it starts with the common interest in HIV prevention, representing gay sexuality (the end point) as being bound up with all the other issues. In this way, it represents the interests of the gay community and of gay men as being essentially the same as those of the Department.

These statements are reiterated at the start of the report, where an even closer tie between safer sex (the object of prevention strategies) and gay community development is made clear:

Developing safer-sex as a community norm only makes sense if a gay community actually exists and is inclusive of all gay men, who are diverse in term [sic] of social background, location and so on. [GLEN/Nexus 1996: 3]

Also important is re-establishing safer-sex as a gay community norm. This, however, can only make sense if a tangible community actually exists. In this sense, gay community development is likely to be an important element of future HIV prevention strategies. [ibid.: 7]

'Tangible' is perhaps the key word here. It suggests the need for the community to be visible, represented, clearly defined, and representative. This goes to the heart of a number of issues which are of importance to the gay community.

For example, the National AIDS Strategy Committee (NASC) had been established to provide the government with specific strategies for combating HIV infection and for dealing with people with AIDS and made its first report in 1992. Despite the fact that homosexual infection represented the second highest statistic for HIV infection, there were no representatives of the gay community on the Committee or on its sub-committees. Nine of the twenty members of the Committee were medical or scientific professionals, another six were representatives of government departments or regional health boards, and the remaining four represented NGOs involved with AIDS services and HIV prevention, including one who represented an NGO dealing with drug users with AIDS and HIV. This kind of exclusion from decision-making which affected gay men was something that the gay community wanted addressed. The idea that when it came to strategies to deal with HIV infection and AIDS gay men did not merit inclusion was clearly not acceptable. At issue was not just the matter of having a representative on the Committee but the wider issue of acceptance that there was a gay community with legitimate social interests and that it could represent its own interests. Rather than having knowledge of the gay community, and of gay sex, generated by those who were not gay themselves, the gay community was insisting on the right to frame its own reality and to construct its own identities. By the time of the NASC's second report in 2000, the membership of the Committee had been expanded to twenty-eight, including eleven medical or scientific professionals, nine representatives of government departments or health boards, and eight representatives of NGOs including one from a gay NGO. If this change demonstrated the increased power of gay men to represent their own interests at this level, the fact that one of the

nine representatives of governments departments or health boards was also a gay man who represented a 'statutory' gay organisation indicates the extent to which the gay community had developed itself and used its resources to achieve recognition of its social interests.

The establishment of the Gay Men's Health Project in 1992 by the Eastern Health Board can be seen as an important step forward for cooperation between the gay community and statutory agencies. As the introduction to its first annual report in 1998 says,

In Ireland many changes have taken place since decriminalisation in 1993 and will continue to do so. The establishment of the Gay Men's Health Project in 1992 as an Eastern Health Board (EHB) statutory service was the first Nationally and one of the first Internationally. Despite the traumas and difficulties in setting up and continuing such a project support has always been forthcoming from the EHB management and the Board itself. Advertising the project both within and outside the EHB has contributed to breaking down homophobia and to the promotion to understanding the needs of gay, bisexual men, both as staff and customers. [Eastern Health Board 1998: 1]

The interaction between medical and science professionals, government and health board representatives and gay men which the Project represents shows clearly the ways in which the gay community has developed its politics around knowledge. A brief look at the work of the Project demonstrates this.

One important aspect of the work of the Project is its drop-in centre. The medical service includes a full range of STD testing, including HIV, which is complimented by the counselling service for those undergoing testing. Doctors, nurses and a consultant are attached to the drop-in centre and in 1998 some 1,757 consultations were carried out at the centre. In addition to the drop-in centre, the Project also runs a wide-ranging outreach service. This is based in Outhouse, the community resource centre for gays, lesbians, bisexuals and transgender people. Outreach work includes the distribution of safer sex packs, affectionately known as 'shag packs,' which contain two condoms, two sachets of lubricant, information on the proper use of condoms, and a card detailing the services available at the drop-in centre. These are available at the drop-in centre and Outhouse, and are also distributed to the two gay bars in Dublin. In 1998, 25,000 such packs were distributed by the outreach service. Outreach is also extended to the saunas, to male prostitutes working around the city, and men using public spaces such as parks and toilets for sexual contact. It was developing a 'gay peer action' group which was to become independent and which was aimed at providing new ways of approaching the issue of HIV prevention among men who have

sex with men. The Project runs workshops on safer sex and HIV prevention for gay men but also conducts these for lesbian, gay and bisexual college societies and provides training for health professionals, nursing courses, probation and welfare trainees, social work and addiction studies trainees, and people working with the homeless and drug users. Issues covered by such training include the creation of safe environments; working with gays, lesbians and bisexuals; homophobia and heterosexism; male prostitution; and sexuality and sexual health. The Project works in partnership with other organisations in the production of HIV test information leaflets, safe sex information packs and booklets, and in the production of articles for Gay Community News. It has established networking relations with various organisations, including the Garda, the saunas, the AIDS Liaison Forum, and the European Male Prostitution Network for which it is the Irish coordinator. The Project has also undertaken research into various areas of sexual health among men who have sex with men.

The Gay Men's Health Project represents a significant interaction between various sites concerned with HIV. As a 'statutory' organisation, it has an obligation to conduct contact tracing for those who test positive for STDs other than HIV. Positive results from HIV tests conducted at the drop-in centre become part of the national statistics. Information from contacts established during outreach work and from specific research undertaken by the Project forms the basis for interventions at many levels. Dealing with all men who have sex with men, from men in parks and public toilets and male prostitutes, to gays in colleges, bars, saunas, and in gay community organisations, gives the Project a wide range of knowledge about men who have sex with men. Given the wide range of contacts which the Project has on an on-going basis with health professionals, social workers and others engaged with health projects through its training programmes, the Project also has a facility for disseminating knowledge and understanding of the men it deals with. This two-way interaction has led to very successful interventions amongst men who have sex with men and has contributed to a clearer representation of those men at other levels from medical professionals to policy-makers. Not only does the project allow the reach of government and health boards to extend into darker areas such as the saunas and sex in parks, but it also extends the reach of gay men into government and the realm of science.

Through its work, the Project has engaged in the 'politics of knowledge.' It has shown itself to be a credible representative of the social interests of men who have sex with men (credible on account of its contact with the health professions as well as with the men themselves) and it has promoted those interests widely. They have used various techniques of representation to frame

the reality of these men, from presentations at European conferences, reports and research, sexuality workshops, to safer sex workshops with gay men. These framings interpellate with the various audiences, so that the Project, its work and its workers are credible to audiences as wide-ranging as male prostitutes and men who have sex with other men in public spaces and epidemiologists, virologists, doctors, nurses, public health and government officials. In all this it has provided enabling identities, working without prejudice for the welfare of those amongst whom it conducts its work, at the same time as furthering the health interests of the Health Board. In its dealings with officials and men who have sex with men, it has engaged in contesting others' framings of men who have sex with men and thus contributed to the representation of those men and their interests at various levels.

Central to this are the various implications of the process of medicalisation. Medicine has sometimes been useful as a means of dealing with deviance from dominant social norms: as Conrad and Schneider put it, "Conditions that enter the medical domain are not *ipso facto* medical problems" (Conrad & Schneider 1980: 249). medicalising a particular problem reduces the possibility of alternative knowledges of that problem. This can be seen in a range of problems such as smoking, obesity, and even safer sex where the medical view dominates attitudes towards the problems to the extent of becoming common sense. Indeed, they are made problematic by medicalisation: it is medicalisation which sets the boundaries of what is to be considered a medical issue. In creating and bounding certain practices as problematic, medicalisation also dictates interventions aimed at eliminating the problem, thus extending control from the control over the denomination of the problem to interventions against the problem. Medical technology provides the basis for intervention and the extension of control, claiming an ability to see what cannot otherwise be seen. Each advance in medical science claims an enhanced ability to see, and carries with it the promise of new possibilities for control over the human body and its environments.

The extension of control can involve conferring a 'sick role' on an individual. Just as medical knowledge dominates and excludes other knowledges, so too the sick role excludes other possibilities. For instance, labeling homosexuality as 'sick' to some extent provided protection for the individual from designation as 'sinner' or 'criminal,' as well as diminishing blame, and in this sense, medicine is understood to be 'value free' and therefore objective. Medicalisation makes discussion of medicalised issues difficult for those who are not medical professionals:

When a problem is defined as medical, it is removed from the public realm, where there can be discussion by ordinary people, and put on a plane where only medical people can discuss it. [Conrad & Schneider 1980: 249]

Conrad and Schneider see this medicalisation of deviant behaviour as being “an individualization of social problems” (ibid.: 250), whereby the individual is excluded from his or her social, economic and political environment and dealt with in isolation.

Medicalisation, then, offers the possibility of exercising a great deal of control over the individual and over his or her environment. With ‘health’ dominating many aspects of people’s lives at the present, we could expect the medical professions to be in almost total control, and that is not really the case. Part of this has to do with the rise of self-care and responsabilisation of health. From the early eighties, the ‘new public health’ has urged self-surveillance and self-care through health promotion and disease prevention. Allied to this has been the rise in so-called ‘self-help’ manuals, particularly those of the “how to” variety: how to lose weight, how to give up smoking, how to have better sex, and so on. These self-help manuals often offer the individual the possibility of taking control over some aspect of their lives. The implication is that the individual has already lost control over this aspect of their lives and self-help therapy can offer ‘recovery’ (which can be thought of as being both ‘recovery’ from ill health and as ‘recovery’ of self-control). This self-help ideal has been part of gay lifestyle from the start. ‘Coming out’ is both a recognition of one’s sexual attraction to others of the same sex and a reassertion of control over one’s life. Heterosexism and internalised homophobia create the situation of self-oppression which the emergent gay seeks to escape through the therapeutic steps process of coming out. Dominant social norms, knowledges and expectations have taken away the control the individual has over his or her life and coming out restores that control. Coming out restores the self-knowing individual. Discovery of an accepting environment is an important part of this and it is such an environment that gay community organisations (as well as the gay commercial sector, including saunas) seek to provide.

Medicalisation also allows for the targeting of ‘problem’ individuals and ‘problem’ lifestyles and for the targeted deployment of resources. An essential part of this is the generation of knowledge through the collection of information. This is made clear in a quotation from the report of the Commission on Health Funding given in the Department of Health’s *Shaping a Healthier Future*:

These choices will reflect the relative priorities accorded by government to the competing demands of society. However, the efficiency of the health services will be increased to the extent that these priorities, and the choices which they determine, are based on an evaluation of the healthcare needs of the population and of the relative effectiveness of the available responses to different forms of need. Such an approach places considerable emphasis on data collection and analysis. Its advantage is that, despite our often limited understanding of the effects of healthcare, it provides some objective basis for how we allocate resources. Otherwise, choices will continue to be made in an arbitrary way and mainly in the interests of those groups able to exert the most influence on the resource allocation process. [Department of Health: 1994: 16]

*Shaping A Healthier Future* goes on to note: “It is clear that comprehensive and good quality information is an essential prerequisite for the application of this approach – information on needs, information on activity, information on detailed costs and information on outcomes” (ibid.: 17). Notice that what is most important about the collection and analysis of data is that it allows not for more effective health strategies but rather the allocation of resources. These statements make it clear that not only will projects be undertaken (or at least resources expended) on the basis of what government decides, but also that a primary function of projects will be the provision of information to government.

## COMMUNITY & DISEASE

An important feature of the government’s strategy in relation to health promotion is the use of communities and community-based organisations to provide the services for which government will provide the resources. This is in line with the notion of a “contracting culture” and the Catholic Church’s social principle of subsidiarity, as well as reflecting the fact that the a small country with limited government resources can manage those resources best by providing them to those who are situated closest to the problem. The fact that there were large numbers of groups working often voluntarily for ends which in other states might have been the prerogative of centralised state institutions made the government’s policy of devolving health promotion to groups and communities much easier. From the statement of the Commission on Health Funding quoted above, we can see how the interests of government in the activities of its population are furthered by the flow of information from communities and groups up to central government. The amounts and kinds of surveillance which this allows has doubtless provided government with a more comprehensive picture of the state of its population, particularly of marginalised groups. It also indicates that the Department presupposes that there are groups and communities that will

want to cooperate with it, and that such groups can extend the ideal of health promotion in a way that the Department itself could not do alone.

If this form of health promotion operates as a form of surveillance of populations and communities, it does so through the targeting of these populations. Epidemiology and health statistics provide one way of targeting specific groups but other factors (again decided and prioritised by government) also influence this. The *Health Promotion Strategy* notes that goals and targets for health promotion are often achievable over the long term, so shorter and medium term goals also need to be set:

These shorter term goals can be set in terms of key settings and priority population groups. In the interest of achieving equity in health status, it makes sense to give priority to those who are often at a disadvantage, e.g. those in lower socio-economic groups. Goals and targets can also be set in terms of risk factors and lifestyle, and within these to knowledge, attitudes and behaviour in relation to the risk factors. The assumptions underlying the rationale for health promotion imply that reducing the risk factors for preventable illnesses will make an important contribution to enhancing health status and ultimately to reducing rates of illness, premature disease and death. [Department of Health 1995: 18]

Whilst this statement seems to acknowledge that “disadvantage” may adversely influence health, that it may provide additional risk factors or involve risky lifestyles, health promotion in these areas is directed entirely at the individuals and communities of individuals, and not at the environment in which they make decisions. This necessarily reflects the limited resources available and the principles of the “contracting culture.” Indeed, the prioritising of the ‘disadvantaged’ makes it clear that the responsibility rests with them: it is their particular risk factors and lifestyles which are the issue, and the purpose of the short term goals is to target these in terms of “knowledge, attitudes and behaviour in relation to risk factors.” This sentence shows a marked difference from the ideal espoused in the earlier *Shaping A Healthier Future*, where environmental concerns are part of the health promotion strategy. Indeed, it is a reversion to a much earlier ‘effects’ theory of health education, the so-called “knowledge, attitudes, behaviour” model (or KAB). KAB reduces the influence of environmental factors and emphasises the role of lifestyles. What is needed (or what the ‘disadvantaged’ lack) is knowledge: providing this knowledge will lead to changes in attitudes towards risk and these changed attitudes will result in changes in behaviour, the long term goal of such a strategy. This ‘inoculation’ or ‘hypodermic needle’ model (injecting information to secure the desired result) takes little account of the environment in which risks are assessed and choices made, or of the cultural factors which

influence risks and choices around risks. It takes no account either of the meanings which risk and risk calculation have in the environments in which risk calculations are made.

The KAB model assumes a lack of *specific* knowledge in relation to particular health issues (for instance, that people who smoke or have unprotected sex do not realise the risks they are taking) at the same time as it assumes another kind of pre-existing knowledge (that something like smoking or unsafe sex is desirable or acceptable). This pre-existing knowledge can easily be attributed to 'culture.' Culture is something the 'other' has and the attempt to instill specific knowledge is an effort to displace this darker pre-existing knowledge, to rid the individual of culture, and to allow access to rationality or good sense.

One of the bases of gay community organisations in relation to HIV and AIDS, and of the government's funding for such initiatives, is the matter of need. The GLEN/Nexus report makes it clear that there is a need for HIV prevention strategies in the gay community, and the work of Gay HIV Strategies has been to further this work by providing funding to gay community organisations to extend their capacity for dealing with HIV prevention and health promotion. Apart from the question of organising the gay community around a single issue, in particular the issue of HIV, there is the question of identifying the community as being in need. This is the first requirement of any approach to funding agencies: the demonstration of a need or lack which projects will address. Not only that, but further funding applications must show continuing need or lack, or find other needs or lacks which require funded initiatives. This is required not only at the establishment of such initiatives, but for their continuity, since the jobs of professionals are at stake. These combinations of the requirements of continuity and of history in the development of community paradoxically produce a worsening of the situation as things get better. The more the community develops, the more it needs to develop and the more issues it needs to find for furthering funding for the continuity of its organisations. This is not unlike the 'missionary position' which requires that you find more and more that needs doing in order to justify further funding:

For Livingstone, as for other missionaries and abolitionists, the African was a creature to be pitied, to be saved from slavery and also from his own darkness, his savagery... At the same time missionaries were strongly tempted to exaggerate savagery and darkness to rationalize their presence in Africa, to explain the frustrations they experienced in making converts, and to win support from mission societies at home. [Brantlinger 1994: 182]

The most basic requirement is a demonstration of 'disadvantage' and this means identifying gay men as being disadvantaged. The GLEN/Nexus report does this, stating "...the development of the gay community can be compared in many respects to the development of many disadvantaged communities currently participating in the local development programme" (GLEN/Nexus 1996: 61). To a large and effective extent, this is a pathologisation of the gay community and of gay men. Not only does it extend disadvantage by continually iterating it as the basis for required funding, but it also fails to address the more significant issue of how that disadvantage came about in the first place. The problem of gay men's disadvantage is something that can be sorted out by running programmes for gay men within the gay community. In particular, as the report states, a major part of this is the promotion of gay men's self-esteem. This puts 'cure' or 'therapy' for low self-esteem squarely in the hands of gay men themselves (they are made responsible for therapy) but fails to address the wider issue of where low self-esteem comes from. That low self-esteem might come from state agencies and institutionalised homophobia is, at least to some extent, sidelined. In fact, the low self-esteem can be seen as being a product of the need for funding, as being produced and re-produced by the gay community itself to further its professional needs as voluntary sector agencies. This is evidenced by the large amount of work that Gay HIV Strategies has put into reporting issues of alcoholism, suicide and the effects of homophobia among gay men. Since all of these issues can now be medicalised, they are effectively depoliticised and progress on them is classed as a matter of health. Since it is the health of the individuals that is at stake, 'therapy' can be effected at that level, and little attention can be paid to the wider issues at stake, and calls by gay organisations for institutional homophobia to be rooted out have very little effect. It is easier for the government agencies to fund 'therapy' amongst gay men than it is for them to admit that homophobia is a social problem that needs to be addressed on several different levels, but particularly within the institutions and agencies of the state itself. Again, this is an impoverished version of health promotion.

Another issue that is raised by the identification of gay community with the issue of HIV is that not all gay men feel this is an issue for them, nor do all men who have sex with men identify themselves as gay or identify with the gay community. Again, this is an effect of the epidemiological privileging of particular classes or groups as low-risk and of others as high-risk. Almost none of the men I met in the course of the research saw themselves at risk of HIV infection. Though some, when questioned, had ideas about HIV transmission that were confused or at worst dangerous, all felt they 'knew' about HIV and all were tired of HIV being thrust in their face all the time. When, at a session of the Gay and Lesbian Film Festival, I suggested that it

would be a good idea if they had some short HIV prevention messages before each film, a friend of mine who worked for a gay organisation said that he was sick of HIV and sick of warnings about HIV being tagged on to everything that had to do with gay men. "People come here to get away from that: that's what these films are all about: fantasy. We want to escape the world that has HIV in it for just five minutes and you want that fantasy to be destroyed by another HIV campaign." One of the HIV prevention workers I spoke to empathised with this:

Our sum total is not AIDS, being gay does not equate AIDS. We've been telling everyone else for so long, why the fuck haven't we listened to it for ourselves? Every event that we organise has to have some AIDS theme to it, why can't we have a break from it? And to some degree I can understand that, people want to get on with their lives, they don't always want to be thinking about those things. The most significant thing that I ever remember was having a conversation with a gay man, was when out of the blue one night we were talking, it was in a night club funnily enough, and he just turned around to me and said to me, D'y'know what I miss, d'y'know what I really, really miss? And I said, What's that? And he said, The days before AIDS when you didn't have to think about it. When you went to a club, found somebody you liked, went to a sauna and saw somebody you liked, you just went and you had sex. The worst thing you looked forward to was getting a dose of crabs, or a dose of the clap, and then you were off to the clinic to get it sorted out. Nowadays, you have to make so many choices, you have to be thinking about what you're doing, and it just takes the fun out of it, the casualness of it, the opportunity of meeting somebody seems to be gone. It's totally limiting to what you can do.

But that's interesting because it brings up two things. One is, what impact AIDS has had in terms of people changing their thinking, and the second thing is his thinking around taking precautions as being a negative aspect of his sexual activity. Because it does come back to that as well. I used to find it very strange when I was working full-time in AIDS support work, every time I went out for my social life, the talk was about AIDS because people wanted to know. They took the opportunity because they knew I worked in the area, to ask me questions they wouldn't ask somebody else. And it got to the point where I was no longer socialising but I was constantly working and so I ended up having to say, Look, in all fairness, I appreciate your need to know information but there are services there you can go to and get that information, and I really don't want to cut you off, but I have a life too. So I can empathise with other people saying, I want to go to a film festival, I don't want to go to an educational programme.

The identification of community with disease, and the expectation that all within the gay community share the same concern about HIV, is one that faces HIV prevention educators all the time. Not only that, but it is a problem for the organisation of support groups for people who are HIV positive or who are living with AIDS, as Aileen O'Gorman makes clear in her report for the support agency Cáirde. She quotes one respondent as saying:

*I have nothing really in common with these people [in a peer support group]...It's like they're bringing these people together for HIV and they've nothing else in common and I find it hard to sort of click with people. [O'Gorman 1999: 31]*

O'Gorman extends this feeling of lack of commonality to the loss of identity experienced by people after a HIV positive diagnosis:

Not only do families [sic] internal lives come to revolve around the virus, but externally the families are perceived and identified, first and foremost, as families with HIV. Despite this, the families themselves have found little opportunity to define their own needs in terms of the support structures they required. In addition, their loss of identity is also accompanied by what Melvin (1993: 229) terms "the chronic erosion of power and control people have over their own lives." Nowhere is this more apparent than in the families [sic] account of their medical treatment. [ibid.: 31]

She goes on to quote one of her respondents on this alienation from the health 'care' system:

*The hospital structure is so formalised, even the white coats. Why do these guys need white coats? It's only to distance themselves. I think it's crazy in this day and age, doctors wearing white coats...Take off your white coats, sit down and talk to the person and then they would learn so much. [ibid.: 34]*

## CONCLUSION

This chapter has explored some of the difficulties of the relations between disease and community, in particular as they have affected the gay community, both in Ireland and elsewhere. Much of the work that has been done and continues to be done concerns the "politics of knowledge":

To engage in the politics of knowledge, individuals and groups must be able to present themselves as credible representatives of social interests and engage in the framing of reality through techniques of representation. They must be able to mobilize a constituency by framing and translating issues and interests in ways that attract adherents. And they must succeed in constructing enabling identities with relatively well-defined boundaries. Different actors will seek to frame AIDS, or construct knowledge, or assert their claims to expertise in quite different ways depending in part on their interests, their social locations, and the organizations to which they belong. By means of these framings, credible knowledge is both assembled and taken apart. [Epstein 1996: 25]

What I have tried to make clear in this chapter is just how the gay community in Ireland has engaged in this politics. Community as an ideal can have its own problems:

On the one hand, community is a device that homogenises, suppresses internal differences, creates exclusionary boundaries and functions as a dynamo of separatism. On the other, community is a site of resistances, of strategic essentialism and strategic difference. What is more, community is a shelter, a site of shared injustice, a symbolic representation. Whichever way you look at it, 'community' – and the unity it espouses – is far from stable, and indeed we might question the function of unity in the constitution of communities. [Woodhead 1995: 237]

Perhaps what is significant here is the instability of community: its very instability allows it to represent diversity, to produce enabling identities for those within the community, and to make credible representations to those outside the community. This has not been possible without contestation, both within the gay community and between the gay community and other communities. Communities, and relations between communities, have been formed and reformed around HIV and AIDS. In relation to HIV and AIDS, gay men represent only one aspect of the issue and others also have a say in how things are dealt with. In the next chapter I want to explore how some of these contestations about knowledge and HIV and AIDS affect the ways in which the saunas are perceived.

## Chapter Three

### **Sex, Saunas, and Strategies: Gay Sex-on-Premises Venues and HIV Prevention**

I have already mentioned in the Introduction something of the complexity of the saunas, and their importance as a site for thinking about the representations of HIV and AIDS in Ireland today. Here, I want to examine the relationship of the saunas to HIV prevention work, in the light of the foregoing chapters' discussion the various issues of cultures and communications, and disease and community.

#### SEX IN THE DARK

In a three page section in the *HIV Prevention Strategies and the Gay Community* report (GLEN/Nexus 1996), the authors discuss the background to the gay commercial sector and detail (over a page and a half) the "Issues Emerging For HIV Prevention." The entirety of this latter section is devoted to the saunas, indicating that before the report was written the saunas had assumed an importance in terms of HIV prevention. The first problematic identified in relation to the saunas is that of gay identity: "Of particular concern however are the saunas which are frequented by large numbers of men who are not 'out'" (GLEN/Nexus 1996: 70). Though the statement goes no further than this, there are a number of possibilities implicit in this. On the one hand, there could be an assumption that the fact that these men are not 'out' makes them in some way more susceptible to HIV infection. This may be because they are not getting the HIV

prevention materials which are distributed in gay-identified areas, such as gay bars and clubs, and hence a strategy to provide information in the saunas themselves seems perfectly reasonable. On the other hand, it may be that the authors of the report think there is some difference between men having sex with men in saunas, and men having sex with men in any other venues or at home. Here the implication is that the sex in saunas is somehow less safe or more risky than that which takes place elsewhere. This goes against the findings of recent research in this field, which indicates that the opposite may in fact be true:

Contrary to what many may expect, my data suggest that homosexual and bisexual *men take larger* risks in their *loving relationships* than when they have casual sex encounters at different *erotic oases*. [Henriksson 1995: 14, emphasis in the original]

That this is the case for persons considered to be at high-risk of HIV infection is clear also in studies of infection among female sex workers:

...evidence from many studies of women sex workers suggest that it is not while at work (where many women have long insisted on condom use) that most women sex workers become infected, but rather at home with husbands and boyfriends. Women sex workers are much less able to gain safe sex compliance while trading sex in the complex bargain of domestic partnering in a sexist culture than when engaging in overt acts of commerce that constitute their work in the "oldest profession." [Patton 1991: 381-2]

It may well be that men in saunas consider the risks of sex in a way different from those who have sex in other environments, but, contrary to the commonsensical view, it is the men in other environments, particularly those in loving relationships, who may be taking the greater risks. Following the discussion in the last chapters of the relation between epidemiological construction of risk and the funding relations between the gay community and the Department of Health, it may be that men who are not 'out' are the more threatening and dangerous element that 'out' gay men. The implication is that men who are not out are somehow 'closeted' or otherwise hiding their (true) identity as gay men. These men may be married men or other heterosexual men, and what makes them most threatening is that they can be constituted as links, carriers of HIV from the high-risk community of gay men to the lower-risk community of heterosexuals. The fact that these men are not 'out' also provides the naïve-psychologisation that they are 'in denial' about their sexuality, and that such denial results in a psychic state that puts them at greater risk than 'out' gay men, or heterosexual men. There are other aspects to this division between 'out' gay

men and men who have sex with men, as was apparent in the work of the pilot project undertaken in the saunas. One of the workers on that project told me:

What we try to do is find the lowest common denominator and that's the baseline to work from, and the lowest common denominator is around the fact that they are having sex with other men. Now how they term themselves, whether they be gay men or they be homosexual or they be queer or they be men who have sex with men, whether they are bisexual, whatever. We're not getting into the politics of being politically correct. It's finding what the common denominator is and then moving on from there, addressing the needs based on that. So all the groups of gay men who are at perhaps a more advanced stage of their coming out or who have already passed by that stage, or who those who have not come out or who possibly will not ever come out, so those issues are separate issues, they're developmental issues around their identity, their sexual orientation and their identity around that. What we're talking about is behaviour. There is a lot of play done on people's self-esteem versus their ability to be able to then make choices around safer sex. Quite often I'm criticised for saying making choices around safer sex because people say there is no choice, you just do it. Well, if that were the situation we wouldn't have the increases in the number of people becoming infected with HIV. So let's understand that there are choices that people make: circumstances vary, and those circumstances will affect the way in which people make their choices. There are gay men for example who would be out, who have been out for a long number of years, and would be very confident around their own sexual orientation and their identity, but still at times be engaged in high risk activities around their sex. And sometimes that has to do with other issues such as age: for example, older gay men may feel that they have to compromise certain things in themselves in order to meet a sexual partner. So they'd be willing to have unprotected sex with somebody just for the fact that they're going to have sex with somebody rather than running, as they might see it, running the risk of not being able to have sex because in addition to their age they're putting other what they might call obstacles in the way. So they're other issues, so we can't just always look in terms of somebody's life experience of coming out and things like that: it's a much bigger picture, much more complicated picture than that. So that's why we have to start at the baseline, the lowest common denominator and then we begin to work from there. Now, once we establish that, there are then opportunities to build on into different areas and in different directions, to hone in on particular needs for particular groups of men. But that's only something we can do after we've achieved the baseline.

Beyond this is the more general problem of sexual identity. What is it and how does it work? Where does it come from, and how (and by whom) is it constructed? For Philip Gatter (1995) the question of identity in relation to HIV and AIDS is very important:

The ability to resignify one's personal identity in the face of HIV was considerably enhanced by a sense of community membership and response. Men

who have sex with men but not socially identifying as gay, as well as women, confront HIV from different perspectives from out gay men, perspectives informed by the overlapping sets of phenomena which together constitute identities. [Gatter 1995: 1530]

Referring to an evaluation of work done by MESMAC (Men Who Have Sex With Men Action in the Community) in England, Gatter quotes the report's questioning of relations between sexual practice and sexual identity:

There may be an underlying issue here about men who have sex with men being a behavioural description not an identity. Does collective action presuppose and/or constitute identity? What are the implications of this for Community Development approaches in this field? [ibid.: 1526]

Part of the difficulty with sauna interventions is this multiplicity and diversity of men with ambiguous identity.

There are also other problems which the GLEN/Nexus report identifies in relation to the saunas. These are: the lack of safer-sex information, difficulty in obtaining condoms, and the attitude of owners and staff. This section of the paper concludes:

...action between the gay community and the sauna owners should be an immediate priority of any prevention strategy for gay men.

Interviews with the sauna owners would suggest that they recognise the opportunities presented to them to engage with the gay community to prevent HIV transmission and to facilitate safer-sex practices within the broad commercial sector. In addition, interviews with both voluntary gay groups and AIDS organisations would suggest that co-operation between HIV educators and commercial venue owners is a key element in any future HIV prevention strategies. [GLEN/Nexus 1996: 71]

Indeed, when Gay HIV Strategies (GHS) was set up, as part of the follow-on from the GLEN/Nexus report, one of the first initiatives it undertook was a saunas HIV prevention project. It is worth noting here that Gay HIV Strategies saw its work as being strategic: that is, as enabling others (gay community organisations) to expand their activities to encompass HIV prevention and health promotion, rather than itself becoming either a service provider, or itself engaging directly in HIV prevention work. The saunas project, then, is something unusual within the work of GHS, being quite different from any other work it has undertaken.

In the report of the pilot project run by GHS in two of the then existing saunas, some space is given to a consideration of “the role of saunas in the gay community.” It notes that

Gay men have been using saunas as a meeting place for a long time. While their [sic] seems to be no documented evidence of their history in Ireland, their [sic] is ‘folk history’ to suggest that saunas have been used by gay men in Dublin as a meeting place since 1948. [Hayden 1998: 18]

The report goes on to note the “disproportionate” number of gay saunas in Dublin for the size of its gay population compared with other European countries. A ‘guesstimate’ of the numbers attending saunas in Dublin was made at a recent conference. Receipts from admission paid at the larger of the four saunas indicated that somewhere around sixty thousand men attended in a given year. This would not include those whose visits were covered by free passes, so the number is actually higher than that. Working on the basis of popularity and size of the other saunas, it was estimated that the combined number of visitors for a year for all four saunas would be in excess of one hundred thousand. This is not to say that over one hundred thousand men visited the saunas, since many of the men would have made repeated visits, not just to one but perhaps to a number of the saunas over the period of a year. Even given that, the receipts from the larger of the saunas would indicate an average of over 150 visitors per night for the entire year.

Whilst the report goes on to talk about the large numbers of older men who attend saunas, and to note the fact that for many of the men who go there this is their only social and sexual contact with other gay men, it does not examine why the saunas are so popular. Hayden does pose the question about the continued existence of the sauna which perhaps reveals some of the thinking behind why men go there:

It is difficult to know if saunas will ever cease to be an important place for men to meet other men for social and sexual contact. Perhaps there would need to be a significant change in social attitudes regarding homosexuality before such a change would take place, but even then perhaps not. [Hayden 1998: 18]

Again, the implication is that the problem of men going to saunas, and the reason they go there rather than to other ‘gay’ venues, has to do with problems of identity. The suggestion seems to be (though Hayden himself does not seem to put too much store in it) that if it were easier to be a homosexual, if it were easier socially to be an out gay man, then more of these men would be using the other gay venues and fewer would be using saunas. That there is something not quite right about this logic (and perhaps Hayden is aware of this) is clear from the fact that the first gay

owned and operated sauna opened in 1980, at a time when homosexuality was still criminalised in Ireland, and that by 1998, three years after the decriminalisation legislation had been passed, there were (albeit for a short period) five saunas open in Dublin. Today there are four saunas in Dublin and a fifth has opened in Cork. It seems that more and more men, rather than less, are finding the saunas attractive, and more businessmen are prepared to operate such facilities than before. This surely suggests that there is more to saunas than some kind of secretive location for those who do not wish to identify as gay, or who do not wish to be identified as gay. When I asked one HIV prevention worker why men went to the saunas, it came down to sex: but even at that, it was complicated:

Primarily it would be sex. The opportunity to meet sexual partners, and that's the primary reason for people going there. That's not the whole picture though, because in my experience, and in the experience of the pilot project, we came across gay men who would use the saunas as the principle social meeting place. And that sex would play a fifty-fifty or less than fifty per cent aspect of their going into the sauna. The reason being, that they choose the sauna over one of the clubs is that they feel it's safer for them in their particular circumstances to go into the saunas and not run the risk of being seen or meeting people they know perhaps from work, because the bars have become quite mixed over the last number of years, quite a number of people would, by chance, meet work colleagues, or neighbours, or friends or whatever who would not know in fact that they were gay, so they've become difficult places for them to go. So the saunas are their principle sort of social gathering place. The interesting thing is that we thought there was an awful lot of emphasis, we started off putting an awful lot of emphasis on gay men going to the saunas were engaged in anal sex, and while there is quite a number of people who are, in fact we would guesstimate, I have to say guesstimate at this stage, that in fact maybe a smaller percentage, maybe about forty percent of those using the saunas would engage in anal sex and sixty percent would not engage in anal sex. And anal sex is an issue because it sparks the primary reason of transmission for HIV. There's obviously a lot of debate around other aspects of sex such as oral sex and whether that's a significant mode of transmission for HIV but in addition to HIV we're also including STIs.

The report of the pilot project in the saunas noted the lack of safer-sex information and the problems of the availability of condoms. Meetings with staff and with clients followed and other issues were added, particularly the levels of awareness and information among the staff. This resulted in four strategies which became the focus of the pilot project in two of the saunas: 1) the better availability of condoms; 2) better use of videos to promote safer sex; 3) better use of safer sex materials such as posters and leaflets; and 4) staff training. In addition to successful outcomes in these areas, the report (Hayden 1998) of the pilot project also notes other positive outcomes:

A first step in developing better relationships between saunas, community and statutory services was made;

Community and statutory services now have a better understanding of the environment of the saunas, which will help them when dealing with their own clients;

This pilot project has being [sic] used as the model, in particular the partnership approach which formed the basis of this pilot project, for a proposed EU funded European HIV prevention project. [Hayden 1998: 17]

In particular, the approach to the sauna owners attempted to ensure that they would come on board. This, as one of the workers involved in the project told me, was a carrot-and-stick approach:

I suppose to be honest with you right at the beginning of the pilot project there was a carrot-and-stick approach used. The stick was that if there wasn't something done about the saunas on a voluntary basis then it would be imposed, because just prior to that time one of the consultants based in one of the hospitals in Dublin had raised a number of issues around regulating the saunas and so therefore we were able to pass that information on and sort of say well, you've got to do this guys or this is going to be imposed on you, that's your business. The carrot for them was that they got something out of it, in terms of their staff were getting some training, they were seen by their customers to be taking more of an interest, some of their customers felt that perhaps there was a value for them in the fact that the saunas participated. So they were getting something in return for that, and the sauna owners had added value for their participation. When we were setting up the second phase of the project right from the beginning, when we approached them and said that we were now approved for the full thing, that we were planning to move it on, they were absolutely no problem. A few issues, a few concerns that a few of them had that we will be able to sort out once we go along, but they're not major stumbling blocks.

Whilst this was quite an extensive initiative, it still remains functional largely on the K-A-P model of health education. Granted, there are changes introduced into the immediate environment of the saunas (the posters, information, and available condoms, as well as trained staff) but the basic premise remains the provision of information and other materials which are intended to effect a change in attitude and thereby a change in behaviour. A great deal of the effort of this pilot project went into the design and production of posters (in association with the owner and management, since both of the saunas in the pilot project were owned and managed by the same people, one of them closing down after eighteen years before the project report was finished) which were then placed in cubicles throughout one of the saunas. Despite the constant reiteration

that many older men use the saunas, the posters were very typical of HIV prevention posters produced elsewhere, depicting young gay men, all with quite perfect bodies, and with messages like "Take the worry out of it – use a condom," and all carrying the strap-line "A message from the management and staff of (names sauna)." However the posters were intended to work, it seemed unlikely that these would appeal to many of the clients which the report itself describes as regulars at saunas. Likewise with condoms, one of the problems was with dispensing condoms, in the effort to make them as freely available as possible. Those engaged on the pilot project actually had drawings made professionally for the kind of dispenser they wanted, but could not find anyone to make them up. In the end, the drawings were included in the report but the dispensers never materialised in the saunas. The project did manage to ensure that leaflets were made available, as well as copies of gay papers which often carry HIV prevention information. The report noted that

The availability of leaflets providing awareness and information on a range of HIV and STI issues was minimal or nonexistent. The difficulty with this situation was that the absence of such material for clients is a lost opportunity. The encouragement of safe sex through poster and messages provide instant reinforcement. Leaflets provide additional information on services available in the community for HIV and STI testing, treatment and counselling for behavioural change. In addition clients can learn about community support services around sexuality. [Hayden 1998: 15]

This was one of the achievements of the project, and this despite the indications from the sauna clients, elicited as part of the preparation for the project:

Leaflets should be made available in the saunas. However it is important to not that none of the clients interviewed had read the leaflets that were currently available.

Leaflets might be read in the saunas, but clients would be unlikely to take them away.

Leaflets were too 'wordy' and visually unattractive. [ibid.: 8]

One might have thought that, taking into consideration the feelings of the clients themselves in regard to the availability of leaflets, there could have been other and better initiatives than simply providing more of stuff that clients found too wordy and unattractive, and that they were not reading anyway. Likewise with videos: the clients' suggestions were

Videos should show safer-sex images and messages.

Safer-sex videos might be useful, but they were not sure. [ibid.: 8]

The report notes the implementation of these recommendations.

Attention was given to the content of all videos shown in the saunas, with only images of “safer-sex” depicted in each scene. “Safer-sex” messages are to be included on the videos at the beginning, middle and end. [ibid.: 14]

“Middle” here refers to the fact that most of the videos shown are re-recordings from originals, usually with two hour-and-a-half long videos run together. The safer-sex messages are themselves American produced, like many of the videos, and often use American porn actors demonstrating the use of condoms, and advising viewers to use them. Like the titles, and the other messages I mentioned as being part of American produced videos, these bits of the videos are largely ignored by clients. What interests clients in the action: and this was clear when one of the saunas used videos produced in England (the “Gay Men’s Guide to Safer Sex” produced by the Terence Higgins Foundation was one such video) which were made by gay men’s health groups and which depict (lovingly) the use of condoms and other ‘safe’ sex. Sauna goers did not find them sexy, and on at least one occasion I was present when a client asked if a staff member would put on some “real” porn instead. One guy I spoke to mentioned these videos as being boring, saying “the men are all so gay; there’s no fun in them.”

#### STRATEGIES FOR THE DARK

If the meanings of the saunas (and of what goes on within the saunas: the sex, the videos, the condoms, the sociality and so on) for the clients themselves is somewhat obscure, their meaning for HIV prevention efforts is clearer. If it is difficult to fix on what makes saunas and sex in saunas attractive to the varieties of men who go there, it is less difficult to see why they are attractive sites for HIV prevention. For HIV prevention, it is the very attractiveness of the saunas for so many men that allows for them to be represented as dangerous sites, sites which demand intervention. As this attractiveness increases (and saunas are getting more rather than less popular all the time) the justifications for intervention also increase.

Saunas may represent a particular outlet for many men who have sex with men, but for public health officials they can represent a public health hazard, and for epidemiologists they can appear as a nightmare disease transmission and an impossible situation for contact tracing. Each of these viewpoints represents a different way of framing the saunas in relation to HIV. The epidemiologist frames the saunas as reservoirs of infection with a constant traffic of vulnerable bodies engaging in potentially unsafe practices. For the public health official, saunas are of

concern because they are quasi-public spaces: members of the public go in and out of them all the time, and if there is infection inside, then it has the potential to spread outside. For the gay community, in pursuing HIV prevention in the saunas, the challenge is to accommodate both of these viewpoints and this has been done largely by representing the saunas as potential learning centres. Framing the saunas as learning centres opens them up to a certain amount of enlightening penetration: information on safer sex practices and general sexual health can make their way into these learning centres, as can other useful tools of protection like condoms. Posters on the walls of the cubicles where sex takes place are almost like windows on another world, a world of safety and protection, a world without risk. This kind of interior illumination makes sense to both epidemiologists and to public health officials. Their opportunities for extending their influence into the very private spaces where people have sex are limited, and saunas offer just that opportunity. Not only that, but epidemiologists and public health officials themselves do not have to go there and do this: it can be done more effectively by those who know the places and know the men who go there.

The following is a reconstruction from my notes of an exchange that took place at a conference on HIV prevention initiatives in saunas. The conference was organised for World AIDS Day in December 1999 by the Gay Men's Health Project, and the participants (including myself) were all gay men interested in HIV prevention work. The conference had already hear papers given by a number of men from England, Holland, and Scotland on prevention work in saunas, and the floor was then opened for discussion:

(1) Tom: [Referring to statistics from Sexually Transmitted Infection clinics] The common theme in all the people who are being infected is that they do the saunas.

(2) Andy: Have the Department of Health not noticed that there are so many infections coming from the saunas?

(3) Peter: There hasn't been that kind of strategic thinking from the Department. I would hate some office in the Department telling us we have to clamp down on saunas and their owners.

(4) Paul: All the men I know go to saunas for sex; they go there to get laid; we have elevated these sauna owners to some kind of status when the saunas are pits of disease.

(5) Eric: What if you close them down? It's like Prohibition...

(6) Peter: [To Paul] I see where you are coming from but there is another side to this argument that we here need to get into serious discussion about. It's the men who use the saunas who have the responsibilities around taking responsibility for themselves. We have to be creative about helping these men to have pleasure but to keep themselves safe [at the same time].

(7) Patrick: We are all responsible for our own sexual health. But we have a power here [to coerce the sauna owners into making saunas safer] and we should be using it.

(8) Eric: But these things are harm reduction strategies.

(9) Tom: STI infections have to be reported and you have to ask where it happened. In this, the consultants are very powerful, and they could say something to the National AIDS Strategy Committee meeting and they could close these places down. We have to work with the sauna owners. It's not for us to be moralistic but if we don't work this way someone else will come in. The health inspector can close them down because of the food aspect.

(10) Andy: For HIV positive men their want is social but they tend to sexualise it.

(11) Joe: [To Tom] I agree. That is the situation and that was our approach, was by saying [to the sauna owners] 'You can do it or you can be made to do it.'

(12) Paul: I think there should be someone from the Department of Health who would go to the saunas that were not part of the pilot scheme [and get them to comply]. People in there are fucked up on drugs and alcohol; we *do* need to police the saunas. These are young people and are susceptible to everything. It's not that we need to do another sauna report: we know what goes on there, it's time to do something about it.

(13) Phil: [Referring back to Andy] There is a social aspect even if only for a minority. But it's a place for making contact with others who don't go to the [STI clinics]. It's an opportunity. Some work has been done, but I wonder how effective it is. The availability of condoms is a joke. To say they [sauna owners] are doing something about it is pathetic. Putting one condom in the locker and saying you have to ask for more is pathetic. The staff have no input into this and their attitude is not helpful.

(14) Tom: One of the things that strikes me is the issues of community and commercialism and exploitation. We have to understand that the sauna owners are in this for profit. What percentage of what they get is profit? Couldn't they lower the profit margin and take some responsibility?

(15) Eric: STI figures fluctuate and you can get STIs even using safe sex.

(16) Patrick: We are seeing the same thing all the time. This issue is not about infection: it's about availability of condoms: they should be in every cubicle and on every floor [in the saunas].

(17) Steve: It's not the availability of condoms, it's the use of them: it's not who is in the saunas but how they have sex that matters. It has to be carrot and stick. Sauna managers are not going to have a community spirit, so it's down to my decision about my safety.

(18) Alan: Part of the issue is to create an environment in which social norms can change. An environment that can affect behaviour because it's all about behaviour.

(19) Patrick: People like that cannot be responsible because they don't have that pick-up of information.

(20) Tom: Partnership is important: we have our differences but we still meet and talk and plan. Some saunas can cut the price to get more people in. What's important is how we plan and do things. Outreach is important. Getting the information to people. That is all it is: the lack of knowledge. Men thinking that they are doing the fucking and they are invincible.

(21) Joe: All we can do is distill what we think in the right approach.

(22) Steve: The sauna owners are our clients as well. It's not how we work in saunas: it's how we work in a sauna.

(23) Patrick: Empirical evidence shows that infection happens. It's about facts and we need to be able to tackle this. [We should be able to say to the owners] 'If you don't help us to get the message across, something else will happen.'

(24) Sean: In the North public bars are impossible to do educative work in. If you close down the saunas you have 60,000 people who will not be able to get help.

(25) Tom: We are all humans. Some of the sauna-goers have problems around homosexuality and homophobia.

(I should make clear at the start that not all the participants were Irish. Eric was a worker with a Dutch gay health group, Steve worked with a similar group in London, and Sean with another group in Northern Ireland. Their contributions can be seen as undermining the more straightforward thinking of the Irish participants, often by introducing elements that are otherwise being black-boxed. All the Irish participants worked in HIV prevention, some in gay-run statutory agencies, others in clinics and services run by the hospitals, and one, Paul, wrote articles on gay HIV prevention issues. All of these men are funded in their work by government health agencies, whether directly by the Department of Health and Children, or indirectly through the Eastern Health Board.)

One thing that is noticeable is the lack of any reference to HIV, except for one comment by Andy (10). Since the conference was specifically about HIV prevention in saunas, it could be that HIV

is taken for granted as being the subject, but as is clear, there is some confusion over what is being talked about here. This exchange gives some idea of the contestations around the saunas and the ways in which gay men working in HIV prevention perceive the saunas. As is clear, there is no real consensus on how to deal with the saunas, or even on what the issues are, apart from a desire to prevent HIV infection. As representatives of the gay community, these men are caught between several different demands and desires. Several of the men present are sauna-goers themselves: indeed, when the conference broke up later in the evening, one of them went around offering free passes to one of the saunas for anyone who wanted them.

One of the primary issues is that of control: control over knowledge and control over boundaries. Some of those who had participated in the pilot project in the saunas were aware of the need for partnership in dealing with the issue of the saunas. Partnership meant gay men working with Health Board officials, statutory agencies, sauna owners, and sauna goers in order to achieve the aims of the project. It meant respecting the boundaries and remits of different parties to the partnership, but it also allowed for creative manipulation of those boundaries. This is particularly clear if we analyse the relations of the saunas and those working on the pilot project.

Partnership meant the acceptance of the saunas as commercial outlets with commercial interests, though Tom (14) (20) does not rule out the possibility that the partnership might extend to the saunas occasionally diluting their commercial interests in the interests of community. This partnership also brings the saunas into the community, crossing the boundary between commercial enterprise and community service provider, recreating them as something that community members have a vested interest in and as a part of the gay community, providing a service (albeit commercial) over many years for many men, but also relying on those men for its own business. In this way the saunas cannot easily separate themselves from the community, nor can the community separate itself from the saunas. Partnership also requires an understanding on the part of the pilot project workers of the ways in which the saunas operate as businesses, but also an understanding on the part of the sauna owners of the work of the pilot project. This required an exchange of knowledge between the two that would go beyond simple statements of their differing positions. Thus, not only were there lengthy consultations between the sauna owners and those undertaking the project, but one of the workers on the project had himself worked in the two saunas which were part of the pilot project and had already established close personal links with the owners. This worker, who had a background in both HIV prevention and in working in the saunas, became central to the success of the project. In effect, someone from the

saunas was in the pilot project as a worker, and someone who was in the pilot project was a worker in the saunas. Indeed part of the pilot project required this particular worker to attend the saunas on a regular basis to help out with any difficulties that implementing the project might cause. Each party was able to maintain control over its particular interests at the same time as each shared that control with the other party. Granted, there were carrot-and-stick elements to this partnership. The operators of the pilot project were under some pressure from the Eastern Health Board to do something about HIV prevention in the saunas, and they used that pressure to pressurise the owners into cooperating. On the other hand, the sauna owners, who might have had good reason to fear Health Board workers wandering around their premises looking at what was going on, were able to allow such intervention without any adverse consequences, and this was held out as a carrot to them at the start.

We might ask why it is that the sauna owners are so heavily criticised in this: is it that they are seen as actively promoting unsafe sex through the provision of facilities which allow it? Is it that they are seen to be profiting from this commodification of unsafe sex? Perhaps an important issue here is the power of the saunas and the powerlessness of community organisations in dealing with them. The “commercial sector” (which seems, as a moniker, to divide the service providers off from those to whom they provide the services, thus implying distance and a lack of concern) is invented as being solely interested in profit, even if that comes from the commodification of unsafe sex. This issue is raised by Tom (14) but perhaps the most vociferous speaker against the sauna owners is Paul who works for a community newspaper. This paper, though it has existed for seventeen years, has only ever had one article on the saunas, and that article was written in the eighties by a lesbian who had gone in to one of them for a bet. Given that the saunas are such a major part of Dublin gay life, why is it that nothing is written about them? Why is it that Paul can come along to a conference such as this and deplore the behaviour of the sauna owners and yet not produce an article for the paper which makes these views clear? Partly, we can assume this has to do with the prevailing view that the saunas provide an important educational resource, and one that future sauna projects will rely on for HIV prevention work. The cooperation of the sauna owners will be vital for this and anything which might ‘upset’ them would be seen as having negative implications for the future of HIV prevention campaigns. However, there is more to it than that.

For as long as the paper has been in production, saunas have been not just regular advertisers but consistent and well-paying advertisers. The sexy presentation of the saunas in their

advertisements are one of the more 'colourful' parts of the paper, and, given that staff photographers are not in the habit of producing sexy photographs of male bodies, these advertisements provide something for the readers to look at or ogle over. The paper itself has had many run-ins with the 'commercial sector' over the years, not usually on account of articles, but most often as the result of publication of "letters to the editor" which criticise the policies or prices or services of the commercial enterprises. The sanction which the commercial enterprises have most often taken as a result of this kind of publicity is to withhold advertising and to ban distribution of the paper on their premises. Since the paper (as a free paper) relies on these outlets for distribution and for advertising revenue, it is caught in a compromised relation with the commercial sector which leaves the paper, at least to a certain extent, powerless to speak against them. It is perhaps the effect of this powerlessness, which makes the paper so vulnerable to the demands of its advertisers, that makes its writers so angry about the saunas and their owners.

That this is the case can be seen to some extent in another issue regarding the paper which was raised earlier at the conference in relation to the role of the paper in HIV prevention work among gay men. For a long time the voluntary and community organisations complained that the paper (which is widely distributed and read by gay men) was doing little to highlight concerns about HIV in the gay community. This can be related to some extent to the attitude that "AIDS and HIV are not all we are about" and that constant reiteration of the proximate relation of gay men to HIV and AIDS would merely be off-putting for readers. As a consequence of the bolstering of community organisations through funding from the Department of Health and the Health Boards for organisations' HIV prevention efforts, the paper appointed a HIV editor who would be responsible for ensuring that HIV received prominent notice in the paper on a regular basis. Funding for the paper to do this kind of work was added to by revenue from the various voluntary organisations involved in HIV prevention work who also advertise their services in the paper. The issue of advertising in the paper was raised earlier in the conference by Tom, who noted the relation between funding and community, saying that not only was the meeting partly funded by Departmental funds, but so was the room and the community centre in which the meeting was taking place. He noted that the gay press was making a lot of money out of HIV prevention groups and the Department, but also that the paper served the "culture of the [gay] pubs" (from my notes taken at the conference). He added that credit for HIV prevention work had to go to the paper, but raised the issue of the paper making money out of HIV by saying that the paper was now demanding a 50% increase in the advertising rates paid by the voluntary organisations. Paul countered this by saying that in the English gay press a lot of money came from drug companies

producing HIV-related treatments, but that in Ireland the paper relied on money from the statutory agencies as there was no money from drug companies. He also added that, despite the number of voluntary organisations involved in HIV prevention, few provided him with information which he could use for articles in the paper. He said there was a very fine balance between government funding for the paper (which operates under a FÁS social employment scheme as well as funding and revenue from the Department of Health and the Health Boards) and the collapse of the paper. Tom agreed that what was needed were “new contracts and new projects,” but it is obvious that the community and voluntary organisations felt pressured and compromised by their funding and revenue relations with both the commercial sector and with the government agencies.

The issue of control is central to the concerns of both the Health Board and gay community organisations. Epidemiologists looking at the situation see the statistics rising and see the black box of the saunas as part of the problem. Men go into this box healthy, and come out diseased in sufficient numbers to generate concern. From this perspective this looks like an uncontrolled situation of disease proliferation. Whatever is going on in the saunas is out of control, and is the cause of an out of control rise in statistics. We see this reiterated in the ways in which some of the gay men in the above exchange talk about the saunas, as with Paul (12) for instance. Exerting a controlling influence means opening up the saunas to some kind of enlightenment, and in the exchange this enlightenment takes a number of forms. Peter (6) thinks it is a matter of responsibility: getting the men in saunas to take control of their own health and safety. Both Patrick (7) and Paul (12) seem to think the best enlightenment comes with the heaviest stick: that threatening the sauna owners with loss of control over their businesses is the way forward.

Phil (13) and Patrick (16) seem to think that condoms are the enlightenment required. Earlier in the conference, some prevention workers from Manchester had mentioned how they had devised “glow boxes” for the delivery of condoms in darkrooms. These boxes were painted with luminous paint and contained condoms and lube. The workers themselves were prohibited from entering the darkrooms as part of an ethical code which required respecting others’ boundaries and meant not going where men were having sex. Another part of this code was a prohibition on HIV prevention workers using the saunas for twenty-four hours before and after work, thus creating a boundary between the saunas as a place of work and a place of recreation. The “glow boxes” were their way of dealing with their self-imposed exclusion from the darkrooms. The boxes were

not so bright as to enlighten the darkrooms, but were sufficiently visible for men to be able to access them.

Condoms crop up quite a bit in the exchange. Granted they are thought of as being the way forward for safer sex, and in this sense their availability is important. Condoms also represent something visible and quantifiable, something which can give some indication of what is going on in the dark. The reasoning is that if men are taking the condoms, they are using them, though Steve (17) is quick to point out the fallacy of such reasoning. One of the important steps taken in the pilot project was making condoms more freely available to men in saunas; perhaps the next step will be to try and make sure they are using them and using them correctly.

Tom (9) raises the spectre of a different kind of control. In his fear of the power of the consultants on the National AIDS Strategy Committee, he implies that if the gay groups do not do something about the situation, others will. The idea of the National AIDS Strategy Committee going over the heads of the gay community organisations may seem a little far-fetched, but the issue has less to do with this than with the loss of credibility for the gay community organisations. To maintain their credibility the gay community organisations must be seen to be doing something effective about HIV prevention in the saunas. The counter to the threat of overreaching consultants is to maintain the framing of the saunas as learning centres, something which the consultants can understand. Another part of this countering comes from Eric's comment (5). He compares closing down the saunas to Prohibition in the United States in the early nineteen-twenties. The effect of Prohibition was a proliferation not just of alcohol consumption (as if Prohibition itself made alcohol more seductive), but a proliferation of organised crime and antisocial behaviour. The threat of closing down the saunas is ineffective because of the variety of proliferations it would cause. More men might take to public spaces for sexual encounters, causing a public nuisance. These men would then be more difficult to contact and HIV prevention work would be made more difficult, causing a proliferation of HIV and other STD infections. Chances are, in the absence of saunas, other premises might attempt to pick up on this trade by opening discrete darkrooms or cubicles, but in private rather than in public, such that they would be difficult to access except for the knowing. Outlawing saunas might make them seem attractive and exciting places, increasing the numbers of men who might want to experience something similar. This kind of proliferation and the kind of loss of control that it implies is something that epidemiologists and public health officials would understand. They too see the saunas best as learning centres.

Part of the understanding of control within the saunas, amongst the men who go there, has to do with activity and passivity. The men are constructed as being passive, tacitly complicit in their own infection and destruction. What is needed is activation. This is implied by what Peter (6) says about responsabilisation. Nonetheless, it is the men's activities which are dangerous, and the responsabilisation programme assumes them to be in some way passive recipients of health information. It is as if an injection of responsabilisation will bring slow down or eliminate the unsafe activities that reproduce infection at the same time as activating the responses which protect against infection. As a model, this is similar to the input/output construction of the black box, and, like the black box, it shows little understanding of what goes on in the space between input and output. What is needed here is some sense of the men in saunas as actively constructing their own meanings: this goes for health education messages as much as for sex itself. The communication model for most HIV prevention takes little or no account of the audience for these messages as anything other than passive recipients. Rarely does it consider that men make choices between different pieces of information and knowledge, that the passive audience is actively constructing its own way of thinking about the issue.

## CONCLUSION

In this exchange of views between gay men engaged in HIV prevention, and in the reportings of the pilot project in the saunas, we can see something of the ways in which the saunas are framed by HIV, and how these framings are contested. Important in this is the credibility of the gay organisations themselves, both in their representations to the sauna owners and sauna goers, and to epidemiologists and public health officials. Maintaining credibility means translating the several concerns of the differing parties into a common language that allows for effective HIV prevention work to be undertaken in the saunas.

## Chapter Four

### Making Communications: Representations in HIV Prevention

*Joe: I met him at the sauna. He is thirty-two and comes from the West. He still has some of his accent, though he likes to think he doesn't. He's a professional working in Dublin for the last ten years. He doesn't get home much at the moment, though he used to go home at least once a month. He has had several boyfriends, though they never last very long. He doesn't think he's very good at relationships. The last boyfriend only finished up three days ago (though Joe had already told me he'd been in the saunas a fortnight ago) and he was quite keen to make it clear that he, Joe, had ditched the other fella. He says that's often the way it happens, as if he were proud in some way of ditching and not being ditched.*

*When I saw him first, he was in one of the less-than-dark darkrooms, the steam-room. I was already sitting inside when a guy came in and sat about five feet away. Joe came in and stood opposite this guy, then, after looking around a bit, walked up to him and started feeling up the guy's legs. The guy seemed nonplussed by this and eventually Joe opened the guy's towel and went down on him. Within a matter of seconds, three other guys, who had been watching from the safety of the darker area in front of me, gathered round Joe, took his towel off and started going at him pretty heavily. Joe and the guy he was doing didn't seem to be bothered by this at first, and Joe was busily sniffing poppers and going down on the other guy. One of the other three obviously tried something on, and Joe grabbed his towel back around his waist. He seemed to*

*pause for a moment as if he were deciding what to do, and then legged it pretty fast out of the steam room, despite one of the three trying to pull him back.*

*I had been sitting on the high bench enjoying all this and watched for another minute or so as the three guys now carried on with the guy Joe had been going down on. They all disappeared into the darkroom and I decided to leave. Joe was standing outside. I said "It was pretty wild in there" and he nodded and laughed, saying "I hate when that happens." Thinking that Joe might be waiting for the guy he went down on to come out, I said "I think the guy you were with is getting off with the others in there" "Fuck him, I'm not into that. I don't like groupie things."*

*We headed for the coffee bar. He asked me if I hadn't wanted to join in with the action in the steam room, that he kind of hoped I would. I said I only wanted to watch. "A watchqueen, eh?" he said, laughing. "Actually, I'm an anthropologist," and the usual exchange (What is that? Why are you here?) followed. I told him I wasn't interested in having sex. He admitted that he probably wasn't up to it anyway as he'd already been with another guy before he went in the steam room, but that he thought the guy he went down on in the steam room had a big cock. "Is that what you're into?" "Oh yeah." "And was he big?" "Fuck yeah. Didn't you see it?" I said I hadn't seen it. "I love going down on a big cock. It's all there is really." "So you're not into fucking or anything then?" "Not at all. So what's your name?"*

*I mentioned something about the poppers and he said "I've only been using them the last few weeks. I came in here one night and this guy gave me a go, and it was fantastic. Do you not find that?" "I don't use them myself." "Do you not find they give you a real rush?" "I never got anything from them, so I don't bother with them. I don't mind another guy using them." "I heard a guy died from them in [names one of the saunas]." "Oh yeah?" "Yeah. I didn't think they could kill you." "Well probably not the poppers alone: it depends on what you were doing and how healthy you are." "But do you think they could kill you?" "Not on their own. Maybe a combination of heat, and poppers and a bad heart, and maybe going at it too hard. It might give you a problem." "I really have to give them up." "I thought you liked using them?" "I dunno maybe they're too dangerous." "Why, do you have a bad heart or something?" "Nah, but they're really addictive. I'm using them all the time in here now." "But you enjoy them?" "Yeah, but, well I only ever swallowed once before, and in the last fortnight I've swallowed three times." "And you think that's because of the poppers?" "You just get such a rush, a buzz, you can't stop yourself." [From field notes]*

I met Joe one night in a sauna I frequented as part of my research. He was a good-looking guy, had an easy manner, and chatted away for about an hour with me before he disappeared back into the dark. I did not see him in the sauna again that night or any other night, but it appeared from what he said that he was a regular visitor there. He had a good education, having taken a degree in the subject which was now his profession, and yet he seemed unsure of the risks he was running. He had no difficulty in talking to me, even after I had told him why I was in the saunas: if anything, he seemed delighted at the opportunity to talk about himself.

Joe, and many other men, present certain problems for HIV prevention education. Intelligent, articulate, and having lots of sex, he still seemed to be missing some of the messages he needed in order to protect himself from sexually transmitted infections, including HIV. He was not unaware of the risk he had taken in swallowing other men's ejaculate, which seemed to indicate that he was familiar enough with safer-sex literature and with the listings of high-, low-, and medium-risk practices in them. Given that he claimed he was not interested in having penetrative sex, he seemed to think himself safe enough in that regard. The fact that he had not accepted the advances of the guy who had tried to come at him from behind probably indicates his lack of interest in anal sex as much as his lack of interest in group sex. It also indicates that he is not unable to resist the unwonted demands of others or assert his own desires with others. Without a word, he was able to communicate what he wanted to the first guy he approached, and later communicate what he did not want to the others.

The Joes of this world are getting the messages about safer sex, but something is missing. Aware that swallowing other men's ejaculate posed something of a risk, he had done it nonetheless, and not just once but on a few occasions. I do not think that Joe is in any way exceptional or unusual in this respect. Many men that I met and spoke to, both in the saunas and elsewhere, claimed a knowledge of safer sex, and HIV transmission in particular, which, as they talked on about their sexual activities, seemed to me to be slightly incomplete always. One of the phrases that recurred in these conversations ran something like "but that was only on that occasion," indicating something they had done that they knew to be risky. Sometimes it was a night of heavy drinking or drug use that led to a less-than-safe sexual encounter, and sometimes feelings of depression or loneliness. Joe's relation of poppers to the occurrences of swallowing has a similar sense to it: as if he only did it on those occasions *because* he was using poppers. That he seemed willing to rationalise it in this way interested me. The curiosity was, of course, that poppers cause a rush of

blood which can help increase erection, and they are reputed to help relax the anal muscle. They are not mind-altering, and they are not addictive in the strict sense of the term. Since Joe was only fellating another guy, was not interested in anal sex, and was not displaying any erection of his own, *why was he using poppers?* There are a number of possible explanations for this: fashion, fun, heightened sensuality, even a sense of added intimacy from sharing a bottle of poppers with others. One of the reasons I had spent so much time in the saunas was that I had listened to men rationalising what they did or how certain things had happened *after the fact*. It seemed to me that perfectly intelligent men could have unsafe sexual encounters about which they could rationalise afterwards. The unsafe sex was something of a compulsion where the compelling feature was not necessarily attributed to desire but rather to something else, like drink, or drugs. It would also be possible to examine a story such as Joe's and say that he was suffering low self-esteem, perhaps on account of his failed relationships, perhaps because he had not been home for some time.

Ordinary Joes are the objects of HIV prevention education. What ordinary Joes know, how they know it, and, more significantly, how they use the knowledge they have, are important questions in the formulation of prevention messages. They are also the product of such education. In Ireland, the strategy used for HIV prevention among gay men is risk reduction: this indicates the different levels of risk attached to different practices, and, providing sufficient information, the intention is that men will choose the safer, less risky practices more often. What I want to examine in the rest of this chapter is how representational strategies are developed and used in HIV prevention communications. An important part of this is considering the cultural conventions and the constraints on the production of such communications. I want to do this by examining two different representations. One is the *Play Safe, Play Sexy* booklet produced by the Gay Health Network (Gay Health Network 1999), aimed at gay, bisexual and other men who have sex with men, and the other is the 'convenience advertising' campaign, operated by the Health Promotion Unit of the Department of Health and the regional Health Boards.

## CONVENTIONAL MODELS

The research I undertook in the sites connected with gay men could be described as being 'opportunistic.' I was already familiar with the gay bars and the saunas, and I had a number of contacts with people who were working in gay community organisations and in HIV prevention, as well as numerous gay friends. To a large extent, I was a "native" taking the opportunity of my familiarity with these venues in order to conduct research. If my nativeness was helpful in terms

of the research, it also caused a number of problems. In particular, I got something of a reputation for being a sauna-goer, such that even people I thought I was meeting for the first time in other venues or situations knew me as someone who spent a lot of time in the saunas. Since the saunas and the bars were places I went to in order to socialise, being known as someone who was a frequent sauna-goer did not help my own social life. These kinds of boundaries are problematic in this kind of work, and no less so in HIV prevention work. Boundary demarcation has formed an important part of interventions in saunas in other countries, especially where the men engaged in the work are also gay and are using the same saunas for recreation. Indeed, one of the guys I knew who worked in a Dublin sauna said that it had affected his social life badly. Other people associated him with the sauna in a negative way, and, having seen the goings-on in saunas he said he was left with little desire to have sex himself.

My research also allowed me the opportunity to become involved with a number of groups, in particular one group which was being set up to conduct peer education and to help with outreach HIV prevention work. Though this group did not get off the ground at that time, participation gave me the opportunity to see how individuals are trained to do HIV prevention work. Again this involved a series of boundaries. Whilst I was interested in becoming active in prevention work of this kind on a personal basis, it was clear that it would also be a valuable experience from the point of view of the research I was conducting. This would mean making it clear to others in the group that I was performing two different roles at once within the group. At our first meeting, we all agreed on certain conditions for participation with the group, one of which was the confidentiality of what was discussed, and this meant there was little left which could be used for research. One thing that was left to use was some work we undertook in distributing the brand new *Play Safe, Play Sexy* booklet which had been produced by the Gay Health Network.

This booklet was intended to replace the *Healthy, Hot, Horny* (Gay Health Network n.d.) guide to sexual health and pleasure for gay and bisexual men which had been produced a couple of years earlier by the Gay Health Network. The Network is an umbrella organisation for a number of gay groups involved in HIV prevention work and working with gay men with AIDS. Over the years it has been used to undertake work which individual organisations would have found difficult on their own, or work that was commonly useful to all the groups.

I first heard about the new booklet in a gay bar a few months before it was published. One of the lads at the bar that night handed me a small peach-coloured piece of paper that read:

**Models Needed!**

**Are You Interested in Promoting Sexual  
Health Along With Other Gay Men?**

**Could You Pose in Various Situations?**

**Clothed or Naked, Be Affectionate,  
Socialising.**

**Then We Need You!**

**For the Gay Health Network**

**New Play Safe Play Sexy Booklet**

(Note. Faces Need Not Be Fully Shown in Booklet)

This was followed by the dates for a meeting and a phone number for would-be models to contact "Our Professional Photographer Now." I asked around to find out if anyone knew anything about the new booklet, and almost everyone had the same thing to say: they're looking for models to get their kit off, so it's going to be worth seeing. One of the things that had struck me about so much of the information that is produced by gay men for gay men is how un-gay, and often anti-gay it seems. I have already spoken about the fact that such information is seen as conveying a particular message, one that comes from microbiological science, and from epidemiology, and which usually only reiterates that message in a 'language' that gay men use. So the gay leaflets use the word "fuck" where others might use "intercourse," and the gay ones talk about "cum" and "pre-cum" where others talk about "semen," as if gay men would not understand the words "intercourse" or "semen," or as if other people would not use the words that gay men used. The previous booklet, *Hot, Healthy, Horny* had been something of a departure in the production of gay-oriented safer-sex publications in Ireland and had presented the information alongside photographs that emphasised the fun and sexiness of safer sex, sugaring the pill of safer sex. It mixed both the 'official' descriptive language and the more colloquial language of sex, though usually bracketing the latter: thus "...anal sex (fucking)..." and "...unprotected vaginal or anal

penetration (fucking)...” Using colloquialisms has become something of a convention in gay publications of this kind, and is what most people I spoke understood as “cultural sensitivity.”

At least initially, the new booklet promised further departures and had people talking, if only about the advertisement for models and what that might mean. Most hoped it would mean more photos of sexy bodies and guys getting it on, and to some extent at least, the booklet did deliver on this hope. The size and the design and layout of the booklet meant that most of the photographs are no more than postage-stamp size with even the larger ones being no larger than a matchbox. Of the twenty-one photographs which accompany the text, only two or three could be thought of as in any way explicit, most of the others containing no more nudity or sexual explicitness than might be found in most television advertisements. The overall design was thought to be very attractive by most of the men who commented on it to me, though most also made the complaint that there were “too many words” and not enough pictures.

Words predominate in this booklet, and no matter how attractive it may be in terms of layout and design or photography, it remains an instruction manual with a great many instructions to follow. It uses the same combinations of colloquialisms and ‘official’ language to describe activities, sometimes reversing the previous format (“...being sucked (receiving oral sex), sucking (giving oral sex using a condom), fucking (anal sex using a condom)...” p. 11). Juxtaposing both descriptions may simply be a desire on the part of those producing the information to avoid any possible ambiguity, and in this sense it does get across the important points about HIV transmission though in a fashion that makes reading it somewhat boring. This boredom comes from the fact that the booklet follows an identifiable convention and meets the audience’s expectations of that convention. This is a health publication (albeit a gay one) and following the convention of health publications is important. Health is, after all, a serious issue, and producing information on which people might base the choices they make in relation to risks around sex is a serious business. The print is small and white on a black background and looks quite striking, and the stark black-and-white design seems to reiterate the idea that these decisions are black and white, right and wrong, good and bad. The convention of health publication requires delivering information in a way that convinces the audience that the information is credible and this may be part of the reason for the juxtapositions of colloquial and ‘official’ languages. Indeed, it is the convention which largely guarantees the credibility of the information. Also, the information has to interpellate its audience, speak to it, appeal to it, and to do so in a language the audience perceive as being their own. This publication also follows the convention of health publication in

other ways. In offering information it shows the individual how to identify problems for themselves, allowing for self-diagnosis and self-surveillance, and offering possible solutions, therapies, or means of avoidance, allowing for self-medication and self-protection. It presents information on what a risk is, what makes it a risk, how the risk can be assessed, how it can be avoided, and why it should be avoided. Though this is done in a largely non-judgmental way, leaving the ultimate choice up to the individual, it none the less makes clear which is the right, better, or healthier choice.

Following the convention gives the information credibility even if it makes the material somewhat boring. Part of this boredom derives from the fact that something is recognisably conventional, and that something like the *Play Safe, Play Sexy* booklet adheres to the recognised convention. The anticipatory talk about the new booklet soon died out when the novelty of the two photographs that appeared to show erections wore off. After that, it was just another health publication. According to Tulloch and Lupton, health education campaigns “act as regulatory sites, suggesting how individuals should conduct themselves in order to live their lives well” (Tulloch & Lupton 1997: 71). This could also be extended to include the conventions of health publications: the convention regulates what can be done and how. Failure to follow the convention threatens the credibility of the knowledge being communicated, disrupting the expectations of the audience. This is true of all forms of representation. Scientists who do not follow the convention of publishing their work in reputable peer-reviewed journals (in the conventional style of journal articles) have not generated scientific knowledge. In particular, if a scientist chooses the convention of the press conference or press release as the means of discovering some new knowledge (as has been the case in some recent notable cases like ‘cold fusion’ and even the discovery of HIV) the credibility of this knowledge for many is reduced, and within the scientific community a press release or press conference counts for nothing unless it announces something that has appeared in a reputable peer-reviewed journal.

These conventions are cultural in that they are developed within particular discourses as part of those discourse, and come to signify certain ideas about the production of knowledge within those discourses. Credibility of knowledge depends on using the conventions correctly. Audiences are enculturated to recognise these conventions, learning to expect certain things, and understanding how to distinguish one convention of representation from another. These conventions are not static, nor are the expectations they produce, and conventions work together to produce knowledge at different levels of accessibility. Most audiences seeing a television news report on a scientific

matter accept the credibility of the science not because they read peer-reviewed science journals but because they have expectations of the conventions of news reporting. Such conventions go beyond the literary and apply equally in other areas. I suggest that there are certain cultural conventions of health promotion which profoundly influence the meaning of HIV/AIDS. These conventions are closely related to the models of health education and communication on which the presentation of health promotion information are based.

In the message-oriented 'effects' model of health education, particular desirable outcomes are the goal:

The 'effects' model outlines a predominantly linear process of communication, in which a discrete message is 'sent', 'transmitted', and 'received' (or 'not received') by the audience. Some critics have called this approach to communication the 'hypodermic needle' model, as it implies that messages can be 'injected' into audiences. [Tulloch & Lupton 1997: 14]

The unilinear flow here is like that through a black box: there is 'input' and 'output' but what happens in between is effectively glossed. The flow can only go in one direction, just as the light can only ever increasingly illuminate the dark, and not the other way around. In fact, the retreat of light in the face of darkness is a regression that is to be feared. The model is theorised as an 'effects' model, where the effect is not simply the final outcome but a series of effects that must be achieved. The best known version of this model, and one that is widely used in health education, is the 'knowledge, attitudes, behaviour' or 'K-A-B' model, where the provision of knowledge effects change in the individual's attitude(s) which in turn effects change in the individual's behaviour(s). This model makes certain assumptions about knowledge, about the target and about outcomes that I will explore in more detail below.

Effecting a change in attitude(s) and subsequently in the behaviour(s) of individuals makes certain assumptions about the susceptibility of the individual to the message. This susceptibility is the basis of the 'Morin model' of health education:

...the 'Morin model'...suggests that a person must hold five beliefs in order to change his or her sexual behaviour in relation to AIDS, and that these beliefs can be directly influenced by educational and motivational programs. The beliefs tend to occur sequentially: there must be a belief that AIDS is a personal threat: 'I am personally threatened by AIDS'; there must be a belief in prevention: 'AIDS is preventable; certain actions will reduce or eliminate my risk'; there must be a belief in personal efficacy: 'I am capable of managing this new low-

risk behaviour'; there must be a belief in the possibility of satisfaction: 'I can carry out this new behaviour and still be sexually satisfied'; there must be a belief in the existence of peer support: 'My peers will support this new behaviour'. [Tulloch & Lupton 1997: 85]

Important to this as a processual model is 'interpellation' whereby "individuals recognise themselves as the subject of the advertisement and constitute themselves as 'the audience' (Tulloch & Lupton 1997: 147). This interpellation has significance in the construction of subjectivity:

The term "interpellation" is used in Cultural Studies to indicate the ways in which people are 'hailed' or 'beckoned' by, for example, the cover of a magazine on a news-stand, and, by extension, how they are hailed or pulled into particular discursive frameworks and, therefore, subjectivities (or, more accurately, subject positions). [Epstein & Sears 1999: 6]

HIV prevention messages, then, do not simply communicate knowledge about HIV but actively seek to reconstitute the individual in particular, desired ways. The individual must internalise particular ways of thinking, of behaving, in order to become responsible and to stay healthy. As Waldby (1996) puts it:

'Targeting' involves the pathologisation of sexuality, the inculcation of a sense of responsibility for potential transmission to others, the adoption of a disciplined sexual practice. It may involve an encouragement of HIV testing, and various kinds of epidemiological and clinical surveillance. In other words, to be targeted involves the internalisation of a sense of one's sexed body as potentially deadly, and the adoption of a different sexual choreography and sense of body limit as a consequence. [Waldby 1996: 9]

In addition to these models of health education there are models of education by which knowledge is transmitted. The Department of Health issued a set of "Guidelines for Effective HIV/AIDS Education" in 1996 to "provide a framework for good practice" for HIV/AIDS education (Department of Health 1996: 4), and these guidelines include a section on "Theoretical Models of Education/Teaching Styles." It offers the following breakdown of ways in which health education can be undertaken:

**Model of Health Education**

Information provision

Self-empowerment

Community-oriented

Social transformatory

[Department of Health 1996: 6]

**Goals associated with model**

Increase awareness

Enhance peoples [sic] abilities to act rationally and establish personal control over their lives.

Bring about changes within organisations and communities so that healthier choices can be made.

Change structure of society so that unequal bias in health no longer exists.

Whilst information provision is seen as being important, the guidelines emphasise interactive, participatory methods as being more effective, and the guidelines are therefore oriented towards participatory approaches based on the following theoretical model:

Participatory processes

Recognition of own knowledge, power and value

Recognition of self and ability to express feelings and needs

Recognition of feelings and needs of others

Understanding the outside forces that influence ourselves and others

Prioritising key areas of concern

Planning action

Community action

Participatory evaluation

[Department of Health 1996: 7]

The rationale behind this model of participatory education demonstrates how it is intended to cover all the goals outlined in the various theoretical models of health education:

The diagram illustrates how participative education can begin with what people know and think about AIDS, addressing the issues about which they are concerned. In exploring feelings, norms, values and opinions, and providing training in negotiation skills, participative education can facilitate behaviour change. Changes in individual behaviour may then impact on the wider community (e.g. peer group norms may alter). [Department of Health 1996: 8]

These models were not devised specifically for HIV prevention education, and are widely used in health education in general. They reflect many of the concerns and attitudes of self-help groups, empowerment groups, community action groups and so on, and within the gay community these kinds of groups, already using these models, have been resourced to deal with the issue of HIV as well as their other work. For the gay community, then, HIV prevention work and other social and health action work are constantly associated with each other. In this sense the guidelines join both the interests of communities like the gay community, and the interests of the Department of Health in ensuring that HIV/AIDS education is somewhat standardised. Nonetheless, it is clear that projects engaged in HIV prevention work that do not conform to this standard are unlikely to be funded by the Department. Joining forces, as it were, community and governmental sectors see a common way forward, one that allows each to do what it sees as necessary for its own protection and defence.

As Tulloch and Lupton note,

Part of the discourse of 'risk society' is the uncertainty of expert knowledge systems and yet the continuing need to trust in expert solutions. This ambivalence, in the days of Chernobyl and HIV/AIDS, is fundamental to the play between risk management and personal identity, rationality and fatalism that characterises anxiety about risk in our time. [Tulloch & Lupton 1997: 5]

The Department's guidelines are part of the effort to assuage this ambivalence by at least providing a clarity of expertise in relation to HIV/AIDS. Expertise here has as much to do with following the convention as it does with the accuracy of the knowledge. The production of this knowledge, however, requires knowing about the practices that can result in the transmission of infection. Thus the gay community provides, through its surveys, clinics, and evaluation reports on interventions, the necessary material for both scientific understanding of the spread of the disease and for the targeting of interventions to combat that spread. In evaluating its interventions, in producing reports and surveys of responses, and in its applications for funding, an organisation must present itself credibly, and this using the conventional formats for doing so.

In dealing with the content of HIV/STDs education, the guidelines say such content should enable participants to

Understand the nature of the viruses and modes of transmission;  
Understand the myths and current debates on HIV;

Understand the symptoms of AIDS and what medical care can be provided;  
Know where to find appropriate resources, counselling and medical care;  
Develop greater understanding of those who are affected by HIV;  
Explore personal value systems;  
Explore attitudes to sexuality and homophobia;  
Explore behaviours which would prevent them from contracting HIV and other  
STDs.  
[Department of Health 1996: 12-3]

The 'understanding' suggested in the first three areas is clearly intended to mean accepted scientific/medical understandings, reinforcing the ideas that 1) HIV is a bio-medical issue, 2) bio-medical knowledge is unproblematic, and 3) transmitting such knowledge is the aim of this kind of education. Despite including "myths and current debates" the guidelines make it clear that it does not intend any debates which question scientific knowledge or expertise. The myths and current debates concern "myths, facts and "grey areas"" in relation to HIV transmission: that is, what practices are believed to transmit HIV, which ones do not transmit HIV and which areas are still unproven. This is reflected in the "Training of HIV/AIDS Educators," also part of the Department's guidelines, which, amongst other things, should provide

Accurate and up to date information on the FACTS about HIV/AIDS, including transmission, testing, progression of the virus, medical issues, statistics;  
Accurate and up to date information on the "grey areas", myths and current debates about HIV;  
Accurate and up to date information on STDs... [Department of Health 1996: 20]

Though the guidelines do not say where this information is to be found, it is clearly intended that the HIV/AIDS educators are to get this from "authorities" that produce such knowledge. Yet this does not imply that the knowledge comes down from above, since much of the partnership relations between community and government has built into it the creation and dissemination of knowledge by gay communities for the use of science, epidemiology and public health. Gay men involved in HIV prevention rely as much on the reportings of international gay publications as they do on information from the Department of Health or the Health Boards. The dominant influence of the Department and Health Boards as funders, however, raises important concerns for this issue of collaboration between state and voluntary sectors in HIV prevention education. The relationship can be seen as similar to the model of the relationship between health care provider and patient, where

The provider's claim is privileged in the process of communication with the patient, since the provider almost always sets the terms of the problem, the parameters of its management, and what behavior is needed for its resolution, before "negotiation" can even start. Patients who question those terms are negatively labeled: "difficult" at best, "noncompliant" at worst... Without an examination of the conditions or warrants for the privileged knowledge claim, "collaboration" becomes a mechanism for *more* provider control, not less. [Lievrouw 1994: 96]

The 'patient/doctor' role relation is a cultural convention just as the 'funder/funded' one is. This approach asserts the sense that there is only one knowledge about HIV/AIDS, and that knowledge comes primarily from bio-medicine. The knowledge which is to be transmitted through this education is medicalised and therefore free of cultural interference. Its dominant influence and the dominance of funding agency requirements for the instilling of this knowledge mean that gay organisations accept it, and the 'non-scientific' ideas that piggy-back on it:

...activist groups and critics of AIDS policy accept the truth of AIDS science even as they contest particular public health policies. It is this legitimacy which I want to call into question through a demonstration of the complicity between biomedical knowledge and non-scientific systems of thought. Biomedical knowledge cannot, I will argue, be quarantined from the general ideas operative in the culture, even when it understands its concepts to be carefully and directly deduced from the factual evidence of the body. Despite, or perhaps because of, biomedicine's assertion of its own innocence of historical and political meaning, it constantly absorbs, translates and recirculates 'non-scientific' ideas – ideas about sexuality, about social order, about culture – in its technical discourses. [Waldby 1996: 5]

Waldby quotes Patton in a similar vein:

For the most part, science serves as the master discourse that administers all other discourses about AIDS... Knowledge is perceived to arise from science and filter out into the social [world]... the [various] knowledges of the epidemic arise and compete (most visibly in the policy arena) but it is the logic of *science* that anchors the power relations which determine *whose* knowledge counts as 'real', as 'objective'. [Patton quoted in Waldby 1996: 5]

Yet, as I have noted, the production of this knowledge is not simply top-down but rather involves the complex juxtaposition of rival claims to production. The gay community can produce and reproduce gayness as a visible entity only if such a community exists. The threat of HIV and AIDS to destroy this community is, at least in part, alleviated by funded initiatives, where the

funding comes from governmental sources, but also results in a flow of information from the gay community into the biomedical system, increasing the visibility of gayness and furthering its claims to legitimate participation in issues concerning the health, welfare and even identity of its members.

Important to this is the recognition of cultural difference, by being prepared for it and by insisting on the value and power of bio-medical knowledge. Though the guidelines do suggest offering trainees the opportunity to express their own attitudes and feelings, they insist on the power of this knowledge and the need for its transmission:

The needs and concerns of the community can be addressed by:  
Recognising peoples [sic] rights to be informed, consulted about and actively involved in the development of the programme,  
Recognising different perspectives on moral issues, while asserting the need for health education to prevent transmission of disease. [Department of Health 1996: 10]

HIV/STD education, offering the opportunity for the trainees to become involved and for education programmes to be aware of and reflective of cultural difference, acknowledges the role of communities in interventions against disease and at the same time maintains the state's interests in furthering disease prevention. This acknowledgement is also an acknowledgement of the interrelation of 'knowledges' rather than the dominance of a singular, bio-medical 'knowledge':

It is because there are differences between ways of thinking about and dealing with risks between sub-cultures that we use the term 'knowledges' in this book. 'Knowledge seems such a neutral word. In at least one dominant paradigm in communication theory it conveys the sense that if only experts can transmit knowledge about HIV/AIDS effectively and transparently enough to members of the general public, then the latter will deal with sexuality and the risk of HIV very differently. 'Knowledges', on the other hand, suggests the idea that there are many different forms of bounded and differentially located 'expertise'... 'Knowledges' suggests also the multiple boundaries that exist – physically, conceptually, and in terms of access and power – between these different cultures of expertise. It suggests that these different competences are conveyed in training, in intellectual discipline, in attitude and in lived bodily experience... [Tulloch & Lupton 1997: 7]

Whilst it is imperative that 'knowledge' about HIV and AIDS must be transmitted to individuals within communities, this transmission is tempered by an understanding of differential 'knowledges.' Part of this understanding is the division between expert and lay, creating the lay person as susceptible to such knowledge and the expert as knowledge maker and provider. This division, however, is not so clear cut, since many of those involved in community interventions as facilitators and HIV prevention workers are themselves producing knowledge and information at the same time as they disseminate knowledge and information in the community. What is important is the credibility of this knowledge, and maintaining its credibility during transmission. 'Laymen' have become 'experts,' learning and producing knowledge which is crucial to the understanding of HIV and AIDS. Susceptibility, however, presumes a lack of knowledge on the part of lay persons, and it is this lack that is seen as the basis for other lacks which render the individual 'sick.' Lack of knowledge implies lack of self-control, lack of responsibility, lack of discipline:

Just as the sick are perceived as essentially different, lacking in the discipline and will power to maintain or restore health, people who are characterized for other reasons as lacking self-control (homosexuals, addicts, minorities) are also perceived as diseased or as agents of disease. [Crawford 1994: 1359]

Reducing the possibilities of ambiguity is part of maintaining credibility in the transmission of knowledge. Scientific knowledge, within its conventions, is not ambiguous. Science is understood as providing clear-cut and unambiguous knowledge about the world, a transparent discourse which is a mirror of nature. Whilst providing singularity of explanation is intended to facilitate individuals making better choices, it reduces the choices available to them, privileging particular choices over others. Providing one explanation also eliminates the possibility of individuals making choices about what to believe and what not to believe, but in doing so presumes that such education is the only source of knowledge about HIV that the audience will have access to. The risk reduction strategy employed by Irish gay groups involved in HIV prevention presents clear-cut information about different levels of risk, and allows the choice to the individual, but it nonetheless makes clear which is the preferred option. An important part of the production of knowledge on the part of the gay community is the production of knowledge of the embodied experience: the embodiment of AIDS and HIV, the embodiment of desire, and the embodiment of otherness. The picture of HIV offered by this knowledge becomes part of the knowledge produced in laboratories and epidemiological statistics, and the result appears as *the* reality of HIV.

Such an approach to education also constitutes subjects in particular ways. Tulloch and Lupton see the contemporary emphasis on risk as part of a surge of individualisation

...in which people have become compelled to make themselves the centre of the conduct of life, and where dangers, threats or crises are frequently seen as individual problems rather than socially-based. [Tulloch & Lupton 1997: 5]

This concentration on the individual turns the problem away from environmental influences and results in the model of the audience for these messages as composed of rational choice-making individuals who, provided with the right information, make the right choices. Such approaches fail to take account of the social and cultural context of decision making, and assume that good health is more important to the individual than anything else. That such a straight-forward link between good health and the choices individuals make is not necessarily the case is something that Irish doctors are well aware of and concerned about. Dr Joseph Barry (1998), in an essay on "Developments in the Epidemiology of Disease in the Next Century," discusses the balance of care between public and private health care, notes that:

The reason so many people opt for private as opposed to public health care are often concerned with the associated "hotel" benefits of private health care, such as pleasant surroundings, shorter waiting times, no lengthy queues and a greater patient choice in how health care is delivered. In contrast, health outcomes are rarely used as a criterion for making the choice between public and private health care. [Barry 1998: 177]

The "hotel" benefits also include things like private rooms, greater and more personal access to consultants, and other benefits that Dr Barry might not consider as being important to such a decision. Being able to attend a 'prestigious' private clinic, being able to afford the private medical insurance that allows the choice between public and private health care, and the 'word of mouth' cultivation of differences between private and public health care that give *kudos* to private rather than public health care, are also important though perhaps less obvious motivations in such choices.

The individualisation of HIV prevention education relies on the creation of the desirability of particular kinds of subjectivity. These subjectivities allow for a division between self and other in terms of 'health.' Perhaps the most significant part of this subjectification is the creation of the self-surveilling individual:

...like other forms of disciplinary power, medical-moral control in the name of health relied, in large part, and continues to rely, of the self-observing, self-regulating practices of the individual pursuing aims of self-enhancement. [Crawford 1994: 1352]

This is done through making the individual internalise a sense of being at risk. Risk awareness is part of the process of responsabilisation, which demands self-surveillance:

The 'at-risk' self is vulnerable; and responsibility is currently said to consist of a willingness to monitor, confront and do something about that vulnerability. ... Risk awareness becomes the opening gambit of a ritual which, in revealing the dangers and simultaneously what must be done to protect against them, affirms rational control which lies at the heart of technological culture and which claims the identities of its most 'progressive' members. Risk consciousness increases the healthy anxiety for which risk management offers its health solution. The ritual thus distinguishes the responsible from the non-responsible individual. [Crawford 1994: 1357]

#### MODELLING INDIVIDUALS

Culture is seen as being in the individual, as a set of 'wrong' and even 'dangerous' beliefs, a dark knowledge which needs to be replaced by something more enlightened. Culture is problematic, and seeing it as being in the individual rather than seeing the individual as being situated within culture, further removes the individual from HIV/AIDS:

'Culture'...is represented as something possessed by 'other social groups', particularly those that are marginalised in some way. In much health communication and health promotion literature, 'culture', understood in this very specific way, is viewed as a 'barrier' that creates problems or the failure of health promotion strategies because of clashing norms and assumptions or linguistic problems. [Tulloch & Lupton 1997: 15]

These individuals are constructed in the literature as being susceptible and vulnerable to all kinds of things, but they are also presumed to be in some way susceptible to health messages. They are constructed as customers or clients, furthering the consumerist bent of health services, but they are also constructed as having particular identities: gay, drug using, young, female and so on.

Such individualisations seem to ignore the possibilities of contingent identities, insisting instead on essentialist and essentialising depictions of the individual, yet the fact that most health promotion attempts to create particular subjectivities is in itself a recognition that there are multiple subjectivities available to individuals:

...subjectivity is fragmented, dynamic, continually produced, reproduced, constituted and reconstituted and highly contextual. At some times and places, people present a self that differs from other times and places. People's own understandings of self and the body are only ever partial, given the unconscious and sub-conscious dimensions to subjectivity. Language and discourse mediate individuals' views and experiences of reality and their embodied sensations, both when making sense of these themselves and when explaining them to others, including researchers. [Tulloch & Lupton 1997: 24]

In essentialising the individual, the literature of health promotion and HIV prevention often uses and reinforces stereotypes of masculinity and femininity, or of gay men, drug users and so on.

This concentration on the individual level has other consequences. It pictures society as populated by rational decision-making individuals, who, regardless of the social and cultural environment, wish to prioritise health over all other considerations. The relation of these individuals to society as a whole is not always clear. This concentration ignores the possibility of seeing sex, for instance, as having collective aspects: as Dowsett claims, "Sex is actually a collectively structured pursuit rather than a private act" (Dowsett 1996: 268). The model of sexual behaviour which underlies much of the prevention literature is that of the satisfaction of individual desire, with little sense of sex as perhaps communal. Again Dowsett raises the question of sexual motive in this connection: "Is sexual practice more about joining in, of belonging, than it is about satiating a deeper, unknowable need? Is sex simply fashion?" (ibid.: 52). What is the relationship between individual and private, and collective and non-private when it comes to sexual practice in a place like the saunas? What role does a sense of community have in this? Where is community in the constantly reiterated emphasis on individuals in community-produced literature? The production of community-oriented information attempts to bridge this gap by reiterating the relationship between the individual and other individuals within the community. Most often, this appears as others in the community providing services specific to individuals in the community. Gay peers provide the services for gay men. Yet the individualisation also problematises the individual, constructing the individual as the locus of the problem of ill health and disease, and offering individual behaviour change as the only way of dealing with the problem.

Concentrating on the individual also demonstrates the uses of HIV and AIDS as part of dividing practices, reinforcing the inscription of certain groups as being 'at risk' or 'high risk' for HIV and AIDS, and others as not. This becomes particularly evident in the differences between the information which different groups get in prevention literature:

Even though each group receives 'facts', the 'public' is given information on the assumption that they have a *right to know*, that is a right to 'protect' themselves, while [risk groups] are educated on the assumption that they have an *obligation to know* and protect the 'public'. [Patton quoted in Waldby 1996: 8-9]

These kinds of division reinforce the perception of a hierarchy of risk and vulnerability to HIV infection:

In these hierarchies of risk the lower represents a threat to the health of the higher, and hence the lower become the object of measures to control contagion. [Waldby 1996: 9]

By remaining the only unmarked category within the terminologies of sexual risk, heterosexual men effectively occupy the position at the top of the hierarchy. As the only group exempted from direct address by public health discourse, they are freed from internalising the idea of their bodies as dangerous or infectious, relying instead on the willingness of heterosexual women to undertake such internalisations. [ibid.: 10]

Individuals divide into the responsible and irresponsible, the healthy and unhealthy, thus attracting moralistic views of certain individuals and forcing them outside the 'norm.' This again introduces dichotomies between 'public' and 'private' in HIV/AIDS talk. Ronald Bayer in a 1989 article on "AIDS, Privacy, and Responsibility" quotes Joseph Califano, then American Secretary of Health, Education and Welfare, as saying that "Indulgence in private excess has results that are far from private. Public expenditures for health care are only one of the results" (Bayer 1989: 81). Frankenberg sees that "...the prevention of disease and the prevention of the need for medical care are easily conflated" (Frankenberg 1994: 1329), and this conflation re-turns onto individuals: as Crawford notes, "The out-of-control individual is also [seen as] one of the causes of out-of-control medical costs" (Crawford 1994: 1357). Though Bayer notes that "the individual calculus of personal risk will conflict with the collective calculus of public health" (Bayer 1989: 95), he goes on to say that

Through education freed from the strictures of moralism and conveyed in forceful and imaginative ways, public health officials can disseminate not only knowledge but also an appreciation of the moral claims imposed by the threat of HIV infection. [ibid.]

Bayer's curious idea of education free from strictures of moralism which also disseminates an appreciation of the dominant moral claim of public health protection extends itself into a culturing of responsibility:

...a culture of responsibility must take hold and be reinforced among those at risk of acquiring AIDS if it is to shape their private acts. It cannot be imposed upon them from above. [ibid.: 96]

It seems to me that, ten years after Bayer's article, this culture of responsibility is still being promoted in HIV prevention literature, perhaps with the difference that responsabilisation is now seen as being a community effort, the gay community taking responsibility for the health of its own, and gay men becoming responsible for the health of the community, rather than simply doing so for the sake of the general population.

One facet of this responsabilisation of the individual is its potential for inducing feelings of guilt. Increasing pressure to make the right choices and do the right thing may well induce feelings of guilt in those who might put themselves at risk by having (even if only occasionally) unsafe or risky sex. There would seem to be a reasonable possibility for such a sense of guilt to be transformed into a sense of fatalism, which defeats the purpose of the educational strategies. Guilt, as Smyth (1998) notes, is not entirely alien to the Irish, and she relates this to the particular influence of the Catholic Church in Ireland. She relates what she refers to as "the indirect influences of Catholicism which proliferate Irish thinking" (ibid.: 667) to cultural constraints on the delivery of HIV/AIDS prevention in Ireland. Feelings of guilt, as she notes, "do not encourage assertive behaviour and are, therefore, not likely to empower an individual to negotiate safer sex or abstain from drug use" (ibid.: 668). She traces how this Catholic-induced sense of guilt and fate might result in a fatalism:

The notion of fate was expressed by one interviewee who worked with drug users when he suggested that, unlike drug users in the United Kingdom, intravenous drug users (IVDUs) in Dublin felt that their becoming HIV+ was "unavoidable". Another worker claimed that users actually "felt a sense of relief" when they received a positive diagnosis because, once again, they felt that they would

eventually be infected through their habit and that there was little they could do to protect themselves in the long term. [ibid.: 667]

The policy of Irish HIV prevention organisations, which emphasises risk reduction rather than risk elimination, is intended to avoid inducing feelings of guilt in those who might occasionally engage in unsafe or risky sexual or other practices, but at the same time inducing a sense of responsibility for one's own health, and potentially the health and infection of others, which maintains a certain pressure of guilt or the fear of guilt.

An extension of this relationship between risk reduction and responsibility for the self has to do with self-esteem. I have already mentioned the perceived significance of increasing gay men's self-esteem as part of community building and HIV prevention. Low self-esteem and vulnerability to HIV infection and other ill healths are closely associated in the prevention literature, particularly in relation to young people, and those who do not self-identify as gay.

Coming Out is a term used to describe an event or process in which you acknowledge, recognise, or declare your sexual and emotional feelings for another man. Coming out begins with self-disclosure. Telling friends or family can be the next step and reactions can vary from denial, anger, acceptance to relief. Coming out can be one of the most challenging times in any gay or bisexual man's life. It can also be a turning point, a rewarding and liberating experience.

As you explore your sexuality you may want to try new sexual experiences. It can be easy, at this vulnerable time, to get carried away in the heat of the moment and forget about risks.

Try to ensure that any sex you have is safe. [Gay Health Network 1999: 5-6]

Vulnerability appears here as the result of an indeterminacy about identity. The emergent, processual sense of 'coming out' suggests the plasticity of the individual, his openness to new experiences which, though formative, might also be risky. The proffered therapy for this is talk:

When coming out it may prove beneficial to have a sympathetic listener. Gay helplines offer a supportive non-judgmental space for you to explore these issues. [ibid.: 6]

Those with low self-esteem are seen as being more vulnerable to infection and risky practices, as well as to alcohol and drug use which are perceived as having adverse effects on individuals' ability to make 'safer' decisions. Poverty, homophobia, physical violence, stigmatisation, lack of

role models and negative depictions of gay sexuality are all seen as contributing to low self-esteem. Low self-esteem is most simply dealt with therapeutically, through workshops which aim at increasing self-esteem and sense of self-worth. As with other individualisations of problems, this therapy keeps the focus of the problem and its solution on the individual: workshops aimed at increasing self-esteem do nothing to address the wider issues which are seen as contributing to low self-esteem. Individuals, then, are made to feel that though their low self-esteem is not their fault and can be attributed to forces beyond their control, increasing self-esteem is the responsibility of the individual, and denying or refusing to deal with low self-esteem is constructed as a contributing factor in suicide, HIV infection, alcoholism, drug use, and inability to sustain relationships. There is some confusion of cause and effect in relation to self-esteem makes self-esteem problematic:

The use of the self-esteem construct is problematical. It is unclear in research results, for example, if "low self-esteem" causes a behavior or is caused by the behavior itself. Thus one may have a temporary feeling of low self-esteem because one has performed an act which broke a social norm (e.g., anal sex without a condom) instead of incurring the supposed and more inherent low self-esteem deemed to be causing the act.

Moreover, the whole notion of self-esteem is built upon a cultural assumption of a cohesive self and a self valuation which may not be valid. According to Katherine Ewing, "At any particular moment a person usually experiences his or her articulated self as symbolic, but this self may be quickly displaced by another, quite different 'self', which is based on a different definition of the situation" (1990: 251). In other words, self-esteem is a fuzzy construct, and one's degree of self-esteem may vary across time and place. Just because one has a lower value of self due to one's oppression or childhood experiences does not mean this lower value is present in all situations – including sexual ones – at all times. [Turner 1997: 13]

Responsibilisation and individualisation in relation to HIV prevention, then, may have effects on the individual's sense of guilt, fatalism, self-esteem and self-worth, effects which may adversely effect the individual's behaviour. Community-oriented prevention information aims at reducing the risks to the individual posed by these adversities.

Individuals are also constructed as 'active' and 'passive': most important is the passivity of the individual who is susceptible to health messages.

... the assumption of the need to transfer a didactic and surveillant message to a passive audience eschews the notion of an active audience reflexively monitoring both [HIV prevention] advertisements and their own bodies. The very notion of a

'campaign' denotes the assertiveness and defined end-point of such texts.  
[Tulloch & Lupton 1997: 30]

Others are then seen as actively resisting such messages, again leading to condemnation.

Health communication proponents often have little sympathy for those individuals who 'know the facts' about such behaviours as unsafe sex, alcohol and tobacco use but continue to engage in them, and limited insight into the pleasures of such activities, viewing them only as pathological, requiring containment. Health education campaigns, therefore, demonstrate a set of assumptions about the ideal human actor... Such an idealised figure draws upon the notion of the 'civilised' body that has been current in western cultures since the Enlightenment. [Tulloch & Lupton 1997: 32]

These 'activities' are highly dangerous as they threaten not just the individuals who 'choose' them, but also threaten contagion to others and the continuing spread of HIV infection and AIDS. This is extended into the metaphors of control and containment through the emphasis on the integrity of body boundaries. The infectious and contagious are unable to contain themselves; their bodies are out of control; whereas the uninfected remain uninfected through maintenance of control over body boundaries. Again, these metaphors work to divide individuals into the controlled and out of control, and allows for moralising about those who are constituted as out of control. Such notions of control and containment take no consideration of the signification which is attached to sexual acts, including unsafe sexual acts: "anal sex without condoms for couples is loaded with meaning, including a signification of trust and commitment" (Turner 1997: 24). Approaches which emphasise simplistic models of rational choice, of individuals, and of responsibility, without taking into consideration the meanings and significances of acts and practices for those involved, run the risk of failing to interpellate the very individuals they are aimed at. Such approaches may also generate 'self-protective' mechanisms which work against HIV prevention. Such self-protective barriers work to protect us from unpleasant realities by projecting them onto others rather than ourselves. Familiarity may breed a complacency which is a self-protective barrier.

Indeed, there is some fear amongst HIV prevention workers that the availability of combination therapy and its widely reported success (for some HIV positive people) in deferring the onset of AIDS may add to the risk of an increase in unsafe sex.

With the advent of the treatments, the combination therapies that are around now, there has been an increase in the number of gay men – I'm speaking from my

own experience, and I'm sure there are papers out there that would back it up – but my own experience is this: that since the advent of those combination therapies, numbers of gay men are actually deciding to bareback, to fuck without condoms, and that they are making that choice because they feel that even if they do test HIV positive that there will be this regime of treatment available to sustain their life. And where I think we are falling down in terms of education is pointing out the dangers of that kind of thinking, and I think that recently at a meeting of community representatives, all working in the area of HIV and AIDS and not one of them had ever considered it. So the situation has changed...As often as we can come up with new ways of doing things, new issues and new problems come up that have us doing the firefighting activities. We have to go and fight the fire, because we're so under-resourced as it is that all we can do is do that. So there isn't time to sit back and say, Well, how can we prevent the fire from happening in the first place, and that's part of the problem. Or can we anticipate where a fire is going to break out and let's be ready for when it does come out, or let's have something in place so we can begin to work at it when it begins to happen. So they're all part of the problems that we have to face. [HIV prevention worker]

In efforts to 'normalise' HIV infection, public health officials and doctors have recently begun to emphasise HIV infection as a "chronic disease" susceptible to management through the use of combination therapy. This has been done both to make HIV appear as less devastating an illness, which might reduce fears in the general public which remain after the "AIDS scare" of the nineteen eighties, but also in an effort to encourage those who might have put themselves at risk to come forward for testing. An early positive test increases the likelihood of the success of the therapy. The fear which has been growing is that this information has reduced the fear with which individuals, perhaps most especially those at risk, feel about HIV, and that this has had the effect of people taking risks and abandoning safer sex precautions. Emphasising the chronic aspect might also have the consequence of reducing the visibility of AIDS and HIV: "Seen less as a raging plague than as a chronic plight, AIDS, like homelessness and drug use, had merged into the background landscape of the late-twentieth-century social life" (Epstein 1996: 325). The availability of post-exposure prophylaxis to those who might have had unsafe sex has been widened so that it is now not just available to those in the medical and other professions who might have suffered accidental occupational exposure, but also to those who may have been exposed sexually or through drug injection.

Self-protective barriers may be induced in other ways. HIV prevention as it is practised in Ireland does not address issues of HIV or AIDS alone. Tied into this, and reinforced by Departmental and other guidelines, is the requirement for general health promotion. HIV and AIDS then become useful tools in effecting general health promotion. This might include increasing awareness of

other STDs (as already noted in the Department's guidelines for HIV education) but also includes awareness of alcohol and other drug use. One of the dangers of associating drink and drug use with prevention of HIV and other STD infection is the construction of alcohol and drug use as associated with the impairment of 'good' decision-making. Citing research by Ralph Bolton, Henriksson notes that

...there is a clear risk (according to Bolton), that a focus on alcohol can indeed obstruct effective HIV prevention because it offers an "excuse" for engaging in risk-taking behaviour. [Henriksson 1995: 9]

This comes back to the kind of rationalisations which Joe can make about his use of poppers. To some extent, he can blame his unsafe sexual encounters on the poppers, though poppers are unlikely in and of themselves to cause unsafe sex. This can lead to thinking that eliminating the poppers will eliminate the unsafe sex, something that the conventions of health publications easily leads to.

#### TOILET TALK

The other form of representation I wanted to look at here is what is known as 'convenience advertising.' This is primarily concerned with producing information in the form of posters which are placed in toilets and toilet cubicles in venues where young, sexually active people congregate. The second report of the National AIDS Strategy Committee notes the usefulness of such campaigns:

"Convenience Advertising" involves the placing of HIV/AIDS awareness messages in toilet areas where the patrons are guaranteed to view them. These advertisements were first placed in third level colleges and following very positive evaluation, the programme was extended to women's health clinics, health centres, gay venues, selected entertainment venues and the offices of the Department of Health and Children. In 1994, the programme was extended so that the messages were designed to target disadvantaged youth. These messages are reviewed and updated on a regular basis and now include broader sexual health messages. The Committee recommends that these advertisements are continued and the venues extended. [NASC 2000: 31]

The association between safer sex and alcohol is important in this:

...the thing with us of putting the stuff in the toilet areas of nightclubs and pubs is that alcohol and drugs do have an effect on people's ability to make safe

decisions. So we hope that the messages which might be seen as they are leaving or in the toilet areas as they're getting more and more drunk act as a sort of a constant reminder, that you better be careful. [Interview with convenience advertiser]

When it comes to the actual posters, however, the message might seem to be a bit confusing:

*In terms of the relation of strapline and image, the strapline is actually questioning whether this is classic or not, which seems slightly anomalous.*

Well, yeah, but the idea is to make people think. Is this the classic combination, well, yes, it probably is: well, that's what we're trying to get them to think anyway. And it goes on to say sometimes too much alcohol can lead to forgetting things. So, again you want people to spend a minute thinking, oh, what's this all about? Classic combination? Huh? What is it saying there, sort of thing. And the image itself is quite strong, you know, people, if they don't read anything, see the condom. Yeah, yeah, a very interesting interpretation. [Interview with convenience advertiser]

(Bear in mind that all this thinking is to be done by the individual while s/he is drying his/her hands in the toilet of the bar or club.) Nonetheless, it seems clear from the evaluations and from the emphasis now being placed on this form of campaign that it has been successful.

Convenience advertising, though an innovation in communicating health messages, still retains conventions of representation which lend credibility to the knowledge presented. These are, after all, advertisements, 'selling' sexual health, and they follow the conventions of advertising and advertisers. The use of terms such as "strapline" and "image" (which I learnt to use very quickly during an interview with one of the people involved in the convenience advertising campaign) come directly from the advertising industry. Straplines and images are the requirements for a successful advertising campaign. Posters themselves are cultural conventions of the advertising industry, having come into their own in the nineteenth-century as a means of selling soap. The uses of advertising conventions in toilets in order to promote sexual health largely ignores the fact that there is a pre-existing convention of writing in toilets. Convenience advertisements for sexual health do not look anything like graffiti, though part of the evaluation of feedback on convenience advertising uses graffiti on the posters to assess audience attitudes. One of the conventions surrounding graffiti in toilets is the sense that they are private communications from one individual to another. The toilet is, conventionally, one of the most private places in our lives. Rarely do two or more people share a cubicle – and the dimensions of cubicles usually mitigate against this anyway. The individual in the cubicle, alone, and private, has the opportunity to

communicate with other such individuals through graffiti. Convenience advertising posters, on the other hand, follow the conventions of poster advertisements rather than graffiti. They are slickly produced, with clear and legible print, not scrawled with a thick marker or etched in the paintwork. Despite their turning up in a place where advertising does not conventionally appear (at least in Ireland), they are recognisable advertisements. They may play on the convention of writing on walls in toilets, but they are a very particular type of writing on walls.

Using the conventions of advertising to 'sell' sexual health suggests a certain degree of intertextuality which is also clear in the sources of information for the posters:

...a lot of the stuff we take from other pamphlets and other things that they've already produced to try to get to know what they are essentially looking for. And the person overseeing our campaign before, recently, he had quite an involvement in the way things were worded and the way things came about...and some things weren't appropriate, weren't considered appropriate, or he just didn't like the way they came across. In which case we just go away and try and; there's two parts, really, you're trying to meet a need and trying to get through to the target audience, and have messages that are going to have an impact at that level, and then you're also trying to get it past the bureaucrats at the other end and make sure that the information is sound... [Interview with convenience advertiser]

In recent revisions to the posters, this concern about getting across health messages has taken over from the advertising conventions to some extent. With advertising posters, the image and strapline are essential components to grab the attention of the audience (interpellate). With health messages, what is important is getting across information. In more recent posters, the image tends to fade into the background, and messages in large print take over the foreground.

The convenience advertising campaign has developed over a period of years and differences between the posters being produced now and earlier posters show something of the differences in attitude of those using the campaign to further sexual health. In earlier posters, the image and strapline dominated. This is part of the convention of poster advertising, that it interpellates the audience relatively quickly through the use of attractive images and quickly read and assimilated information in the form of a strapline. In the latest posters, the image has almost entirely receded into the background behind a great deal of writing which communicates the information in a wordy fashion. The content of the information has also changed. Where before, the effort was to communicate information about HIV and other STDs, now they are being used to promote condom use as a form of contraception. This, I was told, was because the clients (the Health

Promotion Unit and the regional Health Boards) saw increasing pregnancy as a problem, and thought to use the success of convenience advertising to return to the idea that condoms are not just prophylactics but also contraceptives.

The constant reiteration of an association between HIV infection and other STD infection, and the use of drugs and alcohol may offer some people an excuse for the way they behave. Indeed, there is a sense that representing things that are seen as dangerous can in fact increase curiosity about them, particularly in those who may never have heard of or seen them before. This argument has been used against the provision of information on abortion and contraception, in attempts to have depictions of violence removed from TV and cinema screens, as well as against having sexually explicit material in safer sex publications. The comments of one of the HIV prevention workers reiterates this connection between drink and drugs and sexual safety and risk-taking:

The other issue around the bars as opposed to the saunas: I was going to say perhaps drink is an issue but it's probably not the best one to pick because there would be quite a number of men who go to the saunas as I said earlier after the pub who would have quite a lot of drink on them and you would question their ability to make proper judgments of their situation and that. So I'm not sure if that's the best one. I think also that there are some people who do use some recreational drugs, when they go to saunas. They bring them in themselves, they're not freely available, nor are they encouraged in any of the saunas but I do know that people obviously do bring them with them and use them, and if not they'll take them before they go. [HIV Prevention worker]

Repeated STD infections are taken as an indicator of high-risk sexual activity. Even if the sex being engaged in is 'safer' (that is, condoms might be being used), condoms do not protect against all STDs, and harping on condoms as prophylactics may lead to confusion in the minds of individuals about transmission of HIV and other STDs. From another point of view, creating an association between HIV (as an STD) and other STDs increases the anxiety many sexually active people might feel about the possibility of transmission, and thus increases the possibility of individuals taking the HIV test along with tests for other STDs.

A significant part of the Department's guidelines is devoted to the evaluation of HIV education programmes. Such evaluations can be valuable, showing the levels of uptake of information and even the attitudes of participants to the programmes, perhaps even offering modifications which would make them more 'user friendly' in the future. However, since many of the programmes do

not take much account of the environment in which decision-making occurs, or the environment and mind-set of the individuals, or the meaning these activities have for individuals, evaluation is often limited to assessing whether the programme itself fulfilled its own intentions. If say sexual behaviour change was such an intention, it is unlikely that the evaluation will stretch to inspecting participants' sexual behaviour in the future, so the evaluation merely assesses if the participants have taken up the main points offered in the programme and not the extent to which it has influenced their future behaviour. Dowsett raises the issue as a problem for social science sex research in general:

...do we really understand sexual behavior change? More important, are researchers really in a position to assess it and advise those trying to produce such change, when there is an obvious difference between sexuality as it is experienced and sex research as it is done? [Dowsett 1996: 30]

Medical professionals themselves admit that evaluation, though important, is not easy, and have come up with various methods for assessment (see O'Boyle 1998 for a discussion of models of quality of life assessment, where quality of life is seen as an important indicator of 'health gain'). In convenience advertising, there are a couple of approaches to evaluation.

... We have independent evaluations done from time to time...the Health Promotion Unit is just about to do one and we're in the process of organising to do it. And then we get constant feedback because of the medium and the way we set it up, we have people go and check the messages every couple of weeks to make sure they're still up and you can get a lot of feedback from that and from graffiti and general comments made from bar-staff and generally people's responses to them because they're seen with them, leaving the venue with them (laughs) stuck to their back. So you get a feel through that, and there are some messages that are more popular than others and that means that they're appealing to the target audience more and we can gauge all that because we keep quite a detailed record of all that.

*What about graffiti, because I've seen some of that myself around colleges and that practically none of these posters are left intact, they're all graffitied all over. How do you read that?*

Well we write it all down, record it all, keep it all, and it's quite an insightful way of looking at people's reactions to them. A perfect example is in Maynooth –

*Oh right –*

I don't know whether you've seen them. There's the stickers that people have been putting up separately which are saying if this is the size of a pore in the

condom then HIV is ten times bigger, something ridiculous. It's saying don't use a condom, but it's not saying use something else, other things are better, it gives you no alternative and from that we've had graffiti where people question what is being written on our messages and from the maintenance officer whose in charge of the area up there and she called me up and said what's the story, is this true? These are university students who have had sexual health education, and they were making people question the effectiveness of condoms. So you get that feedback through people writing on the messages.

*Is this the only place you've seen those stickers?*

Yeah.

*And do you think it's true?*

It's not true, definitely not true. It's just propaganda, unfortunately I don't have a copy of it 'cos I've given it to a partner earlier.

*I gathered from somebody else who was talking about them that the actual stickers are American or that they come from an American organisation and that in America natural sheaths are more popular than your regular latex, durex manufactured ones and the natural ones do actually have pores that big, that they're not actually preventative [of HIV infection]: they would act as contraceptives but not as prophylactics. So it's true but it's not quite true either.*

Well, it's just when I read it, it was like, okay well fair enough, if that is the case, what else do people use? You're not telling them anything, it's more an advocacy of abstinence and I'm sorry but from a health promotion point of view, it's ridiculous... People are not going to stop having sex because they think condoms might be ineffective... And the agenda behind the people putting them up is obviously very, they've got their own little line that they're trying to take, the same as we have our little line that we're trying to take. [Interview with convenience advertiser]

Another incident which this advertiser recalled involved graffiti on one of the posters in the women's toilet of a popular 'straight' venue. Someone had scrawled "They don't" in lipstick under part of the information which claimed that condoms could protect from certain STDs. Follow up from this graffiti showed that in fact the person who had written it was correct, and that at least one of the STDs mentioned could be passed from person to person despite condom use. This resulted in changes in future advertisements, but at the expense of someone who may well have suffered an STD whilst thinking they were protected by a condom. This again shows the importance of the generation of information at local and community level, and its incorporation into prevention information in general. Another form of evaluation, the one which was being prepared by the Health Promotion Unit, is a bit more standard, using so-called 'intercept' interviews and questionnaires. These are conducted in the venues where the

advertising is on display, and the aim is to see if people noticed the advertisements and how much information they picked up from it.

## SEX & MEDICINE

There are perhaps two dominant conventions for representing sexuality: the pornographic and the medical. Booklets like *Play Safe, Play Sexy*, and the convenience advertising campaigns fall squarely into the latter, and adhere largely to its conventions. The very thing that was anticipated in advance of the publication of the *Play Safe, Play Sexy* booklet (that it would be more pornographic) turned out not to be the case, and this is probably as much to do with the sensibilities of the funders (the Health Boards and the Department of Health) as it does with not interfering too much with the convention of health publication. Mixing generic conventions runs the risk of creating confusion, even if it does offer a disruption of expectations that might make the audience interpellate with it in different ways than they would with the undisrupted generic convention.

Douglas Crimp plays on the conventions of the health publication in titling his article "How to Have Promiscuity in an Epidemic" (1988). This is also a play on the title of the first gay-produced safe sex publication, a 40-page booklet called *How to Have Sex in an Epidemic*, produced by Michael Callen, a gay man who worked as an AIDS activist until his death in the nineties. Callen's booklet was first produced in 1983, suggesting a relatively quick response to the situation of epidemic and its impact on gay men. The very title of Callen's book plays on the genre of "How to..." books, self-help manuals that remain highly popular. The cultural resonances of Callen's book can be heard in the play on the title in Crimp's essay and the title given by Paula Treichler, a cultural analyst writing about AIDS, to a collection of her own essays: *How to Have Theory in an Epidemic* (1999). Crimp's article deals to some extent with the problems around conventions, though it mainly criticises Randy Shilts' account of the AIDS epidemic in America up to the death of Rock Hudson. One of the comments he makes about the involvement of advertisers in health education campaigns claims that

An industry that has used sexual desire to sell everything from cars to detergents suddenly finds itself at a loss for how to sell a condom. [Crimp 1988: 266]

This sentiment applies equally to the convenience advertising campaigns and to the sexual health publications of the gay community. Part of the difficulty, as I see it, is that where sexiness is part

of the convention of advertising and selling cars, selling condoms and sexual health is part of the convention of the health publication. Dragging sexiness into such publications risks the loss of credibility which is attached to the medical representations of science, because it starts to make them look like pornographic medical representations.

Given the interest which most gay men I know expressed in pornography, it remains surprising that there is so little sex in sexual health. This has much to do with one of the origins of self-help and sexual story-telling which Ken Plummer identifies in the 'purity tradition' evident in the Protestant work ethic and in movements like The Temperance Movement:

All of this suggests that much self help is not so much about the unleashing of a potential self but about restraint, regulation and control. Indeed, an underlying fear –embodied in the 'addiction' metaphor – is the fear of a 'loss of control'. Self-control is seen to be extremely important. Most of the recovery stories are hence highly prescriptive: most of the books end by telling the reader exactly what to do, whilst therapy groups provide a strong programme for what must be done (and they will not usually tolerate 'deviance'). [Plummer 1995: 109]

Self-help medical representations are about taking control where there has been, or might in the future be, a loss of control. Pornography on the other hand is usually considered as a practice which is associated with lack of control, with perversion, deviance, exploitation, and anti-social behaviour. Just as we have little idea about how the effects communication models for health promotion and behaviour change actually work or what they produce, we have no clear idea about how pornography works or what it produces. One thing is clear: there are a good many men who enjoy pornography, and few enough who enjoy medical representations.

Another aspect of sexual health education relates to practice. No gay man that I know of ever sat down and read a "How To..." manual in order to learn about sex for the first time. Much sexual learning, and the saunas are a good example of this, has to do with practice. Learning how to feel comfortable with another person in an intimate situation and learning to communicate intimate knowledge about one's self and one's sexual desires, are the material of many "How To..." books, but they are also things that are learnt in private, during solo sexual exploration or during intimacy with others. Though the self-help publications sometimes make reference to practicing in private (usually in relation to how to use condoms), they never advocate promiscuity as a learning process. The dangers of promiscuity and its apparent contradiction of epidemiological knowledge are simply too great. Yet promiscuity is about sexual skilling, the very thing that the

self-help manuals claim to be about. The cultural conventions of health publications, and the cultural conventions of health education and communication, as well as funders' interests mitigate against any call to sexual health education which starts out by declaring "Let's use pornography and promiscuity!"

## CONCLUSION

I have no doubt that a great deal of HIV prevention work, including literature, posters, workshops and outreach work, is successful at informing people about HIV and AIDS, and that it is undertaken in a professional manner by those concerned. As a tool in disease prevention, and more widely as a tool in health promotion in general, education is little understood. This is reflected in the difficulties of conducting evaluations that evaluated more than the simplest issues of didactic information uptake. A significant factor in this, I believe, is the lack of models for understanding behaviour change and the internalisation of health information, as well as a reluctance to deviate from the conventions of particular representations. Perhaps a new initiative could start with an advert reading

## **Models Needed!**

## Chapter Five

### From Silence to Silence

So far in this thesis, I have attempted to demonstrate the significances, indeed the overdeterminations, of words like “knowledge,” “education,” “protection,” “risk,” “identity,” and of “HIV/AIDS,” amongst others. These words become boundary objects, translatable from one world to another, linking those worlds, but also carrying different significances in them. For this final chapter, I wish to take a more exploratory view of one such word, silence, show how it relates to the determinations of other words. In addition, I hope to show how HIV/AIDS effects a silence about itself, making it particularly difficult to deal with.

#### TALKING ABOUT SILENCE

The National AIDS Strategy Committee met for the first time in December 1991, and published its first report (actually the reports of four sub-committees) in April 1992. Its second report, *AIDS Strategy 2000* (NASC 2000), was published in June 2000. On the day of the publication, Tom Moffat, junior minister at the Department of Health and Children, who was responsible for the report’s publication, and Paddy Connolly, director of Cáirde, a support group for people living with HIV and AIDS, were interviewed by Richard Crowley on Morning Ireland, RTÉ Radio’s morning news programme. In the following extract from that interview, Paddy Connolly talks about how the new strategies report fails to address the issue of silence.

Paddy Connolly: Well I suppose it's important to acknowledge the strategies being produced in this time when we are experiencing the highest HIV figures ever recorded in Ireland, and I think the strategy does acknowledge the role of the non-government sector; it does acknowledge that there is a need for education awareness campaigns; and it does recommend that universal free access to free medication be provided. But fundamentally the report makes one mistake. It repeats the format of the '92 report which, as we know with the highest figures, has failed to stop the increase in HIV, and by not adopting a much broader response which we have recommended to the Minister for Health and to the Department of Health and a number of government departments that have become involved in HIV and AIDS, we are not going to have that trickle down effect in various government programmes like [the Department of] Sport and Recreation who are responsible for the drug task forces, like [the Department of] Education is responsible for schools, like the Department of Social, Community, and Family Affairs who are responsible for community programmes. And if those departments don't take on an awareness of HIV and AIDS within their programmes then there won't be that trickle down effect where HIV and AIDS is a topic of discussion which is the central issue around HIV and AIDS: that peers are talking about it, that departments are talking about it, that group leaders and teachers are talking about it, and it's by that conversation and that sharing of information HIV is prevented. In countries like Uganda where they're having success because HIV and AIDS is a topic of discussion and without that kind of broad-based response we're not going to prevent the increase in HIV.

Richard Crowley: Well, it's a subject for discussion in Uganda and elsewhere in Africa because of the scale of the problem; we're nowhere near that.

Paddy Connolly: Well, we're nowhere near but the Minister listed intravenous drug users and homosexuals, but the fastest growing category is the heterosexual category, and drug users are to a degree; [but] whilst the increase was alarming last year, they are capturable in terms of programmes that exist for them under the Department of Sport and Recreation through the drug task forces, but the heterosexual category is a much, is a category of people who don't perceive themselves to be at risk, and there's a significant fear there that if HIV and AIDS takes hold in that category that people don't perceive themselves to be at risk, the children, younger people think more about pregnancy than they do about HIV. Sexually transmitted illnesses are increasing rapidly in Ireland as well so there's clearly an indication that unsafe sex is a common practice for young people. Unless we get a hold of that now, we may be faced with a bigger problem than we think.

Here, the silence around HIV and AIDS appears as a protective and self-protective device, used to insulate the departments and 'the heterosexual group' from involvement in HIV and AIDS. The implicit externalisation of the problem of HIV/AIDS ("It's not my/our problem: it's the problem of risk groups, of others") allows it to be ignored by those who, Paddy Connolly feels, are now more at risk or at least equally at risk of infection. There is a complacency, engendered

by silence, which he sees as being dangerous. Picking up on this, the interviewer turned the question back to Tom Moffat:

Richard Crowley: Tom Moffat: have we become complacent? And I don't mean your department or the government specifically, but as a population, has that population, and particularly that most at risk, become complacent about this?

Tom Moffat: I think to a certain degree, yes, we have become complacent and I think the time is right again for a new emphasis on sexually transmitted diseases in general, and people have said and the consultants have advised us that this is the way forward: that we should take AIDS and HIV out of that category alone and just treat it as a sexually transmitted illness or disease, and that's the way forward.

Richard Crowley: But what about the point that Paddy Connolly makes about making it a multi-departmental approach, if you like: that it should be spread across numerous departments.

Tom Moffat: Well as you may know, Paddy is on our Committee and he has been a very valuable member and he has said so and we have taken his considerations on board and [it shows] in the report that it's a partnership approach right across the board, with the voluntary sector and the statutory sector, and that's something certainly we would be working at and there are many, as he said already there, about the drugs task force, there are AIDS fund housing projects, and throughout the country you have the Cáirde who he represents, doing a wonderful job there, and we have AIDS Alliance, we have people in Limerick, Galway and Cork.

Here, Moffat turns the problem of silence and complacency back on HIV/AIDS as a medical issue, one for which testing, treatment and care are available. "Just" treating it as a sexually transmitted disease (as medical issue), he implies, will lessen the stigma associated with it and allow for freer talk about it. This medicalisation nonetheless glosses over the many social and economic aspects of life for those who are HIV positive or who have AIDS.

The issue of silence and complacency is not one that Paddy Connolly raises here for the first time. In June 1999, almost exactly a year before to the day, Paddy Connolly had been interviewed by Rodney Rice on a lunchtime RTÉ radio magazine programme, on the occasion of the launch of Cáirde's own report, *No Room for Complacency: Families, Communities and HIV* (O'Gorman 1999). On this programme, Connolly had raised the issues around talk about HIV and AIDS which he saw as being particularly problematic. The medicalisation (his word) of HIV and AIDS meant that most people thought of it in solely in terms of those *infected*, whilst the report deals in much detail with those *affected* by HIV and AIDS, in particular the families of those with HIV or

AIDS. He spoke of the mythologies (his word) of HIV and AIDS, the ways in which reporting of them in the Irish media tended to be sensationalised on one hand, and to concentrate on the African dimension of HIV and AIDS rather than the Irish dimension. He spoke of the way in which health promotion materials presented HIV as “difficult to catch” and that this added to the difficulty of health promotion. Such a representation meant that most people considered it not as a communicable disease but rather as a disease of particular risk groups, a self-protective mechanism that reinforced complacency amongst those who ought to be seeing themselves as at risk. As he pointed out, people who are HIV positive are more at risk of picking up infections from the general public than that general public are of contracting HIV from HIV positive people. The issue of multi-departmental approaches was also raised at that time, and Paddy Connolly said that making HIV and AIDS primarily the responsibility of the Department of Health and Children made it seem as if there were no other dimensions to it other than the straight-forward medical dimension. He pointed out the difficulty of getting the Department of Social, Community and Family Affairs to take its part in dealing with HIV positive people and people with AIDS.

The need (as seen by Paddy Connolly and others) for more talk about HIV/AIDS has a number of different aspects to it. Medicalisation silences the social and economic aspects of HIV/AIDS, in particular glossing the fact that many of those most affected (as well as those infected) come from already marginalised and socially excluded populations, silencing the question of responsibility for social exclusion and marginalisation in general (how people came to be marginalised or socially excluded is not of interest, nor is any putative connection between marginalisation and social exclusion and HIV infection, an attitude that further depoliticises HIV/AIDS).

Medicalisation also silences the problems of the *affected*, such that issues of testing, treatment and care are dealt with but not the social (stigmatising) effects of HIV in the population, both for those who are infected and for those who are associated with the infected. Mythologies around HIV and AIDS further marginalise those infected, making them appear as special cases, those who, like drug users and homosexuals, are always already special groups of people. Their particular social and economic problems are seen as being outside of and separate from the syndrome. This externalisation of the problem, as Connolly points out, gives rise to a sense of complacency amongst those who see themselves as ‘normal’ and therefore as unaffected by HIV and AIDS. Mythologies also represent the risks around HIV in a curious fashion. The ‘general population’ is represented as being susceptible to HIV infection from the already infected minority, and is not seen as representing a health threat to the susceptible infected.

What Connolly, and others, have striven for in recent years is the 'normalisation' of HIV and AIDS, such that it is re-presented as not simply affecting those in minority groups but as affecting the whole population. Talk is seen as being important in this: the possibility of people being able to talk about HIV and AIDS without the fear of stigmatisation would allow a more effective dealing with the issues of HIV and AIDS than the present silencings allow. A significant factor in this is the ways in which particular identifications are complicit in the processes of silencing and stigmatisation.

Aileen O'Gorman, author of the Cáirde report (O'Gorman 1999), notes some of the ways in which identification is involved in silencing the effects of HIV and AIDS. The HIV test, for instance, and the epidemiological statistics associated with it, give only a partial representation of the reality of HIV infection in Ireland:

In Ireland, the epidemiology of HIV and AIDS, that is its prevalence and distribution in the population, is difficult to ascertain due to the lack of research conducted in this field. The main source of data available are the quarterly statistics published by the Department of Health and Children. However, these published figures only represent the known HIV/AIDS population, that is the number of people who have had an HIV test and subsequently tested positive. An additional, but unknown number of people are also HIV positive. This hidden population of HIV positive people includes those who have become positive since their last test; those who have not been tested either because they do not perceive themselves to have been at risk of infection, or for a variety of reasons have not come forward for testing; and those who have been tested abroad and as a result are not recorded in the Irish statistics. [O'Gorman 1999: 5]

Some glimpse of this unknown, silent population of HIV positive people is gleaned by the anonymous unlinked surveillance programme carried out through the testing of blood samples from women attending maternity hospitals for antenatal care. According to the National AIDS Strategy Committee's second report,

Drug therapies are available to women who know they are HIV positive, but, prior to the introduction of routine testing for HIV some women may have been unaware that they were HIV positive. It was estimated that in 1997/98 health services had identified less than 50% of HIV positive mothers at an early stage in pregnancy and so the opportunity of early treatment and better health outcomes for both mother and baby may have been missed. [NASC 2000: 18]

Despite the existence of the programme, participation remains on a voluntary basis, and many expectant mothers still opt not to be tested. The figures from this surveillance are not included in

the Department of Health and Children's statistics, adding further to the deficiency of HIV data, a situation that adds to the silencing of HIV and AIDS:

Given the deficiency of HIV data, it is difficult to make a grounded appraisal of current and future trends in HIV transmission. Advances in the treatment of HIV/AIDS and the decrease in the number of new AIDS cases recorded, have contributed to the declined prominence of HIV/AIDS on the public health agenda. Yet, this reduced prominence seems misplaced when the number of new HIV cases continues to rise, and the full extent of HIV in the population remains unknown. [O'Gorman 1999: 18]

This silence of the statistics also tends to emphasise the already marginalised groups and their particular practices as being the main problem in relation to HIV infection, which further diminishes the sense of HIV as a problem for the general population.

### SILENCE & IDENTITY

The identification of those who are HIV positive is linked to the HIV antibody test, which has its own implications for the generation of silence around HIV. Given that the HIV (antibody) test is the only means of recognising someone as being HIV, the test itself is directly productive of HIV as a disease: "The disease becomes that condition which can be tested by the test" (Waldby 1996: 127). In the absence of the test, HIV is perceived as spreading silently in the population, a situation which, in the time before the identification of HIV with AIDS and the development of a test for antibodies to HIV, made AIDS a particularly frightening condition. More than this, the HIV test is productive of particular subjectivity. As Waldby notes:

...the HIV test works as a 'technology of the self'. It is a crucial inscriptive technology through which the recent forms of pathologised sexual identity, those that have emerged out of the biopolitical field of AIDS, are introjected into the identity processes of sexed subjectivity. The HIV test is a technology not just of subjection but of subjectification, a technology which not only compels subjects in certain ways but which also induces the internalisation of new norms of identity and self-management, above all the managements of one's health and one's sexual practices, in the interests of minimising illness and HIV transmission. [Waldby 1996: 113-4]

The notion of the "internalisation of new norms of identity and self-management" shares many structural similarities with the notion of "coming out" as a gay person, where the former identity (internalising society's homophobic response to homosexuality) is discarded in favour of a new

gay identity and the internalisation of feelings of self-esteem and self-worth. The identification of the individual with his/her disease is particular to HIV and a particular result of the outcome of the test. Talk about HIV and AIDS reiterates this, remarking on 'people who are HIV positive' and 'people who have AIDS.' The latter is a reasonably common construction in relation to illness and disease: people refer to themselves and are referred to by others as 'having' something (cancer, hepatitis, a tummy bug), and this reflects the medical aspects of the condition as something you possess that is in some way susceptible to medical intervention, even if not entirely curable. The case of HIV positivity is quite different and reasonably unique (Dowsett 1996: 282): one does not possess HIV positivity, it possesses one. This can be seen as representing the greater internalisation of the social identity of HIV positivity than the medical identity. Just as, within the tropes of identity, one 'is' gay rather than one 'has' gayness, one 'is' or 'becomes' HIV positive. As Dowsett notes,

The transference of terms – “coming out” as [HIV] seropositive, the very notion of their being an HIV “identity – borrows heavily from gay liberation tropes and political tactics. The notion of certain “rights” pertaining to [persons living with HIV and/or AIDS], for example, to treatments, drug trials, and so on, derives much of its character from civil liberties struggles by gay men and lesbians over the last twenty-five years. The collectivity of interest in HIV borrows heavily from gay “community.” [Dowsett 1996: 283]

The interconnection of interests between gay community and HIV may well be a reflection of the early involvement of gay community organisations (in the United States in particular) in the struggle against attempts to deny rights to those with AIDS or those who tested HIV positive.

A significant right which arose from such intervention was the right to confidentiality and/or anonymity in relation to HIV positivity and AIDS diagnoses. At a time when many right-wing politicians and activists were calling for the 'branding' of HIV positive people, for their exposure in various ways, the gay organisations in particular were canvassing for confidentiality and respect for those with AIDS and those who tested positive. This confidentiality has numerous implications for HIV and AIDS for those infected and affected. Primarily, it is about the right to choose who to tell, and when, but as such it creates ethical dilemmas for those involved in terms of the furthering of public health. In Ireland, confidentiality of HIV test results is guaranteed, though that may not always be the case (see O'Gorman 1999: 36). Since HIV and AIDS are neither reportable nor notifiable, there is a certain conflict between the interests of the positive person and the interests of contact tracing and notification. That this is relatively unique to HIV is

clear from the fact that many of the other STDs which are or can be tested for in the same STD clinics which test for HIV *are* notifiable diseases, with the associated requirements for contact tracing and treatment. HIV arises in a quite different set of circumstances from other STDs and is dealt with differently in terms of confidentiality. This raises an ethical problem for those engaged in health promotion around HIV. The right of the HIV positive person to confidentiality clashes with the role of public health in protecting others from the spread of disease. This led to a workshop organised by the National AIDS Strategy Committee's sub-committee on surveillance addressing the question "Should HIV be made a Notifiable Disease?"

This question was raised by public health specialists who proposed that making HIV a notifiable disease would enhance epidemiological data available to service planners and those treating people with HIV/AIDS, which would, in turn, lead to the development of more targeted and effective prevention strategies and better clinical management of people with HIV/AIDS. [NASC 2000: 19]

The ostensible reason here is that the medical services available would be enhanced by making HIV a notifiable disease, but the reason for not making it such makes it clear that the workshop felt there were more important considerations than simply the medical ones:

The Report of the workshop was examined by the National AIDS Strategy Committee which agreed that making HIV a notifiable disease might lead to people being more reluctant to being tested, so other strategies such as the introduction of HIV Case Based Reporting should be investigated. [ibid.]

The social perception of HIV testing would clearly be changed by making it a notifiable disease, and the suggested adverse effect of making people more reluctant to present for testing would defeat the point of the exercise. The issue of case based reporting was also examined by the National AIDS Strategy Committee and here again one of the first issues of concern was confidentiality:

Confidentiality – there must be assurances that patient confidentiality is preserved. The AIDS reporting system has worked very effectively and, in this respect, it is expected that any new HIV reporting system would operate on the same basis. [ibid.]

What all this silence around a HIV positive result is about is protecting the individual HIV positive person from the social environment which constructs HIV positivity in particularly anti-social ways. One manifest discrimination against HIV positive people is in terms of insurance,

with consequences for other things such as mortgages. The Equal Status Act (2000) which prohibits discrimination against people who are HIV positive or people who have AIDS, makes an exception in the case of insurance and lenders, once the difference in treatment accorded to such people

(i) is effected by reference to –

(I) actuarial or statistical data obtained from a source on which it is reasonable to rely, or

(II) other relevant underwriting or commercial factors,

*and*

(ii) is reasonable having regard to the data or other relevant factors. [NASC 2000: 84]

One might question what such data are and where they might come from (are they data on life expectancies of people on treatment, which might be expected to be increased given present treatment options?) but the exception remains, making housing, for instance, a particular problem for people who are HIV positive or who have AIDS.

Another effect of confidentiality is the protection of the HIV positive individual from identification as such by others. This has the effect of making their presentation in the media fit a generic conception of otherness:

The style of the face-to-face, expressive close-up is a convention of television production, the acceptable style that is only abandoned when people are 'suspicious' or 'guilty' in some way, thus requiring the hiding of their identity. [Tulloch & Lupton 1997: 91]

In Alan Gilson's video documentary *Stories from the Silence – Putting a face on Aids* [sic] (no date: c. 1986-7) various individuals are presented to the viewer. The nine people range in age, sex, occupation (one of those presented is a priest, for instance) and mode of infection (where this is revealed in their stories). Things like the physical backgrounds against which they are filmed, the variety of accents and styles of dress, further add to the sense of this being a wide range of individuals. Only one of those presented is filmed in a bed (and not a hospital bed at that) with the sunken cheeks and slow speech and feebleness which had come to be 'the face of AIDS' in the mid-eighties. The documentary cuts between each of the subjects, giving us their stories bit by bit, such that we get a 'before' and 'after' view of their lives. At the end, some of them dispense

information, warning others who might have similar lifestyles on how to avoid infection. As the sleeve notes say,

By focusing on the stories of Irish people living with HIV/Aids [sic], this education resource puts a human face on the people behind the statistics, dispelling the myth that Aids is a remote concern for Irish people.

At the time of its production it was a daring and innovative documentary. Director Alan Gilson and his company, Yellow Asylum, made a number of documentaries touching on difficult and taboo subjects. His 1989 documentary, *The Road to God Knows Where*, made in conjunction with the British Channel 4 television station, showed the problems faced by Irish youth and “was condemned by the Industrial Development Authority as a pessimistic, negative and distorted view of Ireland” (Sunday Times, 13<sup>th</sup> January 1991: 18). This documentary won him a prestigious Jacob’s Television Award, and he took the opportunity of the award ceremony to deliver a diatribe against the government, made all the more poignant by his having been presented with the award by a government minister. Another documentary, *Prophet Songs* (1991), tells of six clerics and their decision to leave the Catholic church.

*Stories from the Silence* shows the faces of these people with AIDS and HIV with one exception: “Donna” is not seen in front of camera: the first time she ‘appears’ in the documentary, we hear her voice over the image of a black-and-white photograph of a small group of children. At each subsequent ‘appearance’ the camera moves in closer and closer to focus on one girl in the photograph. It is not made clear that this is “Donna” as a child. All the others in the documentary are shown facing the camera, but again we do not get their full names, each being presented as John, or Martin, or Grace. Despite the fact that these people were obviously willing to show their faces on national television talking about HIV and AIDS, the convention of giving only their first names keeps the audience in a state of suspicion. Their openness in talking about HIV and AIDS is somehow occluded by this convention so that their lives remain closed to us. It remains as if they have something to hide. This video remains one of the best made in Ireland about HIV and AIDS, and is distributed (by the Irish Family Planning Association with whose help it was made) to schools and other groups for use in HIV/AIDS education.

Associated with this is the sense that a HIV positive identification changes utterly who you were before. Each of the subjects in Gilson’s documentary presents this ‘before’ and ‘after’ story, making it clear that there was an enormous change in their lives as a result of discovering they

were HIV positive or being diagnosed as having AIDS. HIV/AIDS effectively silences who you were before, requiring the adoption of a different identity and sense of self. As O’Gorman notes,

Not only do families’ internal lives come to revolve around the virus, but externally the families are perceived and identified, first and foremost, as families with HIV. Despite this, the families themselves had found little opportunity to define their own needs in terms of the support structures they required. In addition, their loss of identity is also accompanied by an erosion of the power and control they have over their own lives. [O’Gorman 1999: xi]

In this sense, the individual loses their previous identity, and takes on a new identity which may have no bearing on their lived experience or their daily lives. Much of the counselling and support concentrates on the ways in which the entire life of the individual must now take HIV positivity into account. For some, this is too much, and getting on with their lives means silencing the viral aspects of it:

On a daily basis, coping with HIV often involved forgetting about the illness and getting on with life. While many care professionals consider this strategy a form of denial, for those like Pete, who were living with the virus, it allowed them to plan for the future:

*Now I’m looking forward to the year 2000 to see my young fella make his communion and after that I’ll go to the year 2001 to see the other young fella and if I can get to them I’ll be happy...they can’t understand that people can just live with it.*

Others like Tom, whose young daughter was HIV positive, preferred not to look to the future but coped on a day-by-day basis:

*I mean I think in these situations you don’t try to analyse it too much. You just put your head down and get on with it. You don’t try and deal with it. If you try and deal with it, you’d just crack up. You can’t look four years down the line, you just have to deal with the day or the week and if she’s not sick that’s a bonus and if she’s sick you have to work through that and get a doctor, get the medication. [ibid.: 26]*

The difficulty cited by Pete (“they can’t understand that people can just live with it”) makes clear the difficulties some people have with the culture of counselling and support services and the idea that one must face up to issues around HIV and live one’s life according to a new HIV positive identity. O’Gorman quotes others in this same vein:

[Tony] *I’ve never really felt like talking it through was the right approach. To be honest with you, I nearly run a mile when I see the counsellor coming because I mean and I know it’s her job, but I mean she’s there counselling me and I’m not sure if it’s the right approach...* [ibid.: 30]

This culture, arising as it does from a particular time and situation, often does not fit with the understandings of the world that the HIV positive individual has. The originary project for most of these types of counselling and support groups comes from the Shanti Project which “based its approach on the works of death guru, Elisabeth Kübler Ross” (Shilts 1988: 123). The emergence of later organisations changed little of this approach, and the approach became almost a worldwide standard for dealing with AIDS. When HIV was identified and a test provided, organisations taking this kind of approach began to develop capacities to deal with HIV counselling. Organisations which had operated ‘buddy’ programmes for people with AIDS now also developed support and assistance groups for those who were HIV positive. Even a comparison of the names of Irish organisations dealing with HIV and AIDS and those which developed in the United States makes it clear that developments in America were seen as providing models which could (apparently) be transferred globally. (Gay Health Action, AIDS Action Alliance, AIDS Helpline, Lesbian and Gay Health Caucus, Gay Men’s Health Network, Gay Men’s Health Project, even Gay Community News, are all names that have transferred from the American experience to the Irish one). ‘Talking about it’ may play a more important role in American society than in others, however:

On balance, I suspect that the culture of story telling is more in evidence in the USA – it is the strong case for my arguments. In part, this is due to it being a more ‘therapeutic culture’: as I shall explain, the USA is characterised by an intense individualism which has long been linked to self-reliance and self-actualisation. Many sexual stories now link directly to this. [Plummer 1995: ix]

As is clear in the examples that O’Gorman cites, not all Irish people are comfortable with either counselling or support groups, or the kind of talk therapy that is part and parcel of their approach. As we have seen earlier, the talk therapy approach is also an important part of the model of participatory education which is espoused by the Department of Health for AIDS and HIV education in its HIV/AIDS education guidelines. Talk therapy and the culture of disclosure,

which encourage the dis-closing of what are often discrete facets of an individual's life, require an openness that may not be to everyone's taste. Likewise, what follows from therapy, the inscription of a new identity, may not be to everyone's liking. Whether this is the actuality of counselling and support services, or whether it is a perception on the part of HIV positive people, it is clear that these things do not work for all. There may be important social, economic, class, political and other boundaries which are not easily crossed just because a person is HIV positive. Again, some of O'Gorman's respondents talk about the lack of commonality between people in HIV positive support groups, given the wide variety of transmission modes, backgrounds, ages, sexes, and so on. Naïve psychologisations of anti-disclosure strategies as "denial" take no account of the difficulties faced by individuals in dis-closing their lives to others. "Denial" is an insistence on the problem being faced by the individual when the environmental factors may mitigate against that.

Secrecy is a major difficulty with HIV positive identity. Keeping such a result from friends, family, workmates, even from partners can be trying, but often disclosure brings its own problems. Sometimes, as O'Gorman notes (1999: 22) there is the problem of double disclosure, where disclosing a HIV positive result or an AIDS diagnosis may require disclosing a previously unknown lifestyle. People may have to disclose not just that they are HIV positive but also that they have (or have had) a drug use problem, or that they are gay. Breaking the silence about HIV infection then can be a double burden for some. There can be, then, a great sense of isolation which accompanies HIV positivity (see *ibid.*: vi, ix, x) which neither support groups nor counselling helps to alleviate. Most significant is the fact that people may feel they cannot rely on what would otherwise be normal support networks, such as friends and family. This is often reduced to a feeling that HIV is something you cannot talk about. Again, one of O'Gorman's respondents says,

*My Dad died of cancer and the one thing about cancer is that you can talk about it and accept it for people to have cancer but with HIV like a lot of people think it's the person's own fault that they have it. It's just something that's not talked about as easily as cancer is talked about. It's like the way when you're out selling red ribbons it's very hard to get money out of some people but when they're doing daffodils for cancer, people literally hand you lots of money. [*ibid.*: 27]*

This inability to talk is not restricted to those who are HIV positive. HIV and AIDS are simply not talked about at all. The amount and type of media coverage tends to isolate HIV infection to

particular groups of people, dealing with drug users, haemophiliacs, gay men or children. This reinforces the sense that HIV and AIDS are matters for special groups rather than for the 'general public' and further problematises talk about it. Thus, even when HIV and AIDS are talked about in the media the presentation effectively silences those who might want to talk about it. It cannot be talked about without identification with groups.

Amongst gay men in particular, the early ascription of an association between gayness and AIDS has persisted, and talk about HIV, even reading a leaflet about it, can identify individuals in particular ways. One HIV prevention worker had this to say:

It's conditioning, over the years from the days it was first identified it was automatically – I mean the first name it was ever given was GRID, gay related immune deficiency – so right from day one there's been this strong association between HIV and AIDS and gay men, and an awful lot of men, even those who don't even consider themselves gay but who have sex with other men, are constantly aware of that, it's always there in people's minds, whether they are conscious of this, it is there in their minds, that what they are doing is wrong and that what they are doing can be punished in such a way that they get this horrific disease and therefore rather than feel bad about it, let's not talk about it. If we don't talk about it we don't have to face up to it. And that's very often the case. And also I think that, there's also another funny side of it which comes up from time to time and that is that gay men have high expectations of themselves and their knowledge around HIV. They are no more inclined to have any higher level of information than say the general public have, even though there are leaflets put out specifically in gay venues for gay men to make use of, who wants to be seen in a socialising place where they might be looking for a sexual partner, going to a rack where it says Hepatitis B on the front of it, or HIV, and be seen taking up those leaflets and reading them. Now, some of us might it's like looking at the glass as being half full or half empty: some person might look at somebody reading a leaflet like that and say, Well, aren't they a wise individual learning about it, I'd feel safer having sex with them because they'll be more aware. Unfortunately, we seem to fall on the side of the empty glass, or the half empty glass, and that is, if he's reading it, he must have it, he must have put himself at a risk... [HIV prevention worker]

Obviously, there was a time, perhaps early on when information was scarce, when talk was generated, and when gay men did want to know about HIV and AIDS. I have already quoted one of the HIV prevention workers who said

I used to find it very strange when I was working full-time in AIDS support work, every time I went out for my social life, the talk was about AIDS because people wanted to know. They took the opportunity because they knew I worked

in the area, to ask me questions they wouldn't ask somebody else. And it got to the point where I was no longer socialising but I was constantly working and so I ended up having to say, look in all fairness, I appreciate your need to know information but there are services there you can go to and get that information, and I really don't want to cut you off, but I have a life too.

There is, in all of this, an oddly confessional nature, as Waldby notes:

The HIV test is also a technology in the sense developed in Foucault's writing, a technology of sex. 'Technology' here refers to a constellation of administrative and discursive techniques whereby subjects are classified and socially ordered through the securing of a confession as to the 'truth' of their sexuality. [Waldby 1996: 113]

Foucault deals with this necessity to talk in the first volume of his *History of Sexuality* (1981). Starting with a quote from a mid-nineteenth century writer, he analyses the relationship between talk and management:

"The darkness that envelops these facts, the shame and disgust they inspire, have always repelled the observer's gaze...For a long time I hesitated to introduce the loathsome picture into this study." What is essential is not in all of these scruples, in the "moralism" they betray, or in the hypocrisy one can suspect them of, but in the recognized necessity of overcoming this hesitation. One had to speak of sex; one had to speak publicly and in a manner that was not determined by the division between licit and illicit, even if the speaker maintained the distinction for himself (which is what these solemn and preliminary declarations were intended to show): one had to speak of it as a thing to be not simply condemned or tolerated but managed, inserted into systems of utility, regulated for the greater good of all, made to function according to an optimum. Sex was not something one simply judged; it was a thing one administered. It was in the nature of a public potential; it called for management procedures; it had to be taken charge of by analytical discourses. [Foucault 1981: 24]

Much of the talk therapy and negotiation which is advocated in safer sex publications, with its emphasis on individualisation and responsabilisation, works in something of the same way. As we have seen, the matter of making the healthier choice the easier choice is not a matter of choice at all, but rather of inculcating in the subject a sense that the healthier choice is the only choice, eliminating choice altogether and prescribing what the healthier choice is.

Talking about it, **negotiating** it and maintaining it, safer sex raises many issues for us: it doesn't feel spontaneous, you're off your face, you think love and unprotected sex are the same, you like taking risks, it's the other person's responsibility, you don't want to tell people that you're HIV positive, you're embarrassed, your partner insists on unsafe sex. Here are some suggestions to

make safer sex happen. *Take responsibility. Think about what stops you making changes. What does safer sex mean to you? What do you feel you are giving up or losing? Explore how you can express yourself sexually while staying safe. Above all, be assertive and talk about it. The more you discuss safer sex, the more confident and comfortable you will become in negotiating it.* [Gay Health Network n.d.: 14, emphasis in the original]

#### Negotiation

Talking about safer sex isn't always easy, it can seem intimidating and embarrassing. It can raise a number of issues that can be uncomfortable for us to talk about. The more you talk about sex the easier it becomes to discuss the sex you really want. Try to make sure that you establish what you want and like before you get into sex. How you do this is up to you. You could include some reference to safer sex in a chat up line; make reference to a television programme, film or leaflet; or make a joke. If you have discussed safer sex in advance you are more likely to practice it when the time comes. There are other things you can do to help make sure that the sex you have is safer. Make sure you have condoms and lubricant with you, or leave them near your bed. Don't feel you have to wait for your partner to raise the issue of safety, take the initiative yourself. [Gay Health Network 1999: 12]

The inculcation of these norms of behaviour may well work for some, but not for all. It may well be that this kind of assertive talk is alien to persons who are about to become intimate with one another. Social norms can have the effect of silencing as well, reinforcing a sense of guilt or shame or embarrassment at one's inability to maintain the norm. This applies even where the emphasis in prevention messages is one risk reduction and not simply risk elimination.

Social norms can be maintained through shame (as well as by positive reinforcement) if the behaviour is a public one – but sex is usually a private behavior. Shame can nonetheless have an [sic] subversive impact of private sexual behaviors: an individual may continue to perform the behavior in private but just not admit it in public. For a gay man to admit publicly that he did not use a condom during an anal sex experience would bring him shame, stigma, sometimes even a harsh reprimand from other gay men, whether HIV-infected or not, and certainly disapprobation from health educators. Consequently, to avoid shame, gay men may not discuss their private sexual behaviors in a focus group that is likely to include judgmental others. [Turner 1997: xx]

In Ireland at least, the necessity for a non-judgmental environment at such safer sex workshops is negotiated at the beginning: depending on the group, there can be agreement about issues around disclosure of seropositive status, past sexual behavior which may have been unsafe, and so on, which is aimed at making it more comfortable for those present to speak freely about their experiences. Nonetheless, the fact that this is not 'normal' is implicit in the use of phrases like "What's said in this room stays in this room," making it clear that there are certain places where

such talk can happen and certain things that can be discussed in that environment which cannot be discussed outside it.

The kind of assertive behaviour being advocated in the prevention literature hardly makes for sex partnership, something which should be clear to the proponents of this message, for whom partnership is one of the ideals espoused in dealing with HIV prevention. Beyond that, there is also the possibility, unexplored in these publications, that safer sex can be negotiated without recourse to words at all. I have already mentioned how a come-on in a sauna can be refused, politely, without saying a word. Similarly, in sauna sex, though there are few words spoken by the men, this does not mean to say that there is no negotiation taking place. Body movements and gestures, which are the means of communication in saunas for the most part, can also be used to negotiate safer sex. Despite this, and despite the learning that goes into practicing sex in the first place, safer sex campaigns continue to emphasise talking as the means of negotiation.

Curiously, it is the very learning process of men as they become sexual that is not examined in any of the talk about HIV prevention. No man that I know of ever went to school to learn how to have sex, how to enjoy sex, how to know what was pleasurable. This kind of learning, as opposed to the formal education of leaflets, pamphlets, posters, workshops and so on, remains benighted, a dark and possibly dangerous form of knowledge, and the purpose of the formal education of HIV prevention is to incorporate this dark knowledge into a new and enlightened knowledge. This goes also for the meanings that sexual acts have for the men engaged in them. No one has to attend workshops or read a leaflet in order to enter a sauna and have sex, or, indeed, to have sex anywhere else.

### SILENCE & DEATH

Silence, as I have already noted, is widespread in the saunas, but for Edward Delph, author of one of the earliest detailed sociological accounts of homosexual sexual encounters, silence is very much part of community, as reflected in the title of his book: *The Silent Community: Public homosexual encounters* (1978). Delph sees an important connection between eroticism and silence:

The rich and delicate fabric of silent “embodied” information evokes sexual concourse, enhances the credibility and desirability of erotic communicants, and

permits easy withdrawal in dangerous situations and those that prove hopelessly frustrating, misdirected, and otherwise erotically wrong. When silence shrouds a situation and cues are restricted to present and apparent physical sign vehicles, the “actual” self of the individual is not discoverable. [Delph 1978: 26]

In place of this “actual” self shrouded in silence Delph posits a “virtual” sexual self. The participant

...is able to focus on sexual activities to a degree that would be much more difficult to do if speech revealed his emotions, ideas, ideals, social status, occupation, group affiliations, and other biographical data. Only a transient landscape of sexual fantasy momentarily but wholly fills social horizons, disappearing with the withdrawal of those who sustain it. [ibid.: 28]

It is important to bear in mind that Delph is here not just talking about silent encounters in saunas or bathhouses, but about silent encounters in bars (gay or otherwise), parks, public toilets and other public spaces. As a self-protective mechanism, silence protects both the “actual” self and the “virtual” sexual self. The “actual” self is not compromised by sexual encounters with others, and the “virtual” sexual self can maintain its world of fantasy:

Participants do not talk to each other, unless with consociates, because the quality of the voice, and the nature of the vocabulary of everyday conversation destroy erotic portrayals. As H.G. [one of Delph’s informants] so often states, “I don’t want then to talk; it ruins the image.” [ibid.: 114]

In an important statement about the relations between this “silent community” and the then-growing “gay” community, Delph points to the disruption of silence which is part of gay liberation, a liberation which threatens the silent world of public homosexual encounters:

It is the sense of “adventure,” the escalation of pedestrian stuff into a state of erotic tautness, that breath of difference between the abyss and falling over the edge that fire the imagination in public erotic work...The rhetoric of the gay liberation movement pointedly fails to see this side of covert activity. How can such heights be attained if both worlds collide or if the homosexual world if fully legitimated, no longer requiring intrigue and subterfuge? Conventional identities would flatten the sensuousness in the erotic realm. There would be no need for silence and silent communication, and attendant ambiguity and tension. The erotic world would become an extension of the mundane, grounding soaring flights of erotic fancy into commonplace experiences.

By the same token, the flatness of the everyday world is a vivid relief for exotic experience. The sheer weight and magnitude of daily routine restores calm and order from “scene” participation. They are inextricably wedded and mutually complementary. [ibid.: 162-3]

Though he is writing in the time before AIDS and HIV, Delph's work is still an important analysis of this silent community. Though gay liberation was already making headway in the United States as he wrote, it has not, yet, managed to normalise gay life to the extent that silent communication becomes obsolete. Indeed, as I have already mentioned, in Ireland, the number of saunas has increased substantially since the decriminalisation of homosexual acts, and the saunas, far from disappearing, are becoming more and more popular all the time. This might lead us to ask whether, as sites of desire, the saunas can ever be completely "colonised by the language of saneness, health, wholeness and optimism" (Dollimore 1998: 300).

I have already noted the ways in which the types of encounters which occur in saunas (though not only there), described as multiple, casual, anonymous, sexual encounters, carry certain inscriptions from the world of public health, certain attitudes which can be seen as moralistic as well as health-protective. The spaces themselves, however, are most often denoted by two metaphorical descriptions which are overdetermined in themselves and which carry the weight of a great deal of moralistic comment. The two terms, dark and silent, are most commonly associated in the Western (particularly literary) tradition with the grave. Silence and darkness are one with death. This association has been made particularly vociferously in the slogan used by ACT-UP (AIDS Coalition To Unleash Power), branches of which sprang up in many parts of the United States in response to government inactivity in relation to AIDS. (There was, for a brief period, a group in Dublin). ACT-UP's most noted slogan/symbol was

#### SILENCE = DEATH

which appeared in white lettering beneath the pink triangle on a black background. This stark use of the symbol of the pink triangle reached back beyond its optimistic use as a symbol of gay community in the early eighties to its origin as a marker for homosexual inmates at concentration camps in Nazi Germany. Touching these origins, it also resonated with the greater holocaust, and the silence attendant on the genocide of the Jewish population in the years from 1933 to 1945. The realisation of this silence is given dramatic reality in a scene from Randy Shilts' account of the AIDS epidemic in the United States, *And the Band Played On* (1988). He describes the visit of Larry Kramer, one of the notable voices in the early desert of silence around AIDS, to Europe and one particular incident from that visit:

In Munich, Larry saw a sign that said "Dachau." He took the subway to a streetcar, which took him to a bus that made its way through the suburbs to the famous death camp.

"Dachau was opened in 1933," Larry read in the museum.

He stood there stunned. He had had no idea the camp had opened so early, just months after Adolf Hitler assumed power in Germany. World War II started for the United States in 1941, Larry thought.

"Where the fuck was everybody for eight years?" he wanted to shout. "They were killing Jews, Catholics, and gays for eight years and nobody did a thing."

In an instant, his fury turned to ice. He knew exactly how the Nazis could kill for eight years without anyone doing anything. Nobody cared. That was what was happening with AIDS. People were dying, and nobody cared. [Shilts 1988: 358]

Silence = Death is then a rallying cry to defence, in this case the defence of the gay community and those infected and affected by HIV and AIDS, and the instrument of defence is discourse itself. Talk is not just therapy, it offers the possibility of cure: "discourse can defend against the death that must result from the continuation of our silence" (Edelman 1994: 82). This compares with the traditional call of gay liberation for men to "come out," a visibilisation which promises similar defence against the deprecations of homophobia. This "logic of equations" is also the "logic of identities" (ibid.: 83), making two differences identical by equating them, and this is based "on the rhetorical form of mathematical or scientific inevitability ( $A=B$ ), a language of equations that can be marshalled equally in the service of homophobic ("Gay Rights = AIDS") or antihomophobic discourse ("Silence = Death")" (ibid.: 86).

This leads to a situation in which homophobic and antihomophobic forces alike generate, as defensive reactions to the social and medical crisis of "AIDS," discourses that reify and absolutize identities, discourses that make clear the extent to which both view the "AIDS" epidemic as a threat to those structures through which they have been able to constitute their identities for themselves. [ibid.: 86]

There is in all this a proliferation of boundaries, of identities, and of defences, and this is done through the device of the equation, which supposedly offers a literal truth, a truth cast "in the form of mathematical or scientific data beyond the ambiguity of rhetoric" (ibid.: 88). This attempt to do away with epistemological ambiguity relies on the dissemination of information, knowledge and facts about HIV and AIDS that in itself acts as a defence against the dissemination of the virus. That dissemination, transmission, coding, transcription, misreading and so on are all metaphorical constructions of the action of the virus in the body shows the domination of scientific discourse by metaphors and models.

Reverse transcriptase and immune defense systems are metaphorical designations that determine the way we understand the operations of the body; they are tropological readings that metastasize the metabolic by infecting it with a strain of metaphor that can appear so natural, so intrinsic to our way of thinking, that we mistake it for the literal truth of the body, as if our rhetorical immune system had ceased to operate properly, or as if the virus of metaphor had mutated so successfully as to evade the antibodies that would permit us to distinguish the inside from the outside, the proper from the improper. [ibid.: 91]

Viral “passing” metaphorises the silent spread of the disease, both within the body and within the population:

Within gay/queer subculture, ‘passing’ is the term for the practice of mimicking the straight world successfully, of adopting the appearance of the ‘normal’ and the heterosexual. When I say that the virus can ‘pass’ in the body, I mean that the biomedical representation of the virus constantly attributes it with a repertoire of mimicry, deceitfulness and false identity. [Waldby 1996; 117]

This parasitic passing is also the fear science, epidemiology and public health have of the unseen presence amongst the public of those who carry and transmit disease. Visibilisation and identification, naming through classification which makes something visible, are part of the defence against this proliferation and dissemination. This goes for the gay community in just the same way. Speech, discourse, partnership-dialogue, visible presence of representation on committees, vocal presence rather than silent (tacit) absence are the means to defend self against other. This model is also the model of government relations with the social partners, of the Northern Ireland peace process, and, in general, the model for the democratic process in the Western world in general.

## CONCLUSION

What is at stake in these metaphorical uses of silence and talk is describe by Plummer’s coinage, “intimate citizenship” which he uses

...to suggest a cluster of emerging concerns over the rights to choose what we do with our bodies, our feelings, our identities, our relationships, our genders, our eroticisms and our representations. [Plummer 1995: 17]

Now, and I suspect increasingly in the future, people may have to make decisions around the *control (or not) over* one’s body, feelings, relationships; *access (or*

*not*) to representations, relationships, public spaces, etc.; and *socially grounded choices (or not) about* identities, gender experiences, erotic experiences....[There] can no longer be an expectation that blueprints pure and simple will be found. Intimate citizenship does not imply one model, one pattern, one way. On the contrary, it is a loose terms which comes to designate a field of stories, an array of tellings, out of which new lives, new communities and new policies may emerge. [ibid.: 151-2]

The relationships between the various inscriptions of subjectivity and the embodiments of those subjectivities, and resistances to them, are centrally concerned with talk and silence. Both silence and talk are overdetermined, packed with metaphorical meanings and allusions of all kinds, but talk of all kinds is vital to the process of story making and story telling. It is through our stories that we create and recreate ourselves and the world we live in.

...our lives are a mesh of our own and others' stories. In the telling and the re-telling, they flex and develop as we create and recreate ourselves. The impulse to tell is strong in us all, but...valued stories are all too often told by the powerful. [Bolton quoted by Fox 1993: 114]

Silence and silences are also important in this process, and understanding the metaphorical constructions and uses of silence can help us develop better stories to tell. Sometimes, silence is more powerful than any speech, generating discourse as a defence, mobilising resources, generating stories, creating identities. The scientific, epidemiological, public health and gay reactions to the silent unknown of AIDS has produced a wealth of talk demonstrative of the cultural interrelatedness of fields as different as the laboratories of science and the "laboratories of sexual experimentation" (Foucault cited in Dollimore 1999: 298).

## Conclusion

### There's More In The Dark Than You Think

'Silence' and 'darkness' are very powerful metaphors of mystery and otherness in the creation of stories around HIV and AIDS. These metaphors are used in the construction of many stories around HIV and AIDS, and nowhere more so than in the stories of AIDS and HIV in Africa. The Irish government and media have given a great deal of attention to AIDS in Africa, particularly in the last six months or so. Despite, or maybe because of, the fact that these stories are about Africa ("over there") they tell us a great deal about AIDS and HIV in Ireland ("over here"). To conclude this thesis, I want to look at the construction of our stories about Africa in the light of what I have already said about AIDS and HIV in Ireland, to show how the same configurations of notions such as 'silence,' 'the dark,' 'knowledge,' 'health,' 'education' and so on which are used in the construction of inventions and interventions of HIV and AIDS in Ireland are repeated in the inventions and interventions of HIV and AIDS in Africa.

In a report for RTÉ television news on Friday 14<sup>th</sup> January 2000, Seán O'Rourke, following the Taoiseach Bertie Ahern's tour of southern Africa, referred to AIDS as "the illness that dare not speak its name." It was a curious coinage, given its reference to the Wildean nomination of the unnamable homosexuality in the context of AIDS in Africa which is transmitted largely through heterosexual contact. Homosexuality was unnamable because of the fear of seduction: naming or representing it would make it attractive to those who had never heard of it before, so that silence (the refusal to name or identify) is a protective mechanism. The conflation of "the love that dare

not speak its name” and (predominantly) heterosexual AIDS in Africa is also a protective mechanism: people have been murdered for the fact that they were known to have AIDS. This silent refusal to identify, as a protection, is similar to the Irish situation where, although murder might be extreme, social death is common.

This silence around AIDS and HIV extends to the level of government. So far as I am aware, the Taoiseach, Bertie Ahern, has never made any speech on AIDS in Ireland. Even when radio and television interviews are being given, it tends to fall to junior ministers and Ministers of State to talk about AIDS and HIV. This makes Bertie Ahern’s talk about AIDS in Africa during and after his visit there all the more interesting.

I am giving here the full text of a report which appeared in *The Examiner* on 15<sup>th</sup> January 2000. The report, by Karl Brophy, the paper’s political correspondent, concerns the last day of the visit by Taoiseach Bertie Ahern to South Africa. It appeared in the “News from Ireland” section of the paper.

Taoiseach pledges help as AIDS rips Africa apart

Taoiseach Bertie Ahern has vowed to enlist the European Union in the fight to curb the AIDS crisis in Africa.

Hours before he left Cape Town, after a five day visit to South Africa, Mr Ahern said that he would be asking the European Commission to come up with a strategy to combat the rapidly spreading disease.

He quoted statistics which show that one in ten people in South Africa are now HIV positive and the disease is spreading at the rate of 1,700 new infections every day.

In other countries in Africa, the infection level is even higher and threatens to wipe out a whole generation of sexually active people between the ages of 15 and 30.

“I don’t think the world can sit back and watch the figures get worse,” said Mr Ahern.

“It was the one thing that really struck me on this trip. I did not realise the situation was so bad. In parts of Lesotho up to 40% of the people have it; amongst the young people the figure is 53 or 54%.

“Throughout the week every single person mentioned it first or second to me as one of the major problems, and most people mentioned it first.”

The Taoiseach likened the disease to the black plague which ravaged Ireland and Europe in medieval times and warned that AIDS could quickly become a problem outside of Africa.

“With people so mobile now, we can’t just sit back and wait for it to hit us,” he said.

Mr Ahern will raise the issue with Ireland’s EU Commissioner David Byrne, who his [sic] responsible for health and public safety in Europe. Following this,

Mr Ahern said he hoped that a document will be drawn up by the EU which will lead to a plan of action for implementation in Africa.

"The biggest problem is that the countries in Africa simply cannot cope with their own people," said the Taoiseach.

"They can only help five or ten per cent of their own people.

"We have to examine what Europe can offer them medically and otherwise."

Mr Ahern said that he will also be instructing FÁS, the state training agency, to provide the South African Government with details of Irish training courses which encourage vocational training.

It should be noted that, whilst other daily newspapers covered the Taoiseach's statements, no other newspaper reports the same statements as *The Examiner*. The *Irish Times* of the same day records him as saying, "Africa's biggest problem is the AIDS problem. They are crying out for help," and, in relation to the EU, "I haven't heard it discussed in any form, and then I come down here [South Africa] to find it's the biggest problem." The report goes on:

In his own mind he had associated AIDS with "drugs and cities" and it was a shock to go to rural drug-free parts of Lesotho "to see 40 per cent of the people with it, and 50 per cent of those aged 18 to 35. I don't think the world can just sit back and watch the figures get worse," Mr Ahern said.

The *Sunday Independent* on the following day (16<sup>th</sup> January), under the heading "Shocked Taoiseach 'committed to tackling Aids'" gives a similar report of his statements, ending:

Mr Ahern said he had expected poverty in South Africa, especially in the light of the country's past. But, out of an "innocence" of sorts, he had not appreciated the extent of Aids. "If it's not a serious problem of world health order...then I don't know what is," Mr Ahern said.

"You're either going to stand back and wait until it comes out of Africa and hits you, or you try to help out."

He committed himself to raising the matter urgently in Brussels. "I want to see if there is something practical that can be done. I don't know where my European colleagues are on this issue, but I don't think the world can sit back and watch the figures getting worse."

Despite the differences in reporting, it is reasonably clear that the reporters all heard the same comments made. In particular, they all report one statement almost identically:

I don't think the world can sit back and watch the figures get worse.  
(*Examiner*)

I don't think the world can just sit back and watch the figures get worse.

*(Irish Times)*

I don't think the world can sit back and watch the figures getting worse.

*(Sunday Independent).*

Of particular interest here is that, whilst AIDS in Africa is quite often the subject of newspaper reporting in Ireland, so far as I can ascertain, this Taoiseach has never made any statement about AIDS in Ireland. Nonetheless, the construction of AIDS in Africa in statements like those quoted above can serve to illustrate attitudes towards AIDS and HIV outside of Africa:

Criticizing recent American and European failures to imagine Africa without prejudice, Chinua Achebe notes the continuing "desire – one might indeed say the need – in Western psychology to set Africa up as a foil to Europe, a place of negations at once remote and vaguely familiar in comparison with which Europe's own state of spiritual grace will be manifest." As Achebe points out, whether they come from Victorian or modern England, the America of Grover Cleveland or that of Ronald Reagan, "travellers with closed minds can tell us little except about themselves." [Brantlinger 1994: 197]

Significantly, there is an association made in Ahern's comments between aid and AIDS, between the possibility of intervention (through relief and/or development aid) in Africa on the one hand and the invention (through AIDS) of Africa on the other. Africa is invented as a homogeneous continent of disease, inability to cope, passivity, and primitiveness, against which European intervention is presented as the only possible outcome. Inventing Africa in terms of AIDS justifies the intervention of Europe. This is made even more apparent by the fact that Bertie Ahern's comments come just a fortnight before Minister of State at the Department of Foreign Affairs, Liz O'Donnell, launched a new HIV/AIDS strategy for the Ireland Aid programme which, on one hand, emphasised the role that development aid could have in combating AIDS, and, on the other hand, emphasised the negative impact of AIDS on development in Africa. Bertie Ahern, in his speech to the opening of the Council of Europe meeting in Dublin on Monday 17<sup>th</sup> January, just after his return from southern Africa, reiterated the same position:

During my visit to South Africa and Lesotho, I witnessed at first hand how high levels of HIV/AIDS infection are undermining efforts to raise living standards. At Copenhagen in 1995 we did not, I believe, fully grasp the devastating implications of the spread of HIV/AIDS through some of the poorest regions of the world. The recent UN Security Council debate on HIV/AIDS underlines the international concern at the potential impact of AIDS. The capacity of AIDS to set back years of economic and social progress is now an issue of central international importance which demands our urgent attention.

The Irish development aid programme will integrate the fight against HIV/AIDS into all of its development assistance programmes and will devote increasing resources to the fight against AIDS. [Government Press Release]

This position is restated in Liz O'Donnell's Introductory Remarks in *An HIV/AIDS Strategy for the Ireland Aid Programme*:

HIV/AIDS is not merely affecting the health of the world's population. It has also reversed progress in human development, nullifying the effects of decades of expenditure on both aid and development...HIV/AIDS is not simply a health issue. Its impact goes beyond the tragedy of the millions of young sufferers, their families and communities. HIV/AIDS has other profound catastrophic economic and social implications. Poverty and social unrest thrive in its wake....The challenge now for Ireland Aid and our partners is to strengthen our organisational capacity and improve our interventions to prevent and help treat the disease. [IAAC 2000: iii]

Thus, AIDS simultaneously justifies and threatens development aid and development itself. Development offers a light to counter the darkness of Africa, but Africa's disease threatens to extinguish even that possibility of light.

If we look more closely at the statements that the news reports had in common, we can understand something of the attitude, at very least, Bertie Ahern's attitude, towards AIDS, both in Africa and in Europe:

I don't think the world can sit back and watch the figures get worse  
[*Examiner*]

I don't think the world can just sit back and watch the figures get worse  
[*Irish Times*]

I don't think the world can sit back and watch the figures getting worse  
[*Sunday Independent*]

Working from the end of the statement, "worse" implies a graded scale of effect, going minimally from good to bad to worse. The suggestion seems to be that while Africa faces the threat of AIDS figures getting worse, "the world" is not in that position. This belies the fact that there are still new AIDS cases on a daily basis elsewhere, including Ireland. The implication is that there is a qualitative and quantitative difference between AIDS in Africa and AIDS elsewhere in the world, as well as a hierarchical arrangement of danger, with Africa in greater danger than Europe. Also, what is getting worse is not the situation, or the plight of people, but rather "the figures." This privileges statistical knowledge as a particularly potent form of knowledge, and, in the

*Examiner's* article, both statistical and experiential knowledge are mixed in such a way that they seem to compliment each other. Bertie Ahern, having visited South Africa and Lesotho (experiential knowledge) comes away with a set of figures (statistical knowledge) for which there are no quoted sources but which are instantly given credence because they are uttered by the Taoiseach on his return. The fact that there are differences in the statistics reported by the *Examiner* and by the *Irish Times* (see above) does not really matter: both sets of figures are knowledge for the respective readers (despite the difference) *because* the figures are quoted by Bertie Ahern who has visited these countries.

The idea that the figures are 'watched' by "the world" seems to imply that this kind of statistical knowledge is not being generated indigenously, and that "the world" is in a privileged position to "watch," a position that no African or African country is in. Watching is made active, rather than passively observing, and this is added to by linking with the previous statement that "the world" cannot "sit back" and watch. Again the implication of passivity is given to 'Africa' and activity, both in watching and in not sitting back, is given to "the world." "The world" is not defined in any way, but the implication is clearly the "western" world, making a division between 'Africa' on the one hand, and "the (rest of the) world" on the other. As in other statements recorded in the *Examiner*, 'Africa' cannot cope with its own people, with the implication that the rest of the world can and does. Where Liz O'Donnell comments that poverty and social unrest thrive in the wake of HIV/AIDS, this obviously does not apply outside of Africa. African AIDS and its consequences are out of control, where AIDS and its consequences in the rest of the world are under control. This adds further weight to the active construction of 'watching:' what the 'rest of the world' has been watching is "Africa's" failure to deal with AIDS, implicit in the "figures getting worse," a further primitivisation of 'Africa' as well as a justification of intervention. The world not being able to sit back and watch the figures get worse also carries a straightforward moral prerogative for intervention, again implicit in the idea that these people cannot cope: "the world" must help them to help themselves. Yet the very opening of the sentence makes it clear that this moral position is far from clear. "I don't think" turns this from a direct statement of impossibility ("The world *cannot* sit back...") to one of improbability ("*I don't think* the world can sit back...").

Probably unawares, Bertie Ahern makes a significant contribution to the 'darkening' of 'Africa.' The myth of the "Dark Continent" is one that Brantlinger explores in terms of a "genealogy of the myth of the "Dark Continent." By mythology, he means

Ideology, or modern, secularized, “depoliticized speech” (to adopt Roland Barthes’s phrase) – discourse that treats its subjects as universally understood, scientifically established, and therefore no longer open to criticism by a political or theoretical opposition. [Brantlinger 1994: 174]

Brantlinger outlines what can be referred to as the ‘missionary position,’ that the African was to be saved from his darkness, but needed simultaneously to be seen as dark in order to allow for missionary work:

For Livingstone, as for other missionaries and abolitionists, the African was a creature to be pitied, to be saved from slavery and also from his own darkness, his savagery....At the same time missionaries were strongly tempted to exaggerate savagery and darkness to rationalize their presence in Africa, to explain the frustrations they experienced in making converts, and to win support from mission societies at home. [Brantlinger 1994: 182]

It is this ‘missionary position’ that Bertie Ahern reiterates in his comments on AIDS in Africa. Essential to this is the implicit medicalisation of AIDS, the passivity of Africa under this ‘missionary position’ being like a patient, waiting for the doctor/surgeon to commence the operation. AIDS is constructed as a medical and humanitarian issue, free of political implications, and outside of any political discourse. It is a medical problem, one that can be dealt with in purely medical terms. Yet Bertie Ahern’s model contains within it a threat: that if something is not done, there will be consequences for “the world:”

“You’re either going to stand back and wait until it comes out of Africa and hits you, or you try to help out.” [*Sunday Independent*]

The Taoiseach likened the disease to the black plague which ravaged Ireland and Europe in medieval times and warned that AIDS could quickly become a problem outside Africa.

“With people so mobile now, we can’t just sit back and wait for it to hit us,” he said. [*The Examiner*]

It may be that in the latter comment, the Taoiseach hardly means to imply the mobility of African people, characterised as they are by poverty and a lack of economic resources. The mobility might more likely be that of Europeans and others who find themselves in Africa. Yet the increasing influx of refugees and asylum seekers into Ireland may also be part of Ahern’s fear of the spread of AIDS, particularly as AIDS and HIV in Ireland are constructed as being primarily the problem of problem groups, rather than, as in southern Africa, the problem of the general

population. Also interesting is the notion that something might come out of Africa and “hit us.” This seems, from the Taoiseach’s construction, to imply AIDS itself, as if AIDS did not already exist outside of Africa, but might also have other implications. If it is AIDS, then the implication is that it is a *different* AIDS to that which already exists in the rest of the world. Perhaps what he fears is the spread of heterosexually transmitted AIDS. Most importantly, it is the permeability of a boundary that is at stake. The boundary between ‘Africa’ (as Bertie Ahern constituted it) and the rest of the world (as Bertie Ahern constitutes it) is constructed as being permeable, and whatever rightly belongs on one side (namely ‘Africa’) cannot be allowed to slip over that boundary. It allows for the construction of a mysterious object (which might be AIDS, or HIV, or both, or neither) which threatens ‘Africa’ and thereby threatens ‘the (rest of the) world.’ ‘Africa’ is contagious, and this contagion threatens not simply the infection of the rest of the world but the regression of that world.

In comparing AIDS in Africa to the black plague in medieval Europe and Ireland, Ahern is bringing the threat of regression to the fore. The way the “black plague” affected Europe and Ireland in medieval times is the same as the way AIDS affects Africa today: Africa is medievalised, and threatens to turn back the clock on Europe. This is made clear in recent announcements about AIDS in Africa and its comparisons to the black death. Health officials and epidemiologists attending the international AIDS conference in Durban in South Africa claim that, in Africa, deaths from AIDS will soon start to reduce the populations of seven sub-Saharan countries. This would be the first time in history since the black death that a disease has resulted in changes in demographics. If this contagion were to spread outside of Africa, Europe and Ireland could go back to medieval times. AIDS therefore threatens not just the geographical boundary between Africa and Europe (and indeed the rest of the world) but also the temporal, imagined boundary between the modern and the primitive (or, at very least, the medieval). ‘Africa’ is therefore contagious, both in danger *and* dangerous, threatened *and* threatening, at risk *and* risky, and it is this simultaneous constitution of danger on both sides of a constructed-as-permeable boundary offered by AIDS that suggests the double justification for intervention: in saving ‘them,’ ‘we’ are saving ‘ourselves.’ This is also clear in the decision by the United States to declare AIDS a threat to national security in May 2000.

Intervention is constituted along military lines, using the same military metaphors as medicine (as in the *Examiner* article where we find words like “enlist,” “fight,” “strategy,” “combat,” and

“plan of action”), justifying the same kind of militaristic activity on medico-moral grounds. Interventionism is as much a principle of medicine as it is of the military. This is a just war, a moral intervention. Ahern’s reference to AIDS in Africa as a threat to “world health order” (see *Sunday Independent* above) neatly conflates ‘world health’ and ‘world order,’ and his reference (in his address to the Council of Europe meeting) to the “recent UN Security Council debate” both help fix the association between AIDS and the security of world order. It perhaps also hints at the interest Ireland has in attaining a seat on the United Nations Security Council in the next few years, for which a neutral record of concern for human rights and world health would make Ireland an interesting candidate for support from African countries, in particular South Africa. What is at stake is a boundary, or a series of boundaries, and HIV/AIDS becomes the effective translator across these boundaries. It acts as a dividing practice, organising the contents on each side of the boundary and justifying the boundary itself:

‘Border anxiety’ demands the strengthening of immunity (distinction of me from not me) and the mobilization of personal resources so that the individual can remain within the boundaries of normality. [Crawford 1994: 1357]

One of the implications of darkening Africa is the silencing of African voices. In what Bertie Ahern has to say, there is no room for any voicing on the part of any African. This goes back again to the privileging of the outsider’s viewpoint over that of the African, and the privileging of outsider knowledge (medical knowledge, statistical knowledge, economic knowledge) over indigenous knowledge. Thus indigenous talk of any kind is ‘black boxed,’ effectively glossed over in such a way as to deny its complexities, its politics, indeed its very existence. The talk of the expert outsider silences all other talk, and represents itself as the only talk. Medicine, in particular, is very effective at depoliticising talk, and here AIDS, and the humanitarian mission of using development aid as part of the fight against AIDS (indeed, enlisting it as part of the fight against the failure of development aid), seems so commonsensical as to obviate any other solution. Yet there is something behind this that remains unmentioned, perhaps even unmentionable.

In an address given by the Taoiseach “at a business breakfast for trade mission participants” (Government Press Release, 12<sup>th</sup> January 2000), he outlines what he sees as the key to Irish economic success, and presses for closer economic and trade links between Irish and South African businesses. Dealing with “Trade Development” he refers to the “Pharmaceutical and

Healthcare sector,” but only in relation to what Ireland can do for South Africa in the provision of such “top class products.” There is no mention here of the legislation the South African government attempted to introduce as the Medicines and Related Substances Control Amendment Act 1997, one provision of which would give the Minister for Health power to “prescribe conditions for the supply of more affordable medicines in certain circumstances so as to protect the health of the public...notwithstanding anything contrary contained in the Patents Act” (*The Examiner* 29<sup>th</sup> June 1999). The *Examiner*’s reporter goes on to say,

The act doesn’t spell out exactly what the government can and can’t do to get AIDS drugs. But theoretically, local companies could produce their own versions of drugs patented by pharmaceutical giants, a practice known as compulsory licensing. They could also import AIDS drugs from other countries if they could get a better price overseas than the one being offered by companies at home.

Even later, at the EU-Africa conference in April 2000, where Bertie Ahern again raised the issue of AIDS in Africa and its consequences for development, no mention was made of comments by President Thabo Mbeki’s office that drug companies were enriching themselves on profits from AIDS drugs, nor of the decision by the South African government to convene a panel to investigate if HIV leads to AIDS, and whether HIV is sexually transmitted. Parks Mankahlana, a spokesman for Mbeki’s government, said:

Like the marauders of the military industrial complex who propagate fear to increase profits, the profit-takers [shareholders in pharmaceutical companies] who are benefiting from the scourge of HIV/AIDS will disappear to the affluent beaches of the world to enjoy wealth accumulated from a humankind ravaged by a dreaded disease. [*Business Day*, 20<sup>th</sup> March 2000]

The military metaphors so prevalent in medical discourse, and evident in the *Examiner* article, are here turned back on the pharmaceutical companies, which become identified with the “marauders of the military industrial complex.” Beyond its questioning of what have come to be seen as self-evident truths about HIV and AIDS, produced in the West, the government’s statements challenge the prerogative of the so-called developed world in relation to the production of AIDS treatment drugs, as did the Medicines and Related Substances Control Amendment Act. Yet this attempt to challenge the hegemonic discourse of the ‘developed’ world in relation to the ‘un(der)developed’ world makes no appearance in any of Bertie Ahern’s statements. The talk of the ‘developed’ world silences that of the ‘un(der)developed.’ AIDS in Africa is black-boxed,

such that what is going on on the inside is kept from view, and a particular external appearance is given to it by the dominant talk of outsiders. AIDS is medicalised and thereby depoliticised. The moral position of the outside world is dominant and effectively obviates the moral position of 'Africa.' The 'crisisisation' of AIDS in Africa in the last year or two, the escalations of story-making and story-telling on all sides, has had the effect of producing some of the most dramatic changes in the attitude of Western nations to the situation in Africa. This has extended, by association, to the whole issue of debt and development, and the continuing dependency of Third World countries. An executive decision by American President Bill Clinton allows for the production of cheap, locally produced versions of antiviral treatments to be produced in countries such as South Africa and India. Mbeki's insistence on the failure of monocausal theory to deal with the problem and effects of AIDS and HIV has incensed scientists and doctors, but has increased the sense that AIDS and HIV are related to fundamental problems of debt, underdevelopment and dependency, giving a new impetus to action in those areas, including the Irish Aid intervention.

In these statements by Taoiseach Bertie Ahern, we can see the linking of aid and AIDS, the linking of intervention with invention in the homogenising of 'Africa' and the 'African' AIDS situation. AIDS in Africa is seen as being qualitatively and quantitatively different from AIDS elsewhere, and AIDS is used to create a boundary between 'us' and 'them,' a boundary which is under pressure because 'they' are contagious, both dangerous and in danger, risky and at risk. The fear of contagion, of the breaching of this boundary, is also a fear of regression, that 'Europe' will slide backwards and become like 'Africa' is now or like 'Europe' was in the time of the black plague. This kind of talk privileges statistical knowledge, backed by an appearance of experiential knowledge, and iterates the superior surveillance position of the active 'rest of the world' over a passive 'Africa.' Medicalising the 'African' situation allows for and justifies intervention, intervention being a principle of Western bio-medicine. This superiority also allows for the silencing of oppositional voices and for the black-boxing of the situation in relation to AIDS in 'Africa.' Thus HIV/AIDS offers the opportunity of a dividing practice, in the creation and protection of boundaries, in depoliticising yet maintaining of control over relations between self and other. Yet this invention and intervention is hugely productive. As surely as Mbeki's actions and speeches have outraged scientists and Western governments, he has demonstrated how the silence can be broken, how black boxes can be prised open, and how this can result in leaps forward in dealing with the problems of HIV and AIDS. If anything, the crisisisation of AIDS in Africa has resulted in the most significant changes in the way that AIDS and HIV are viewed.

Naming and talking about the unnamable have brought AIDS and HIV into the light, questioning knowledge and knowledge making, proliferating alternatives, and making boundaries more permeable.

We are, as Plummer puts it, "*homo narrans*: humankind the narrators and story tellers" (1995: 5). We are categorisers, metaphorisers, makers of knowledges, truths, identities, and communities. The proliferation of discourses is our way of dealing with, indeed creating, the world we live in. Our inventions of our world are our ways of dealing with it, of intervening in it. What I have been concerned with in this thesis is how these stories are created, the cultural conditions under which knowledge is produced and disseminated, and how the conditions of production affect the ways in which this knowledge and these stories are received by audiences. Certain stories have greater authority or power attached to them, and much of what I have presented here has to do with the various contestations around the authorisation of stories and the power they have. The power to set the questions, to decide priorities, to establish how to deal with a given situation, is not the privilege of any one group but requires the interaction of many different voices, many different stories, and many different and diverse story tellers. This diversity means that not everyone gets to tell their story, and that certain stories are never heard. One person living with AIDS gave the following response to a session of the recent XIIIth International AIDS Conference at Durban in South Africa where Dr Ho spoke on "Living With AIDS":

For the silence to be broken you need a lot of noise, and except for the occasional ACT-UP gatherings showing up when Gro Harlem-Brundtlandt (WHO) is delivering her speech, not much noise is being made. Why don't people listen to People Living with AIDS? When the session is on "Living With AIDS" people only talk about treatment. Where is the real dialogue taking place between PWAs and scientists? At yesterday's plenary meeting with Dr Ho, a PWA turned around to me and say [sic] he didn't understand a word of what was being said. There is a general feeling that it's academics talking to academics. [Notice posted on the official website of the XIIIth International AIDS Conference 1999]

The Conference, which had as its title "Break The Silence," hosted the first Jonathan Mann Memorial Lecture, given by Mr Justice Edwin Cameron of the South African High Court, the title of which was "The Deafening Silence of AIDS." Two sessions of the Conference were titled "Exposing the Silence."

The closing speech of the conference was given by Nelson Mandela, former President of South Africa, who said:

It is never my custom to use words lightly. If twenty-seven years in prison have done anything to us, it was to use the silence of solitude to make us understand how precious words are and how real speech is in its impact upon the way people live and die...The challenge is to move from rhetoric to action, and action at an unprecedented intensity and scale. There is a need for us to focus on what we know works... We need to break the silence, banish the stigma and discrimination, and ensure total inclusiveness within the struggle against AIDS; those who are infected with this terrible disease do not want stigma, they want love. [Mandela's speech as posted on the official website of the XIIIth International AIDS Conference 1999]

In this thesis, I have attempted to move beyond the rhetoric and the merely academic to look at the production of knowledge in talk about HIV and AIDS in Ireland. This talk is not merely about text-based discursive productions of knowledge, but also about the ways in which these stories are told by people, have meaning for people, and affect people. The stories we tell about AIDS and HIV are cultural. They are created within, and given meaning by, culture, and they create and give meaning through culture.

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