

## **Moral barriers to HIV prevention and care for gay and bisexual men: Challenges in times of conservatism in Brazil**

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### **Abstract:**

This article examines narratives about promiscuity that are emphasized by some gay and bisexual men who are themselves living with HIV. We used semi-structured interviews to assess the processes, outcomes, and meanings of HIV diagnosis among 10 young gay and bisexual men aged between 18 and 30 years old. Interviews were conducted in health service settings for the diagnosis and treatment of HIV and AIDS in Salvador, Brazil. Based on a socioculturally-oriented approach, the narratives suggest that discourse about promiscuity seems to persist, or is even strengthened, in order to explain HIV infection among young gays/bisexual men and to emphasize a more restrained sexual life following HIV diagnosis. Despite the biotechnologies and biomedical advances, some difficulties and tensions also persist in the daily life of young people living with HIV. Difficulties in starting new relationships, dilemmas around responsibility for infection/transmission, fear and guilt are elements that stand out in these narratives, demonstrating that HIV discourses and practices may produce greater stigma and discrimination in current times, individualizing and blaming certain people for the infection/transmission of the virus, and marginalizing practices that do not conform to hegemonic heteronormativity.

**Keywords:** HIV and AIDS, sexualities, stigma, biotechnologies, HIV care

## Introduction

Although there is evidence of a relatively stable prevalence of HIV in the general Brazilian population, the rate is disproportionately higher among gay men and other men who have sex with men (MSM)<sup>1</sup>. In the global context, systematic review studies estimate a prevalence of around 15.4% in this population (Beyrer et al, 2012), and studies in Brazil indicate prevalence at this level. In 2016, a study among gay and bisexual men in 12 large Brazilian cities estimated a prevalence of 18.4% (Kerr et al, 2018), much higher than the estimate for the general population (0.6%) (Brasil, 2014).

The current epidemic profile has drawn attention to the growth of HIV and AIDS among young men. From 2006 to 2016, data from the Brazilian Ministry of Health indicated that the AIDS detection rate among men aged from 15 to 19 years old had almost doubled, while for those between 20 and 24 years old, the rate had more than doubled (Brasil, 2017). When compared to data from studies undertaken in 2009 and 2016, a substantial change in the behaviour of young Brazilian gay and bisexual men was noted, with an increase in the prevalence of the use of illicit drugs (from 40.5% to 49.3%) and of unprotected anal sex (from 33.6% to 41.8%) (Guimarães et al, 2018). Furthermore, the prevention and care of HIV and AIDS in Brazil have faced an increasing challenge in the under-funding of the National Health Service and a moral crisis in the field of sexuality, with pressures from conservative groups, which have expanded into the arenas of government solutions and decisions and which have had repercussions on actions and responses to the epidemic (Greco, 2016; Seffner & Parker, 2016a).

Despite the progress and international prominence that Brazil historically displayed in the field of HIV, at this moment concerns and fears are growing. As Seffner and Parker (2016b) note, we are experiencing tension between “help them live” and “let them die”, in that we have new treatments and biomedical methods for prevention, while also observing “reinforced” stigma and discrimination against vulnerable populations. A reduction in investment and the resumption of the “moral” discourse in the field of HIV and AIDS prevention are ingredients that could increase the vulnerability of historically stigmatized people and groups, such as gay and bisexual men.

In the midst of the resurgence of the AIDS epidemic among gay and bisexual men (Brasil, 2017), optimism predominates in the scientific community, especially due to recent evidence from the biomedical field that someone living with HIV, if treated with antiretroviral therapy and with an

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<sup>1</sup> The MSM category is used in epidemiological studies to include cisgender men who identify themselves as gay/homosexual and those who have sex with other men, even if they identify themselves as heterosexual or bisexual. In this article, we'll use only gay and bisexual men, taking into consideration our research participants and how they identify themselves.

undetectable viral load, does not transmit the virus during sexual intercourse (Rodger et al., 2016, 2019; Grulich et al, 2015; Cohen et al, 2016; *The Lancet HIV*, 2017), indicating that treatment is also prevention. Beyond the new biomedical prevention strategies available in health services, such as testing and treating HIV infection at all CD4 counts, PEP (post-exposure prophylaxis) and PrEP (pre-exposure prophylaxis), this optimism underlines the need to incorporate other structural strategies to confront and combat the HIV vulnerabilities of gay and bisexual men (Aggleton and Parker, 2015), especially stigma and discrimination (Magno et al, 2017). We note that these vulnerabilities' processes and effects are not homogenous, meaning that the diversities and intersectionalities between such groups must be taken into consideration, for example, in terms of gender performance and of generational, socio-economic (Philbin et al., 2018), and ethno-racial (Halkitis et al., 2013) differences.

Several studies have pointed out that HIV stigma continues to produce socio-affective barriers in the lives of those with a positive diagnosis (Flowers, 2010; Simões, 2018), with adverse effects on the sexual and mental health of gay and bisexual men in several places around the world (Anderson et al., 2015; Berg et al., 2015; Ha et al., 2015), despite the advances in HIV treatment, and the apparent departure from "HIV/AIDS exceptionalism" towards HIV's "normalization" as a chronic disease (De Cock and Johnson, 1998, p. 291). In other words, despite important changes and discontinuities in the HIV and AIDS scenario - something that was previously seen as a "death sentence" is now a "life sentence" (Flowers et al., 2001) - problems and conflicts continue to exist (Squire, 2010), such as the uncertainties (Davis et al., 2006; Rosengarten et al., 2004) generated by new medical technologies for treatment and prevention.

As Flowers (2010, p.117) asserts, the psychosocial consequences of an HIV diagnosis appear "resistant to processes of normalisation". In relation to HIV positive gay and bisexual men, for example, difficulties in revealing their positive status to other people have been highlighted (Flowers and Davis, 2012), as has the fear of rejection and isolation from potential sexual partners (Jeffries et al., 2015) and other HIV negative gay and bisexual men (Courtenay-Quirk et al., 2006; Smit et al., 2012). Difficulties around revelation, predominantly fear of stigma, also have an impact on access to health services for testing and treatment (Hoffman et al., 2015; Li et al., 2012), and reinforce feelings of guilt and shame about the infection (Cloete et al., 2008). As Paiva et al (2011, p. 4208) argue, one cannot forget that people living with HIV "continue to be seen as dangerous". It is no surprise, therefore, that some men are more discreet about being HIV positive than they are about "being gay" (Takács et al., 2013).

Based on this scenario of ambiguities and dis/continuities around HIV, in this paper we attempt to highlight narratives about promiscuity which seem to persist, including in Brazil (Gomes et al., 2011; Ribeiro et al., 2019), or even to have been resumed as a justification for HIV cases

among gay and bisexual men, as well as for the new imposed limitations which are required to live with HIV. These are, therefore, narratives that move towards blame, marginalizing and normalizing subjects, neglecting or minimising other elements related to sexual scenes and encounters. As Simões (2018, p.335) emphasizes, despite the current context of biomedical advances in which young gay men live, promiscuity is still seen as an “expression of irresponsible sexuality”.

Personal narratives are structures of language that give an account of the narrating subject, often in moral terms (Butler, 2005; Riessman, 2008). This characteristic means that analysing young Brazilian people’s contemporary narratives of their lives with HIV can allow us to understand if and how discourses around promiscuity, stigma, and biotechnologies are operating, within the context of increasing HIV incidence among those young people.

For beyond the discourses on promiscuity that continue to simplify, individualize and blame subjects in relation to HIV cases, there is a moral dimension that must be considered. In other words, the narratives in focus here bring important social and political issues to think about who or what practices are accepted or appropriate, in the context of hegemonic heteronormativity. What these narratives may suggest is that sexual practices/sexualities will be accepted or legitimized as long as they are assimilated by an ideal image of normal gay/homosexual subjecthood (Dean, 2009). In other words, it seems they may be accepted as long as they are not perceived as excessive or promiscuous.

### **Methodological pathways: producing narratives about living with HIV**

The study called *The sociability of young people living with HIV/AIDS: new biomedical discourse and its impact on sexual and emotional relationships*, conducted between March and November 2017 in the city of Salvador, capital of Bahia State, Northeast Brazil, produced the narratives discussed in this article. Over this period, we sought to interact with HIV positive young aged 18 to 30 years old who were users of a Reference Service for the diagnosis and treatment of HIV and AIDS in Salvador, in order to discuss their life histories and the repercussions HIV had had on the construction of their sexual and emotional relationships.

During the study, we conducted 10 semi-structured interviews with gay and bisexual men, mostly young, that is 30 or younger, who enrolled in the service for treatment. These interviews were conducted individually in a private room provided by the service. All of them had undetectable viral load at the time of the interview. The team of interviewers (two graduate students trained in qualitative research and the project coordinator) recruited the participants through a display of information about the research in the clinic waiting room. Furthermore, posters and postcards containing social network addresses (Facebook and a blog) and project telephone

numbers were displayed on the unit walls and distributed among users to allow further contact between the young men and the researchers. As suggested by the participants, due to difficulties related to timing and availability to meet the researcher at the clinic, two interviews were held outside the clinic. One of the interviews took place in a private room at the Federal University of Bahia where the research coordinator worked; the other occurred through an online text and voice app (WhatsApp), in line with the model and strategy developed by Silva and collaborators in research with young people living with HIV (Silva et al., 2017). In this last interview, the conversation with the young person alternated between text and voice messages, depending on their preference for providing short responses (text) or a longer, more detailed, narrative (voice).

Of the ten men interviewed, eight self-identified as *gay*, one identified as *homosexual* and the other as *bisexual*. The participant who self-identified as “homosexual” was 30 years old, older than the other interviewees. The age of other participants were between 20-28 years old and the majority self-identified as “gay”. One of those who self-identified as gay mentioned that he was “an effeminate, non-binary, fag”. Six of the other interviewees self-identified as white, two as black and two as mixed race. One of the participants resided in a middle-class neighbourhood while nine in low-income neighbourhoods in Salvador.

During the interviews, we sought to produce a scenario for dialogue and conversation in order to produce narratives about HIV and AIDS and its repercussions on the construction of sexual and emotional relationships. At the beginning of the interview, we asked the interviewee to describe freely what it was like when they discovered they were HIV positive. The conversation was guided by an open script, covering the following topics: 1) post-diagnosis events and experiences; 2) repercussions on participants’ relationships and effects of revealing their positive status; 3) antiretroviral treatment, medication routines and care.

The project was approved by the Ethics in Research Committee at the Institute of Collective Health/ Federal University of Bahia (number 1.684.862/2016). All the interviews were conducted following clarification of the research’s objectives, and the reading and signing of an informed consent form. It is worth noting that in the case of the online interview the informed consent was registered in the interlocutor’s conversation window when they made contact with the researcher. On issuing a positive response, the interlocutor began to participate in the study. All the interlocutors were informed of our guarantee to maintain the anonymity and confidentiality of all the information supplied, at all stages. They were also informed that they could leave and/or withdraw their consent at any time.

Here we will highlight certain narratives in which the theme of promiscuity occupied an important place, despite medical changes that have taken place within the AIDS scenario that might suggest this narrative theme would be less salient than previously.

From our perspective, as in Squire et al. (2014, p. 277-278), specific stories coexist with and emerge in relation to a more generalized storyline regarding the contemporary HIV and AIDS epidemic profile, centred on progress in biomedical treatment and prevention. Therefore, we also consider the importance and force of the narratives, with their heterogeneity and polyphony operating as one way of opening up issues (Mol and Law, 2004).

We started from a dialogic, performative and sociocultural perspective on the construction and analysis of narratives - which may involve many modalities of orality, of writing, of image or based on other non-verbal symbols, producing meaning through “movement”, “progression” and the “sequencing” of signs (Squire, 2013). As Squire et al. (2014) posit, this movement may be interrupted, contradictory and non-linear. Despite being produced and situated within specific stories, narratives enter into dialogue and (inter)connect with each other, to the extent that they update or put forward other voices from our history and culture. In this sense, we understand narratives according to a *socioculturally-oriented approach*, in other words, based on the assumption that “personal” and “cultural” narratives are interconnected (Squire, 2013). As posited by Plummer (1995, 2001), in order to talk about the proliferation of auto/biographical stories about coming out throughout the 20<sup>th</sup> century, we need to situate these reports within important political and social changes, and for such reports to flourish, it is necessary to have a “community to hear” (Plummer, 1995, p. 87). Clearly, there have been changes in the direction, and form of such reports, based on new happenings, as was the case with HIV and AIDS, with older tragic or resistant, activist dimensions to coming out appearing in the form of poetry, drama, film, biography, etc. (Plummer, 1995) and more recent narratives, particularly since the advent of effective treatment, expressing resistance, redemption and transformation (Plummer, 2001, 2019).

Narratives are, in dialogic and performative terms, as Squire et al (2014) note, co-constructed; in other words, they are socially situated and interactively produced, and understood. Narrators and listeners/readers are involved and actively participate in the production and interpretation processes. When we narrate, that is, when we tell, write, picture or record a narrative, we also anticipate or imagine a listener/reader or audience. Therefore, from a Bakhtinian perspective (Bakhtin, 1999), the utterance, as a link in the discursive communication chain, has an address, whose response, completion or production of meanings presupposes the active participation of the other.

Both narrators and listeners/readers are woven into the production of narratives, as are other (previous and past) voices/utterances, and as is additionally the case with moral values that legitimize certain sexual practices while condemning others. In performative terms, this interweaving also underlines the fact that not only do we express something, we also act and do things with signs and with the narratives that they may constitute. Thus, as Squire et al (2014, p. 29) highlight, when we perform our stories to an audience, we create ourselves, and our experiences

through such performances and reiterate norms (Butler, 2008), although also holding the possibility of destabilizing them.

Finally, while analysing the narratives outlined in this article, it is important to understand that they are social artefacts - not stories that have fallen from the “sky” or emerged from participants’ “deepest being”. These are stories that were produced and are received in “interactional, historical, institutional and discursive contexts” (Riessman, 2008, p. 105). In addition, by highlighting a materiality that interactively produces phenomena (Law, 2009), we are adopting a more pragmatic approach to discussing and understanding such reports, mediated by the existence of novel communication and biomedical technologies which are enabling the production of new effects and new auto/biographical narratives about HIV and AIDS. Therefore, we also note that these new narratives or “effects of HIV”, as situated or contingent results, are the product of collective activities with many actors, both human and non-human (Race, 2012, p. 327).

The attentive reading and thematic analysis of the study narratives were also based on dialogue and discussion between the researchers in their efforts to articulate the utterances regarding promiscuity, taking into consideration the articulation of this theme within the same story and in dialogue with the other voices, from our research, culture and history. This was an eminently dialogic process, not only in order to understand the many voices that produce this moral thematic narrative, but also to include the collective reflections of the researchers, analysing and narrating, like the participants, in the contemporary Brazilian context.

We have used fictitious names for all the interlocutors throughout the article, as part of our ethical commitment to the anonymity and confidentiality of information.

### **Promiscuity in focus: following HIV diagnosis**

The fear of rejection is felt by many people living with HIV, including in Brazil (Giacomozzi et al., 2019; Simões, 2018), and taking into consideration different narratives from our research. If the possibility of transmission, albeit a remote one given an undetectable viral load still remains frightening and present in relation to the existence of HIV, among gay and bisexual men, such feelings may be articulated through an image of homosexuality as unrestrained. This aspect appears strongly in the narrative of Alex, a white, 22-year-old gay man who works in a call centre, lives in a low-income neighbourhood and was diagnosed with HIV in 2017. During the conversation, Alex talked about one good thing that the disease brought him, in the sense of imposing limitations on what he could do; and further, of focusing and being sure of what he would do before doing it. In this sense, although he sought to minimize the limitations imposed by the disease, Alex also sought to emphasize limitations in relation to the way he lives.

If disease narratives, particularly those about chronic diseases, speak of the ruptures, discontinuities or even resignification of a way of life (Riessman, 2015), we cannot overlook the fact that the existence of HIV and AIDS also appears to bring up aspects of sexuality that are considered dangerous or promiscuous (Squire, 2010). As Alex notes, even in the presence of condoms, or when recognizing that AIDS is not only a disease of homosexuals, by associating most of the gay population with easy sex, he did not take care of himself. So Alex emphasizes that now he cannot do everything he would like to do:

[...] Because, like, I was even playing with him [the psychologist], I had a really crazy life, I did what I wanted to do, not really – not that I took drugs or anything like that – but, like, I sometimes had sex with people I didn't really know, even if we used condoms and all. It wasn't anything advisable for anyone. And it's something that I always had, but I didn't put into practice: sexual relations are when you know someone and you trust that person enough. But sometimes, like, I talked to someone – and I think that most of the gay population functions like this, unfortunately – at the most one week later the person already knows the other person sexually, when it's not on the same day, and it's not cool. Unfortunately, I ended up falling in with that crowd and I didn't take care of myself properly. I don't know how I got it and finding out how I got it isn't going to change anything. So, what I can do now is take care of myself and impose limitations [...]. I need to do what I can do, within my own limits. And obviously, I can't investigate someone and ask them to have an HIV test, or a hepatitis one, or whatever. But there are, yes, precautions that we always have to take, a condom, all that involves.

To fall in with that crowd suggests a movement towards a loss of rationality, control or limitations, especially in relation to sex. These are the images or movements that now appear to redraw the health care, following the discovery of HIV. Certainly, although the virus is permanent in the life of HIV positive people and requires periodic check-ups, many other things happen and begin to happen in the lives of people living with HIV. One may say that, following the shock or impact of an HIV diagnosis, one has to learn to deal with the new positive status, at the same time as other life events and dilemmas may occur, when the HIV may no longer be the only protagonist. When new possibilities for dating or relationships appear, HIV returns to the scene and these dilemmas, fears or conflicts re-emerge.

In Alex's case, at the time of the interview, the diagnosis was recent. However, during the conversation, he mentions a series of important concerns and events in his current life, which appear to push his HIV into the background: family relationships, professional choices, inclusion in the world of work and financial independence. At the same time, he highlights certain new priorities, which have begun to take the place of dating and sex. This makes us consider how much his HIV infection still mobilizes him, to the point of avoiding the possibility of a relationship. Paradoxically, while at a certain point in the interview Alex says that his sex drive simply stopped after the discovery of HIV, at another point, he recognizes that he still has desire, although there is now a need to establish a new profile or priorities:

After my HIV diagnosis, I didn't have any more sexual relationships. Some people wanted to have sex with me, but I didn't want to, because, firstly, I don't think it would be safe for me, or for the other person. I didn't tell them either. The only person who wanted [to have sex] who I told is a friend of mine. I explained the situation to him, I said that I didn't intend to have sex before being sure that I could, that it would be safe and that I was going to begin treatment. He's supported me, he's helped me a lot in relation to this. I still have desire, like anyone who wants satisfaction in their sexual desires, only for me it's no longer that thing where I have money in my hand and go out to do it, because my priorities aren't like that now. Now my priority is to leave home, my job, my independence and to live in peace. But my granddad got ill, my mother got ill, the problem with work, I got ill and one thing led to another.

Alex says that, following his diagnosis, he did not have sex, that his sex drive simply stopped, that his passion had died. However, at the same time as reporting that he used to be a very passionate person, he also says he would not just go with anyone. To some extent, this appears to involve an effort to differentiate himself, or not be completely identified with the image of easy sex. As we will see in other narratives, Alex highlights the current need for vigilance and continuous care, not only in the sense of caring for his own health, but particularly of not being responsible for a new virus transmission. He asserts that today he will not transmit the disease (he had an undetectable viral load), but that this could happen if he had sex without a condom and if his viral load was very high. During the conversation, he notes that with the HIV positive diagnosis, he became worried if he had really passed it on to anybody. Therefore, Alex began to look for people he had had sex with, but they seemed to be well. In this sense, he says that today he has to be on his guard and take care not to pass [HIV] to anyone else.

Regarding this image of the dangerous subject and more precisely when focusing on young people living with HIV, it is important to highlight an aspect that appears to be present in discussion groups (both within and outside health services) - that is, the idea that bodies infected with HIV are dangerous bodies (Cunha, 2012). Therefore, it is seen as necessary to control them through education about their sexuality (Cunha, 2014), suggesting denial of exacerbated and uncontrolled sexuality and a responsibility not only to oneself (to prevent and treat) but, particularly, to others – in other words, to live with HIV without disseminating the virus. These images of “dangerous bodies” and “risky subjects” seem to persist, despite biotechnologies advances (Silva, Duarte and Lima, 2020)

In this discursive trajectory about sexual practices, references to the promiscuous gay are frequently used to recall the hierarchy of sexual values, separating “good” from “bad” sex (Rubin, 1984). Even within homoerotic practices, therefore, the image of promiscuity serves to categorize gay lifestyles and identities between, for example, those that are promiscuous and those that have a more “healthy” relationship - balanced, normal, rationalized, self-regulated. These are discourses that may produce more stigma and barriers to healthcare in a scenario that individualizes

and blames some for the infection/transmission of the virus, while at the same time marginalizing practices and behaviour that do not conform to hegemonic heteronormativity – a political dimension of social organization which takes heterosexual standards and models as its principle (Gamson and Moon, 2004; Seidman, 1994).

It is worth noting that we also found reports in the literature indicating that HIV infection among gay and bisexual men is often represented as a matter of deserving, a kind of punishment due to immoral behaviour (Jeffries et al., 2015). There are other negative and stereotypical images linked to homosexuality which may hinder access to services and healthcare, such as the idea of homosexuals as “social deviants, adept at reprehensible or dangerous habits” (Miskolci, 2015, p. 82), or even that male homosexuality is linked to “sexual desire devoid of bonds” (idem, p.75).

### **Dilemmas about HIV transmission and new biomedical performances**

As some narratives from our research show, the experience of HIV makes one rethink or consider some of these dangerous images and those related to a lack of control in relation to oneself and to the other. Further, they also attempt to demarcate a boundary which distinguishes some of these young people from a certain other (an ex-boyfriend, for example) - unfaithful, promiscuous, irresponsible and to be blamed for the infection. Unlike other chronic diseases, the act of revealing one's HIV positive status also delineates differences between people, in that the revelation appears to be associated with ideas of integrity and honesty (Flowers and Davis, 2012). In this scenario, to varying degrees and levels of nuance, reports of promiscuity, easy sex, excesses, lack of control or indiscretions will appear to be responsible for the existence and circulation of HIV and are often also used to support the discourse of healthcare and prevention itself. At different times, such images may be updated, mobilized and triggered in the daily lives of these young people, including in their participation in/performance of tests/procedures and from the perspective of their healthcare professionals, and are able to concentrate (and individualize) those responsible for the infection.

In order to further discuss the scenario of practices taken to be excessive, we now come to the story of Andre, 26 years old, white, who lives in a low-income neighbourhood with his mother and works as a salesman. He brings to the scene, or locates, another as responsible for HIV's transmission, which he discovered in 2016. Andre tells his story of infection based on a partner he had for more or less one year and eight months. He also talks about a “stupid thing” he did by having sex without a condom before he took the HIV test. According to Andre, he generally only began to have a more intimate relationship with other partners after they had both taken the test:

[...] And with him, I don't know why, I didn't. So, we began to have sex without a condom, and he began to have certain symptoms, I began to get a bit hung up about what these symptoms could be. So, my 'brother' [from *Candomblé* religion, an Afro-Brazilian religious tradition] came up to me and said: "look, let's go and have the test, because I think your partner maybe has HIV". So, like, I hadn't thought of it, right? And then I discovered that I was positive. And then I went and told him. According to him, he didn't have it, he didn't know he had it. According to him, he found out about the result then too, right?

Andre also says that he stopped trusting his partner because of his health condition, but when asked, his partner said that it was gastritis. When he stopped trusting his boyfriend, he reports that he went back to having sex with a condom, but, according to him, it was too late - when he took the HIV test, he was already infected. He also stresses that he was asymptomatic and did not feel anything. In a conversation with his doctor, because of his CD4, CD8 count and low viral load, she said that he might have been recently infected. Following this discovery, however, he reports a series of events that made him change his image of his partner, ending the relationship:

[...] So I went there and I sat down with him, I talked to him. In fact, I wanted him to be sincere, if he had said: "no, I was, I was HIV positive, I didn't know I was HIV positive and by the time I found out I was already with you and then I got scared, I'm sorry," something like that. But, no. And after that, other things happened in the relationship. I discovered that he had syphilis – but I didn't contract syphilis. I discovered that he had other problems as well, psychiatric problems, other social problems. And so it finished.

During this conversation, in order to justify or conclude that his partner was responsible for his infection, Andre adds and brings up a number of elements to support his convictions. As well as the test results (CD4, CD8 and viral load), his mother's and his doctor's opinions emerge and these make him rethink a set of behaviours by his partner, which appear to be associated with the HIV transmission:

Because, it's like, you don't discover HIV overnight, you start having symptoms. And he, from the lifestyle he had before – it's not that I want to accuse him of anything, you know – there's a high chance. And so I discovered it later... I immediately told my mother, right, I opened up to my mother, I talked to my mother and she said to me: "look Andre, it was so-and-so", because, it's not that HIV has a particular characteristic or a form, it doesn't have anything [like that], but his behaviour made her believe it.

This behaviour in relation to unprotected sex, therefore, acquires new meanings (and effects) once it is linked to other elements and actors. In the case of gay and bisexual men, for example, such practices are regarded as promiscuous, disorderly or uncontrolled and will situate, distinguish, rank or classify these very people. In this sense, Andre classifies his partner's behaviour as "promiscuous":

Till then, I didn't know. Till then, to me, he was a great guy, to me, he was a guy I was going to have a long-term relationship with. Then, once you find out, the person begins to reveal themselves. And this really upset me, because, till then, he didn't have the same level of promiscuity that he had – at least I didn't know that he had. So then, once I began to find out about

these betrayals, I began to find out about the other things he did, I began to see another type of partner, which, if I had seen before, I would never have got involved.

As well as this emphasis on his partner's promiscuity there is another important point in Andre's narrative worth noting, which seems to be crucial when we consider new and old narratives regarding HIV and AIDS, which at times persist, are triggered or reconsidered, and at others are produced in unprecedented ways through new resources, language or biomedical technology. From this perspective, the point we would like to highlight here, concerns the participation of doctors, tests and results (CD4, CD8, undetectable viral load, dates, etc.) in (re)asserting the type of infection: "because my doctor is very sincere and she told me that due to my CD4 count, my CD8 count, my viral load, everything appeared as if I had caught it recently". Certainly, these new aspects enter into contact with and are linked to the production of such discourse and of subjects (who was infected, who can transmit the HIV virus and how the infection occurred), which, for its part, moves from and beyond these resources.

Although the objectives of these tests/technologies are initially not to indicate or identify subjects or those responsible for the transmission, in our interlocutor's narrative the test results and the testing, as well as the technical discussion about these results were linked, repositioning his partner within his HIV story. If there had been a suspicion that he had been responsible for the infection, based on indices of promiscuous behaviour, now, with such material elements it appears to be difficult to support or maintain the relationship based on a (subjective) agreement of trust. These narratives are about the self (and the other) which appear to be produced differently, based on and with these new elements. They are subjects and diagnoses differently performed through these new resources, which, for their part, may mobilize and/or fix negative images and values in relation to specific subjects and practices.

Different linkages and multiple effects therefore also mean that some people may be seen as more responsible for prevention or guilty of not protecting others. In this new AIDS scenario, in which technologies are available and through which a new range of information and bioethical discussions circulate, including the participation of different actors, such as the criminal law (Race, 2012), responsibility will be differently produced or performed. What appears to be in play in this production about what constitutes HIV infection, is morality regarding sexuality and particularly sex between men.

### **Regarding sexual relations and practices: complexifying the scene of infection**

Narratives about promiscuity, lack of control or excess in relation to sexual practices between men, often mixed with feelings of guilt or regret, may simplify, fix or naturalize the causes of HIV infection/transmission, producing greater stigma in relation to homosexuality. Such stigmata, like

derogatory stains (Goffman, 2015), appear to intensify vulnerability to HIV and AIDS, setting aside other difficulties and actors who complexify the scene of infection. In this sense, it is worth considering the narrative of Lucas, a 27-year-old university student who defines himself as gay and mixed race, and who lives on his own in a low-income neighbourhood.

Certain points in Lucas' story are worth highlighting. One such aspect refers to fascination and wonder about his new sexual discoveries after leaving an inland city to study at university in Salvador. Lucas says that ever since he moved to the state capital he started having sexual relations with a lot of people and that he always felt that there was a possibility of catching HIV. He reports that he really became certain following an HPV diagnosis. This strong sensation that he had HIV meant that he was not that shocked when he received the test result in 2015:

I was always policing myself, forcing myself to say to myself, “you have to have the test, you have to have the test to find out what you have”, because I felt that I already had it, even before the test. So, at some point I went to the health centre here in my neighbourhood and I had the test there – that test that people generally have during carnival – and it came out positive. So, she referred me to the treatment centre, there at the CTA [Referral Centre] and then they did the more detailed test and it showed that I had HIV. But, as I told you, before this, I already had – this was in 2015, when I discovered that I had HIV – before this in 2014, I got anal warts. Then I went to the proctologist and the proctologist discovered that it was HPV. So, since then I really became certain that I had it. Since I'd this strong feeling that I'd had HIV for a long time, since 2013, the result didn't shock me that much, I had prepared myself, psychologically, to deal with this situation.

When narrating his journey, Lucas draws attention to the limitations imposed by his family and evangelical religion during his adolescence and his “naked lust” for the novelties (and magic) that opened up for him far from his inland city. He highlights his discoveries, wonder and fascination for new possibilities and the plurality of men, to the point of a certain type of imaginary gay man, letting himself go along “with the music that was playing” and agreeing to everything that other people requested:

[...] I am someone from an evangelical education, I was born and brought up inland, I was born within the church, I am an only child and everything was always repressed. My mother created a bubble around me, to protect me from everything; I couldn't go to the neighbouring city on my own, there were so many prohibitions in my life. I lived in my bedroom, in a closed world, where I tried to find out about new things. I gained access to the internet when I was 16 and I began to watch pornographic videos and then my imagination began to develop, based on that. Until, one day I took the initiative to take the university entrance exam – this was in 2012 – and I passed, and in 2013 I moved to Salvador. When I got here, it was all magical to me, because what I had seen in the videos, the sexual education I had got from the videos at that time, in my adolescence, I found all that here. I found wonderful men, with wonderful bodies, with masculine mannerisms, like straight men, who approached me and I couldn't resist it. And with these approaches, I was weak and thought it was much more natural, much more pleasurable, I ended up having sex without a condom because of my naked lust, because I didn't have the sense to know what might happen, because we had always learnt that you have to use a condom, OK, but at the time, see, it's very different. [...] So, basically it was not so much a question of my choosing to have sex

without a condom, because my conscience says I should have [sex] with [a condom], but the moment was so surreal to me, it was something so beyond my normal experience, inland, that I ended up letting it happen and having sex without a condom and I accepted it as normal, I always agreed to everything because for me I had to be there to serve the person who was having sex with me.

By bringing other voices into the narrative, those of his parents, Lucas is not seeking to make them responsible for his HIV infection, but is drawing attention to a lack of support and conversation regarding his homosexuality. According to Lucas, if this support and conversation had taken place, perhaps his story would have been told in another way: “if I had had support from them (his parents) regarding to my homosexuality, if I had had their instruction regarding HIV and protection, I think these things would have been a bit different”.

Certainly, if stories (and lives) are open and unpredictable, as well as the care practices (Mol, 2008), produced according to a flow of encounters (and relationships), Lucas’s narrative also reminds us that health care practices (and HIV and AIDS prevention) are socioculturally situated and materially mobilized by a range of resources, which may enable or limit the care itself. In this way, even though it is not always possible to use a condom (Terto-Jr., 2002), and even though, particularly in relation to sexuality, we are not always guided by rationality (Carballo-Diégues, 2001), we cannot overlook the fact that the moral boundaries that organize behaviour and people, the separation of what is taken as “natural” on the one hand – heterosexuality - from what is “deviant” on the other – homosexuality - may adversely affect people’s health and well-being. If there are possible openings for other stories and positive reports of discovery and belonging to a gay group or community (Plummer, 1995), HIV infection may still appear to make one rethink or highlight certain tensions and difficulties regarding homosexuality.

Based on Lucas’ report, we cannot neglect a type of body or homosexuality that appears to be less socially valued. Alongside his surprise at the possibility of the existence of other images of gay men who passed as heterosexual men (with the mannerisms of a masculine/straight man) we stress that bodies which present as more feminine, which are considered affected or effeminate, are bodies and ways of being that appear to be more rejected or devalued in the sociability network, in meetings and friendships. In contemporary new scenarios, which include interactions mediated by the computer/internet, if there is an opening up to new forms of sexual and emotional interaction between men, including beyond the active-passive polarity (Braz, 2007; Silva, 2009), there is also a devaluing and/or rejection of men who are considered affected, “fags”, “queers”, effeminate (Silva, 2009), valuing the more discreet, who are “manly”, “healthy” or masculine (Miskolci, 2015). These bodies and relationships, therefore, are guided by heteronormative models that value the attributes of bodies taken as more masculine to the detriment of bodies with feminine qualities, seen as more open, permeable, fluid and uncontrolled (Grosz, 1994). In this

sense, the muscular/masculine body appears as the opposite of the “thin” and “fragile” body, an image still linked to “effeminacy”, “lack of strength”, and the tendency to “get ill” (Miskolci, 2015, p. 83) – including with HIV. As Lupton (1998) notes, it is no wonder that the idea or possibility of a man’s loss of control over his body may produce feelings of hatred, repugnance, humiliation and horror, and therefore the fear of being assimilated (or confused) with the other side of the border, with non virility or the feminine.

It is important to remember that homosexuality, as a modern social invention (Foucault, 2001), falls within a set of institutional and discursive practices that demarcate the moral boundaries between legitimate and illegitimate sex (Seidman, 1994), causing new and different descriptions of subjects to emerge and shift. In this sense, what may be tolerated, assimilated or taken as normal can be understood according to a “positive” and “political” conception of normalization. As Foucault (2010, p. 43) notes, “the norm brings with it a principle of both qualification and correction [...] linked to a positive technique of intervention and transformation”. Therefore we are talking about bodies and sexualities that reproduce and conform to acceptable and possible bodies, modelled on “heterosexual hegemony”, while others are despised, marginalized or relegated to abjection (Miskolci, 2015).

## Final considerations

We have argue here that the negative images, marks and values that stigmatize people and lives, as is the case with the moral discourse about promiscuity, have an effect on the prevention and care/treatment of HIV, in that they fix, naturalize and individualize the risk of infection/transmission, ignoring the unequal distribution of resources (both material and symbolic) and the difficulty some people have in living and negotiating pleasures and practices. In this perspective, we are also talking about bodies (and pleasures) which are not neutral and which may be seen and lived as promiscuous and/or dangerous. Clearly, there are discourses that (re)produce, burden or value these bodies differently (Butler, 2008).

Based on the narratives highlighted here, we have sought to consider the way in which promiscuity appears in the stories of young gay and bisexual men, reproducing and reifying the risky subject to HIV infection. As discussed, promiscuity appears to play an important role, an “actor” that leads to, makes a difference or defines the scene of infection. Certainly, there are other elements that complexify sexual and emotional relationships and, therefore, prevention itself. However, such elements may remain in the background. At the same time, this positioning as promiscuous reproduces stigma, hindering engagement in new relationships and generating further suffering. On the one hand, HIV and AIDS activism has involved efforts to shift the image of HIV and AIDS from (promiscuous) gay men and homosexuals seen as responsible for the epidemic. On

the other hand, some narratives appear to suggest that the idea of easy sex and promiscuity associated with gay men persists, and hinders the reconstruction of new sexual and emotional relationships following the discovery of HIV positive status.

Paradoxically, efforts to dissociate an image of promiscuity from gay men also seem to have contributed to “normalize” ways to live, considering a heteronormative ideal. As Seffner (2011) argues, while LGBT communities have conquered some rights, they also have been more assimilated to a certain “correct” and “acceptable” model of being LGBT people, reducing spaces of freedom and experimentation.

It is noteworthy that in Portuguese (as in English) the word *promiscuity* means “the state of being promiscuous; an indiscriminate or haphazard mixture”. In these terms, someone who is promiscuous may be someone who confuses or transgresses “the order of things”. In other words, they are guided by “impulses”, “desires” and “passions”, mixing with others, losing the rational dimension of “who we are”. References and discourse about promiscuity, therefore, separate and re/organize moral subjects and re/orient behaviour and practices (Silva, 2010).

In addition to hindering the search for healthcare, some of the negative values and images linked to HIV and AIDS may adversely affect access to new prevention strategies. This is the case, for example, when PrEP use is linked to an image of “unbridled homosexuality” (Race, 2015). As Race argues (2015), there is a fear and a certain dread of the possibility that, with PrEP, what appears to be an “exception” will become a “rule”, allowing a return to “unbridled” sex between men. In this sense, PrEP forces people to deal with something that scares them, in relation not only to risk, but also to sex, from the “apparently terrifying prospect of unbridled homosexuality” (Race, 2015, p. 17).

All these discussions open up new challenges for HIV prevention and care practices beyond the moral discourse, which marginalizes specific people and behaviours. At the same time, it is important to advance an open discussion about pleasure, eroticism, human rights and HIV with young people in a range of contexts, such as schools, communities, etc. Such discussions have been neglected and weakened in recent years in Brazil (Seffner and Parker, 2016b), by voices from the past, which have returned to produce strong echoes in the present, making projects and lives unfeasible and which could considerably hinder other forms of negotiated protection beyond condom use, given the diversification (and complexification) of practices, prevention methods, choices and situations (Terto Jr., 2015).

Certainly, such reflections must be added to the agenda, particularly so that moral discourses and values are not supported or reproduced through a scientific and epidemiological repertoire regarding HIV risk factors, which includes the number of sexual partners, without reference to an individual’s or group’s situation or context of vulnerability. We cannot simply fix or generalize

these “factors” without understanding how and in which situations (and interactions) such vulnerabilities occur and are produced, or how certain lives are constructed “as lives that do not matter” (Seffner and Parker, 2016b, p. 298)

Finally, we need to remember that the field of HIV prevention and care has evolved and does involve many heterogeneous elements and actors, including discourses and traditions that clash with each other. As well as demanding of ourselves (scientists, professionals and activists) a permanent imaginative state of openness in thinking about and connecting knowledge and political action, we need to recognize that these elements (viruses, people, meanings, institutions, technologies etc.) operate together and mutually affect each other. In this way, we should consider prevention to be something that is “ontologically open”, whose interactions produce multiple effects and “functionalities” (Rosengarten and Michael, 2010). This means that we have to make a collective effort to overcome some dichotomies, for example, between nature/culture, good/bad, in order to understand the ramifications of these interactions, as well as to maintain our collective and cooperative persistence in caring for life.

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