

Moving Beyond Biomedicalization in the HIV Response: Implications for Community Involvement and Community Leadership Among Men Who Have Sex with Men and Transgender People

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As the world enjoys the promise of biomedical advances against HIV, numerous challenges remain. Some of these are connected to politics, others are connected to resource constraints. Other barriers are linked to the need to ensure that the concepts used to think about HIV remain current. Terms such as “MSM” (men who have sex with men) and “community” require critical interrogation at a moment when their political origins seem forgotten. Likewise, struggles between groups most affected by HIV and scientists and policymakers (an enduring feature of the epidemic) remain a key aspect of the response. The dangers of co-option and distraction remain real. In this context, it is vital to promote community ownership, political commitment, solidarity, and respect for differences, not as competing values, but as part of the ultimate solution to HIV. (*Am J Public Health*. 2015;105:1552–1558. doi:10.2105/AJPH.2015.302614)

Anyone who has worked internationally on the HIV epidemic knows the importance of politics,¹ and how the way in which the issues are framed influences the ability to address them effectively.² It is of vital importance, therefore, to think critically about how best to describe the global HIV epidemic and the challenges it poses. It is also imperative that we think critically about the need for a major switch from the discourse of 3 to 4 years ago—from an earlier vision of “doom and gloom”—to a more optimistic outlook.

It is also important to recall the lessons of history in relation to global health and development. We cannot help but remember the misplaced optimism in relation to the Declaration on Health for All by the Year 2000, adopted at the International Conference on Primary Health Care held in Alma-Ata, USSR, in 1978,³ and the World Declaration on Education for All that emerged from the 1990 World Conference on Education for All in Jomtien, Thailand.⁴ The world is still far away from both health for all and education for all.

What then are we to make of the targets regularly announced by UNAIDS, such as “Getting to Zero” by 2015,⁵ “90-90-90” by 2020,⁶ and “the end of AIDS” by 2030?⁷

What are we to make of the promises of biomedical advances and the prospects of “an AIDS-free generation” we heard about at the 2012 Washington AIDS Conference⁸ and the 2014 Melbourne AIDS Conference,⁹ which is a promise that seems to provide the foundation for such optimistic target-setting? Increasingly, as we listen to these slogans, we cannot help but wonder if the time has not come for a little more realism as the world struggles to develop meaningful strategies to address the epidemic in the midst of its fourth decade.

The grim reality is that in many contexts, rates of new infection among gay and other men who have sex with men (MSM), among transgender people, and among numerous other socially excluded groups, are not on a steady decline toward zero, but instead, these rates are rising rapidly.^{10,11} The same is true for the notion of zero discrimination. Particularly, in parts of Africa, in Russia, and in India, as well as in Central Asia, there is evidence of increasing hostility toward sexual and gender minorities and people living with HIV. This hostility is sometimes fueled by claims of the “unnaturalness” and “foreignness” of the behavior and is often encouraged by politicians and religious leaders.^{12,13} In some cases, a new

wave of repressive laws amounts to nothing less than state-sponsored discrimination and should be understood as such.

As for the notion of zero AIDS-related deaths, it is true there have been remarkable advances for those who have access to the most up-to-date medications and good quality health care. However, many people still lack complete access to these or are in receipt of outdated regimens with debilitating side effects. In addition, relatively few rich countries have followed the lead of the United Kingdom in making access to antiretroviral therapy non-dependent on migration status. UNAIDS itself currently estimates that no fewer than 22 million people currently lack access to the treatment drugs they need, which is nearly twice as many as those who currently have access to treatment.¹⁴

Therefore, even the most general overview of the global HIV epidemic in 2015 suggests that almost none of the various slogans and targets devised to inspire the global response come close to providing an accurate picture of the challenges that confront us. Instead of being provided with a realistic portrayal of the current situation, we are invited to enter into an *Alice in Wonderland* world in which most everything is the opposite of what it claims to be. Because of this, there is an urgent need to think critically and more realistically about the current status of the epidemic, and to seriously consider: where are we now, what have we learned, and what needs to be done?

This is obviously a large and collective undertaking that must involve wide participation by researchers, policymakers, advocates, and others, and it is a task that goes far beyond the scope of 1 short article. However, it is a task that has to begin somewhere, and our goal is to make a modest contribution by focusing on the important challenges for community

involvement and community leadership in responding to the epidemic in the 2 key populations we have worked with extensively since the earliest years of the epidemic: gay, bisexual, and other MSM; and transgender persons.

In thinking about the challenges facing these communities, we focused on 3 different but related sets of issues: (1) the continuing importance of context (time and place really do matter when it comes to responding to HIV), (2) the limits of present terminologies and understandings (the social world is changing faster than the available terminology), and (3) the need to rethink the idea of “community” in certain respects, and to rediscover instead a challenging new politics of HIV.

If we fail to address these important social and political concerns, no biomedical advances, no matter how remarkable, and no policy or program objectives, no matter how inspirational, can ever succeed in bringing about an end to AIDS, whether for these populations or any others.

CONTEXT (STILL) MATTERS

The last 15 years have seen a progressive push toward what some call the science of HIV, the science of HIV prevention, the science of treatment and care, and the science of HIV-related stigma reduction. This emphasis on the importance of “science” and on the evidence that science produces led to the commissioning of systematic evidence reviews during the early years of the epidemic, later to community trials, and more recently, to varieties of “behavioral intervention science.” Behind all of these initiatives is the pursuit of interventions that work, regardless of who conducts them, where, when, and with whom. The belief is that there are fundamental aspects of human behavior, and perhaps even of “mind,” that remain constant, regardless of context. If only scientific investigation can discover these, then we will be able to develop “recipes for success” or best practices that can be applied anywhere, with much the same effect.

The result of the search for these successful approaches was the development of a set of techniques and methods that have dominated policies and programs during the last few years. Information education and communication,

behavior change communication, voluntary counseling and testing, and couples counseling were some of the earlier policies. More recently, they have been superseded by “test and treat,” “circumcise,” and so on. Importantly, although these latter approaches have often been described as biomedical interventions, they are not really such at all. Each of them requires people to understand, act, comply, and adhere, all of which are profoundly social practices and behaviors.^{15,16} It is naive to think that any of the currently promoted biomedical interventions could be implemented without consideration of their social dimensions and the social context; many proponents realize this. However, when their proposed use is translated into technical “guidelines,” context frequently disappears. In addition, when technical guidelines are translated into media reports, that are, in turn, interpreted and taken up (or not) at the local or grassroots level, oversimplification and even outright misinformation may follow.

No clearer example of this exists than what took place with the publication, immediately before the 2014 Melbourne World AIDS Conference, of the World Health Organization’s *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*.¹⁷ This almost immediately led to inaccurate reporting and to the claim that all members of population groups (e.g., MSM and transgender persons) should immediately initiate HIV pre-exposure prophylaxis. Although the guidelines themselves were more nuanced, the process through which the World Health Organization arrived at these recommendations was not transparent, and the ways in which their launch was mishandled and the message oversimplified played into an ongoing tendency to erase significant social differences, and to fail to perceive the lived realities of the some of the communities most affected by the epidemic.

The key problem here is not merely the inaccuracy and misunderstanding that too frequently occurs in the translation of research findings into policy recommendations. Crucially, recent efforts have taken the expertise from the users, consumers, and communities most affected by the epidemic and placed it instead in the hands of an ever-narrower group of experts. This “theft” threatens to undermine

one of the most important outcomes of 3 decades of AIDS activism: namely, the recognition that affected individuals and communities also produce knowledge and possess expertise, and that the democratization of science and the involvement of lay outsiders is as important as the contribution of scientific insiders in successfully responding to HIV.^{18,19}

This progressive narrowing of what was once an expanded understanding of expertise is especially visible in the International Conference on AIDS. Teachers, educators, community workers, social workers, sociologists, and anthropologists are increasingly absent from the meetings, which are held every 2 years. There are many reasons for this, including the high cost of registration, the expensive locations in which the conferences are held, and the fact that members of these groups are unlikely to be asked to speak in major sessions. Consider, too, the titles of conferences themselves. Once, these stressed the social and political dimensions of the epidemic. The Fifth International Conference on AIDS in Montreal, for example, the first conference at which people living with HIV “sat at the high table,”²⁰ was subtitled “The Scientific and Social Challenge of AIDS,” and the sixth International Conference on AIDS in San Francisco was named “From Science to Policy.”²¹ More recent conference titles delight in bland abstraction: “Turning the Tide Together” in 2012,²¹ “Stepping up the Pace” in 2014,⁹ and even “Logo Wanted” (as of January 14, 2015, at least) for AIDS 2016.²²

In addition, tracks have been renamed, prevention has been moved from the social sphere into epidemiology, and “intervention research,” “translational research,” and “implementation science” have replaced a focus on effective programs. Activist responses are now carefully contained in the side events in the Global Village, helping to guarantee the safety and security of well-guarded pharmaceutical industry exhibition booths, and assuring that civil society representatives lucky enough to be asked to participate in scientific sessions have been hand-picked by the scientific experts.

This progressive sleight of hand means that instead of figuring centrally in a conference such as AIDS 2014, events addressing the concerns of affected communities, such as gay men, other MSM, and transgender people now take place in satellite events such as the Global

Forum on MSM and HIV Pre-Conference Meeting. The real scientific program can then be organized by the scientific experts, free of contestation, and without inconvenient disruptions. None of this is entirely new,²³ but it continues apace, because the response to the epidemic on the part of experts and administrators takes precedence over that of affected communities and meaningful engagement with the social dimensions of the epidemic. Put succinctly, this removal of the “social” means, as Gary Dowsett recently said, that “human innovation becomes replaced by formulaic imposition” (personal communication, July 14, 2014).

By contrast, we want to emphasize that when, where, how, and by whom an action takes place really do matter. When things work, it is usually because the communities and individuals involved make them work, rather than because wise scientists—be they biomedical or behavioral—have hit on a “bright idea.” Most importantly, we want to call attention to the fact that there is an intense politics of HIV at play—now just as in the past—that seeks to privilege certain understandings of what to do in response to the epidemic and systematically downplay others. HIV is and remains one of the most political of diseases.¹

LIMITS OF PRESENT TERMINOLOGIES AND UNDERSTANDINGS

Nowhere is the deeply political character of the response to HIV so clear as in the uncritical use of language deployed to talk about the epidemic. More than 25 years ago, Treichler described HIV and AIDS as “an epidemic of signification.”^{24(p263)} Yet as time has passed, critical reflection on the problematic use of language has waned. Now more than ever, it is important to ask whether the language and the concepts we use to talk and think about HIV are up to the task.

Categories

We focus here on one especially problematic term—MSM—to demonstrate what we mean, although we might also focus on other terms such as MSW (sometimes used to describe men who have sex with women, but which is also sometimes used to designate men who sell sex), MSWM (men who have sex with women and

men), and even MSTW (the male sexual partners of transgender women).

The term MSM was invented quite early in the epidemic in the United Kingdom (and not, as is sometimes claimed, in the United States). It was not originally coined by epidemiologists (which has also been sometimes erroneously suggested).¹⁰ Its first use was by London HIV activists such as Peter Scott, who wanted to distinguish between reasonably articulate gay men, who were relatively self-confident about their sexual identity, and “other” more closeted men, who, it was believed, could potentially be reached by HIV prevention methods through a range of “community-attachment strategies.”^{25–27}

We both took part in meetings at the time (in locations as diverse as London, UK; San Francisco, CA; Geneva, Switzerland; and Brasilia, Brazil), in which participants discussed the limits of earlier biomedical (and psychiatric) terms such as “homosexual” and “bisexual,” which very few men identified with. Other categories were also considered, such as the then popular Australian term “gay and other homosexually active men,” but such terms were found wanting. In the end, the term “men who have sex with men” was adopted (although not the currently used acronym MSM; the original acronyms were MWHSM and later MeSM).²⁸

Crucially, the term MSM was not initially an inclusive one. Instead, it described those men who could not be considered (and did not consider themselves to be) gay. Nor was it intended as an identity category. In many cases, the term seemed to imply neither inclusion nor identity, but served instead to designate specific segments of a broader social universe rather than the whole of what would later be transformed by epidemiologists into an overarching behavioral category.

Currently, things are quite different. Being gay has changed enormously in some contexts, with marriage equality and a degree of openness on the agenda in Canada, parts of the United States, in many European and Latin American countries, and in New Zealand.²⁹ In other countries, however, little has changed; homosexual acts and homosexual love are still viewed as immoral, a crime, or a “perversion.”

However, with the many changes that have taken place, there has been a dramatic growth in new identities, subjectivities, and subject

positions, signaling a major fractioning of what is sometimes described as a gay or MSM community. The early work by Khan³⁰ in India, for example, pointed to the existence of different groups of men who have sex with men in that context; these included, but were not restricted to “panthis, kothis, and double-deckers.” In parts of East Africa, local categories such as “mashoga” and “mabwana” remain strongly salient.³¹ In the country of Georgia, multiple categories based not on identity, but on situational and circumstantial factors have been highlighted.³² Across all contexts, many of these categories highlight the role of gender in structuring sexual relations between men, with feminized men often adopting a “receptive” role in oral and anal sex, and more masculine men (at least in public) characterizing themselves as “insertive.”

Building on such work, research has shown how race, gender, class, and age influence the forms that sexual and gender identities take, both in high income, as well as in middle and lower income settings. However, the key message remains the same: there is no one group of people we should embrace and involve in HIV-related programs. Rather, a burgeoning multiplicity of subjectivities and practices needs to be engaged. Crucially, people differ both in their gender identification (as women, as men, as neither) and in their sexuality. Gender and sexuality, although related, are not the same thing, and they are not necessarily fixed or unchangeable.³³ By contrast, they are often in flux. For example, many men who may think of themselves as gay or transgender today did not always see themselves that way, and what seeing oneself as gay or transgender might mean in terms of sexual experience and sexual practices varies greatly.³⁴

Any uncritical extension of categories such as MSM and increasingly transgender in AIDS discourse ignores the importance of differences in sexual culture and sexual practice, and conflates identities and practices, as well as sexuality and gender, through a series of unexamined assumptions. This is even more evident in relation to transgender populations than among MSM, precisely because in relation to HIV, the category of transgender women initially emerged as what was perceived to be a subpopulation of MSM (cases of HIV infection among transgender women initially were, and

in many places still are, categorized epidemiologically as cases of transmission among MSM). Significant differences in experience and practice that lead different transgender women and transgender men to distinguish between someone who is transgender, gender bending, gender variant, gender nonconforming, gender queer, or any number of other variants, are often dismissed even by well-intended public health experts, who easily ignore the processes of gender transition and the cultural contexts in which these take place. These are processes that highlight the fluidity of attraction and desire, as well as sexual practice, and the very real complexity in the constitution of sexuality, sexual orientation, and gender identity.³⁵

One of the most striking ironies is that in the 1990s and 2000s, social research clearly documented significant diversity among gay men, bisexuals, and other MSM, as well as among transgender persons.^{36,37} However, at the same time the adoption of the categories “MSM” and “TG” (an acronym that is sometimes used for transgender persons) as unifying categories in epidemiological and programmatic discourses had quite the opposite effect, which has erased the perceptions of diversity within these populations. Ignoring diversity and heterogeneity, or reducing the diversity of MSM and transgender people to a set of etic, outsider categories commits violence to the individuals and communities concerned. It also leads to policies and programs that fail to meet the needs of what are of their essence, very diverse populations.

Communities

We turn now to an equally problematic concept, that of “community.”³⁸ This slippery word, just like the words gay, homosexual, or MSM, can mean a multitude of different things. There are probably few concepts that have been used so broadly and so imprecisely.

In classic 20th century social theory, for example, community was defined in terms of locality, as social activity, as social structure, and even as a sentiment. In political science, there is a long tradition of examining political communities and imagined communities.³⁹ In health education and health promotion, we often talk about community organizing, community mobilization, and community empowerment. This proliferation of ideas about

community is not limited to the academic disciplines and professions. In everyday life, we hear mention of the scientific community, the business community, religious communities, ethnic communities, and so on.⁴⁰ These renderings of community all seem reasonable enough, although they become questionable when extended to notions such as the transnational community, the global community, or the community of nations, in all of which the referent becomes difficult to locate.

It should come as no surprise, then, that the concept of community should be central in thinking about how best to respond to the HIV epidemic. The idea of community was already articulated in relation to sexual communities: the gay community; the lesbian community; the lesbian, gay, bisexual, and transgender community; and so on. During the early years of the epidemic, the only meaningful responses emerged from within the affected communities themselves, which organized themselves to care for people living with HIV and AIDS, mobilized to develop prevention activities, and advocated politically for more meaningful responses on the part of governments.

That said, the idea of community has often been driven by what Joseph⁴¹ described as the romance of community, rather than by a careful analysis of what community is, how communities are organized, and why they should serve as the basis for responding to the epidemic. If we are to continue to draw on some notion of community as central to organizing our work in relation to HIV, it is crucial to articulate more clearly what we mean by this concept, and why we view it as so essential. At least 3 key meanings have been associated with the idea, with differing degrees of accuracy and efficacy.

Community as identity. First, and perhaps most frequently, community has been linked to identity. It is because people identify with affected communities that they view themselves as “involved” in the epidemic, whether they are infected or affected by HIV. It was because they identified as members of the gay community that early AIDS activists were able to mobilize so effectively, turning anger into action and unleashing the power of political resistance. However, it is also because of this that we should be wary when we hear references to things like “the MSM community,” or

even more problematically, the heterosexual (or straight) community. It is precisely because the individuals concerned did not identify with one another as members of a conscious collectivity that the very notion of MSM was created in the first place. In addition, the power of identity as a point of departure for political mobilization and resistance is most usually located in its oppositional potential, not in conformity and normativity.

Community as locality. The second important meaning of community in HIV-related work is linked to location or locality. Again, the concept of the gay community is crucial here, because of the fact that at the time the epidemic emerged, and in many of the societies in which it first manifested itself, gay enclaves had taken shape in urban centers as a response to ongoing social stigma and discrimination. These local communities helped structure the sexual networks through which the virus moved, but at the same time they laid the foundations for responding positively to the epidemic through community and political mobilization. Even in societies with less clearly demarcated residential concentrations, the space of same-sex interactions (ranging from commercial venues to public cruising sites) would later provide a focus for “community-based outreach” work.

Community as solidarity. A third use of the idea of community—and arguably one of the most important—refers to bonds of solidarity, of shared sentiment, and of the desire to work together for the better good. It was the collective capacity to build bonds and bridges across the differences that otherwise constituted divisions between groups affected by the epidemic, which was one of the defining characteristics of the grassroots movement in response to the HIV epidemic.⁴² This recognition is all the more important because recent research increasingly suggests that the underlying diversity that is masked and even erased by categories such as MSM and transgender (or “TG” for that matter) has important parallels at the level of community. What is sometimes described as a single, unified gay, or transgender community is made up of multiple, heterogeneous subcommunities, which may or may not be linked together either through identity or through solidarity.

The article by Peacock et al.⁴³ titled “Delineating differences: sub-communities in the

San Francisco gay community” was one of the first articles to recognize the diversity of subgroups comprising the gay community in San Francisco: academics, activists, AIDS service organization volunteers, artists, bisexuals, closeted men, Castro St crowd, drag queens, drug users, HIV-positive men, leather men, men “connected by computers,” men who went to the gym, men who went to clubs, and so on. When linked to the other aspects of diversity that cut across categories like MSM (such as racial/ethnic differences, class, and status differentials), understanding this complex patchwork quilt of “subcommunities” pushed us to recognize the heterogeneity that had to be engaged with in responding to the epidemic.

REMEMBERING OUR PAST AND BUILDING OUR FUTURE

We can only move forward by rethinking some of the key concepts that have evolved during the 3 and a half decades of the epidemic; these have become, in the process, somewhat static “mantras” or “tropes.” We must develop new understandings that are up to the task in front of us.

However, before doing so, we must be clear. Our goal is not simply to dispense with the categories that have emerged over the history of our response to the HIV epidemic. Instead, we want to stress the importance of carefully remembering the detail of that history, the provisionality of many of the categories of understanding that were developed (MSM, community, risk, vulnerability, and so on), and the political purposes these once served. In this spirit of remembrance, we offer some directions for the future.

First, we should never forget that gay men all over the world—through conversation, discussion, and debate, and through the lived practices of sex—literally invented safe or safer sex, even before HIV had been isolated and identified.⁴⁴ They did this in a creative way, using a technology (the condom) that was not given to them by doctors or by public health experts. In the same way, people who injected drugs advocated for and used clean needles and syringes, once again well before HIV was identified.⁴⁵

Second, we must also never forget the tense relationship between community and science

that has been at the heart of the epidemic since day one. This was evident in the early struggles by ACT UP and other community groups to enhance treatment access at a time when some members of the biomedical establishment were unwilling to abandon standard protocols. It was equally clear in grassroots efforts that highlighted the damaging side effects of some early anti-HIV medications at a time when these were seen as unimportant matters by some clinicians. Such actions continue to the present day in an effort to influence the legitimate anxieties some community members have about the efficacy of male circumcision, test and treat methods, and pre-exposure prophylaxis.

Likewise, there have always been difficult relationships between community groups and international agencies. We both remember meetings at which United Nations system experts were called to account by sex workers, transgender people, and gay men. Sometimes, administrators and bureaucrats were seen as pushing a line that rode rough-shod over personal dignity, respect, and rights, all of which had been hard-won community values. We need to have effective forms of prevention, treatment, and care, but those most affected by the epidemic should be involved, not as docile “partners” in program development and design, but as the leaders of what they know best: how to work with and for heavily affected communities. In this respect, we need to consider the ethics of an uncritical push toward biomedical intervention in resource-constrained settings in which health systems might be nonexistent or weak, and where less costly, but equally effective, alternative modes of intervention (e.g., male condoms) have already shown their worth.

Spivak⁴⁶ and Fraser⁴⁷ were among the first to claim, through the notions of the subaltern or the counterpublic, that socially oppressed and marginalized groups—which in the context of HIV include gay and other MSM and transgender people⁴⁸—form their own arenas in which to organize. Their work points to how, rather than rule by the overt exercise of power, it is rule by ideology that holds sway in most modern day societies. This is no less true in the area of HIV than in other fields. How often are we told, for example, that science and medicine have all the answers in the form of microbicides, treatment drugs, and male circumcision?

Why is it that education and the social sciences have to fight for space in meetings such as the International Conferences on AIDS, and are not even involved in the programs of other International AIDS Society meetings?⁴⁹ Why is it that community groups are expected to advocate for every new initiative that comes along—as handmaidens to science and big pharma, and to the international bureaucracies that often support such work?

However, there is hope. As any politician knows, every act of imposition and oppression generates resistance. If gay men literally invented sex with a condom long before a virus had been found, they then went on to invent negotiated safety, sero-sorting, strategic positioning, and many other strategies to manage risk while still ensuring that sex remained exciting and pleasurable.⁵⁰ As Race⁵¹ and others have shown, in the face of stringent efforts to sanitize and regularize sex, gay men have continued to do so today through their creative use of the social media and new hookup technologies. At the very time, when marriage and monogamy increasingly monopolize the public discourse of gay life, digital devices afford novel ways of arranging sex, intimacy, and a sexual community.

In this changed context, what then is the role of community? What forms of community organizing serve us best? In a recent article, Holt⁵² described Australian gay men’s increasing ambivalence about the gay community. He argued for greater subtlety in the ways we think about gay men in HIV education and health promotion. No longer will one size fit all. The concept of “personal communities” (with communities definitely in the plural) may better reflect the ways in which gay men engage with each other and their social networks.

However, there are dangers in this collapse to individualism and the belief, as expressed by “Keith,” one of the respondents in a recent study by Boydell-Wright et al.,⁵³ that there is now no gay community. As he put it,

I don’t actually believe that there is a gay community. I believe there is many, many small communities, and whether that is groups of friends, or people who go to different things, and I think each person belongs to maybe hundreds of different communities.⁵³

These were the same limitations that Adam wrote about when he suggested that gay men

and transgender people struggle under the burden of norms and ideologies that seek to construct them as “self interested individuals” who must take personal responsibility for their lives in a “marketplace of risks.”⁵⁴

Since the beginning of the epidemic, the challenges of responding to HIV and AIDS have brought together a wide range of highly diverse groups. Indeed, one of the greatest legacies of global mobilization against the epidemic has been the ability to build on this diversity to create a “politics of solidarity” as the foundation for key aspects of the international response.¹⁹ However, when solidarity tolerates no dissent, and when scientific “orthodoxy” substitutes for more careful thought, we risk losing our way. Crucially, although gay men and transgender people have struggled to create community, we are not all the same. In addition, any artificial erasure of difference as part of the larger struggles for recognition and resources will come back to haunt us in the end, especially if we forget that this artificial elision of interests was originally a time-bound, tactical maneuver in the struggle against HIV.

What then is the best way forward? We argue that this path lies in carefully remembering our purpose and our past, and never forgetting our roots—even today—in the profound conditions of social marginalization, oppression, and struggle. It lies in being willing to critically evaluate, and, if necessary, jettison concepts that are limiting rather than helpful in the current response to HIV; the term MSM and overly glib notions of community are just 2 of these. It lies in remembering that there is as much (or perhaps more) expertise to be found in affected communities as in the more than 200 page manuals of advice, the shorter but even more directive “policy guidelines,” and the often artificially constructed consensus statements that countless agencies have commissioned and prepared.

Ultimately, as has been true for nearly 3 and a half decades now, the way forward in confronting this epidemic lies not in sloganeering or in social marketing, but in careful thought; in anger, rightful, righteous anger; and in political action. A properly strengthened and renewed response to HIV requires us to acknowledge not the imminent end of AIDS, but that all is far from well in the current context. For gay and other men who have sex with men, and for

transgender people in particular, things are getting worse, much worse, and not better at all. Honesty must be the first step in building a new future for HIV, both for populations at greatest risk and others affected by the epidemic.

Second, sexuality and the erotic really do matter. Currently marginalized, trivialized even, by the search for a biomedical “solution” to HIV, sexual practice must once again be brought center stage. At the end of day, it is through unprotected sex that the majority of HIV is transmitted. Denying this reality through a focus only on biomedical remedies or only on that which has first been sanitized and given respectability through prohibition, admonition, or marriage, is bound to fail. Normalization, routinization, and bureaucratization have taken a serious toll. In efforts to identify supposedly universal solutions, a worrying number of organizations (together with some of their leaders) have completely lost touch with local realities and the growing impact of the epidemic on the very constituencies they claim to speak for and represent.

Third, even when well-intended, efforts to erase difference and diversity in the name of coalition building do little other than to weaken our collective response. Co-option to the targets dreamt up by spin doctors is as unacceptable in confronting the real politics of AIDS as it is in relation to any other serious political endeavor. Ultimately, it is through the forms of sexual citizenship and the kinds of sexual community we can build together, and through the rights to respect, recognition, and participation that sexual citizenship and a community life worthy of its name imply, that lasting answers can be found.⁵⁵

We should begin this work now by recognizing and responding to the shockingly poor access that gay and other men who have sex with men and transgender people have to both old and new forms of HIV prevention; we should respond to the health and social services that show little respect for gender and sexual diversity, to education that fails to speak honestly and openly about gender and sexual difference, and to lack of the civil recognition and inclusion by the state. If this calls for a more overtly political strategy for HIV than we have seen in recent years, then so be it. The “end of AIDS,” if there is ever to be such a thing, can be brought about only through

good politics and the consequences—both social and biomedical—that flow from it. ■

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