

‘MSM-ing’ as a networking concept

Becoming a global health category

Paul Boyce, Fabian Cataldo

Abstract

This article explores the creation of ‘MSM’ as global health category over the course of the HIV and AIDS epidemic, and across country contexts from India to southern and eastern Africa. We conceive of ‘MSM’ as a mode of ‘doing’ and ‘becoming’: ‘MSM-ing’, so to speak. Actor-network perspectives and ethnographic reflections are engaged to elucidate ‘MSM’ as a term that both enables and inhibits communications about sexualities and risks. We consider the term as a plural form of evidencing that offers wider perspectives on flows and boundaries in global health–knowledge making and HIV prevention.

Keywords

MSM, evidence, global health, actor network theory, sexualities

Introduction: Querying ‘MSM’ in India

In 1996, the first author, Paul Boyce (PB), became employed by a ‘male-to-male sexual health programme’ in the West Bengal state capital of Kolkata (then Calcutta). The project, at the time named ‘Naz Calcutta’, was one of the first community-based organizations focused on male-to-male sexualities and health that were being set up in India under the auspices of the UK-based Naz Foundation, an organization that was

instrumental in founding some of the first internationally funded HIV-prevention projects for men who have sex with men ('MSM') in South Asia.¹ During this period, PB was particularly caught up in wondering how a focus on male-to-male sexualities and sexual risk was taking shape amidst emerging funding for 'MSM'-focused HIV prevention in the city and in India more widely. He found himself asked to talk about his developing research interests by representatives from the main international donor offices in the city, the West Bengal Sexual Health Project (WBSHP), a regional sexual health funding hub for the UK Department for International Development (DfID),² which was funding Naz Calcutta.

During the meeting, PB conveyed his interest in how conceptualizations of same-sex sexual intimacies and risk traversed (or failed to traverse) across these settings. One of his interests was regarding how community workers in different locations employed the term 'MSM' in ways that might have appeared commensurate with local sexual alterities, but that also engendered divergent interpretations and inconsistent connotations. He was especially concerned with the specific deployment of the acronym form: 'MSM'. At the time, these three letters were becoming rapidly popularized in a manner that seemed to run counter to an accurate description of who and what the acronym was commonly being used to indicate (see, for example, Young and Meyer [2005] for similar observations).

Even in the early days of his work on HIV prevention in Kolkata and London, PB had become acutely aware of the peculiar ways 'MSM' was being used in reports and in conversations containing phrases such as 'MSM communities' and 'MSM behaviours'.³ Spelled out, these articulate as 'men who have sex with men communities' and 'men who have sex with men behaviours'. Such oblique and grammatically awkward prose seemed in many ways to obscure the referent under discussion, PB reasoned. This was so even as the use of the 'MSM' acronym enabled conversations to take place that might not be possible otherwise (for example, where explicit mention of male-to-male sex especially might not be possible or desirable in formal programmatic contexts). In some ways, the

- 1 This is not withstanding other forms of community support pertaining to hijra, kothi, and other, 'otherwise' gender experiencing and same-sex desiring peoples that have a long history in West Bengal (as elsewhere in India), a history sometimes overlooked in accounts of the urban-sexualities-oriented community organizing that began to take shape in India from the mid-1990s onward (Dutta 2012; Reddy 2005; Dhall and Boyce 2015).
- 2 DfID was not formally named as such until 1997 but the funding infrastructure in 1996 was principally the same as that which was soon to be consolidated under the DfID rubric.
- 3 PB's questions about 'MSM' came about in context of discussions with community workers in India and the United Kingdom who shared similar reflections on the acronym, and in the context of publications on the effects of 'MSM categorization', for example, Dowsett (1990) and Parker, Khan, and Aggleton (1998).

effacement of meaning brought about by using the acronym 'MSM' enabled discourse. Yet, we suggest, this occurred with obfuscating effects.⁴

Amidst such complexities, one of the ways that PB sought to specify interest in the effects of the public health risk categorizations was by employing language that marked a space between 'MSM' and the array of sexual and gendered ways of being that the term was becoming caught up in, even if indirectly. It felt important to use the acronym form, therefore, only when talking about it as an acronym, that is, as a categorizing device rather than as unproblematic signifier for a population of men who have sex with men in any given setting. To mark this separation, PB decided that it was better to use the long form 'men who have sex with men' when talking about his work. He hoped that this usage might make the intended referent under discussions clearer (not withstanding that 'men' and 'sex' are far from straightforward categories).

Employing this discursive strategy in his meeting at the WBSHP, PB found that talking about 'men who have sex with men' was met with confused expressions from some of his interlocutors, who were locally employed programme officers in the project. Eventually this led one of the officers to ask PB if he was referring to 'MSM'; 'Was this what you mean?', he was asked. The clarification in this instance became necessary in order to make the subject under discussion evident. Ironically, as noted, PB had been deliberately avoiding the use of the acronym 'MSM' in an attempt to bring more specificity to the discussion. And yet this attempt also had the effect of rendering the object of reference at least partially unintelligible. There was genuine confusion in the meeting about 'men who have sex with men', while employing the acronym 'MSM' made this 'clearer', at least in the sense that it enabled conversation to continue more readily. The weight of a standardizing discourse came to bear in that moment.

Looking back on the example from Kolkata we wonder, did PB's anxieties about using 'MSM' matter? Was the attempt to slightly alter the discursive convention relevant, or was this effort a somewhat clumsy intervention, unnecessarily oblique or pointlessly pedantic? Or, perhaps this was a small personal moment that offered insight into the functioning of health promotion terminologies amidst networks of meaning making as they manifested locally, in a specific programmatic context. Certainly, the memory of this instance has lingered in PB's recollections as a signifier that pointed toward something important, a miscommunication that continues to resonate with the ongoing iteration of 'MSM' as a vexed category in global health research and practice.

4 This is somewhat similar to how Stacy Leigh Pigg (1995) has described uses of the acronyms 'TBA' (traditional birth attendant) and 'TMP' (traditional medical practitioner) in health and development discourse. The acronyms allow for such practices to be included in orthodox forms of development knowledge making and practice, but they also efface local realities, even as the use of the terms is intended to make such perspectives cognisable.

Drawing from our experiences in the health and development sectors, often working with community-based organizations, state agencies, and health-promotion organizations, in this article we approach 'MSM' as a networked concept through which manifold subjectivities, embodiments, documents, resources, policies, places, and processes come to bear. We examine 'MSM' as a form of 'doing' – 'MSM-ing', so to speak – both a verb and an active practice of networked knowledge making brought about by the acronym itself, at least in part. In doing so, we seek to contribute to the continuing unsettling of 'MSM' in global health work from the standpoint of our own situated encounters.⁵ We offer these as perspectives on the varied 'making-up' of 'MSM' as a global health category.

Networking 'MSM'

In applying this perspective, we draw attention to how the 'MSM' rubric is multiply encoded through various acts and responses. Even as such 'things' come to bear across varied domains, the typical use of 'MSM' in much global health work is to render such interconnections, and their effects, invisible. What has been less written about is the multiple encoding, envisioning, and erasure of same-sex sexual lifeworlds through the use of the 'MSM' acronym, these being the kind of acts of 'MSM-ing' that we refer to here. Not all aspects of the 'doing of MSM' are necessarily visible or intelligible to one another in global health knowledge making. And they may not necessarily arise as the outcomes of active choices by people working in global health. We seek to address such concerns by exploring 'MSM' as a thickly networked concept (Latour 2005) that both connects and refracts diverse topographies of research, community intervention, and self-understanding across systems of information making.

In following this line of thought it is not our intention to offer an in-depth analysis of social scientific network theories. Nonetheless, we take inspiration from Bruno Latour's actor network theory (ANT) for its emphasis on how human and nonhuman entities come to act in networked social experience. This perspective pulls away from a focus on humans only and asks us to consider how different material objects, terminologies, and processes pertain as attributes in the making up of social worlds and subjectivities. For Latour, 'a subject is produced by external actants, "plug-ins" such as official and legal papers, and intention is replaced by supplementary tools ... that equip people to choose and calculate' (Humphrey 2008, 365).

We consider 'MSM' along such lines, as a term that might be understood to operate beyond performing as a simple descriptor of male-to-male sexual subjects, a noun designating same-sex practicing men, and a term applied by human actors only. Rather,

5 See, for example, Killen, Harrington, and Fauci (2012) for discussion of reflexive critiques of the 'MSM' category.

we consider ‘MSM-ing’ as a codifying process in knowledge-making actions about sexual risk, health, and HIV. Such processes, we suggest, draw many concepts, things, practices, and people together, albeit often obliquely or opaquely; ‘MSM’ does not always foster common understanding. Moreover, such drawing-together of information through the ‘MSM’ rubric often takes shape, we conjecture, beyond explicitly thought-out decisions about the term by those who come to employ it. Rather ‘MSM’ can itself be seen as an external actant: a term of reference that encodes global health discourse and documents.

One of the potentialities of ANT approaches to global health work is a focus on how standardized terminologies, such as ‘MSM’, come about and endure. In a recent analysis of such processes Angèle Bilodeau and Louise Potvin (2018) have reflected on the different material, discursive, and human interactions that go into the making of global health categories. They note that an important concept in ANT is ‘translation’, ‘which refers to the linkage operation that connects disparate entities – humans, things, new ideas, interests, values, specialized and lay knowledge, financial resources, institutions, regulations, etc. – in a situation’ (Bilodeau and Potvin 2018, 176). One attribute of translation is problematization, which consists of ‘assigning the entities, roles and interests related to the situation. It also includes identifying problems, as well as potential solutions and controversies’ (Bilodeau and Potvin 2018, 176). Such problem making requires linguistic terms that establish knowledge of social worlds after the requirements of whatever problem is to hand.

In the case of ‘MSM’, the citation and measurement of such subjects in health promotion work (a man having sex with men being the person of interest) arises in relation to the problematic at the time of the term’s conception: how to intervene into male-to-male sexual risks. Its emergence occurred when the only methods available were the promotion of changes in sexual practice (the promotion of safer sex); efforts at the time focused on particular strategies (condoms, testing, promoting partner disclosure) because biomedical models of intervention (such as prescribing antiretrovirals to prevent HIV infection) were not available or did not exist as currently conceptualized. This left little room to imagine subjects of interest and intervention in anything other than behavioural terms. Indeed, behaviour change communication (BCC) was the predominant health-promotion strategy from the early days of HIV prevention.⁶ The term ‘MSM’ helped to translate the concerns with behaviour change into a problematized population category that could pull networks of action together around ostensibly common purpose and concept. In short, to problematize something is to give it a name. In turn, naming feeds back into social worlds as referents via which relations and persons come to be defined. In the case of ‘MSM’, such defining processes pertain to the circulations of the term in

6 This is not to imply that the promotion of antiretroviral drugs for HIV prevention does not imply changes in behaviour pertaining to drug use and attending clinics. But such methods had not been developed at the time under discussion.

official documents but also to the wider uses of the acronym as it has been taken up beyond formal health-promotion contexts.

Against this background we have each in our work certainly experienced the category 'MSM' as a definition of behaviour. And yet we have also witnessed the term functioning as an epithet for self-identity, a marker of communal connectedness, an antithesis to community, and a putatively objective public health category among other possibilities, often all at once. In wondering about such effects, in this article we draw on some of our own diverse research experiences to reflect on how 'MSM-ing' takes shape through the category's travels across health promotion programmes, and beyond, at different scales and to different effects.

We see our approach as especially important in the present moment. We are living in a time when post-AIDS futurities are ever more explicitly projected in international policy and programming. And yet too, as Richard Parker, Peter Aggleton, and Amaya G. Perez-Brumer (2016) have recently argued, many peoples, and especially gender and sexual minorities, have been failed by the global HIV response. In part, they note, this is because of the categorical frameworks by which such people's needs have been inserted into evidence making and policy, categories that far from adequately address the multiple lifeworld experiences, and health promotion priorities, of those targeted.⁷ In light of such concerns, it is important to look back and reconsider some of the ways categories used to frame the needs and risks of 'key populations' have engendered forms of knowledge making that have not met their intended purpose. After such concerns, we consider 'MSM' as a term that has helped to bring focus to male-to-male sexual risks within the epidemic but that too has erased much salient knowledge, with deleterious consequence.

Denaturalizing the discursivity of 'MSM'

The experience in Kolkata, recounted above, served as an instructive incident for PB, one that informed a choice made some years later when he was commissioned with Peter Aggleton and Ann Malcolm to write a Rapid Assessment and Research (RAR) guide for a health research intervention with men who have sex with men for the World Health

7 Recent data published by UNAIDS (2018, 8), for example, indicates '47% of new HIV infections globally in 2017 were among key populations and their sexual partners'. Many of these infections are among men who have sex with men, globally. UNAIDS advocate for new research measures to address this unequal distribution of HIV infections. However, it is notable that the focus is on improved metric models, which we conjecture are a part of the problem for their reliance on categorical data. See also Adams (2016) for discussion of the effects of metric measures in global health research.

Organization.⁸ PB and his colleagues introduced the guide with an explanation as to why they had decided to avoid using the MSM acronym:

The shortened version of the phrase ‘men who have sex with men’ – ‘MSM’ – has become a convenient shorthand way of talking and writing about men who have sex with men in some contexts. We prefer the longer phrase ‘men who have sex with men’ though, since it encourages us to think about issues more precisely: not just as a convenient phrase, but also as a way of describing a diverse population of men who, for the purposes of an RAR, are labelled together because they all have sex with other men. Throughout this guide, therefore, the full term ‘men who have sex with men’ is used to encourage clearer thought about the diverse cultural contexts, lifestyles and health needs of men who have sex with other men. (Boyce et al. 2004, 9–10)

For PB this choice was directly tied to the enduring memory of his encounter with the WBSHP programme officials. This is not to overinterpret what was, in the end, at least in some ways, just a moment of misunderstanding. Instead, the attempt here is to situate such a moment as a glimpse into how a discursive term – ‘MSM’ – was coming to bear as an emerging norm. Indeed, back in the mid-1990s in West Bengal, PB and his Naz Calcutta colleagues did in fact end up employing the ‘MSM’ acronym in the reports they produced for the WBSHP. This standardized term was commensurable with evidence-making documentation, enabling mutual intelligibility and, moreover, ensuring the flow of funds into the organization. This was so even as these same terms of data occluded other more complex realities about sexual lifeworlds and risks. As noted elsewhere, the use of ‘MSM’ in programmatic contexts has contributed to the reproduction of fixed and rigid behavioural categories, which often remain at odds with the lived experience of ‘target’ populations for HIV prevention (also see Munoz-Laboy 2004; Carillo and Hoffman 2016). And yet, those of us working in programmes may use the term, nonetheless, mindful of its effects.

This is not an unusual situation. It is the kind of scenario that endures in many global contexts today in which the terms that community-based organizations employ in the production of knowledge are often made (up) to align with the requirements of funders even as other ‘realities’ are evident (in other terms) to the people working in such projects (Biruk 2014, 2018; Lambert 2013; McKay 2016). Different worlds of information may exist in complex interaction in such processes, but often have little capacity to affect health promotion research about these interacting meanings. ‘MSM’, for instance, is most often made to operate in health-promotion work as if universally intelligible, as if it were a rubric that could be used unproblematically in compiling data

8 This commission came about through PB’s employment at the Thomas Coram Research Unit (TCRU), University of London, and was arranged by Peter Aggleton, then director of TCRU.

about sexual risks, describing behaviours unencumbered by the weight of identity politics or epistemological reflections (also see Lorway, this issue). But such usage has always seemed to be a proximate to one's positions within a network of other possible interpretations and experiences. Other attributes of lifeworlds nested in the 'MSM' rubric sometimes seem to run over, rupturing the boundaries of its original behavioural containment. Thus, for instance, 'MSM' has also been seen to have been taken up as a term for recognition in many settings, whereby a statement such as 'I am MSM' has become a discursive form, suggestive of shared modalities of self-identification, albeit in far from straightforward terms (Boellstorff 2011; Boyce 2019; Thomann 2016).

'MSM' might, then, also stand as a form whereby knowledge about sexualities is brought about relationally. Sometimes this usage might be effected by those who invest in the term as a means to say something about themselves and their sociosexual relationships. At other times, however, the term may be employed with the effect of erasing intimate attributes of experience from view. Eileen Moyer and Emmy Igonya (2018) attest to the inadequacy of 'MSM'-oriented interventions for male sex workers in the Kenyan context, for example, whilst Nhan Truong and colleagues (2016) have documented disjunctures between the use of 'MSM' and the complexity of lived experiences of black men in the United States' Deep South. They note that the extrapolation of 'MSM' to much public health work often indirectly refers to men of colour who might not identify as gay. Yet the use of 'MSM' as an overarching label in such work fails to reflect intersections of race, class, gender, and sexuality in relation to social forces such as stigma, discrimination, poverty, and low education in contexts of male-to-male sexual intimacies and (structural) vulnerabilities (Gosine 2009; Truong et al. 2016).

That 'MSM' describes, and avers, so many disparate attributes of experience speaks to the ways the category travels: amid evolving research agendas, policies, subjective claims, politics of recognition, and technical approaches in male-to-male sexual health promotion. These and other inclusive and exclusive factors are densely encoded in the term, even as it is used as a neutral global health signifier. Indeed, it is often this putative neutrality that enables the use of the 'MSM' category to defuse the politics of sexualities at their interface with other attributes of social exclusion and stigma. This is so because, even if not stated, the shadow of 'MSM' in its original problematic as a BCC category endures, a frame of reference that factors out the social and the political in favour of the behavioural.

Encountering 'MSM': Further contextualizing our research

As coauthors we have each encountered various uses of 'MSM' as it has become somewhat ubiquitous in the social worlds in and around male-to-male sexual health interventions. Alongside emerging strategies for HIV prevention, treatment access, and long-term follow-up, we have seen the use of 'MSM' intensify across public health interventions, research, and advocacy efforts, with intentions that were at times at odds

with each other. Some have used the acronym to bring more visibility to male-to-male sexualities in contexts where such debates were not welcomed or even possible. But also we have seen the term used to blur its referent, burying overly explicit references to same-sex sexualities, and allowing for relevant discussions and projects to take place without needing to even refer to sexuality.

As we have independently traversed multiple spaces of health research and fields of practice, with different players, we have both become fascinated by the quotidian moments in which one could witness this globally circulating health category operate across complex scalar domains. This occurs often in the same moment as intimate sexual lifeworlds come into contact with the terminologies, documents, and other attributes of global health research and programmes, for instance in the contexts of community-based organization offices where people may come to find themselves categorized as 'MSM' (or another health promotion term). In such encounters, people become global health categories, in a way, as their life experiences get encoded into data (and in turn such encodings refract back into lifeworlds in subtle ways, see Lorway et al. 2009; Boyce 2007, 2013). These are not flat processes whereby lives are neutrally inscribed into evidence. Rather, as we have seen in our experience, such actions involve densely alive and networked encounters, productive of variant meanings, choices, and affects. These pertain to the use of 'MSM' in the making of HIV prevention data and policy but are often not expressed or explored within such fields of practice.

By way of further contextualizing our involvement with such concerns, the second author, Fabian Cataldo (FC), has worked for several anthropology and global health academic departments, not-for-profit international agencies, and as an independent consultant in research and ethics. His work has largely focused on the lived experience, meaning, and perception of accessing (or being excluded from) prevention, treatment, and services related to HIV. A central thread in FC's research is shifts in individual agency and how one may become further 'responsibilized' (Cataldo 2008) or disfranchised in the course of seeking or providing treatment and care, as well as the changing nature of care relationships and evolving paradigms of HIV care (Kielmann and Cataldo 2010; Cataldo et al. 2017). With such a perspective, FC has led several ethnographic studies conducted over extensive periods of fieldwork amongst 'marginalized' groups for HIV prevention in Brazil and southern African countries (Malawi, Mozambique, Zambia). These have focused on the social dimensions of care and access to HIV treatment in low-income settings. Across these domains FC has been struck by the way life experiences become increasingly narrow, compartmentalized, and translated into behavioural categories. Over the course of different fieldwork engagements, FC has encountered many examples of what seemed to be either some form of 'self-reification' or instrumentalization of public health categories. These terms tend to define individuals as 'at risk', 'vulnerable', 'discriminated', or 'marginalized' in relation to acquiring HIV or to accessing care and treatment. How do such reifications

come about and what do they suggest about how people's perceptions of themselves are bound up with the networking of HIV knowledge production?

In a similar vein, elsewhere PB has written about his experience of working in HIV prevention in different contexts (Boyce 2019). This has involved periods of ethnographic research in West Bengal⁹ as well as working in an academic department of anthropology, a policy studies unit, and as a consultant for international development agencies, such as the UNDP, The International HIV/AIDS Alliance (now Frontlines AIDS), and Family Health International (now FHI 360). In retrospect, these development experiences, not necessarily by design, have nonetheless enabled a perspective on how global health categories, such as 'MSM', have operated and indeed inserted themselves in knowledge-making practices and networks in divergent contexts of evidence making.

Thus, for instance, in 2010–2011 PB was working on a project (funded by the Futures Group) for the Indian National AIDS Control Organization. This involved comanaging a study, encompassing fourteen national sites, that aimed at amassing data on 'male-to-male' sexual risks. The research respondents were people of diverse genders, not only men who have sex with men per se, and represented other intersecting experiences of caste, class, religion, and ethnicity. Nonetheless, the reports arising from the research used the term 'MSM' in data analysis as a kind of overarching category (although not without some explanation of the diverse cohort of the study). PB worried that using 'MSM' would subsume the represented diversity and contextual, regional specificity of the project. Nonetheless, in the end, he went along with the usage because this was the 'choice' made by the research team (not without some queries) and because 'MSM' had become the commonly intelligible term within the context that the research sought to influence (national HIV prevention policy and funding for NACO's next five-year cycle). Doubt about using 'MSM' did not recede but it was also evident that in order to be influential 'MSM' was going to be the necessary discursive device. And yet describing the above outcome as arising from the singular choices of the people involved in the research would be an incomplete perspective. 'MSM' came to bear in the research because of a range of processes and expectations that themselves iterated the terminology as the necessary convention; the documents and policy discourses insisted on 'MSM', so to speak.

Such examples, we conjecture, are emblematic of the kind of 'trade-offs' that are made in much HIV programming. 'MSM' may be a 'necessary' term sometimes, not only to secure funds for NGOs conforming to dominant paradigms (at least in public) but also as an attribute of how knowledge communities operate, within standardized terms of

9 Doctoral and postdoctoral research in West Bengal was funded by the Economic and Social Research Council. More recent work was funded by the Wellcome Trust (a grant held with Rohit Dasgupta).

reference. The networked nature of information in national and global HIV prevention programming, for instance, is such that ‘MSM’ functions to facilitate flows of information without dissenting voices or concepts complicating the scenario. This may be so even as some people who work in the sector already experience ‘MSM’ as an imperfect paradigm.

In a way, as PB decided in this instance, prevailing against the use of ‘MSM’ might not always matter, even if such a choice runs counter to a personal epistemological and ethical commitment. What mattered more in this instance was to be able to insert information into the development of NACO’s next five-year plan in a way that would include ‘MSM’ well enough. Perhaps this choice was a submission to the structural hegemony of the term. And perhaps too it was a pragmatic option. But, also, it took shape through the requirements of particular knowledge systems in which ‘MSM’ was engaged. Other debates, for instance about the ontologies of ‘MSM’¹⁰ as a category that variously binds knowledge making and sexual lifeworlds together, perhaps are best voiced in settings where such discussions can better breathe amidst relevant theories (such as in the present *MAT* special section). Elsewhere, ‘MSM’ might serve other functions, for instance to fulfil ‘targets’ for inclusiveness in interventions, or to conceptualize ‘imagined’ communities during intervention-design processes. Our task, as social scientists, is perhaps not to resolve these competing logics but to attend to them in our analyses.

With such thinking in mind, and in respect of our varied HIV prevention involvements, we have each come to realize that no matter who we have worked with (in UN agencies, community-based organizations, national AIDS programmes, etc.), or where we were (India, Brazil, Malawi, etc.), a key ingredient was both the ubiquity and the diverse effects of ‘MSM.’ Our encounters with, and sometimes uses of, the category have not only allowed us to describe sociosexual worlds for specific purposes but have also enabled us to perceive a topology of interactions whereby different scalar orders of knowing and being might come together and/or talk past one another amidst systems of information production about sexualities and HIV. We speculate that one of the reasons for this is because the acronym ‘MSM’ in particular does not compel discourse back into a precise reckoning of taking an actual, more explicitly stated focus on ‘men who have sex with men’ as a definite subject. Rather, the effacement that ‘MSM’ brings about means that the term can function somewhat ambiguously and capaciously to both refer to and defer focus from male-to-male sexual subjects.

Situating oneself and the paradox of ‘MSM-ing’

FC’s work has led him to consistently encounter the complex and refracted intersectional effects of the ‘MSM paradigm’ within the changing modalities of care and care-giving

10 See the introduction to this special section for discussion of ontological perspectives on ‘MSM’.

relations in the context of large-scale intervention programmes. His ethnographic fieldwork amongst socioeconomically 'marginalized' groups has allowed him to explore changes to individual agency and health-seeking trajectories in relation to accessing services for HIV and sexual and reproductive health. Contrasting with the study of individual lived experiences related to accessing HIV treatment and care in some of Brazil's shantytowns (Cataldo 2008), FC has, for instance, explored how related interventions (providing access to HIV treatment) were perceived by different groups in southern African countries. 'MSM' has been one such category of interest, whereby dissimilar investments in the term have revealed themselves to varying effects in, for example, peer interventions to promote routine testing for marginalized groups or the promotion of mobile services for 'hard to reach' populations.

As part of several studies on access to HIV services in Mozambique, Malawi, and Zambia, FC witnessed a lack of self-identification with the term 'MSM' among many individuals who were nonetheless encoded as such at the point of health promotion intercession. Interventions planned to gather together 'MSM' for the purpose of testing and counselling in Malawi, for instance, often failed to recognize that the creation of a 'safe' testing place could be highly stigmatizing and at odds with how men might self-identify. Accompanying the day-to-day work in HIV clinics and mobile outreach interventions were opportunities to explore how health care workers, patients, and researchers (such as FC himself) were able to explicitly 'disassociate' themselves from the 'MSM' label. During these projects, for instance, several research and medical colleagues made a point of publicly announcing that they had no discriminatory feelings towards 'MSMs' but that they were not 'MSM' themselves. Others, FC included, tended to use the term without self-reference, perhaps in an effort to ensure that they could continue to work in places where homosexual relations were criminalized and considered as unacceptable.

In the same settings, the reification of the term 'MSM' as an imagined community or network of men led to the development of a multitude of interventions aimed at 'reaching out' to these 'communities' through mobile services, peer-support programmes, specialized 'MSM clinics', decentralized testing, and community-based treatment initiation. Paradoxically, perhaps, FC observed that these interventions also tended to implicitly negate the very reason that gave rise and popularity to the use of the 'MSM' acronym; on the ground, the goal of reaching 'MSM' – as a target set by programme designs – seemed at odds with the desire of individuals not to be identified as such, for those explicitly rejecting the label 'MSM' as a common identifier and who refuse to engage with health services on that basis (see also Davis 2017).

One example of such distancing with the 'MSM' label was observed during some of the regular 'community-based' testing campaigns taking place in remote areas in Malawi aimed at reaching 'MSM' for HIV prevention, testing, and treatment initiation. On a monthly basis, a small team of NGO-based health providers booked a local lodge to host

what they named an 'MSM event'. Numerous activities were planned to attract men from surrounding villages on that day, including sport matches, music, drinks, and barbecues in an effort to create a friendly and 'nonjudgmental' atmosphere. FC accompanied the activity regularly, traveling long distances on mud roads with a team of community health workers, a nurse, and a coordinator.

On the way to the lodge where the event would take place, there was a palpable sense of excitement among the team at the idea of providing health services targeting individuals who would not otherwise come to health facilities. While discussing with the team how these services were to be provided, FC realized that part of the excitement and enthusiasm at organizing these outreach services was related to accessing individuals who were considered largely 'invisible', and somehow 'mysterious', for some of the health care workers and researchers that FC encountered. In the Malawi context, some believed that homosexuality did not exist, and working on an outreach programme aimed at 'MSM' was often presented as a novelty by other NGO staff. FC's own participation as a researcher during these long trips to remote parts of the country seemed to be perceived by his colleagues and other health care workers as an opportunity to showcase their work, in an effort to justify the need for such interventions to continue being funded, and tended to further objectify 'MSM' as a homogenous behavioural group that would not otherwise be accessible. During staff meetings, FC observed senior staff members express that they would only agree for 'MSM' interventions to continue as long as they (the whole staff) were not seen as 'promoting' homosexuality and 'homosexual behaviours', implying that they would only allow these projects to take place if there was a clear and unambiguous distance between 'them' (the staff) and 'MSM'. The need for confidentiality within these interventions added a layer of 'secrecy' too, which perhaps created some tensions in the team and resulted in these activities becoming a popular conversation topic amongst the NGO staff when they returned from field visits.

While these interventions were conceptualized as 'safe places' for 'MSM', which generated some relative interest in health promotion messages around HIV, they also appear to represent key moments when the term 'MSM' was collectively banned and rejected. No participant would self-identify as 'MSM', and health promotion messaging was not specifically addressing sexual risk and prevention relevant to male-to-male sexualities. In the same way, FC observed that researchers, including himself and other anthropologists, often refrained from referring to their own sexualities, contributing to the intricate networked density of the 'MSM' terminology; it both accommodated workers' use of the term to define others but also, in the same acts, enacted a protective distancing from the same categorization. This in turn, facilitated professional 'access' to target groups of same-sex practicing men.

This example illustrates how the term 'MSM' evolved and fluctuated as a networked concept within a singular setting, as it became instrumentalized by individuals, health promotion programmes, and researchers who sought to situate others and themselves

both inside and outside the category. Indeed, the tension generated by the simultaneous adoption and rejection of 'MSM' in this instance attests to the complexity of the term as a global health category; it can quickly become a limiting social and political construct, even as it can enable health promotion.

Reframing 'MSM'

In 2008, the International AIDS Conference took place in Mexico City, where FC participated in the first large preconference on 'MSM' organized by a newly formed coalition of activists and experts, the Global Forum on MSM and HIV (Ayala et al. 2011). The coalition was formed in 2006 in response to the 'invisibility' of MSM as well as the absence of specific funding, research, and interventions for these groups. The aim of the Global Forum on MSM and HIV (MSMGF) was to generate greater interest in and traction towards 'MSM health'. Attending the preconference in Mexico City, FC was impressed by the sense of active political mobilization generated by the event, and by the breadth and reach of the growing interest in research and interventions focusing on 'MSM' globally. During his discussions with other participants at the same event, FC was struck by the seemingly unanimous agreement to adopt the acronym at the time, and to actively promote its use to bring more visibility to male-to-male sexualities in the context of HIV research and interventions globally. Over the years, the coalition was successful in forming a global network of experts working on 'MSM-related topics', including a large representation of members from countries where homosexual relations are illegal and criminalized.

Over a decade later, in July 2018, researchers and activists reunited in Amsterdam, where a change in name was announced, corresponding to a shift in the use of previously adopted behavioural categories. 'MSMGF' became 'MPact Global Action for Gay Men's Health and Rights', reframing the organization's scope of action around a more explicit sexual health and rights approach. Moving away from using the term 'MSM' exclusively to describe male-to-male sexualities, MPact's rebranding also signified an increasing political presence and the reappropriation of the terms 'gay' and 'bisexual' as a central tenet of an approach combining rights-based and public health discourses across global health infrastructures. In the early days of the HIV epidemic, these terms were eschewed for their perceived regional, Western, and hegemonic effects, and 'MSM' was favoured because it held the promise of reducing the AIDS-related stigma that had been irrationally attached to gay men and lesbians (Young and Meyer 2005). A turn back to these terms of reference suggests a new repoliticization; in part it would seem a reaction to the term 'MSM', as it had become weighted down, associated with confusing political intent and exclusionary effects.

Given these complexities, the tensions and changes we have both described in the use of, and distancing from, 'MSM' can be seen to have arisen from imperatives to produce evidence that may be verified and quantified, versus other, more open-ended means of

transmuting understandings of sexual and gendered experience into data, and ultimately into health promotion and intervention programmes (Boyce 2019; Biruk 2018 and this volume; Khanna 2011). Such actions connect and bifurcate in multiple unexpected directions. Indeed, the relation between sexual experience and language might be imagined as intimately inscriptive and elusive simultaneously; sexualities can be imagined as situated at the nexus of power and discourse but also somehow out of reach (Moore 2012, 2007).

‘MSM’ might be similarly conceived as a term that responds to the limits of language in relation to sexually subjective experience. This is because the term does not presume identity and facilitates understanding that labels such as ‘gay’ and ‘homosexuality’ are culturally constructed. At the same time, however, the extended use of ‘MSM’ across global health contexts over the decades means that it has been and is linked to many effects. These may not be seen or understood from every standpoint. Indeed, the term ‘MSM’ is still variously and often used in many research papers as if it is simply a self-evident category of concern for the sexual health and HIV prevention of men who have sex with men.

In other forms of writing and analysis, however, the term is conceived of as a discursive construct with an askance relation to actual male-to-male sexualities, which also are understood as invoking contextually and intimately varied experiences of gender and sex. Such different uses of ‘MSM’ are indicative of the divergent knowledge communities and processes found in global health work, often concerned with similar objects while also speaking past one another, each unable to conceive of what the other is preoccupied with knowing (Boyce 2019).

Networking ‘MSM’ again: HIV prevention – past, present, future

The issues described thus far become ever more concerning as the paradigm of contemporary global HIV prevention shifts toward pharmaceutical solutions, via the endorsement of Pre-Exposure Prophylaxis (PrEP) and Treatment as Prevention (TasP) regimens as a newly mainstreamed preventative measures being aimed at key populations

in many global contexts.¹¹ Possible funding for relevant research and programmes about, for, and with sexual and gender minorities has, over time, been supplanted by biomedical hegemonies in international HIV-prevention work. The rapid increase in availability of PrEP as a biomedical prevention strategy across diverse settings, for instance, has generated a renewed interest among researchers to explore risk in relation to behavioural changes attributed to PrEP by some early users (Rosengarten and Michael 2009).

We both attended the International AIDS Conference that took place in Amsterdam in 2018. A notable characteristic of the meeting was that conference panels about PrEP promotion were typically completely full, standing room only. Many presenters on such panels commented on this and as we wandered around the conference, separately and together, the evident media interest in PrEP was palpable. And yet, as we visited one panel after another, an overwhelming observation was that much of such work tended to present PrEP as a foregone conclusion, the given future of HIV prevention globally. Broadly speaking, social research about PrEP as presented at the conference was about how it might be better distributed globally across varying health infrastructures. Other kinds of questions (for example on the ethics of pharmaceutical citizenship and so on) appeared to be foreclosed or were at least not given much airing.

We live in an era wherein promises of post-AIDS futures have become prevalent in global health discourse and programming (Essex 2017; Walker 2017; Leclerc-Madlala et al. 2018). Much of this work is organized around established key populations, where the promotion of PrEP is being targeted at already recognized categories of risk groups, most often sex workers and men who have sex with men. PrEP (and to some extent TasP) may represent potentialities for post-AIDS futures. But concerns arise too that the increasing availability of the drug Truvada, used as a prophylaxis within a PrEP regimen, has become rapidly associated with a renewed emphasis on 'unsafe' sex practices, risk compensation, and 'raw sex', which until recently was described as unsafe in mainstream health promotion messaging (Blumenthal and Haubrich 2014; Dean 2015).

Such policies and actions can be seen as deriving from the accumulated correlation between sexual risk and HIV as it built up and became normalized over time: the bodies of certain people, such as those who have been categorized as 'MSM', have been made to correspond with PrEP promotion because of already assumed sexual risk characteristics

11 In the PrEP model, HIV-negative people take drugs previously used to suppress viral load – either commercial or generic forms – as a prophylactic measure to prevent their acquiring HIV in event of sex with an HIV-positive person. PrEP is being promoted in a range of global contexts; data can be found at <http://www.prepwatch.org/>. TasP is an HIV-prevention method derived from a 2011 study named HPTN 052, which found that those on effective early-stage-infection HIV treatment were significantly less likely to pass on HIV to sexual partners, a 96 percent reduction in infection. TasP has been strongly advocated by UNAIDS (see <http://www.avert.org/>).

that have in many ways acquired facticity over the course of the production of information about the epidemic. These mark such people generically as sexual risk entities.

Subjects such as ‘MSM’ – and other key populations – come into view in HIV-prevention work as already problematized for intervention; as noted above, this is much as Bilodeau and Potvin (2018, 176) have described translation from an ANT perspective. An attribute of this is that key populations become defined in HIV and AIDS work as always already the expected recipients of whatever form of HIV-prevention technology prevails at the given moment (Behaviour Change Communication, circumcision, PrEP, TasP and so on, among others [Aggleton and Parker 2015]). And yet the actual complexity of the lifeworlds of people designated under key population categories have often been given little attention in such intervention processes. ‘Facts’ about such people, as we have noted in the case of men who have sex with men, have arisen over years in contexts of what we perceive as ambiguous and often-misdirected information flows. ‘Other’ kinds of information about the lives of key populations that run counter to the seeming quantifiable ‘truths’ presented in the production of relevant data sets are often left out, deliberately or otherwise, because such information may not be seen to pertain directly to correlations of risk categorizations and HIV (prevention) (Adams 2016; Biruk 2012; Fan and Utretsky 2017).

As such, key populations have come to exist in an isomorphic relation with sexual risks and HIV. In these terms, and presently for instance, these populations can be seen to emerge as unmediated targets for the promotion of PrEP, as if no new social science or close attention to sexual lifeworlds is required, so to speak. This seems to be because of the accumulated weight of evidence that has established connections between such people, viral transmission, and HIV prevention over decades, as if nothing more need be known about such connections. This is not to say that correlations between key populations and HIV transmission may not reflect social circumstances of risk and structural vulnerability related to HIV transmission. Nor is it to suggest that there is no social science examining the uses of PrEP. This has been so, for instance, vis-à-vis the moral censure that some users may find themselves caught up in via associations with promiscuity, especially men who have sex with men, among other compounding, institutional factors driving inconsistent PrEP use (Race 2016).

Nonetheless, the overwhelming momentum in much social research on PrEP in mainstream HIV-prevention contexts is to focus on the drug regimen as a necessarily positive development, with social research employed to examine how to promote it. This is a continuation of the already noted trend that simply marks key populations as the expected recipients of each newly developed HIV-prevention technology. This was certainly our experience of attending PrEP-focused panels at the 2018 Amsterdam AIDS conference. Another instance is the recent publication of the ‘Key Population Activist Toolkit: PrEP’ (2018) by the International Treatment Preparedness Coalition. The text in

many ways conflates rights and recognition for key populations with demands for access to PrEP, iterating tropes of activism with promotion of this drug regimen.

Amidst such concerns, scholars, policy makers, activists, and community workers need to attend to how sexual subjects of HIV prevention are becoming newly involved in the mediation of (new) medical regimens amidst global health actions. An important consideration, as Elizabeth Mills (2017) has recently argued, is to orient research toward closely contextual understandings of medications as permeating bodily experience through their iteration in health initiatives and policies. Antiretroviral drugs emerge in these terms as actants in fields of biopolitical struggle, both within people's bodies where they interact with HIV, and beyond in the political and health systems that affect people's everyday technological relations with the virus. Similarly, we argue, it is necessary to understand how the promotion of (new) medications and regimens in current HIV and AIDS work is permeating the categorization of risk populations. Such categories are being animated anew as actants in their presently evolving relationship with HIV-prevention technologies.

Conclusion: Refiguring the category

Global health paradigms typically prefigure population-level entities as the objects of intervention and derive the figure on the ground – here, the imagined individual 'MSM' – after population-level scales of analysis. This is particularly so with respect to how such terms are commonly used in the health sciences, as 'flat' self-evident signifiers. In reflecting on this problem we have wanted to be cautious not to overstress how information flows through 'MSM' terminology, as if the term was at the hub of information networks, enabling conversations about same-sex sexualities and risk across global health knowledge communities.

Certainly, the term 'MSM' does enable such dialogues; it effects a translation of 'male-to-male sex' into a discursive register that has had palpable purchase in global health promotion for more than three decades. Yet, we have also sought to offer a perspective that prevails against any easily imagined global congruity. Thus, as much as 'MSM' may be encoded as a transnational figure in global HIV prevention it is also a site of complex fractures and failures in information exchange; the term may appear to evoke commensurable meanings in reference to an imagined self-evident subject (men who have sex with men), but also operates as a rubric that stops the flow of much knowledge and understanding about that same subject.

We have steered our analysis away from the term as a given noun that designates a particular category of people upon which scientific paradigms and health interventions come to bear. Instead, we have drawn attention to how evidentiary forms that circulate in global health constitute outcomes of particular forms of ongoing effort and 'doing' ('MSM-ing', in our case, so to speak). This can involve the acting of global health

categories and processes themselves as these inscribe systems of knowledge making and drug promotion with intent and meaning. Such actions can be seen to nurture classifications into being, figurations that come to operate as objective kinds of entities across global scales of analysis and practice but that also come to function otherwise.

This perspective allows room for thinking about global health not only as a site for the (mis)amalgamation of plural forms of evidence (Lambert 2013) but also for engendering further understanding of terminologies of intervention such as 'MSM'. Such terms can be seen as sites of multiply-unfolding meaning making, labour, and experience; containment fields that hold a particular epidemiological view together around imaginaries of risk practice, as if embodied by people who may be objectively known, quantified, and labelled. But such forms of knowledge often aver other intersecting realities that occur in and around the uses of health promotion rubrics, such as 'MSM'. Here we have offered glimpses of such other realities in different places, over time, and amidst divergent actions and technologies. 'MSM', in our reading, might be seen as always already a plural form of evidence making; a multiple discursive entity in a state of continuous becoming; and an attribute of the research infrastructures, policies, imaginaries, material documents, HIV-prevention policies, medicines, and networks that require 'men who have sex with men' to exist categorically.

Acknowledgements

We thank the editors of this special section, Elsa Fan, Robert Lorway, and Matthew Thomann, for their vital and encouraging help with this article. We also thank the anonymous reviewers for their critical insights and helpful interventions. We also of course especially thank the many people whom we have worked with over the years in the contexts cited in the paper.

About the authors

Paul Boyce is Senior Lecturer in Anthropology and International Development at the University of Sussex. Recent coedited publications include *Queering Knowledge: Analytics, Devices and Investment after Marilyn Strathern* (Routledge, 2019) and *Researching Sex and Sexualities* (Zed, 2018). He is currently preparing a monograph entitled 'Sexualities, HIV, and Ethnography: Sexual Worldings and Queer Misrecognitions in India' (Routledge).

Fabian Cataldo is Senior Advocacy Adviser at the International Planned Parenthood Federation and affiliated to the Institute for Global Health and Development at Queen Margaret University. Over the past twenty years, he has led research and advocacy efforts in Brazil, Malawi, and several southern African countries, with a focus on the social dimensions of care, health activism, HIV care and treatment access, and sexual and reproductive health and rights.

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