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Undoing and Redoing an At-risk Group: The Objectivation and Prevention of AIDS Among Male Homosexuals in the Antiretroviral Era

Each year in France, several thousand people find out that they are HIV-positive, despite relentless information and prevention campaigns since the 1990s. Associations and public authorities have been decisive in the struggle against the epidemic. The authors revisit the history of public health policies to combat AIDS and examine the transition from a prevention policy aimed at the general population to one targeting the individuals who are most at risk. To this end, using a variety of data, the authors analyse responses to three crucial questions: What is an at-risk group? How can we target at-risk individuals without stigmatizing them? And what are some strategies that can help protect them?

Since the start of the AIDS epidemic, the definition of risk borders has posed a problem in France. Seeking to avoid stigmatization, the country's public health culture has hesitated between attributing risk to groups and behaviours (Pollak, 1988; Calvez, 2004). In the 1990s, the fight against AIDS became a cause concerning the entire population, enabling the introduction of a public health policy without designating specific populations, or at least not explicitly (Pinell, 2002; Dodier, 2003). Focusing on the situation among immigrants, Didier Fassin analysed the problems involved in this type of policy. He demonstrated that it was underpinned by a knowledge production system based on avoidance and over-determination (Fassin, 1999) in which the refusal to stigmatize led doctors and politicians to refrain from using sexual or ethnic affiliations as explanatory variables, though these affiliations persisted in discourses without being called into question.

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In the late 2000s, this system of knowledge production and dissemination, oscillating between the unsaid and the unthought, came to an end. As illustrated in the Lert–Pialoux report on risk reduction (Lert and Pialoux, 2010), prevention experts began to identify “high-risk groups” in an increasingly explicit manner.⁽¹⁾ With statistical tools and a view to greater effectiveness and realism, epidemiologists and organizations came to identify the main groups exposed to AIDS as male homosexuals and immigrants from sub-Saharan Africa. Testifying to the issues in therapeutic efficiency spanning the definition of populations, these two most exposed groups are often referred to as “transmission groups” in the epidemiological literature and, more recently, as “key populations” (Desgrées du Loû and Spire, 2013), a concept used by the World Health Organization and UNAIDS. These observations allow for the implementation of programmes that are specific but not perceived as discriminatory. How might this shift be understood? For some players involved in the fight against the epidemic, the silence of the 1980s was succeeded by a well-founded and more effective scientific realism. This process of making explicit what once could not be said appears to have dismissed any political or moral issues to the benefit of epidemiological facts alone.

Yet this reading obscures changes in the objectivation of at-risk groups and the political and moral issues that continue to be involved. Following sociological research on quantification, we approach objectivation as a producer of target populations in a two-pronged process of “reality-seeking” and “institution” regarding these populations (Desrosières, 2008, Chapter 11). From this standpoint, identifying an at-risk group necessarily entails the following: the implementation of specific collection systems to identify changes in at-risk behaviour and attitudes to risk; the definition of the populations giving rise to prevention work; the delimitation of the spaces in which the groups thus defined are concentrated and/or less difficult to reach; the identification of the intermediary players liable to reach the sought-after groups and carry out prevention work; and lastly, the consideration of social and moral issues, particularly in terms of stigmatization, which the production of data on these populations involves (Schiltz, 2005).

In the case of AIDS, the definition of at-risk groups has changed considerably in recent years, a result notably of the efficacy of antiretroviral treatments. These reduce both the number of AIDS deaths and the risk of transmission. It is considered, under certain conditions, that a seropositive individual in treatment with an undetectable viral load cannot transmit AIDS (Race, 2001; Vernazza et al., 2008). That being so, neither sexual practices nor serological status provide sufficient information to define risk-taking, the latter also depending on the initiation of treatment for infected individuals and patient compliance.

(1) Commissioned by the French general health directorate (Direction générale de la santé, DGS) in 2009, the report was written by France Lert, research director and epidemiologist at the French National Institute of Health and Medical Research (INSERM), and Gilles Pialoux, head of the infectious diseases service at Hôpital Tenon in Paris.

Furthermore, the epidemiological situation is seen as preoccupying. New infections remain at a high rate in France (around 6,000 a year according to Cazein et al., 2014). The number of recent syphilis cases has increased since 2000 and doubled among homo-bisexual men between 2007 and 2017 (from 500 to 1,000 cases a year according to Ndeikoundam Ngangro et al., 2016). The incidence of HIV among men having had sexual relations with men is 200 times higher than among heterosexuals (Le Vu et al., 2010). The targets of prevention work thus need to be redefined. Since the 2000s, people living with HIV but unaware of their status or seronegative individuals with high-risk virus exposure practices are key concerns of public health. In this context, epidemiological and sociobehavioural surveys are targeting increasingly pinpointed spaces and groups. This trend also determines new prevention practices, including rapid and “targeted” screening in which organizations rather than doctors alone are now authorized to participate, while pre-exposure prophylaxis, based on the preventive rather than curative use of antiretroviral treatments, may be used by non-HIV-positive people. At no point have repeated screening or pre-exposure prophylaxis been envisioned for the population as a whole. These two interventions contribute to re-forming an “at-risk group” by extending and clarifying the learned definition.

The usage of the concept of risk itself is changing. The emphasis placed in the 1990s on “risk-taking”, i.e. occasional exposure to the risk of HIV contamination through unprotected sex, and on “risky behaviour”, implying repeated risk-taking, was aimed at distinguishing the individual from the behaviour they adopt at a period in their life, and thereby refuting “at-risk groups”, a concept seen as stigmatizing. The information disseminated – initially by organizations and then by state agencies at the end of the 2000s – on the contamination risk levels corresponding to different sexual practices acknowledged the difficulty of using condoms consistently. The idea was to equip people with the knowledge enabling them to observe “risk-reducing” practices, for example by replacing a “high-risk” practice, such as anal penetration without a condom by a partner with an unknown serological status, by a less risky practice, such as oral sex without a condom. In addition, independently of knowledge on contamination risk levels, relationships to HIV risk among homosexual men involve the perception of the risk by the individual, their ordinary experience of prevention, and their conception of social relations among homosexuals (Girard, 2013).

This article retraces the changes in the work on the objectivation of at-risk groups and the work on prevention specifically targeting those groups. It draws on a range of different material aimed at furthering understanding on a general logic through the diversity of objects.⁽²⁾ The paper primarily relies on the analysis of surveys on male homosexuals and AIDS in France carried out since the 1990s. To fully grasp objectivation in practice, the article also draws on field surveys on the implementation of rapid HIV testing and pre-exposure

(2) The collective project articulating the research of the authors of the article, from which this text is derived, received funding from the ANRS.

prophylaxis. The data on screening rely on an examination of the archives of the AIDES organization and reports by government bodies responsible for public health.⁽³⁾ The data on pre-exposure prophylaxis derive from our participation as sociologists in the Ipergay trial, aimed at assessing the effectiveness and feasibility of pre-exposure prophylaxis.⁽⁴⁾ We interviewed the people involved in the trial (participants, promoters, organization employees, and the French National Agency for Research on AIDS, or ANRS in French), took part in meetings, collected the documentation and communication media produced as part of the campaign, and monitored debates in community spaces.

I. How does the use of protection relapse? The identification of new at-risk behaviour and changes in objectivation

The introduction of a policy to fight against AIDS in France fostered the production of medical and epidemiological knowledge as well as sociobehavioural knowledge, notably sociological and anthropological, intended as vital tools in intervention. The ANRS has played a key role here in financing, organizing, and centralizing knowledge on HIV (Calvez, 2004). A consensus formed in the early 2000s recognizing a change in prevention practices, with “new realities, new challenges” in the relationships between AIDS and immigration (ANRS, 2000) and “new relationships to risk” among homosexual men (Bozon and Doré, 2007). For gays, studies gradually established the idea of a relapse in protection practices. Following a period in which condoms were adopted widely as part of sex between men, their use was shown to be decreasing. These behavioural changes should conceal neither changes in the instruments used to measure that behaviour nor the target populations.

1. New target populations

Since the end of the 1990s, numerous quantitative studies in France have demonstrated an increase in at-risk sexual behaviour among gays. This trend is consistent with comparable surveys led in other Western countries, including Australia, Canada, and the United States. In France, the 2000 Presse Gay survey revealed an increase in the reporting of unprotected anal sex with an occasional partner compared with the previous survey (in 1997).⁽⁵⁾ It also demonstrated the less frequent use of condoms with stable partners and a rise in sexually

(3) This documentary research is combined, in the sociological thesis of Maud Gelly (Gelly, 2016a, 2016b, 2018) who received partial funding from Sidaction, with an ethnographic survey based on interviews with screening officers and the direct observation of screening initiatives.

(4) Gabriel Girard was a member of the scientific committee of the trial from 2010 to 2016.

(5) Introduced in 1985, these surveys took their name from the fact that the questionnaires were disseminated by the press targeting male homosexuals. Fourteen surveys were administered and, starting in 2004, the survey was also disseminated on websites targeting male homosexuals.

transmitted diseases other than HIV. In 2000, 23% of respondents said they had unprotected anal sex with occasional partners, up from 16% in 1997. Regarding sexually transmitted diseases (STDs), 15.7% of respondents said they had been infected in 2000, compared with 13% in 1997 (Adam et al., 2001). Changes in at-risk behaviour since 2000 are presented as a “relapse” in preventive vigilance. This decrease in preventive practices was confirmed over the next 14 years in several surveys (Baromètre Gay in 2002; Presse Gay survey in 2004; Baromètre Gay in 2005; Prevagay in 2009; Presse Gay survey and Net Gay Baromètre in 2011). These surveys were based on different convenience samples and collection strategies, which no doubt explains the differences in results. According to the surveys, between 20% and 40% of homosexuals were considered as having at-risk practices for the transmission of HIV.

Furthermore, the populations targeted by these surveys were not entirely the same. The consensus formed by the surveys conducted in the 1990s was that men having sexual relations with men (MSMs) were the target population. The objective with this category, which comprehends individuals based on their practices, was to focus work on sexual practices and dismiss issues of identification, the latter being complex in a context of stigmatization and considered as secondary in the dynamic of the epidemic.⁽⁶⁾ Consequently, men who have sexual relations with men but do not declare or consider themselves as gay, as well as men who have sexual relations with partners of both sexes, are not excluded. More broadly, the initial objective of the Presse Gay surveys was to understand a range of profiles, even if the recruitment method (through the press) mainly addressed gays defining themselves as such and with a feeling of belonging to a community. While this objective has not disappeared, several surveys since 2000 have targeted more strictly delimited populations, including individuals frequenting sexual sociability venues and bareback meeting sites,⁽⁷⁾ those with multiple partners, young people, and seropositive men, considered as target populations for prevention discourses.

These populations are appraised through increasingly delimited spaces, and in particular gay commercial venues. It is not simply the space of the surveys that has changed; it is also the perception of these spaces. Sexual sociability venues were not excluded from the research initiated in the 1990s by the ANRS, which between 1993 and 1997 led a series of ethnographic surveys in pick-up venues, both exterior and commercial (de Busscher et al., 1999; Mendès-Leite et al., 2000). The aim of this research-action was to favour prevention in these spaces, with backrooms being considered as spaces where risk may be negotiated: “once prudish fantasies on ‘the dangers of promiscuity’ have been dismissed”, they can be “real sources for prevention” (Mendès-Leite and de Busscher, 1997, p. 66).

(6) For a critical analysis of the MSM category and its migration from the domain of epidemiology to that of organizations, see Thomas (2011).

(7) The category is subject to debate and comprehends either the absence of protection or the desire to be contaminated, but in all cases indicates the refusal to use condoms (Girard, 2013).

Another academic construction of these spaces emerged in the 2000s. The 2000 *Baromètre Gay* was a short survey targeting the customers of “Parisian gay establishments” (bars, sex clubs, saunas) and based on the assumption that these individuals constituted a “particularly sexually active population” (Adam, 2002). The 2005 *Baromètre Gay* extended its scope to include France as a whole and disseminated the questionnaire in exterior pick-up venues and “identitarian” sites (Velter et al., 2005; Velter et al., 2006). The 2009 *Prevagay* survey (Velter et al., 2010) followed on from this work while objectivizing HIV seroprevalence among this population. The behavioural survey via questionnaire was carried out in Parisian bars, backrooms, and saunas with 886 men and supplemented by a blood sample (a capillary sample taken by the individuals themselves from their fingertips). The match between the behavioural data and the biomedical data showed that 20% of seropositive gays were unaware of their status.

Besides targeted groups and spaces, changes have also occurred regarding the frameworks for interpreting the sexual behaviour of male homosexuals. The work of Philippe Adam, head of the 1997 and 2000 *Presse Gay* surveys and the 2000 *Baromètre Gay*, illustrates this trend. His sociology thesis analyses the emergence in France of organizations fighting against AIDS, the trajectories of activists, and changes in homosexual experiences since the 1980s (Adam, 1997). Adam’s thesis draws on archives, interviews, and the data of the *Presse Gay* surveys to highlight the diversity of sociosexual experiences with regard to risk management and to underline the importance of class membership and homosexual sociability in explaining adaptations of sexual behaviour within the context of the spread of the epidemic. AIDS is not considered as an agent of change but as revealing prior changes, and in particular the growing social acceptance of homosexuality. From this standpoint, Adam sees the relapse in preventive practices as an overly simplified explanation of a broader change in gay sexualities and lifestyles (Adam and Schiltz, 1996).

Adam’s research took on a more psychosociological – and more alarmist – focus in the 1990s. In the results of the 2000 *Baromètre Gay*, he saw the development of a “specific risk culture” among the seropositive customers of backrooms (Adam, 2002, p. 79). In 2004, he contributed to a survey with the users of a French dating site addressing the desires of gay men and, in particular, the emergence of fantasies about unprotected sex. Class membership and differences in sociability were trumped here by criteria more related to public health, namely alcohol and drug consumption and serological status. The different ways of managing risks and the influence of social structures and experiences stressed in Adam’s thesis give way to at-risk behaviour, determined by new dating techniques. The thesis also highlighted the different place accorded to sexuality relative to social belonging, with sexual behaviour being replaced by the non-sexual experiences of individuals and in particular their occupational situation and conception of homosexuality. This second survey

paid greater attention to the sex drive, favoured by new sexual dating technologies (online dating sites) but independently of social contexts (Adam et al., 2006; Adam et al., 2011).

Targeting new populations thus calls for the introduction of specific collection systems aimed at addressing certain male homosexuals. The latter are defined not just by their sexual practices but by the venues they frequent and, more broadly, by a specific relationship to sexuality in which prevention is secondary.

2. Redefining risk practices

The redefinition of at-risk practices is a second change in this work on objectivation. In the early 2000s, the relapse in the use of prevention was seen first of all in increased reports of unprotected anal penetration (UAP) among respondents, particularly with occasional partners with an unknown or different serological status. Gradually, in the following surveys, only certain forms of UAP were identified as indicators of risk: not those occurring with a stable partner but those occurring with occasional ones; and not a single act of UAP in the last 12 months but repeated acts of UAP. The idea, then, was not so much to record accidents but the relationship to risk.

Redefining at-risk practices was also related to implementing the risk-reduction paradigm imposed in France in the 2000s (Girard, 2016). As part of this paradigm, promoting the use of condoms on the basis of an opposition between at-risk and safe practices was supplemented by a risk scale taking account of various aspects such as sexual role (passive or active anal penetration), the use of lubricant gel, or the partner's serological status. The reduction of risks targeted situations in which condoms are not used. The 2011 *Presse Gay et Lesbienne* survey recorded this change. While it recorded unprotected anal practices and oral sex with exposure to sperm as at-risk practices, the 2011 survey, like that from 2004, also recorded practices corresponding to a risk of contamination that is not zero but lower than the practice of anal penetration by a partner with an unknown serological status. This is true with "serosorting", i.e. taking part in UAP with a partner of the same serological status. In the same order of practices corresponding to a variable risk level, the survey also addressed "seropositioning" (participating in UAP in an active or passive position, the former being considered as less risky than the latter) and viral load checks (Velter et al., 2013).

The redefinition of risk had consequences on the results of the 2011 survey, in which 18.4% of seropositive individuals and 58.5% of seronegative individuals said they always used protection for anal penetration with occasional partners; in the 2004 survey, these percentages were 50.9% and 73.4%, respectively. It may be assumed that this change shows not simply an increase in UAP but a relativization of the risks involved. Some of the respondents, and notably seropositive respondents, had no doubt formed the idea that, thanks to treatment,

UAP is not necessarily akin to an at-risk practice and were perhaps more inclined to report such activity. The questionnaire itself shed greater light on these individuals by addressing the various risk-reduction strategies.

The changes in preventive behaviour and the “relapse” of male homosexuals in the 2000s are thus related to a dual redefinition of target populations by surveys and at-risk behaviours. It was no longer just MSMs but certain male homosexuals and certain spaces that were targeted as part of a more precise coverage of the space of sexual practices between men. The target of surveys was no longer simply unprotected penetration but certain sexual behaviours distinguished according to partner, positions, and frequency. Consequently, it was not just the behaviour of male homosexuals but the instruments for measuring that behaviour that were changing.

II. Ignorance and powerlessness: the renewal of prevention practices

The objectivation of a relapse in preventive practices among gays starting at the end of the 2000s gradually led public health bodies, particularly the ANRS, to implement new research, intervention, and prevention strategies, which followed on from the work on defining at-risk groups initiated in quantitative surveys. The work no longer involved measurement instruments but prevention practices in which the definition of a target population is also that of a population in which it is possible to intervene. This work involves producing a figure of an at-risk individual that takes note of the lack of protection without making prevention pointless. This tension is illustrated by two forms of intervention: targeted screening and pre-exposure prophylaxis. And to diminish that tension, it was not just sexual behaviours that were to be taken into account but the relationship to the disease and HIV risk, characterized by ignorance as to one’s serological status and powerlessness in the implementation of consistent prevention. With at-risk sexual behaviours persisting in an era of triple therapies, it is important to screen and treat at an early stage individuals contaminating each other and offer other preventive strategies to individuals failing to use condoms systematically.

1. From reinforced screening to targeted screening

The acknowledgement of the efficacy of triple therapies after 1996 was followed in the 2000s by renewed public initiatives. The French National AIDS Council (Conseil national du sida, CNS) in 2006 and the French National Authority for Health (Haute autorité de santé, HAS) in 2009, followed by the national plan to fight against AIDS in 2010, advocated reinforced screening by targeting the most exposed population, notably gay men. Two objectives were involved. The first was to reduce the number of delayed diagnoses, the second

to screen the 32,000 to 68,000 people (according to estimates) unaware of their seropositive condition (French Ministry of Health and Sports, 2010, pp. 35–45). In other words, the aim was to detect seropositive people unaware of their status. While targeted screening addresses homosexual men and migrants alike, the specificity relative to the former group is that it is designed as repeated screening, with a view to establishing a diagnosis as quickly as possible after contamination and treating the individuals before they contaminate their partners. The results of the HPTN052 trial published in 2011 confirmed the benefits of early-stage treatment by demonstrating that HIV transmission in couples had been reduced and that the clinical condition of the individual had improved (Cohen et al., 2011).

While reinforced screening was introduced after the launch of triple therapies in 1996, targeted screening for homosexual men is more recent and has been implemented against a backdrop of increased risk-taking and changes in recommendations in favour of earlier-stage retroviral treatments regardless of the infection's stage.

Reinforcing screening to treat seropositive individuals and limit contamination

In the initial years of the epidemic, the promotion of screening was not central to HIV strategies. In the absence of effective treatments, individuals learning of their HIV-positive status mainly experienced anxiety and isolation (Hirsch, 1991). In the second half of the 1980s, organizations, medical specialists, and health authorities agreed to refuse mandatory screening (Dodier, 2003). It was after the launch of triple therapies that screening became a major focus of public action in this area, as a way of detecting HIV-positive individuals unaware of their status and quickly administering treatment to limit contamination. The strengthening of screening and the assertion of its “targeted” nature were subject to a broad consensus among public health bodies (including the HAS and DGS) and organizations.

The French national research group, AIDES, organized a special day on “screening issues” on 22 February 1997. It reported its conclusions to its national council on 15 and 16 March 1997 as follows:

The group recommends that the National Council rule in favour of a more incentivizing screening policy by the community for the community ... with a view to earlier access to treatment While our discourse was formerly “better counselling⁽⁸⁾ than screening”, it may now become “better correctly proposed and administered screening than (poor) counselling”.⁽⁹⁾

(8) Interview method recommended, among others, for screening.

(9) National Archives, AN 20030474/3, AIDES National Council, 15–16 March 1997. “Le groupe recommande au CN [Conseil National] de se déterminer pour une politique de dépistage plus incitative par la communauté vers la communauté ... dans une perspective d'accès plus précoce aux traitements ... Si notre discours a été ‘il vaut mieux du counselling que du dépistage’, il pourrait devenir ‘il vaut mieux un dépistage correctement proposé et correctement effectué qu’un (mauvais) counselling.’”

The organization quickly changed direction, with the benefits of triple therapies being immediate and obvious, and agreed on by all experts. AIDES was even in favour of “self-samples ... sent to the laboratory, interpreted by a professional, and given to the patient by telephone” as they tied in with the same “incentivizing approach” (*logique incitative*). This proposal had no immediate effect, self-sample kits being launched nearly 20 years later in 2015.

At the same time, the French Ministry of Health criticized a screening system that was unevenly implemented in favour of the most socially fragile groups and much too late, and recommended that screening be extended.⁽¹⁰⁾ Extending screening means extending it in time, by doing it earlier, and in social space, by addressing groups defined on the basis of social rather than sexual and behavioural criteria. This was reflected in the 29 May 1997 meeting of the information and communication subgroup of the Ministerial working group on the early diagnosis of HIV infection:

Two major issues underpin early diagnoses: prevention (the reduced risk of transmission to partners) and care (more specifically, the treatment). ... The underlying screening models come down to:

- the conventional approach to screening transmissible diseases inherited from [the] fight against sexually transmissible diseases and the fight against tuberculosis;
- the approach of screening programmes linked to a possible benefit for individuals and populations in terms of morbidity and incapacities. This approach now becomes possible.⁽¹¹⁾

As has generally been the case in the fight against AIDS since the 1990s, the AIDS division of the DGS combined the French government, doctors, and organizations, since the representatives of the DGS, the Île-de-France regional union of general practitioners, and the Arcat-Sida and AIDES organizations contribute to its work. A consensus thus existed between the French government, the medical sector, and organizations on the extension of screening and of the groups targeted by public action. But screening was not uniformly extended in the social space, and homosexual men were subject to specific targeting.

(10) National Archives, AN 20030474/50, AIDES Federation / Therapeutic action / National information group on treatment / Ministerial working group on early screening 1997, memo from Françoise Bélingard-Deybach to the Director General of Health, 25/03/1997.

(11) National Archives, AN 20030474/50, AIDES Federation / Therapeutic action / National information group on treatment / Ministerial working group on early screening 1997, minutes of the meeting of the information and communication subgroup of the Ministerial working group of the early diagnosis of HIV infection of the DGS AIDS Division, 29/05/1997. “Deux grands enjeux sous-tendent le dépistage précoce: la prévention (réduction des risques de transmission aux partenaires) et la prise en charge (très précisément les traitements). ... Les modèles de dépistage sous-jacent ramènent: au schéma classique du dépistage des maladies transmissibles hérité de [la] lutte contre les maladies sexuellement transmissibles ou de la lutte contre la tuberculose; au schéma des programmes de dépistage lié à la possibilité d’un bénéfice pour les individus et populations en termes de morbidité ou d’incapacités. Ce schéma devient possible”.

Legitimizing targeted screening

In 2010, the French Ministry of Health drafted a national plan on the fight against HIV/AIDS and other STDs for the 2010–2014 period, determining five “strategic focuses” to combat the epidemic. The second of these was screening.⁽¹²⁾ At the time, HIV screening in France had been stable since 2006, with five million tests a year (or 80 per 1,000 inhabitants), three-quarters of which at city laboratories and 7% at anonymous and free screening centres (Centres de dépistage anonyme et gratuit, CDAGs). The proportion of positive serologies was 2.2 per 1,000 at the national level and higher at CDAGs (3.6 per 1,000; Cazein et al., 2014). Summarizing the surveys made on this issue, the national plan identified two profiles in delayed diagnoses: “members of an identified at-risk population” having failed to be screened, having failed to contact the healthcare system, or not having been screened during this contact; and “individuals with low ‘apparent’ risk (for example, French heterosexuals)” (French Ministry of Health and Sports, 2010, pp. 35–45).

The first profile corresponds to a group of individuals liable to transmit AIDS more widely, not the second. While the two groups have the equivalent individual benefit of being screened and treated at an early stage, the reduction in the number of contaminations at the collective level is greater where screening targets the first group. In other words, to reduce the spread of the virus among the population as a whole, screening needs to be reinforced among homosexual men and migrants from sub-Saharan Africa (drug users now account for just 1% of new contaminations, following the introduction of syringe-exchange and substitution policies).

To screen these two categories, the national plan promoted a “screening tripod”. This initially included the screening of the general population through more systematic proposals for screening by healthcare professionals, and notably general practitioners, as well as the possibility, from 2010, of laboratory screening without a prescription (Article L. 6211-10 of the French Public Health Code). The second component of the system was “screening by peers for high-incidence populations”, “the idea being to develop ‘community’ screening carried out by peers. This screening method aims to respond to the needs of populations who either do not want or are unable to use the ‘conventional’ system. The screening method above all targets MSMs”. Lastly, the system was rounded out with anonymous and free screening carried out by CDAGs, in response to a voluntary approach on the part of users (French Ministry of Health and Sports, 2010, pp. 35–45).

To each of these two public-action approaches corresponded a type of actor: general practitioners, to implement widespread screening with the aim of increasing the lifespan of each individual screened to that of the population

(12) The first concerned prevention, the third medical treatment, the fourth social care and the fight against discrimination, and the fifth research.

as a whole; and specific systems, to implement targeted screening aimed at reducing the contamination risk of the general population. Reaching these target populations called for specific approaches on the part of the government and organizations.

Mobilizing organizations to reinforce the screening of homosexual men: the emergence of community screening

Despite the scientific and political consensus on the extension of screening, public action changed very little. The early 2000s saw an increase, initially outside France, in screening tests at organizations. These were carried out using rapid-screening techniques in which a sample of blood was taken from the fingertip and the test results provided immediately. This was the case with the Checkpoint project, launched in Amsterdam in 2000 (Darmon, 2008). Most of these tests were community based, with screening managed not by healthcare professionals but activists from among the target population, in this case homosexual men.

In 2007, taking its inspiration from these initiatives, the AIDES delegation from the Hérault department developed the Checkpoint rapid-screening project, styled as a “public health and community health” project.⁽¹³⁾ On 24 and 25 February, the AIDES board of directors committed to the research-based approval of “community” screening.⁽¹⁴⁾ Harnessing Com’Test community research,⁽¹⁵⁾ AIDES initiated negotiations with the DGS and the Health Ministry, which resulted in November 2010 in a decree on the legalization of the practice of rapid screening by non-healthcare professionals.⁽¹⁶⁾

Despite the overtly “demedicalized approach” (*démédicalisation*) and the tradition of criticizing the medical authorities that gave rise to AIDS organizations, the strategy of organization-based screening highlighted changes in the division of labour in the public health system. The contribution of organizations took the form of “community research”, which, not unlike community health actions (Fournier et al., 1995), was led “for, by and with” the groups that the public health system was unable to reach or know, as explained by a collective guide on community research written by activists (notably from AIDES) and researchers (Demange et al., 2012). The production of knowledge thus appears to be closely linked to the delimitation of populations for whom this knowledge is valid, the focus being on practical knowledge that consists in finding infected individuals. The extension of screening was mainly based on “community

(13) AIDES, “Memorandum on the opening of a screening Checkpoint to the delegation of the Hérault department” (preparatory document for the Board Meeting of 8 and 9 September 2007), 2007.

(14) AIDES, Board Meeting of 24 and 25 February 2007, Point 8, “Screening resolution project”.

(15) Research led since 2009 by AIDES to assess “community” screening, i.e. implemented by the activists of the organization.

(16) Order of 9 November 2010 determining the operating conditions of rapid diagnosis tests on the human immunodeficiency virus (HIV 1 and 2), *Journal Officiel de la République Française*, 17 November 2010, no. 0266, p. 20,499.

screening” tests aimed at reaching, through mediators (be they employees, activists from organizations or, more rarely, employees of care institutions), the groups most exposed to HIV.

The aim with the *Presse Gay* and *Baromètre Gay* surveys was to count the number of men who did not want or were unable to protect themselves from the risk of contamination. With targeted screening, and notably community screening, the idea is to detect these individuals as early as possible after contamination. And the initial assessments of this screening approach have demonstrated its effectiveness, achieving a positive screening rate of 8.6 per 1,000, higher than that of the CDAGs (Cazein et al., 2014). With pre-exposure prophylaxis (PrEP), the idea is to provide these people with the tools for coping with a risk that they are unable to control.

2. PrEP: treatment for gay men unable to protect themselves

The second example of new prevention strategies introduced in France in the 2000s is the *Ipergay* PrEP trial (*Ipergay* standing for *Intervention Préventive de l'Exposition aux Risques avec et pour les Gays*, or preventive intervention on risk exposure with and for gay men). *Ipergay* offered gay seronegative men with at-risk practices the opportunity to assess the efficacy of an antiretroviral drug to avoid contamination. Several sociological issues are involved in PrEP (Auerbach and Hoppe, 2015), but we will focus on the way in which this trial targets particular individuals. The literature on AIDS quickly established the way in which learned perceptions of sexuality, and male homosexuality in particular, contributed to prevention frameworks by opposing “good” and “bad” sexual subjects (Edelman, 2013, Chapter 6; Treichler, 2013). By addressing risk-taking gay men but without the aim of reforming their behaviour, *Ipergay* focused not on the exemplary nature of gay men who use condoms but the fallibility of those who do not succeed in doing so. While the aim of this image is to pinpoint the characteristics of risk-taking homosexuals, it also produces a singular figure, that of an individual unable to systematically protect themselves and simultaneously able to follow a complex course of treatment and rationalize their sexuality, and who is thus likely to be receptive to new prevention strategies (Trachman and Girard, 2018).

This singular figure distinguishes PrEP from another prophylactic use of antiretrovirals: post-exposure treatment, which has been available in France since 1998 (Paicheler, 2007). Individuals having had at-risk sex follow an antiretroviral treatment in the hours following the encounter and for a 28-day period to limit the likelihood of infection. Despite its efficacy, few individuals follow post-exposure treatment. The aim, then, is to fight against a lack of information on the part of potential users, such as medical services (Lert and Pialoux, 2010). With PrEP, the key focus of researchers is not on the lack of knowledge but the difficulties encountered by individuals in

introducing preventive practices, and thus the necessity of renewing them. The goal is not just to raise awareness but to provide individuals with the tools best adapted to their relationship to sexuality – as demonstrated by the Ipergay trial.

Launched in France in February 2012, Ipergay was a randomized PrEP trial in which seronegative gay men with at-risk sexual practices were able, on a voluntary basis, to access reinforced sexual health treatment, including an antiretroviral drug, to limit the risks of contamination. Only a part of the sample, selected on a random and double-blind basis,⁽¹⁷⁾ had access to the real treatment; the others were administered a placebo. According to the trial protocol, the idea was to offer “a pragmatic and easy-to-observe prophylaxis model” depending on the subject’s sexual activity. In practice, the participants had to take a pill 24 hours before a sexual encounter (and no later than two hours before), followed by a pill every 24 hours during the period of sexual activity, and a final pill 24 hours after the sexual activity. Again according to the protocol, the aim was to assess the feasibility of PrEP with a “well-informed European population” and thus the specific sociobehavioural characteristics of populations in their relationship to risk and AIDS. Besides its PrEP assessment objective, Ipergay fostered the use of other means of protection. PrEP was accompanied by the promotion of “combined prevention”: taking as granted that at-risk behaviours exist does not lead to abandoning behavioural prevention methods to the benefit of biomedical prevention, but instead reinforces them.

Individuals were included in the trial based on medical, demographic, and behavioural criteria. The individuals selected were men (or transgender individuals) aged over 18 with a “high risk of HIV contamination” (defined as at least two UAP encounters with different partners in the last six months). The subjects were recruited by the members of AIDES and other organizations in gay sociability venues and sexual meeting places, as well as on online dating sites. The trial thus engaged with the new risk spaces identified by surveys in the 2000s.

A communication campaign was rolled out to facilitate the recruitment of volunteers. The campaign also helped to determine the population targeted by the trial, above and beyond the inclusion criteria. The first poster campaign showed men with relatively varied profiles saying, “I’m Ipergay. And you?” (*Moi je suis Ipergay, et toi?*) This wording may seem redundant and short on information, but it serves to generate a question.

The trial also targeted “people with a high risk of contamination”.⁽¹⁸⁾ The 2013 poster stating that “HIV affects 200 times more gays than heterosexuals”

(17) In which neither the participant nor the doctor knows what the pill contains (active molecule or placebo).

(18) These words were used in the newsletter published in the summer of 2013 and communicated to doctors by the trial coordination team.

was not a simple epidemiological reminder. It broke with the habitual caution of prevention campaigns that, afraid of stigmatizing populations, failed to highlight differences in prevalence in as forthright a manner. Yet Ipergay communication did not make a difference between responsible individuals and others. It did not necessarily target individuals who intentionally take risks, as with the worrying figure that has haunted debates over bareback activity (Girard, 2013). In the prevention campaigns, this figure is depicted just once, in a highly specific context: the campaign for a specialist website explicitly referring to the bareback subculture. This campaign highlighted the “love” of “sex without condoms”, even though the explanatory text immediately stresses combined prevention. Prevention, then, is carried out with a “total acceptance of practices”, an expression used several times in the campaigns.

This discourse was exceptional. The campaign targets were those who are powerless to protect themselves consistently, those who do not reject prevention but for whom it is problematic. A web banner showed a questioning young man accompanied by the words, “How do you protect yourself from HIV?” A 2013 poster asked if readers had “a problem with condoms”. The first page of a leaflet for recruiting volunteers showed a man looking the viewer straight in the eyes along with the question, “Had enough worrying after each time you have sex?” Confronting prevention difficulties and mobilizing affects was central to the campaign.

The trial did not focus on subjects who do as they please, either with or without protection. Participation in the trial presumed that the volunteers wanted to reform their behaviour but were unable to do so; it acknowledged at-risk practices by interpreting them as the powerlessness to protect oneself rather than the desire not to protect oneself. The way Ipergay targeted populations takes on its full meaning in respect to the “relapse” of preventive practices, considering risk-taking gay men as fallible individuals rather than “lost causes” or “reckless” people who deliberately take risks and intend to keep doing so. The acknowledgement of weakness on the part of certain gay men relative to risk provides a basis for prevention that takes account of the inadequacy of behavioural prevention.

Conclusion

In the 2000s, through a combination of repeated surveys, epidemiological data, and specific prevention systems, knowledge and intervention defined a population of male homosexuals considered as privileged targets for prevention. While avoiding stigmatization no longer played a decisive role, the production of an at-risk group was not based solely on realism regarding relationships to risk. A few years before the market launch of triple therapies, Michaël Pollak wrote about debates between broad-based and targeted prevention policies as follows:

[W]hile there is much talk of a necessary adjustment of the messages addressed to targeted groups, there is also a need to distinguish between the two definitions of the adjusted, one focused on accuracy (technical) and the other on justice (political and civic).⁽¹⁹⁾

At the start of the 2000s, technical accuracy prevailed over political justice, the fear of stigmatization faded, and objectivation and prevention techniques were renewed and adjusted to the targeted group. But this technical accuracy was not free of unformulated ideas relating to the various aspects of defining an at-risk group, including practices as well as spaces where this group could be understood, and the determining of some of the sociodemographic characteristics of the individuals (meaning that other sociodemographic characteristics were deemed as irrelevant to the definition of the group).

Beyond the resurgence in risk-taking, it is the definition of relationships to risk and seropositivity that has changed. The recognition of a “relapse” in prevention among gay men has given rise to a new problem that plays a decisive role in the establishment of an at-risk group. How are we to grasp these populations that appear to refuse prevention as hitherto practised? As in the “surveillance medicine” described by David Armstrong in his genealogy of screening in the twentieth century (Armstrong, 2012), the target is not the consultant but the non-consultant, the individual that falls through the holes in the prevention net. The mobilization of individuals from organizations conceived of as members of the target population is a way of meeting this objective. The challenge is not simply to design new resources to capture this population but to produce an image of risk-taking individuals, which sees non-protection as a possibility without rendering all forms of intervention and prevention obsolete. The idea, then, is to adjust target groups to prevention techniques. The consideration of the complexity of relationships to risk and sexuality, characterized by ignorance and powerlessness, may thus be understood both as a more accurate description of risk-taking and as the delimitation of a target for prevention work. The definition of an at-risk group does not rely exclusively on medical and epidemiological data and the attendant trends. It is subject to a set of constraints stemming from the therapeutic modernity analysed by Nicolas Dodier: the development of controlled and randomized trials, the break with paternalism, and the work of organizations, ethical committees, and laypeople (Dodier, 2003). The case of male homosexuals shows that the definition of an at-risk group should also justify prevention by offering footholds for that action.

(19) “[S]i l’on parle souvent d’un nécessaire ajustement des messages aux publics ciblés, il convient par ailleurs de distinguer entre les deux définitions de l’ajusté, orientées l’une vers la justesse (technique), l’autre vers la justice (politique et civique)” (Pollak, 1988, p. 20).



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Mathieu TRACHMAN, Maud GELLY, Gabriel GIRARD • UNDOING AND REDOING AN AT-RISK GROUP: THE OBJECTIVATION AND PREVENTION OF AIDS AMONG MALE HOMOSEXUALS IN THE ANTIRETROVIRAL ERA

In the 1990s, the fight against HIV became a national cause, the preventive initiatives of which addressed the entire population to avoid any stigmatization. In the 2000s, recognizing the existence of “high-risk groups” no longer posed a problem and determined more targeted action. In response to the resurgence in risk-taking, the players involved in these efforts worked to understand groups through the close observation of their behaviour. Focusing on male homosexuals, the article analyses two recent innovations embodying this trend: the demedicalization of screening and pre-exposure prophylaxis. These developments show that the observed changes are not simply about expressing what should not be said, but instead involve renewed work on objectivation, the mobilization of members of the target population, and a certain idea of the risk-taking individual. The detection of at-risk behaviour also serves to delimit the populations with which intervention is possible and the implementation of the necessary tools.

Mathieu TRACHMAN, Maud GELLY, Gabriel GIRARD • DÉFAIRE ET REFAIRE UN GROUPE À RISQUE. OBJECTIVATION ET PRÉVENTION DU SIDA CHEZ LES HOMOSEXUELS MASCULINS À L'ÈRE DES ANTIRÉTROVIRAUX

Au cours des années 1990, la lutte contre le VIH est devenue une cause nationale dont les actes de prévention s'adressent à l'ensemble de la population afin de prévenir toute stigmatisation. Dans les années 2000, la reconnaissance de l'existence de « groupes à risque » n'a plus posé problème et a déterminé des actions plus ciblées. Constatant la recrudescence des prises de risques, ces acteurs se sont donnés les moyens de saisir les groupes au plus près de leurs comportements. À partir du cas des homosexuels masculins, l'article analyse deux innovations récentes qui incarnent cette tendance : la démedicalisation du dépistage et la prophylaxie préexposition. Celles-ci permettent de montrer que l'évolution observée ne se résume pas à l'explicitation de ce qui devait être passé sous silence, mais suppose un travail d'objectivation renouvelé, de mobilisation d'individus appartenant à la population ciblée et d'une certaine conception de l'individu preneur de risques. Le repérage des comportements à risque permet aussi de délimiter les populations sur lesquelles il est possible d'intervenir et la mise en place d'outils pour y parvenir.

Mathieu TRACHMAN, Maud GELLY, Gabriel GIRARD • DESHACER Y REHACER UN GRUPO DE RIESGO. OBJETIVACIÓN Y PREVENCIÓN DEL SIDA ENTRE LOS HOMOSEXUALES MASCULINOS EN LA ERA DE LOS ANTIRRETROVIRALES.

Durante os años 1990, la lucha contra el VIH en Francia se ha convertido en una causa nacional y las acciones de prevención se dirigen al conjunto de la población para evitar toda discriminación. En los años 2000, el reconocimiento de la existencia de “grupos de riesgo” ya no ha planteado ningún problema y se han podido determinar acciones más selectivas. Ante la recrudescencia de las asunciones de riesgo, se ha sentido la necesidad de aprehender los grupos por una observación precisa de sus comportamientos. A partir del caso de homosexuales masculinos, este artículo analiza dos innovaciones recientes: la desmedicalización de la detección et la profilaxis anterior a la exposición. Las dos permiten mostrar que la evolución observada no se limita a la explicitación de lo que habría tenido que haber sido silenciado, sino que supone un trabajo de objetivación renovado, de movilización de individuos pertenecientes a la población considerada y de una cierta concepción del individuo que asume riesgos. La identificación de comportamientos de riesgo permite también delimitar las poblaciones sobre las que es posible intervenir y establecer los instrumentos para lograrlo.

Keywords: HIV/AIDS, male homosexuality, prevention, screening, prophylaxis, at-risk, PrEP, France

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