

INTRODUCTION

Virtual issue on HIV/AIDS

Critical voices in public health have engaged with the HIV/AIDS pandemic since its emergence, and papers on HIV/AIDS have been a recurrent presence since the first volumes of *Critical Public Health*. The ways in which the pandemic has, through its history, delineated 'at risk' groups in particular times and places, and further stigmatized such groups as inherently 'risky' has been a key theme. Early papers tended to focus on risk as an empirical category, often concerned with identifying who was at risk and what was risky (Haour-Knipe & Aggleton, 1998). An example is Howarth's assessment of the risks for undertakers (Howarth, 1993). The early focus on individualised health education as a response to risk behaviour attracted some comment on the forms that education and publicity took. Thorogood, for instance, critiqued the social control implicit in even the 'empowerment' models of sex education that were arising in response to the need to inform young people about risk Thorogood (1992), and Wellings' (1992) assessed the strengths and weaknesses of the social marketing approach. Critiques of health promotion campaigns and broader media outputs, usually drawing on some variant of discourse analysis, continue to be a rich seam of enquiry. Southwell (2000), for instance, used the concept of 'analytic audiences' to explore the ways in which the US Centres for Disease Control constructed particular target groups through information aimed at specific 'minority' audiences. Lupton (1998), in her analysis of the history of mass media representations of AIDS in Australia, shows how the construction of the problem has shifted from that of a public health threat to a biomedical problem. This was linked, she argues, to changing political interests and perceptions of the disease in terms of who was at risk: gay men, or the whole population?

As Haour-Knipe and Aggleton (1998) note, before AIDS emerged, there was little research on sexual behaviour. In Foucauldian terms, the emergence of the pandemic has been an incitement to discourse. Not only did it become permissible to research and write on sexual behaviour, but understanding it became a public health imperative, although of course still politically sensitive in many settings, as Schuboltz, Rolston and Simpson (2004) note in the context of their survey of the sexual attitudes and lifestyles of young people in Northern Ireland. In many developed and, more recently, low income, countries HIV has been the spur for explorations of sexuality, particularly young people's sexuality. Stewart, Mischewski and Smith (2000) for instance, draw out the implications of the prevention of HIV/AIDS and sexually transmitted infections (STIs) in general from their research on sexual identity and behaviour among young people in Australia, which suggests that identities are both less stable and more ambiguous than much health promotion assumes. Dowsett et al. (1998) make a similar point in the context of sexual behaviour in low income countries, suggesting that traditional knowledge, attitudes and practices (KAP) type surveys are insufficiently nuanced to identify the context and culture of sexual behaviour. They used a more qualitative methodology to look at how young

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participants understood sexuality and sexual activity across seven countries, concluding that although there were cross cutting themes (particularly around gender relations), the imperative was to understand risk in the context of expectations and relationships, and remembering that this context is shifting with changing discourses of gender. Rivers et al. (1998), in their study of how women could negotiate the use of female condom in four sites in Costa Rica, Mexico, Senegal and Indonesia, also point to the need for careful delineation of contexts in outlining the specific conditions under which this negotiation is more likely to be successful (Rivers et al., 1998).

Despite the growing acceptance and sophistication of research on sexual behaviour, and the more subtle accounts of local contexts, some broad generalisations are still pertinent. The risks associated with sexual activity remain a powerful source of stigma in much of the world, as Malcolm et al. (1998) note in their review of how discrimination acts as a barrier to effective prevention programmes. The forms such stigmatization take may vary, with the disease being associated with, for instance, those from other countries, or from particular sub-groups in the population, and result in a range of discriminatory practices (including compulsory testing, bars to employment, and even imprisonment), but Maclom et al. (1998) conclude that both are widespread in many parts of the world. The risk of HIV/AIDS of course acts as a marker or amplifier of other kinds of social stigmatization and discrimination, and discursively also functions to legitimate the stigmatization of particular behaviours. Shoveller and Johnson (2006), in their review of public health research and provision related to youth sex in Canada, suggest that HIV/AIDS has been the vehicle for marginalising some forms of youth sex as unhealthy. Victimization is of course not unique to the AIDS pandemic, and STIs have long been linked to the marginalised or stigmatized, as Yang and Southwell (2004) show in their review of advertising from Shanghai in the 1920 and 30s, which depicted sex workers as a source of danger and instability. Sex workers continue to be a vulnerable group in terms of risk, and also victimisation. As Scambler and Scambler (1994) note in their paper on the health needs of women sex workers, of all the risks they face, it is those of STIs, including HIV, that have been most researched.

More than 1.6 million people in high income countries are living with HIV. Since 1996, this group have had (in theory) access to antiretroviral treatment (ART). However, even in the wealthiest countries, coverage is by no means universal, and inequalities in access persist. In the USA, Mamo and Mueller (2003) outline how the ways in which health care is organised, as well as barriers of gender, ethnicity and poverty, mean that there are inequities in access to the most effective treatments. The arrival of ART also brought with it changes in behaviour. As van de Ven and colleagues (2004) describe, gay men in Sydney, Australia, began to report higher rates of unprotected anal intercourse after the mid 1990s, but coupled with other risk management strategies. The gay community, they note, has evolved with the epidemic, with safe sex strategies part of a gay identity for many men, and a growing use of the internet in promoting disclosure of HIV status.

The early years of the pandemic created a proliferation of interest in how risk and riskiness were socially constructed, with the focus often at the level of discourse, or on micro-level interactions. Over time, as less individualised models of HIV risk emerged, researchers have developed more structural approaches that take the community level into account, and look specifically at the impact of economic and political factors. Linking health and social justice, this kind of broader perspective on HIV and inequality was taken by Zierler and Krieger (1998). They begin by noting that poor women, both globally and within the US, are more at risk of HIV infection. As well as focusing on the micro-level,

as risk practices in sexual behaviour, we should, they argue, be looking at the social, economic and political structures that put some women at higher risk than others.

The global figure of HIV infection is estimated at 38 million, with 25 million infected in sub-Saharan African alone. However, the focus in most articles in *Critical Public Health* has been on developed countries - a symptom perhaps of global inequality, with publications drawing on evidence from developing country settings in the minority over the last 15 years. Historically, this may reflect inequities of both research funding and capacity, although recent investment from, for instance, the Gates Foundation may shift the focus in future. The exception was the special issue of *Critical Public Health* devoted to papers from the HIV/AIDS Symposium, which were selected to illustrate issues in a range of settings (Aggleton & Mane, 1998). Insights from developing country settings include several highlighting the important role of gender relations and the value of taking a more structural approach (Dowsett et al., 1998; Rivers et al., 1998; Warwick et al., 1998). Warwick et al. (1998), in a study across the Dominican Republic, Mexico, India, Tanzania and Thailand, focus on the level of the household and community, arguing that it is here that both the impact of caring for someone with HIV/AIDS and the impact of any support, is most keenly felt. Key factors affecting such outcomes as how care was provided and who cared for bereaved children were the economic position of the household, and prevailing norms about gender relationships. The focus in many of these papers on male-female gender relations as an influence on the impact of AIDS in a community is welcome reminder of the ways in which social factors shape experiences of illness, responses to it and capacity to cope. However, Parker, Khan and Aggleton (1998) also note the importance of recognising the needs of men who have sex with men, arguing that they have been absent from much of the policy and academic discourses relating to low income countries, where policies and programmes rarely address this group and, despite evidence that they are vulnerable in all countries of the world, there is often a denial that they exist.

As well as contributions to our empirical understanding of the pandemic and those it has affected, work on HIV has provided a case study for an exploration of one recurrent theme in discussions of public health knowledge: the role of evidence generated by trials versus other methods. Kippax and van de Ven (1998) review the methods used to evaluate the effectiveness of HIV health promotion, observing that they have led to the 'privileging' of experimental methods in evaluations. However, Bonell's work, based on his analysis of two UK-based trials of HIV prevention strategies, suggested that such evidence does not, in practice, impact on policy in the ways intended (Bonell, 2002). Experiences of working with activists and user groups have also promoted methodological development. From the perspective of institutional ethnography Mykhalovskiy and McCoy (2002), used their research with people living with HIV/AIDS to explore ways of collaborating between the academy, community based health organisations or popular movements.

This collection of papers, then, tracks the development of public health research around HIV/AIDS from initial concerns with the individualised models of health education aimed at 'risk behaviours', through the growth in our understanding of sexual identities and behaviours to more structural issues of how the pandemic has reflected and intensified social inequalities of economic deprivation, gender, ethnicity, sexuality and economic deprivation. This body of work has drawn on insights from sociology, epidemiology, policy and economics and has often been (of necessity) at the forefront of methodological development, pushing forward methods for international comparative studies of behaviour and more micro-level sociological studies of issues such as individual

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sexual identity. The ‘problem’ which this research addresses is of course constantly shifting, as social institutions, communities and individuals respond to and shape the pandemic. As Bonell (2006) notes, in many developed countries there is now a period of ‘normalisation’ in which health providers and governments have moved from dealing with a new problem to an enduring one. New questions will emerge around, for instance, how new therapies shape social responses, but it appears that many of the ‘old’ questions, around how best to counter stigma and discrimination, and how to ensure equitable access to preventative and therapeutic resources, sadly still remain.

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