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Autoimmunities after COVID: An Interview with Cindy Patton

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Wrong (1996), *Inventing AIDS* (1990), and *LA Plays Itself/Boys in the Sand: A Queer Film Classic* (2014).

Taken collectively, Patton's scholarship and activism has laid the foundation for insights in the health humanities, particularly AIDS studies, that consider the inextricable connections between epidemiology and ideology. Patton's theorizations of stigma and discrimination patterns, her deconstruction of "truth" discourses subtending science, her critical re-evaluations of axioms associated with risk, safe sex, community, and knowledge production have been crucial interventions in the understanding of health and illness as cultural and discursive scripts. Among Patton's most enduring contributions has been her theorization of how "African AIDS" was invented and circulated—that is, the notion of geographically bifurcated HIV pandemics split by the essential linkage between Africa and blackness generally with pathogenesis. Equally influential has been her elaboration of the insurgent queer research practices that fused with antiracist struggle to combat this split.

In the interview below, Travis Alexander and Nishant Shahani engage Patton in a discussion on a range of topics—from (dis)continuities between the HIV/AIDS and COVID pandemics to the role of queer activism in forging epidemiological counter-publics and the geopolitics of medical bureaucracy.

Keywords

HIV; Pox; pandemics; history of medicine; entangled history

Travis Alexander and Nishant Shahani: In the past five years, we seem to have had waves of different forms of epidemic, each crashing into the one before. Going into this momentous half decade, the knowledge of HIV *as pandemic* had been pushed aside in favor of a shared narrative of HIV's *chronicity*. Of course, the experience of time is subjective, but it felt like COVID and Mpox arrived back to back, and at the same time, several once-controlled severe diseases surged (polio, Ebola, measles). We want to ask about the challenges of writing a "history" of a pandemic while in its midst, a question that already purports to frame the temporal start and finish of any specific pandemic.

Cindy Patton: History evolves and our understanding of how to "do History" evolves. In the early 1980s, I was engaged in producing a "history of the present" of the AIDS pandemic in its very earliest moments. I was just a "kid" with no training in historiography or social theory, and so I relied on journalistic ideas about mobilizing facts to tell a story. Given that one cluster of "facts" rested on the premise that homosexuality was pathological, the battle to tell the story from the gay and Black communities' points of view was immediately bound up in the

politics of contesting homophobia and racism, and, at that time, asserting specific subcultural identities. I want to remind us that in the early 1980s, both the gay liberation movement and the women's health movement resisted the idea that AIDS was an epidemic, and Black communities were in the early days of embracing their lesbian and gay members—the queer of color articulation was audible, just barely, but not yet an intellectual and political movement. The women's health movement was organized around the idea of the "well-woman," that is, the movement's initial aim was to depathologize the female body. Gay liberals working within the field of psychology were similar in their early efforts to remove homosexuality from the *Diagnostic and Statistical Manual*. Both gay liberationists and lesbian separatists were experimenting with utopian forms of community and often new understandings of sexuality. In this context, there was no easy way to contest right-wingers' assertion that gay liberationist calls for radical sexual experimentation had led directly to the emergent pandemic. I remember how shocked even gay liberationists were when Charley Shively, a law professor active in the radical newspaper *Fag Rag,* wrote an article called "Are You Ready to Die for Sexual Liberation?" (1983), itself an homage to Claude McKay's 1919 "If We Must Die," which was a call to Black communities to fight back in the context of the massive violence against Black spaces and persons in the so-called Red Summer of 1919.

This was the context in which the gay health movement that was most successful in advocating for treatments and fair treatment of individuals with HIV and communities affected most directly by the pandemic emerged. In time, academic historians and epidemiologists would understand that other groups of people had also manifest patterned symptoms that should have triggered officials to declare a new disease. However, those groups (drug users in particular) did not have an emergent health movement to make their plight visible.

TA and NS: You have just invoked a lost piece of gay writing that itself invokes an important but perhaps also not widely remembered poem by a Black intellectual who we now understand was bisexual, and then you speak of scientists! Your research draws on a very wide range of source material. Have your approaches to historicizing ongoing crises changed since your original work?

CP: I think both the academic and political contexts have changed radically since those early years, when many untrained people tried to document the pandemic and the people who were living it most intensely. The late 1980s was a watershed intellectual movement even without the object of AIDS. Cultural studies was in its heyday, and continental theory was transforming the North American academy, and there was a broad move toward interdisciplinarity. Quite a few so-called AIDS activists came through the university at that time, and thus, the analysis that came to characterize AIDS activism was laced with Foucault's understanding of historiography. Together with the broader rise of video activism and new forms of

political solidarity-building, AIDS activism and its documentation were very attuned to the "polysemy" of images and concepts. I look at material from that time period—including my own writings—and they seem very tied to this broader critical movement, and thus, it is hard to know "what actually happened." From the moment the pandemic appeared in the lives of those of us whose twenties and thirties and forties would be taken up with documenting and critiquing the social and cultural aspects of "AIDS," we were always "too close in time" and yet, for those who see a disease up close, we are never able to step outside the Time of the Pandemic. I think we are at that moment now with COVID—it's apparently "over" for some people, but many people will never cease dating their lives from their entry into knowledge of COVID. We can also see that many gay men, who did not experience AIDS during its "pandemic" time, still interpellate themselves into the "AIDS pandemic" through their practices of avoiding HIV. We saw this when Mpox came on the scene, and young men immediately read Mpox through the shared (and produced) memory of AIDS.

TA and NS: What methods and cautions do you call upon when you work in this way—how do you navigate the risks of your differential familiarity with different fields of expertise and your use of different genres of writing? What moves you to take up one source or another?

CP: I guess I try to think from as many perspectives as I can, while remaining grounded in my commitment to a queer, feminist, anti-racist politics. But to me, this means not only understanding those counterpublics' "structure of feeling," as those who follow Raymond Williams might conceptualize it, but also understand the rationality of that which they confront—in this case, not so much the personal feelings of those within the health and research systems, but the historical development of their "thoughtstyle," to use the concept from Ludwik Fleck (1979), which I, and many people in social studies of science and medicine work from.

One of the things that motivated me to push harder on the historical/archival research I have started to do around 2010 was a moment about in 2022, as North America emerged from its second full winter of grappling with COVID-19, and especially the new clade Omicron. Data from the largest population centers suggested that Canada was still experiencing "waves" sufficient to require public health interventions, but despite the Canadian chief health officer's announcement of the ongoing need for masks and vaccines, many Canadians believed that the country had achieved the long sought "herd immunity," albeit a "hybrid" one wrought as much by extremely high Omicron clade infections as by the impressive early generation vaccination rates: Canadians looked forward to what they hoped would be the first "real summer" after COVID. But just weeks after the cautious suggestion that we were done with one pandemic, but should be wary about when or how a next one might emerge, the World Health

Organization announced the first "next" epidemic: atypical cases of the inaptly named monkeypox, a known virus, jetting around the world in a new pattern of distribution suggestive of new modes of transmission.

For weeks after the first atypical cases of Mpox that appeared in May of 2022, public health officials equivocated about whether the new pattern of spread among "men who have sex with men" meant that Mpox was now a sexually transmitted disease, or simply something that you might catch during sex—there is an important semiotic difference between these. Given this uncertainty about how to classify Mpox, I was struck by how quickly some gay men asserted that the public health response (urging caution) was "the AIDS epidemic all over again." Certainly, the reaction to both the new disease and the public health reaction was mixed on the ground, but the media represented gay men as feeling deeply under siege by the government.

I hesitate to say there was a sense of déjà vu because the majority of these voices had only second-hand knowledge of the 1980s, so the "memory" of the response to AIDS was selectively focused on charges that public health inaction was homophobic. How did the "memory of AIDS" get reworked and reproduced so that two diseases and their manifestation as social phenomenon got superimposed, especially given that the public health establishment is also now even more populated by LBGTQ+ practitioners? Others will write the full history of Mpox. I want only to open up the possibility of writing history both through the collective experiences of those who are subject to the disease, and through the effect of "other diseases" on the one in question. In this way, we might peer through the broader palimpsest of "epidemic learnings" to understand what it is we are supposed to hope for in "future immunities."

TA and NS: Can you explain what you mean by the "palimpsest of epidemic learnings"? How does that phrase guide your thinking?

CP: The idea of a text as a surface being written over and over, obscuring some parts and reinscribing other parts comes from Derrida and others writing at the beginning of deconstruction: I envision a broad tissue of many temporal events of epidemic laminated one on top of the next. Of course, they will never cover exactly the same surface area, and some "past" epidemic knowledges all but disappear underneath the inscription of others on top of them. But it is always possible to find traces, and also to discover that strong traces are interlinked with now-weaker inscriptions. When I find stories whose narrative is too regular, too certain about causal effects, I want to scrape away some of that layer and see what has been covered over and what has been traced exactly, so as to make it appear inevitable. The method that has most interested me over the past decade or so is "entangled histories," or *histoire croisée*—a method that refuses straight lines between past and present, instead identifying possible influence and

confluence among things of different scales and different temporalities. But people have a hard time reading across influences and confluences because the writing with the greatest fidelity is a kind of zigzag.

TA and NS: You seem to be suggesting that the internal histories linking past epidemics to the present are shaped by a conception of and desire for immunities present and future? You often think across time and space to examine multiple epidemics—can you be more concrete here? You have been alluding to Mpox and HIV; are there other histories you would point to as also internally linked to questions of future immunities?

CP: Yes, I have a specific set that I've been thinking about over the past twenty years. I'm sure there are other layers to this palimpsest that other scholars could add. I would say that while many features of the Mpox discourse are resonant with both the public health language and the activist feelings and reactions remembered from the earlier AIDS pandemic, there are at least three intermediate pandemics that altered how global public health was administratively structured and how the connection between sex and disease was conceptualized: Zika (2016), H1N1 (2008), and SARS (2002–2003). I was to start with Zika for two reasons: first, we will be going backwards in time. But second, both Zika and Mpox were said to change their form when they changed their locale. Let me wander through these to show you how one might start to trace out small connections, à la an "entangled histories," that might lead us to a different understanding of the hows and whys of pandemic management.

Zika was a recognized mosquito-borne virus with fairly mild symptoms, just one among the many diseases endemic to various tropical locales. When Zika moved to new regions as a result of mosquito adaptation to urban environments and new levels of global mobility, a new disease pattern emerged; a small number of Zika cases show dramatic symptoms, in particular, microencephaly in neonates. This sensational disease sequelae caused WHO to take notice and declare a public health emergency of international concern (PHEIC), indicating the highest level of concern about an emerging but not-yet-pandemic disease.

Let me zigzag to 2002–03 to remind us that *how* pandemics are conceptualized and announced was quite different in 2022, when Mpox was redefined, than it was in 1982–83 when HIV emerged as a viral phenomenon and was labeled "GRID" then "AIDS." The intermediate pandemic of relevance is the first SARS pandemic. I want to be careful here to use parallel terms—what we today call the HIV pandemic was originally labeled by the syndrome name, AIDS, not by the underlying virus, HIV. Zika was from its start labeled by the causal virus's name. SARS, like AIDS, was labeled by its symptom cluster, while COVID is labeled by its causal virus.

The "public health emergency of international concern" is a designation that was created after the 2002–03 SARS pandemic. The change in WHO's notification structure explicitly recognized the changing patterns of disease spread and disease identification, in particular, the role of air travel in complexifying the system of global public health controls that dated from use of vaccination and border restrictions in relation to diseases like smallpox. The response to SARS, which was so strikingly related to air travel, was deemed too slow, and thus, the notification system was amended at the level of the definition of *how* to declare a pandemic (how much spread over how many locales). Most importantly, the new designation was a kind of BOLO ("be on the look out") for disease phenomenon that had begun to look problematic and might require global coordination.

This brings us to the nearly forgotten H1N1 pandemic of 2008: I have written about this pandemic episode in a pair of articles, so I will just summarize quickly here. The identification of H1N1 and its elevation to the status of declared pandemic resulted from two changes: enhanced epidemic surveillance in the wake of HIV and pandemic-declaration process in the wake of the rapid spread of SARS. In the North American winter of 2002 through spring of 2003, an unusually severe flu-like disease made a rapid circuit from Asia, to Canada, the US, and a few European countries. This would turn out to be the world's first major encounter with coronavirus.[1] Because of the ubiquity and seasonality of influenza, most countries with developed disease surveillance systems use reporting of "FLI" or flu-like-illness as a kind of early warning system for respiratory diseases more generally. In 2008, after nearly three decades with no unusual influenza outbreaks, and with global health attention focused on a pandemic caused by the hard-to-contract and slow manifesting HIV, the appearance of "SARS" shook up the surveillance strategies, resulting in a demand for improved monitoring systems. Further, the investment in HIV monitoring and treatment meant that there were more small countries around the world feeding data into the global system. WHO's then-existing definition of the point at which local, regional, and international disease prevention measures should be initiated had to change—that is, the definitions of epidemic ("more than expected") and pandemic (across a larger number of spaces) needed an overhaul.

H1N1 caused a level of concern that eventually far outstripped its health impact in part because member states in the Pacific region had taken a page from the health infrastructure development strategy used in the sub-Saharan region during the first two decades of the HIV pandemic to simultaneously address the immediate needs of people with HIV and develop long-term health infrastructure. Reasoning that so-called avian variants originate or accelerate in the Pacific region, smaller states argued that flu pandemic preparedness required investment in health infrastructure, and in particular, in surveillance capabilities. This left the imprint of regional AIDS activism and global debt restructuring initiatives on the literal medico-scientific surveillance apparatus. But it meant that when H1N1 was

identified in Mexico, where relatively little flu surveillance then technology existed, the "expectation" part of the epidemic definition was so rapidly exceeded that the pandemic looked larger than it actually was.

In fact, H1N1 was the first major epidemic to occur after the WHO implemented a new multi-step process for declaring pandemics after the SARS experience. Fortunately, there was a formula that could combat this influenza that had arisen in an unexpected place—Tamiflu. Again in response to the pushback against Big Pharma that had occurred in the race to find HIV therapies, a European-based "small pharma" emerged, and they had a near-monopoly on Tamiflu. In the context of then-emergent treatment-as-prevention strategies, promulgated (as Pre-Exposure Prophylaxis) by many HIV activists and (as near-mandatory treatment) by public health officials, Tamiflu was both. Tamiflu works by blocking flu virus's ability to release the copies of itself that it has made, allowing Tamiflu to be prescribed both as a treatment and as a prophylaxis, doubling the demand for its use. The breakdown of the line between treatment and prevention (although perhaps this is a false distinction carried over from an earlier paradigm of medical care) was even more pronounced in the world of HIV pharmacology—"treatment as prevention" included aggressively identifying and treating those with HIV, and offering similar medications to people who were perceived especially at risk of contracting the virus. This episode haunted the COVID vaccine roll out in interesting ways with HIV being a treatment used in the absence of a (still unattainable) vaccine, while the COVID vaccines operating in the absence of reliable treatment (still lacking). Combined, these public discourses about treatment (HIV) and vaccines (COVID) blurs the difference between "not getting it," "not getting sick from it," and "not passing it on."

TA and NS: Tracing the internal connections in this way seems to open up the space for understanding a range of things that have bothered us recently. Here, you are pointing to the contrasting role of prophylaxis as they were deployed for HIV and for COVID…Can we loop back to Zika and talk about how a tropical disease was transformed into a sexually transmitted disease?

CP: Yes, that raises the question of how disease phenomena interact with the systems that categorize them. Unlike HIV, which was a previously unrecognized virus, Zika's symptomatology and distribution was well described—it was a mosquito-associated tropical disease with dramatic "flu-like" symptoms. Like the two rounds of coronavirus (SARS and COVID-19), a known phenomenon suddenly jumped locale to affect large numbers of people in a very dramatic way. Initially described after World War II, the virus was first in Uganda, and then spread throughout the Asia-Pacific region, presumably via animal movement. Suddenly, in 2016, Zika appeared to break out of its well-described and stable mosquito-monkey-mosquito zoonotic loop, with occasional transfer to humans, and began a new pattern that included a human vector via sexual practices, and then later, a

human-mosquito-human loop in places with no monkeys. Public health officials had some difficulty reconceptualizing a once run-of-the-mill mosquito-vector disease as *sexually transmissible*. If you don't mind, I can show you something very curious that I found. This is the updated (2019) US CDC's [Centers for Disease Control and Prevention's] advice for avoiding Zika, which focuses mainly on mosquito control, but also contains this interesting discussion of Zika and sex:

> **Can I get Zika from sex?**
> - Yes, you can get Zika from sex with a partner who has Zika, even if your partner does not have symptoms at the time, or if their symptoms have gone away.
> - Only people with sex partners who live in or traveled to an area with risk of Zika are at risk for getting Zika through sex.
> - Sex includes vaginal, anal, and oral sex, and the sharing of sex toys.
>
> **Should I be concerned about getting Zika from sex?**
> - Zika is of greatest concern for pregnant women and women who may become pregnant. This is because Zika can cause birth defects in babies born to women who are infected during pregnancy.
> - For everyone else, Zika rarely causes serious illness. Many people with Zika won't have symptoms. When symptoms do appear, they are usually mild. The most common symptoms are fever, rash, joint pain and conjunctivitis (red eyes).
>
> **What can I do to reduce my chance of getting Zika from sex if my partner traveled to an area with risk of Zika?**
> Condoms can reduce the chance of getting Zika from sex. To be effective, condoms should be used from start to finish, every time during vaginal, anal, and oral sex. Not having sex also eliminates the risk of getting Zika from sex. (CDC accessed 2022)

I want to underscore that this advice sits at a temporal mid-point between the "lessons learned" from problematic HIV (sex) education and the explanation of risk and risk mitigation for COVID-19. Notably, the CDC enumerates the "sex" of concern, a feature mystified in much early HIV education. You can see the traces of many of the intervening discussions. For example, trans health discourse inflected in the idea of pregnant persons rather than pregnant women. Thus, while discussion partially reprises an idea of risk groups that is familiar to use from the early AIDS designations—those who will experience major effects (pregnant persons) and those who won't (everyone else)—we can also see a foreshadowing of the logic that eventually led the vast majority of people to imagine COVID as a disease only really dangerous to "old people." In addition, the parsing of "risk" into places that have and don't have Zika inherits the slide from places to people

that characterized HIV education's understanding of differences in disease patterns as differences in people. Because Zika was initially strongly associated with "the tropics," and most Americans are oblivious to the reality that the US contains major swathes of tropical areas, the advice ends up shifting the risk calculus back onto people "from" the spaces marked out as "diseased."

Read together, the construction of an at-risk group and conflation of space with risky people leave the idea of unfettered sex unchallenged; paradoxically, unless you *want* a pregnancy to occur, you needn't bother with condoms, except that condoms stand in the way of pregnancy: for some people (inhabitants of the figurative "tropics" of pregnancy-seeking) risk reduction is impossible. The mystification of literal and figurative tropicality is redoubled in the CDC edu-bite about how a zoonic loop works: "Zika is mainly spread through mosquito bites. Travelers should take steps to prevent mosquito bites for 3 weeks after returning from an area with risk of Zika. This is because you can have Zika in your blood and a mosquito can bite you, get infected with Zika virus, and spread the virus to other people" (CDC 2019). In this almost sci-fi scenario, humans actually pass Zika to mosquitos independent of sex; thus, sexual transmission of Zika is contained by condoms, but the bidirectional mechanism of spread—being bitten by a mosquito—is not. The presumptively domestic space of becoming pregnant, which is left in limbo by Zika, leaves the "other sex" out in open (even public) spaces. The acceptability of risk within reproductive domestic space lingers on in COVID discourse—for the most part, public health has viewed recommending masking at home (except in on behalf of "elders") as ridiculous, even though the same officials downplay "open space" transmission by arguing that most infections occur among people who live together. Zika as a sexually transmitted phenomenon is intensely racialized, and COVID, more overtly racialized, is intensely desexualized.

TA and NS: Can you talk a little bit about the consequences of this desexualization of COVID, and then what foundation that shift played into the political imaginary into which Mpox arrived?

CP: One of the massive paradoxes of the pre-Omicron bouts of COVID was the lack of detailed attention to "household transmission." In general, the space of the home was considered problematic only to the extent that there were "old people" who might be infected by younger family members. The idea that *some* of the COVID rapidly spread within the household came during sex was largely only the stuff of stand-up comedy—sketches of people wearing underwear face masks, or avoiding each other altogether, the funny side of the reality that the predicted "stuck at home" baby boom did not materialize. If Zika was almost exclusively the concern of baby-making couples, and COVID—especially in the wake of the ultra-contagious Omicron clade—was so omnipresent that it was unthinkable to undertake domestic risk reduction measures, Mpox fell somewhere in between.

Partly built on the idea that only specific people (those who want a pregnancy) need to worry about sexual transmission of disease, and partly built on the idea that once launched into the group of intimates, there was little beyond a vaccine that could stop a disease's spread, the official response to Mpox focused primarily on the idea that the disease is already "contained" by virtue of being properly located as a zoonotic disease in "Africa" (where there is, bafflingly, no sexual transmission) and something else (sexual but not casual?) or in the bodies of party-going homosexual men.

The echo of the early 1980s was clear. Like the current pattern of a socially linked network of people (in this case, those who celebrated the first "real summer after COVID" with island "raves" that have the same kind of status as an earlier generation of elite gay men's circuit parties), AIDS too was initially identified among youthful gay men who succumbed to a range of known ailments at that point not considered "sexually transmitted." They included enteric diseases, known to be endemic in one or more tropical locale; to cancers, previously confined to a totally different social group; to respiratory failure, initially misidentified as a bacteria, later identified as a kind of fungus. The link among those disparate atypical disease presentations was sex-gender/sexuality, and this connection was made quickly only because the first identified cases were patients of doctors or clinics that were able to recognize that these were *gay* men, a poignant tribute to the early success of the gay health movement.

TA and NS: You have referred to the emergence of a "full-fledged queer health bureaucracy" (Patton 2011b). Could you expand on what you mean by this phrase?

CP: Often people invoke "bureaucracy" as an epithet, but following Pierre Bourdieu's (2014) concept (itself indebted to the German social theorist Max Weber [(1919), 1978] who was arguing with Marx about the nature of the modern state), I use it neutrally to define a specific relationship between the state and professionals.

Early in my documentation of the epidemic (perhaps around 1985), I wrote an essay called "From Grassroots to Business Suits," in which I described the transformation of liberationist groups into gay health organizations. At the time (and still) many people understood this through a loose hegemony-like model as a kind of "selling out," but I prefer thinking of it through Bourdieu's notion of bureaucracy—that is, spaces within the state in which people with professional values framed through some form of training act "on behalf of the whole." Bourdieu suggests that this dual alliance—to "the whole" and to one's professional norms—creates perpetual conflicts for bureaucrats that must struggle for legitimacy in separate spheres. In the early 2010s I conduct detailed research in Walter Lear's private papers and understood this process more fully. Behind the scenes, lesbians and gay men had worked within the fields of

medicine, social work, and psychology to lay the groundwork of a network of informal clinics that would allow gay men in particular to work quietly within the public health establishment and create about half a dozen publicly named gay clinics. That activist-bureaucrat work throughout the 1960s and 1970s was the condition of possibility for gay doctors to work with gay patients. Absent that organizing, it is entirely possible that the recognition of "GRID" would have occurred even later than it did. One of the interesting aspects of this formation is its roots in gay liberation—I think this meant that the groups' sense of "acting on behalf of the whole" was specified as the gay community as a whole, placing these early bureaucratized professionals in a three-way conflict in that they had to effect their professional norms, the norms of the larger state, and the evolving shared sense of who "the community (or the movement)" should serve. If we conceptualize the transition of all the new social movements' relationship to the state in this way, I think we can make better sense of the battles among gay men over safe sex advice, the tensions between lesbians coming from the depathologizing "well-woman" model of the women's health movement, and the ongoing failure to fully understand the different historical trajectory that queer people of color brought to "the movement."

TA and NS: That's a very different way to think about the relationship of movements to the state. Does this help us pinpoint some of the linkages between a history of bureaucratization and a history of epidemics?

CP: I was talking earlier about the epidemics that seem to me to be unrecognized as inflected in Mpox and COVID. Your question now asks us to focus in on the specific ways in which some, but not all, epidemics shift the relationship of queer practitioners to health policy and practice. The queer health bureaucracy developed fairly rapidly during the AIDS epidemic because the state really had no alternative. Similarly, a kind of supra-national queer bureaucracy emerged with the WHO and a range of international organizations. Thus, when Mpox appeared, the invocation of "AIDS denial" carried great political weight within the public health system and in gay communities because both now accepted that the initial response to AIDS had been framed by homophobia. However, this consensus misrecognizes the relationship between queer professionals and the state—this was the condition of possibility for identifying the early AIDS cases among urban gay men, and also the condition of possibility for the moral demand on the state to "act on behalf of the whole." That is, when AIDS first appeared in gay urban communities, the linkage to the public health system was already strong and recently infiltrated by young, openly gay/lesbian/bisexual practitioners, who were also agitating on behalf of the (queer) "whole" within their professional organizations. The rapid development of this bureaucratic space meant that HIV could be fairly quickly reconceptualized as a sexually transmitted but blood-borne disease (these had up to this point been two distinct and separate categories of disease). The whole debate about what acts are essential to gay men's identity

was interconnected with demands that queer health bureaucrats experienced from the professional norms to use clear medical definitions: as Heather Worth (Verlag 2008) traced out more than a decade ago, the trajectory of gay identity went from doing a range of physical acts with other men in defiance of procreation to the exchange of semen (mainly via fucking) as a symbolic act of brotherly union. Gay sex = fucking; the key was to manage the dangerousness of semen, and this was the major task of gay men's health care up to the arrival of Mpox. Other sexually transmissible diseases were mitigated, if not tolerated, and HIV was managed through post-infection treatment or pre-infection prophylaxis. The idea that condoms were a widely effective health tool increasingly rang hollow.

These ideas about gay men's psychological-identity needs and the relative significance on non-HIV sexually transmissible diseases stabilized as the queer health bureaucracy devoted considerable energy to reconceptualizing its "whole" to include trans people, whose needs rearranged what had been "men's" and "women's" health. Again, I want to remind us, gay men and lesbian women's health movements both emerged in the 1960s, and were intertwined but still distinct in concept and in the location of their practice. Lesbians fought to be included in "women's health" (with its depathologizing well-woman focus) so gay health clinics that included lesbians also had a split habitus. Trans health further stressed that conceptual conflict by utilizing the "well-body" framework to counter healthcare approaches that reduced "trans care" to what was initially conceptualized as "sex reassignment." But trans men were also new entrants into the cultural space of male sexual desire and practice, which by the mid-2010s, included widespread use of HIV PrEP. This is a complex set of new linkages that should also be explored.

All of these stabilities upended again when Mpox arrived. At that point, queer (now including trans) health folks had to reverse gears on the definition of the disease. The latter was previously associated with skin lesions and was, as such, managed with isolation of the afflicted and careful washing and disposal of linens and clothing that might carry the fluids that leaked from the "pox." Scientists were slow to differentiate touching and rubbing from transfer of semen as the source of the men-who-had-sex-with-a-man's infection with Mpox. The narrowing of the definition of "sex" to "penetrative, with fluids" that occurred incrementally through AIDS education itself, ran headlong into the possibility that the stuff of foreplay—the touching and rubbing that is not *really* sex—might now require intervention. (Remember the Zika campaign tried to expand this idea, but flailed against its own definition of non-pregnancy-inducing sex as important, and "everyone else's sex" as apparently worth the price of flu-like symptoms of most Zika infections.) The reluctance to draw skin-to-skin transmission back into the fold of "things you can get in the process of getting down to sex" has to do with the trajectory of advice to gay men in the first decade of the AIDS pandemic.

Before HIV, "venereal disease" was understood to be primarily "diseases on the skin," even though scientists realized by the 1960s that these were also blood-borne diseases. The shift to "sexually transmitted disease" (later sexually transmitted infection) evolved to include "blood-borne diseases," moving at least one form of hepatitis, and various diseases once more commonly contracted through consuming contaminated water or food, into the category of "STD/I." Because HIV education focused so tightly on "insertive" forms of sex, *STI* incrementally lost any sense of "diseases on the skin," and connoted "diseases carried in semen." This was partly a result of efforts to destigmatize homosexuality by destigmatizing HIV, and reassuring people (correctly) that "You can't get AIDS from casual contact."

But there is another reason for the strange understanding of immunity—both for the "general population" and for those who might access a vaccine. Mpox is the first "new" disease to strike a still stigmatized but much more diversified "queer" community. The consternation about how to address advice to "men who have sex with men" was in part a product of the fact that the very category of "men," and its corollary "homosexual" is under expansionist pressure.[2] The question put to the research community was the extent to which Mpox is spread through rubbing among "men who have sex with men" or spread through the fluid identified as the culprit in HIV. At a moment when trans health challenged settled questions within the queer health bureaucracy (itself still challenging the larger health bureaucracy), how are we to intercorrelate the categories of "men," "those with semen," and "those who receive semen"? "AIDS" seems not to have lost its metonymic relationship to *gay men*.

This seems to raise more questions about how evolving science in a pandemic blurs the ideas of prophylaxis and immunity—that is, an immunity that is understood to be produced by a barrier and one in which people are somehow naturally non-susceptible.

CP: That's right—when science is unsettled about routes of transmission, then the logic of responses also falls apart. Two internally contradictory "facts" were circulated in relationship to the first new wave of Mpox—that those initially diagnosed with Mpox in North America are "men who have sex with men," but that Mpox could be spread during face-to-face conversation. That is, researchers were divided about whether Mpox was a "droplet." If we followed the initial (if incorrect) logic of the first phase of the COVID-19 pandemic, then we should be re-instituting social distancing and/or masks. But we don't because "gay men" are perceived to be already contained, especially if their "diseases" require transfer of semen to places where it ought not go. In the wake of the mediagenic pre-exposure prophylaxis (PrEP), a treatment mirrors COVID vaccines in that both stave off infection in the absence of any mechanical barrier.

On the other side of the intransigent idea that a disease might be always, already contained by virtue of the sort of people who have it, is the idea that we must *do something* to contain disease. The idea of "already contained" is complexly interrelated to the idea of a herd. Border regulation that works together with quarantine (either in camps, or in homes) is the large-scale version of containment, and masks are the most intimate form, operating as a techne on each individual body. The third option is vaccines, a paradoxical techne instituted on the individual body, but part of a medium to large scale containment. Border controls and enforced isolation require policing, while masking (which could be made a legal requirement and hence policeable) primarily requires the will of those who must don them. Vaccination requires a combination of government distributional power and individual will.

TA and NS: This reminds us of early calls for an AIDS vaccine.

CP: Indeed, much like the 1984 pronouncement by America's then-public-health czar Margaret Heckler that an AIDS vaccine was around the corner, within four months of the first report of US cases, the response to COVID-19 was framed in terms of vaccination. The public was primed to engage in mechanical prophylaxis (masks) and accept sometimes extreme limitations on their movement only until the vaccine arrived. Fittingly for a Donald Trump–controlled government, the US launched a reality-show-like competition to produce the first vaccine under the name Operation Warp Speed. The private-public program pitted scientific innovators (often in small tech companies) and manufacturers (often multinational big or mid Pharma and the generics manufacturing industry that had developed in India, and later China, Japan, and Singapore, in the wake of battles of control of drug markets that had begun when Highly Active Antiretroviral Therapy promised to dampen the global HIV pandemic only if cheaper drugs could be produced). But the COVID-19 vaccine rollout was hampered by public uncertainty about the speed of approval of a new vaccine technology, the shifting anti-vaccine movement, and different approaches to creating distributional justice on local and global levels.[3] One of the arguments for loosening patent restrictions was allowing middle-developed countries to have "vaccine sovereignty." Although "first tier" in terms of economic prosperity, Canada had been unable to get the vaccine because much of its scientific effort was put into a China-Canada collaboration. In addition, the pre-purchase agreements Canada had made with Moderna were not honored. Moderna had difficulties with its manufacturers, and Canadian reporters visited some of the factories that were supposedly producing the vaccine earmarked for us, in particular, a small town in Belgium that was supposedly producing the vaccine that was destined for our shores. Moderna was criticized for its initial lack of enthusiasm about distributional justice, and then committed to delivering to COVAX, leaving Canada bumped to the back of the line. The Canadian vaccination

program only really got moving once the US decided to give a block of its Pfizer to Canada, and soon, after suspicions arose about side effects in subgroups, the US essentially dumped its AstraZeneca on Canada.

Despite the skepticism that had surrounded the COVID vaccines and their rollout, at the first hint that there was a vaccine for Mpox, gay health activists and public health called for its immediate use. Indeed, places with large queer communities more or less demanded control over their own doses on the logic that they were best situated to serve the needs of a still partially hidden community. But what about the preventative measures that are under the individual's control? Or, put another way, whether the things we do in private have public consequences. Because of the resistance to (or failure to normalize) mask wearing, combined with the mobilization of anti-vaccination "libertarians," COVID prevention has devolved into admonitions to take "individual responsibility" and "individual care," ideas permeated with racism and its overlapping logics of classism. Mpox, with its sudden invocation of vaccination as individual protection over and against other potential changes in sexual community-making, has suppressed the problems of diseases' imbrication in intimacy and domesticity in favor of repeating the vaccine distribution politics that allowed COVID vaccines to largely remain a luxury of wealthier countries that eschewed masks because they were inconvenient.

Can there be any globally just logic for future immunities? Without a deeper understanding of the changes in global policy that occur with each new pandemic, and without a collective understanding that it is largely humans and not pathogens that drive pandemics, the answer is probably "no."

Notes

[1] The understanding of SARS as a "respiratory virus" proved problematic in public understanding of COVID-19. The easiest route of acquisition is through the nose, with the disease developing in the lungs, and the most obvious signs are respiratory; however, the virus attacks multiple systems, and these are significant in the long-term consequences of COVID disease. The understanding of COVID as "respiratory" meant that once these symptoms were no longer bothersome or even absent, people believed that COVID was "just like the flu."

[2] The category "homosexual," which was transformed with great effort by AIDS activists into "homosexually active" and the "men who have sex with men," had to be transformed again with the emergence of a public and vocal group of "trans men" and "trans women" who are (apparently) more likely to choose "homosexually active" "(cis-)men" as partners, if only because the recent formation of a trans community was enabled (and hindered) by the stabilization of a "gay" community. Interestingly, in my own local community, billboards advertising (HIV) pre-exposure prophylaxis represent a wide range of gender

presentations. The new Mpox vaccine tracks back to very conventional representations of persons coded as "gay man."

[3] My own province created a faster system for Indigenous people and those living in care homes, but also fast-tracked the AstraZeneca to younger workers in the hospitality/service industry, initially vaccinating virtually everyone in places like the ski resort Whistler, which had our earliest cases, and had to shut down twice due to the concentration of global travelers and young workers, who lived in tight quarters and partied together often.

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