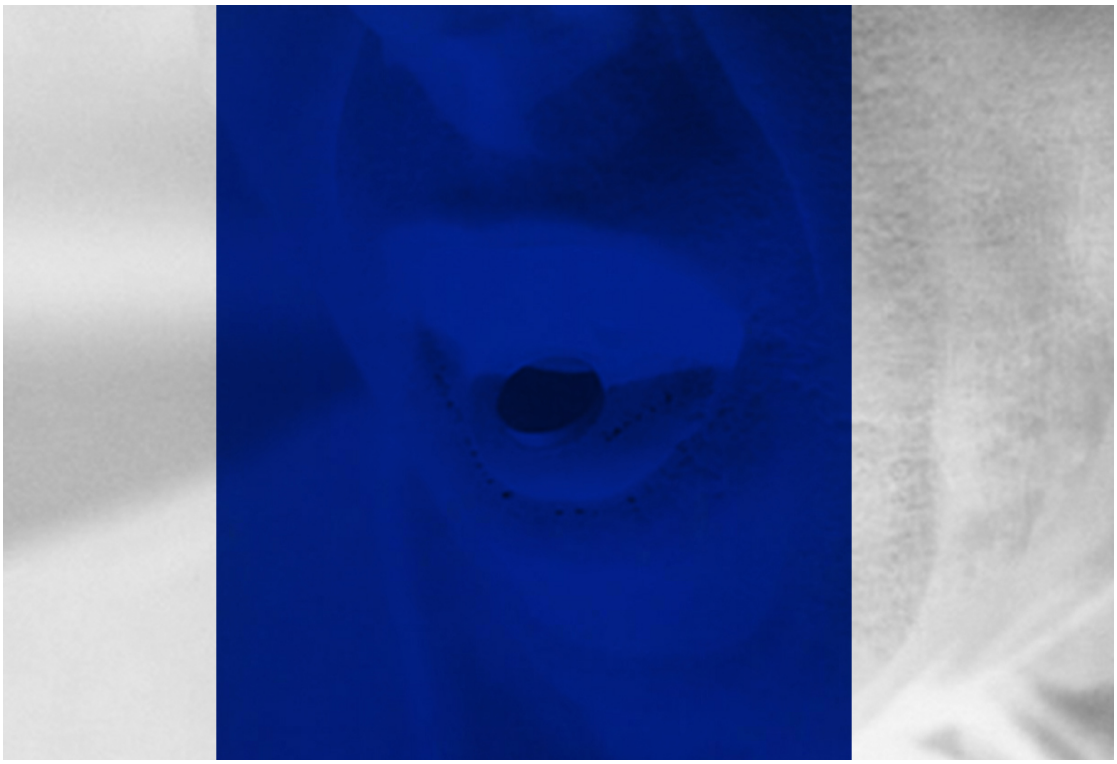
ESSAYS & REVIEWS

Blue Dream

PrEP allows gay men of color to feel cared for but also managed and made into data

By MARCOS SANTIAGO GONSALEZ AUGUST 30, 2017



An audio version of this essay is available to subscribers, provided by curio.io.

ONE pill, once a day. The prescription will run out in a little over a month. Before the doctor will refill the prescription, I will have to return to this Lower East Side clinic that accepts Medicare, answer a slew of questions about how I have sex, undergo an anal examination, piss out a urine sample, give a swabbing of the back of my throat, and have vials of blood drawn. Doctor's orders.

Her questions and my answers are typed into the clinic's database which someone will use for some report, some line graph, some percentage, some brochure. Once they return from the lab that insurance partially covers, the results from my STD screenings will go into this database as well, no doubt. All of this is done with a soft smile and sympathetic voice. She is asking me my preferred position for having my rectum inspected with her gentle and affirming fingers. The sonic and visual and haptic markers make me believe my health matters. The softness of her method is comforting. The doctor cares.

I acquiesce to all of this because I know if I do not adhere to her probing I will not receive my prescription of PrEP, pre-exposure prophylaxis, administered via the name brand pill Truvada that, when taken every day by a HIV-negative person, can prevent HIV transmission upon contact. The doctors will withhold from me that blue pill, which fights off what they have told me to fear, to demonize, to reject: seropositivity. They will make sure I return every two months for an examination, making my body and my queer brown life available for examining. They let me know I need them, and that they will care for me—or else.

An exchange: the body for the little blue pills. If the prescription runs out a few days before the return to the office, she will not refill it. She emphasizes on the phone, oh so sweetly, that I must come in if I want the little blue pills. This is her way of caring. This is the business she is in, the dispensation of care. The little blue pill is the agent by which her care is made possible, distributed, and legitimated. It is also how her care is made innocent; It is welcomed and asked for.

I know I am not alone in receiving this care. She does this for every other poor Black and Brown person who ambles through these overcrowded, understaffed, and underfunded doors. We are desperate for help in managing our diabetes, or our high blood pressure, or our teenage pregnancies, or our infections. Her care extracts data from our worries, those worries we so generously give to her because she performs caring-ness so well. In turn, our worries are monopolized. Our bodies work on behalf of better research, better medicine, and better care that we are unable to afford. Gilead Science Inc, the biopharmaceutical company selling Truvada, will soon find itself in competition with generic brands after the FDA's recent approval. Generic offers access but competition creates new pressures for research advancements which are ultimately geared towards creating high-end drugs and cementing the exclusivities of who receives care.

Even more profitable is monopolizing on an illness not-yet-here. The installation of worry over what might be, over what is highly probable given the statistics and research related to racial and cultural identities, is more profitable than the illness already in existence. The not-yet-here of illness fully enthralls the patient. We feel we are not experts, that our bad English or lack of degrees gives us no legitimacy to question or doubt or improvise the diagnoses not-yet-here. We feel the research is against us, the research that represents and accounts for us, the research that tells us trends of "bad" habits and "bad" behaviors and "bad" diets which have been our means of survival and inheritance and adaptation in this post-1492 moment.

We feel we need management and give ourselves over to being managed. Management of our sexualities, appetites, and flesh is not for a second questioned because, for once, finally, thankfully, we feel we are being cared for. Prevention from the illness not-yet-here, though lurking in the foreseeable future, is the lure in which management—and the accompanying investments, interests, privatizations, and data extractions that medical management secures on behalf of so many conglomerates and nations—is accepted, praised, and naturalized. They don't let you forget: one pill, once a day, no exceptions.

In my hand the Truvada blue is a universe. Entities large and small are contained within it: the rising percentages of Latino men infected yearly and Gilead Science Inc and Magic Johnson and New York City and ACT UP and the Black

gay man criminalized for being seropositive and NGOs and my tio who died two months before I was born from an unidentified yet fully identifiable "illness." All are atomized, made molecular, compounded together, and contained within this capsule the size of my fingernail, entering via the molecules and substrates and compounds dissolving into my blood. Antibodies are built in mass to construct fortresses which will repel the *loudmouthbrickthrowinginsolentandangryqueengenderfuckfag*. Walls of molecules are erected, further concretizing an "us," those who are negative, and "them," those who are positive.

The little blue pill swallowed promises an extinction, a forgetting, a rewriting, a white picket fence, a *homociswhiteablebodiednationalism*. The pill is made to subsidize queer legacies and queer presents through negation, benefitting from flesh of yesterday and flesh of today. The pill's administration negates the leaky bodies and the zine manifestos and the high heels thrown and bootleg hormones, a negation entering my bloodstream. The little blue pill promises itself to be the queer future. A future cleansed of its deviants, those deviants future, present, and past. Take it down with a glass of water, and swallow carefully.

HOW many partners in the last month? Three. A click, and some typing of words. Are they cis or trans (no option for both)? Cis at the moment. Click. Receptive or Active? Receptive for the past few. Click. Have you have ever had sex for money? Not that I can remember. Click, and some extensive typing. Have you ever used drugs or alcohol while having sex? Once or twice. Click, several words jotted down into the computer.

Skin quantified, body juices aggregated, kinks rounded up to the nearest percentile. The accumulation of data makes queer sex a privatized exposé. The spectacle of cum in the ass, squirtings and spittings, the strap-ons and butt plugs, is siphoned into a program, an algorithm, a code. Intimacies both physical and virtual are compressed into data and then storied by doctors and therapists and marketers and case workers and CEOS. They tell the story of various scales of corporate, governmental, and nonprofit hierarchies coming together to

determine how best to care for and on behalf of flesh relations. Caring means to care about which sexual behaviors contribute to improved research methods, or inquiring into how many partners one has in order to best assess who might be eligible for a prescription of PrEP.

The corporatization of care becomes a means of engineering sexual relations and sexual promiscuities into predictable variables of cost benefit and loss. “Do X activity with Y kind of people because this report tells us so.” Commoditized care demands the compliance and complicity of the queer, who, in due time embodies this market driven care, naturalizes it, distributes this care through every sext and ejaculation and recording and quickie. Alliances are forged with those who are on the little blue pill. Hookup profiles announce loud and proud “ON PrEP U BE 2.” Does this mean that bareback sex is no longer the torch bearer for queer perversity, no longer the deviancy of yesteryear? With the rise of PrEP, bareback sex becomes a means of regulating the relations between queers, imposing limits upon who is worthy of un-condomed cocks, allocating value to the movements of flesh according to biopharmaceutical standards. Investing in corporatized care is an investment in profit is an investment in surveillance is an investment in public health is an investment in the management of queer of color relations.

The process however is not strictly one of extraction. Data is made from us and data is put into us. Case in point: PrEP ads on the NYC subway. Trials and tests and case studies and population censuses and database analyses have gone into the construction of these ads. We make the ads and the ads make us. They are in Spanish and in English. Brown men together, Black men together, a Brown and a Black man together, and even a poster with a Black woman without any kind of partner in sight. Where’s her desire, who’s she desiring? These posters lack desire. Purposeful, no doubt, because if they contained desire, or, rather, attempted to represent desire within their two dimensions, then these ads would have to contend with desire’s unwieldy relations. The sensuous unmappable that is skin against tongue against ass or the indescribable that is foreplay wordplay through text message and videos and photos.

The fantasies of desire that include text messages and fingers and audio messages and costumes and public restrooms are not isolatable within the

parameters of data's representative mediums. Data extraction and dissemination requires a minimalism which works to downplay desire's assemblages, minimizing them to the point of non-existence, thus effectively managing the unruliness of bodies and desires. We soon find ourselves settling for matching wedding bands or hand-holding (if even that) in our ads. This management of desire through its reduction makes desire commodifiable. How to relate, how to interpret, and how to desire one another according to the rubrics of medical markets is our accepted and celebrated means of conversion therapy. It feels nice to feel ourselves represented in these ads. But the feeling of being represented as a population forfeits desire; our health and well-being and respectability are better off without desire. Desire exceeds the bounds of data's limit.

New York City's public health services know their audience and their demographics. The A train—going uptown into communities like Harlem, like Washington Heights, like Inwood, or downtown into communities like East New York, like Flatbush—is dominated by Black and Latino bodies. The message of the posters is clear: we see you, we care about your health, we include you. Protect yourselves from yourself. The absence of whiteness tells us seropositivity is no longer the condition of white gay men. If anything, the white gay man now stands in for a kind of innocence, an upwardly mobile fantasy, gay domestication at its finest.

This is apparent in the imprisonment of Michael L. Johnson, who, in 2015, was convicted to 30 years in prison for "recklessly infecting" a white male partner. The media reporting on Johnson's case eschew the fact that the white male partner went around having bareback sex with many others before Johnson. His white body was never identified as a public health risk like that of Johnson's. His unidentified white body is victim, innocence. Having moved on from the disease-carrying gay white man, public health services have taken it upon themselves to strip the stigma from our communities. Forward into progress, forward out of shame and silence and backwardness. The NYC ads are in living color.

Diversity is in, diversity is profitable, and the data taken from diversity is equally as profitable. Our fathers and grandmothers and childhood friends cannot look

away. They see men their color holding the hands of other men, gay sex suggested and referenced but never stated or named or seen, blood of their blood quantified into these ads. The city rectifies erasure, and amends exclusion. The visibility of disease is no longer the white man's burden. Image after image through the decades, white gay man after white gay man in the queer archive, one would think we didn't die, that we were not there, and are still not here. Immortals in black and brown.

DATA is not in the service of analysis. Its function is in service of a particular analysis, a particular story or language that is serviceable, strategic, determinate, and absolutely congenial to profit, exploitation, intelligibility, surveillance, and our ever-increasing dependence on the state to manage our lives. Data, then, is serviceable when it can make legible bodies and sexual practices and communities who are otherwise opaque: "Truvada is more than X percentage effective in combatting infection if Y or Z criteria is met…" "more than X amount of gay and bisexual Latino men a year are infected with…" "1 in X number of Black men have unprotected sex…" and so on and so forth. The structure of data requires these absolutes. Whether by the CDC or research pharmaceutical companies like Gilead or NGOs like The Human Rights Campaign, data needs to be reductive, reduced to generalities and trends. Difference is allocated accordingly.

The politics of queer racialized lives are emphasized when they are profitable (depoliticized, deemphasized, denounced: the *Paris is Burning* effect), and excised when they are unprofitable (too politicized, too emphasized). Parceling out what is consumer friendly in queer racialized difference subsidizes the flesh and flesh relations. The embodied knowledge that queers of color carry, dance, sing, and fuck with is funneled into a report, a statistic, a number. The intent: immediate intelligibility and serviceability regardless of what realities and imaginaries must be bulldozed over in the meantime.

Data is lived by bodies; Bodies live in data. Somewhere on that line graph is my friend, somewhere in this percentile is me. Our data contributes to combatting homelessness, (de)stigmatizing sex work, designing PrEP ads, and to the rising

costs of HIV/AIDS medications. We are risks and exposures and prescriptions and yeses and nos and maybes tallied up, quantified, fleshed out in data. Sometimes regrettable, sometimes helpful, and always inevitable, maybe there is an opportunity to attune the sensibilities of languaging and storying and bodying data in a manner which runs contrary to the logics and rationality of racial capitalism it finds itself tethered to.

Think, for example, of the line graphs dedicated to illustrating the rising rates of infection in the Southern United States among Black men who have sex with men. The steady ascension of the lines up the x and y axis, if it is to remain a tool of the state and its affiliates, works to fortify a sense of dread over seropositivity, hyping up witch-hunts to better scope out queerness/DLness/transness for new markets, trying to undo the stigmatization of disease it imposed through more profitable forms of stigmatization that fit a consumerist homonationalism. What if the red line ascending up the x and y axis can tell us stories contrary to the machinations of state and capital, of how the increase in infections can illustrate more regional and localized stories of queer (and non-queer) relationality, of how prevention discourse operates for the satisfaction of a corporatized medical industry, of how health and well-being can be theorized and mobilized apart from corporatized care and stigma and markets? The rise of the line, as well as the decline, should be a rise in inquiry and doubt and critique, a speculating on how the aggregation of flesh into a red line can create (or not) collectivities and epistemologies and networks and bodies hitherto unimagined.

The data is all around us, the data is all up in us, the data is us. Better put it to some use.
