

**Facing the plagues alone:**  
**Men reshaping the HIV and heroin epidemics in Colombia**

by

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In my PhD dissertation, I show that HIV-positive heterosexual men and heroin users are often forced to bear the intensity of HIV and opioid addiction, respectively, in silence and without institutionalized care. I argue that the absence of support for these groups and the political blindness towards the suffering of these invisible populations makes their chronic diseases fatal.

I show that Colombian HIV prevention and treatment policies, known for their inclusiveness of diverse gender dynamics, have systematically excluded heterosexual men from prevention and healthcare, most profoundly impacting men living in poverty. I examine how heterosexual men find out about their HIV diagnosis, how they understand it, and how they cope with it. I highlight the struggles that heterosexual men must undergo to access support and medical networks, as well as the complicated role of HIV in romantic and family relationships. I also show how the neoliberal fragmentation and privatization of the Colombian healthcare system, as well as the centralization of HIV clinics in cities, magnifies the negative experiences of men living in poverty in urban and rural areas of Colombia.

My dissertation also explores the effects of the rapidly growing heroin epidemic in Colombia, a “risk group” for HIV and Hepatitis C infection, through the experiences, photographs, and narratives of heroin users in the first state-run methadone clinic in the southwest of Colombia. I explain how inter-American shifts in the legal and illegal opioid markets have resulted in the production and marketing of heroin within Colombia, sparking an

unprecedented national epidemic with nearly non-existent public policies to deal with the issue.

Moreover, my research shows that HIV and heroin addiction can sometimes become experiences of self-reflection that promote positive changes. These reflections with positive outcomes are typically the product of the labor of men in conjunction with partners, family members, friends and idealistic institutions. The dissertation concludes with a discussion on family formation and legal opioids as technologies of hope that give meaning to the lives of men and women I talked to.

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## List of abbreviations

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral treatment
ED	Erectile dysfunction
HAM	Heterosexually active men
HIV	Human immunodeficiency Virus
HUV	<i>Hospital Universitario del Valle</i>
ISS	<i>Instituto de Seguros Sociales</i>
LGBTQI+	Lesbian, Gay, Bisexual, Trans, Queer, Intersexual.
MSM	Men who have sex with men
MSW	Men Who Have Sex with Women
PrEP	Pre-exposure prophylaxis
PWID	People who Inject drugs
STI	Sexually Transmitted Infection
TB	Tuberculosis

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## 1.0 Introduction

I was born in 1983, the year in which the HIV virus was discovered and linked as the cause of AIDS. I grew up watching news about the HIV and AIDS epidemics and AIDS prevention campaigns promoting the use of condoms. I even remember giving a presentation in sixth grade about the importance of condoms and how there should be condom dispensers in schools. My generation was targeted with the importance of using condoms to prevent HIV, other STIs and undesired pregnancies. I believe these campaigns were pretty effective, and I remember they portrayed HIV as a risk that everybody who was sexually active should consider. Ads on the TV and in newspapers included hetero and homosexuals couples in their campaigns. This was at a moment when Colombia was on its way to becoming a more progressive nation, with a new 1991 constitution that gave rights to minorities, while simultaneously going through a very bloody chapter of its long-lasting civil war, and rapidly implementing neoliberal policies that promised economic stability and growth to the developing nation.

Of course, the promised stability and growth never came to realization, but in the meantime the HIV epidemic—among other plagues— spread through the nation, hitting men who have sex with men (MSM) and sex workers especially hard. In response, the '90s in Colombia saw the rise of a robust Gay Movement that, inspired by similar ones around the globe, articulated its fight with an impressive civil response to AIDS, which was the base of an effective public health response. For example, the 1991 Colombian constitution mandated that the state provide free HIV treatment to those affected with the disease.

In the '80s, Colombia also saw the rise of another plague, the *basuco* epidemic. *Basuco* is a low-quality, highly addictive, cocaine paste. It comes as a residue of the cocaine manufacturing

process and because it does not meet export quality standards, it is sold cheaply in Colombia. Since the '80s *basuco* rapidly became a signature drug in the streets of Colombian cities where a rapidly growing population of homeless people, driven to the streets because of war and poverty, embraced the sweet smell of *basuco* to cope with the harshness of homelessness. The *basuco* epidemic became chronic in Colombia and has left hundreds of thousands of people dealing with their addiction without support and treatment. Public policy efforts have unsuccessfully focused on controlling the production and distribution of cocaine, so it does not reach the US and European markets. It is within this scenario that a decade ago Colombia began experiencing the rise of a heroin epidemic. Heroin began to circulate through *basuco* markets and rapidly sprawled throughout urban Colombia. Today the opioid epidemic is affecting mostly poor men.

This research project is situated in Cali, Colombia, and deals with two epidemics among men, HIV and heroin addiction. Initially, I wanted to understand the impact of HIV on self-identified heterosexual men because even though they are reshaping the epidemic, little is known about how the epidemic affects their lives. However, the presence of the heroin epidemic so heavily overlapped with my initial research project, that I also decided to inquire further in this matter. Specifically, my research project deals with men who take methadone in order to cope with their heroin addiction in the context of a harm-reduction program and self-identified heterosexual men who live with HIV, and how they try to give sense to their lives. These two universes do not necessarily and obviously overlap but, beyond the more visible links between HIV infection and the use of drugs and alcohol, there is a deeper question about two (in)visible actors in the HIV epidemic in Colombia, heterosexual men and injection drug users, and the emergence of the heroin epidemic, which is concentrated among men.



I situate this project in the context of contemporary Latin American urban men's anxieties and desires towards pleasure, sex, romance, and reproduction. Furthermore, I analyze how the multiple interactions of the HIV virus and heroin addiction with class, race, and gender not only shape bodies, identities and emotions, but also outline health policies and civil-society responses. Additionally, I reflect on HIV as affect, analyzing how its unexpected presence among heterosexual men, and the poor resources available for them to acquire emotional and social capital to interpret it, reshapes men's lives and emotions, translating the experience of HIV into one of sorrow and anxiety, experienced very commonly in solitude and silence. Moreover, the presence and support from female partners and mothers is effective in translating men's unknown and awkward emotions towards HIV into more positive feelings and experiences (break sentence here) that often times mutate into positive changes in masculine roles and the possibility and desire to assume HIV as a chronic disease. Unfortunately, many men who do not find this support die sooner than those who do, experiencing HIV as an acute disease, when globally the rhetoric is that it is chronic. Finally, I discuss the chronicity of HIV/AIDS in relation to the Colombian healthcare system, the Colombian HIV biopolitical apparatus<sup>1</sup> and the ignored intersection of heterosexual masculinities and HIV/AIDS.

Regarding the piece of my research on masculinities and heroin addiction, I analyze through a community-based participatory research method, named PhotoVoice, how access to methadone treatment in the context of a harm reduction program transforms participants' daily lives positively in their journeys to control their heroin addiction. Furthermore, I discuss how,

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<sup>1</sup> The assemblage between the Gay Rights Movement, HIV organizations and the HIV medical response is what I will call throughout my research the HIV biopolitical apparatus.

paradoxically, in a country that produces high quality opioids, there is no policy to provide legal opioids for the treatment of a population addicted to heroin. Finally, I argue that access to legal opioids for the treatment of heroin addiction in harm reduction contexts provide clients the possibility to incorporate pleasure into their control addiction processes while transforming their addiction into a chronic-like disease where they can put limits to risky situations such as HIV or hepatitis C.

### **1.1 Cali, Colombia**

Cali is the capital of the Valle del Cauca state and the most populous city in southwest Colombia with 2,227,642 residents according to the 2018 census. The city spans 560.3 km<sup>2</sup> (216.3 sq. mi) with 120.9 km<sup>2</sup> (46.7 sq. mi) of urban area at 1,018 m. (3,340 ft) of elevation in the western Andes cordillera of Colombia. Cali is the second-largest city in Colombia by area and the third most populous. As the only major Colombian city with access to the Pacific Coast, Cali is the main urban and economic center in the south of the country and has one of Colombia's fastest-growing economies. Cali also has the second-highest incidence of HIV infection in Colombia and, as in the rest of Latin America, the HIV epidemic is expanding rapidly within the heterosexual population. Cali is also the city with the second largest Afro-descendant population in Latin America, after Salvador de Bahia in Brazil.

In the 1970s, Cali became an important knot in the Americas airplane route map. Often Cali was a mandatory stop for planes traveling from north to south America and vice versa, usually with a one-night layover to refill fuel, food and do mechanical check-ups. Cali also entered the global party scene at this time, with travelers from around the world having transitory days and

nights to spend out of their long airplane trips. By the same time, Cali's local elites managed to attract international capital to set up factories seduced by Cali's privileged location and a vast amount of cheap labor fueled by a massive rural migration into the city composed of people escaping violence and poverty. As an example, Goodyear and Colgate had factories in the city for decades (Martínez, 2012).

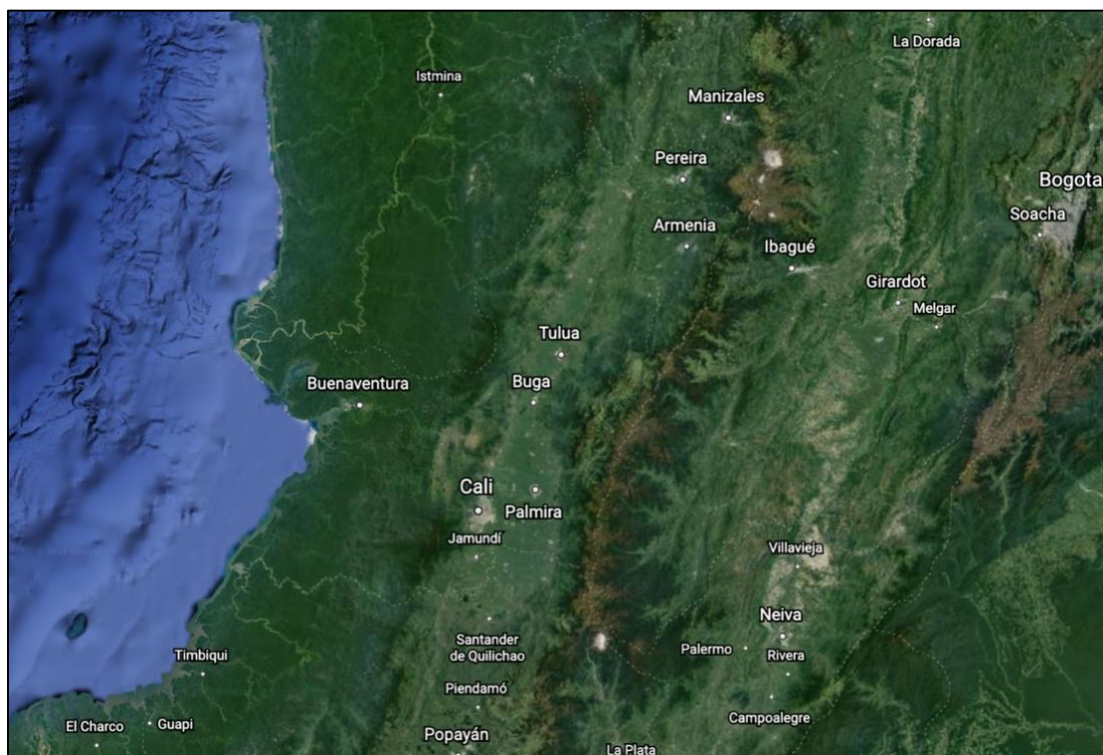
This rapidly growing population of urban proletarians adopted salsa, an urban musical beat that often talked about the social and political hardships of Caribbean countries and their diasporas in places like New York. The lyrics resonated with Cali's migrants' own experiences. Within this vibrant scene, local DJs in Cali started playing the 33 RPM records at 45 RPM, speeding up the way of dancing salsa in a unique way that caught the attention of the whole salsa industry (Ulloa, 2009). This shift revolutionized salsa, and Cali became the Global Capital of Salsa, a place where the music, party, and sex industries bloomed. Plus, in the '80s, the Cali Cartel anchored the city as one of the global cocaine-escapes of the world. This story is important because it frames the transformation of Cali into what Brennan calls a pleasure landscape (Brennan, 2004).

Cali is a city of pleasures, known by the "party, sex and drugs" dictum. It has a well-known music industry linked to the global networks of salsa beats; a robust sex industry, today famous for the webcam business; and the latent legacy of the infamous Cali cartel which normalized the trade and consumption of multiple kinds of drugs in the city. Furthermore, Cali is a key economic nexus in the Colombian southwest and the South American Andean zone, intrinsically connected to the most important Colombian seaport in the Pacific Coast, Buenaventura. Very important for this project, Cali is a city open to sex. People are open to talking about it, and an urbanistic example of this is that every neighborhood in Cali has one or more "love hotels," locally named *moteles*,

openly acknowledged as such by neighbors and citizens. There are even a few that are city landmarks.



**Figure 1. Cali among other cities in the region.**



**Figure 2. The Cali and Buenaventura region.**

## **1.2 Note on pseudonyms and participant's socio-economic status**

Unlike sex, HIV and heroin use are not easy topics to talk about. There is shame, stigma, and fear of confidentiality leaks. Gossip is a powerful tool, and especially the adults living with HIV wanted to know their information was safe. Thus, all the names of people living with HIV are pseudonyms. A bit surprisingly to me, heroin and methadone users were less concerned with the confidentiality of the information they shared. All them even agreed to use their real names in the copyright of their images, and I have decided to respect that. With respect to health professionals and activists, I have decided to keep their real names. Hiding their identity would be

almost impossible with the rest of the data given, and in a few cases, I have just omitted their names.

It is important to mention that almost all the participants I talked with belonged to low socioeconomic status classes, with the exception of some of the health professionals and HIV activists. The great majority of my interlocutors were affiliated with the *subsidiado* healthcare regime, and a few with the *contributivo*, through formal low-wage paying jobs or family affiliations. This puts my dissertation among the majority of research on HIV/AIDS and opioid addiction, in which the gaze focuses on poor people's experiences. I believe bottom-up studies in these research areas are needed to have better comparative data, however my research does not help to remedy this gap.

### **1.3 Methodological aspects of fieldwork with HIV-positive heterosexual men**

I carried out the fieldwork for this research project when I was in my early and mid-thirties. I identify as a heterosexual man, and I would classify myself as a middle-class. I was born and grew up in Bogotá, Colombia, where I lived until I left to start my PhD in 2012. I am an only child, the result of the union of a social worker and a physician. By the time I conducted my longest period of fieldwork in 2017-18, I had been an HIV researcher for more than a decade and had eight years of experience with community-based participatory research methods with hard to reach populations.

Cali is not my hometown, and even though I love this city, I would not say I became a *caleño* (someone from Cali). I was easily identified as a non-native from Cali, which I think allowed people to be more open in our conversations because my presence in the city was read as

temporary. Cali is a middle size city, by Latin American standards, but gossip travels fast, and I believe that especially for heterosexual HIV-positive men, who have to circulate through specialized HIV clinics, there is fear to be spotted by a neighbor, a colleague, or whoever who might know them. Thus, the fact that I was temporarily in the city, I think, helped to build rapport, though typically for only one interview.

I also believe that my heterosexual identity allowed me to establish rapport with them more easily, especially in the context of a society that is deeply homophobic and in which the biopolitics of HIV/AIDS are markedly designed by and for gay men. By this I can say that my gender was part of a successful methodology for recruitment and rapport, but it would be interesting to test further how researchers' gender identities affect data collection among heterosexual men dealing with sexual issues. It is important to note here that I took inspiration from ethnographic work done by two female anthropologists, Emily Wentzel, who studied Mexican men suffering from erectile dysfunction (Wentzell, 2013b), and Marcia Inhorn, who worked on men suffering from infertility in the Middle East (Inhorn, 2012).

Between 2013 and 2018, I visited Cali three times, completing 18 months of fieldwork during which I visited several HIV clinics and NGOs, having the chance to talk and interact with men and women affected by the virus as well as with health staff and activists. I conducted many hours of participant observation at clinics, hospitals, people's homes, NGOs, and public events from which I have fieldnotes. I conducted individual interviews with 36 HIV-positive men, 30 HIV-positive women, 3 HIV-positive couples, and 30 NGO and health care professionals, totaling 99 interviews.

Of the people I talked to who lived with HIV, all were adults within a 21-62 age range, all were poor or had low-income, most had jobs in the informal economy and very few had stable



jobs. Most of them paid rent and lived with extended family members in self-built houses. All of them self-identified as heterosexual except for two who identified as bisexual and two as homosexual. This set of interviews took place in Cali but not all people lived in the city; the majority of non-Cali residents came from Buenaventura and others from Buga, Palmira, Popayan and other small towns close to Cali, since Cali centralizes the attention from NGOs and clinics for HIV for a vast region in the Colombian southwest.

Recruiting heterosexual HIV-positive men proved to be challenging and almost all the interactions occurred only one time, and often for short periods of time, as men were often in a rush. I took the decision to skip a demographic survey I had planned to distribute and start the interview as soon as I could, thus my demographic data is not very detailed.



**Figure 3. Cali's working-class neighborhood alley. May, 2018. Photo by the author.**



The HIV experts I interviewed had more stable jobs linked to their organizations, but these were not necessarily well-paid positions. A few of them lived with HIV too, but not all. The NGOs I worked with in Cali had an emphasis on working with HIV-positive women and families and gender violence prevention programs. Medical experts ranged from nurses, to social workers, to psychologists, to immunological system experts. Interviews with national agency staff members were held in Bogotá where the main offices are located.

NGOs and HIV clinics made initial contacts for me with some self-identified heterosexual men and women living with HIV. Nevertheless, at the beginning of my research, reaching HIV-positive heterosexual men proved to be hard, especially because heterosexuality as a category created a lot of confusion among HIV professionals, as it was difficult for them to assess the “true heterosexuality of men.” But in those initial fieldwork seasons, I also learned many heterosexual men and women became aware of their HIV status during pregnancy, and since measuring men’s heterosexuality posed a challenge for HIV professionals—my key nexus for referrals—I decided to change gears and look for HIV-positive fathers. This change proved to be an effective way to overcome the mentioned difficulty and to put me in contact with men who self-identified as heterosexual, with the exception of two who self-identified as fathers and homosexuals, and two who self-identified as fathers and bisexuals.

All the interviews were recorded, transcribed, and analyzed in MAXQDA18. The interviews’ main topics were 1) How do HIV-positive heterosexual men grapple with fatherhood, gender roles, and romantic relationships? 2) How does the presence of HIV reinforce, contest and subvert gender roles and identities associated with *machismo*? 3) Are the Colombian healthcare system, the HIV bureaucrats, or the HIV NGOs promoting positive change in the lives of HIV-

positive straight men and their families? If so, in what ways? (See appendix A and B to take look at the complete interview guides I used).

Convincing HIV-positive heterosexual men to participate in an interview was not always an easy task. Men were often reluctant to talk, and the majority of the times I had the chance to interview them only once. However, in almost every interview, men opened up and shared their anxieties, fears, desires, and questions with me. These men, who were many times hard to convince to talk, would, during our talks, suddenly open up, showing vulnerability. They often told me they liked the interview, because they were able to share things they never had the chance to talk about with anybody. A few of them literally referred to the interviews as cathartic and useful to process thoughts and emotions. However, even though the majority of times men were moved during the interviews, when I asked them if we could meet again, most of the times they rejected the idea, and many who agreed to do so never answered my follow-up calls or text messages. One time, by chance, I ran into one of the men at an HIV clinic, days after we had an interview. When he saw me, he acted truly surprised and, I would say, uncomfortable with my presence there. He barely said hi. My gut tells me he thought I had already left Cali, and must have thought: What is he still doing here? In fact, I had initially thought of conducting a PhotoVoice with HIV-positive heterosexual men, but when I mentioned the idea to participants almost nobody showed interest. In fact, one man told me he felt it was too compromising; he felt photographs could become evidence he did not want to eventually become exposed. Only two men, whom I have known since 2013, agreed to the photographic exercise, and a few of their photographs are incorporated in this piece.

In sum, I learned that most of heterosexual men living with HIV were reluctant to talk and to do follow-up, but once in the interview they opened up and shared a lot, thus methodologically

speaking it means that with this type of population the researcher has only one shot for gathering data, and it has to be used wisely. In my case, I rarely had the chance to do follow-up interviews. Also, as Ligia Lopez, an HIV activist told me in an interview, men and women do not have time. Their multiple occupations, plus the bureaucracy related to their healthcare, just took people's free time away, a fact that made the time available to meet with an anthropologist not relevant, and probably sort of a burden. However, and even in spite of these difficulties, people were willing to talk to me, most of the times for only one time, and that was golden.

#### **1.4 Methodological aspects of fieldwork with clients from the methadone clinic**

When I arrived in Cali in 2017 to collect data for my longest fieldwork period, finding HIV-heterosexual men willing to talk proved to be difficult during the first months. Most of the men I had spoken with before were untraceable and recruiting took much longer than on my previous visits. Through dialogues with friends and colleagues, however, I knew a heroin epidemic without precedent was booming in many cities of Colombia, and Cali was one of the hot spots, so I started inquiring about that. I was put in contact with a needle exchange program which had just started to run a pilot program with methadone, funded by Cali's health secretariat. At the beginning, I thought this route would allow me to connect and talk with HIV-positive men; instead, I ended up engaged with this specific community and decided to conduct a photographic community-based participatory research project with clients of the methadone clinic. This allowed me to take a unique ethnographic approach to the opioid epidemic in Cali, which affects mostly young men at high risk of exposure to hepatitis C, HIV, overdosing, and homelessness. Research

on the impact of the opioid epidemic often focuses on its impact on the global north, add a clause here about how this project is different?

The professionals working with heroin users who were key to my understanding of the heroin dynamics in the city—and who allowed me to conduct my research—ran two NGOs under the same umbrella. One was CAMBIE, a needle exchange program, and the second one was the pilot methadone clinic. The majority of clients enrolled in the latter were recruited in the first one. The three experts that appear in this text are the psychologist of both NGOs, the peer who handed out clean paraphernalia for injected drug use at the needle exchange program, and the director of both NGOs.

My research approach to the heroin epidemic in a Global South city, Cali, is based on PhotoVoice, which is a methodology that seeks to invite participants whose perspectives are often excluded from artistic authorship, historical knowledge, and decision-making to capture with a camera how they perceive their reality, and then generate a collective dialogue around what their photos represent and what actions are necessary to fight injustices and promote social change (Latz, 2017; Ruiz Sánchez, Pardo Gaviria, De Ferrari, Savage, & Documet, 2018; Sitter, 2017). In this sense, through PhotoVoice I had access to a multi-sighted intimate gaze from heroin and methadone users narrating their daily challenges with healthcare, addiction, family and love relationships, work, and the city. Participants of this project responded through photographs and narratives to the question: How does methadone use affect your daily life?

During 2017 and 2018, I visited a needle exchange program and methadone clinic where, in collaboration with 13 clients (12 male and 1 female), I conducted community-based participatory research (CBPR) that includes the use of participant's photographs and narratives from people often excluded from artistic and academic authorship, historical knowledge, and

decision-making (Latz, 2017; Ruiz Sánchez et al., 2018; Sitter, 2017). This methodology is called PhotoVoice, and I used it to invite heroin and methadone users to capture with a camera their perspectives on: how does methadone intake change their daily lives?

In the PhotoVoice project with clients of the pilot methadone clinic, thirteen people participated, twelve men and one woman. Their age range was 21 to 43 years old. Only one person had a formal job, five were unemployed, two said they lived from *rebusque*<sup>2</sup> and the rest had informal jobs. One was homeless, one lived in a shelter, and another one rented a room in a motel. The rest lived in rental housing or with extended family. The highest degree of education that participants held was a technical degree and the lowest incomplete high school. Only one lived with a partner. Four were parents and, of those, two were taking care in some way of their children. Eleven used injected heroin and two smoked it. Five had more than 16 years of consuming heroin, while the other eight had between 4 and ten years of heroin use. They also referred to consuming alcohol, marijuana, *basuco*, cocaine, benzodiazepines, energetic beverages, and tobacco.

The photographs presented by participants and the conversations around them were audiotaped, transcribed and analyzed in MAXQDA18 along with some bibliographic references. I also conducted six individual interviews with clients and three individual interviews with staff of the methadone clinic, plus several hours of participatory observation at the needle exchange clinic, the methadone clinic, and the streets of Cali, while hanging out with clinic staff members and clients. This set of interviews was not transcribed, but I have listened to them and have taken notes that I have incorporated into this piece.

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<sup>2</sup> *Rebusque* is a Colombian term used to refer to ways people employ to survive in a precarious job market. Usually it refers to activities with no stable salary, done in the streets, and informal.

### **1.5 On my choosing of key words and concepts**

Taxonomies always end up being arbitrary decisions. We invent them to give order and sense to universes of individuals and behaviors. In western societies anchored in Christian ideologies, heterosexuality is a norm-category to label and describe sexual desires, acts, and identities that are based on a rigid bipolar division of sexes and genders. Heterosexuality has governed discourses of biopolitics for centuries now, and terms such as heteronormativity have emerged to criticize the exclusionary biases of heteronormative constructs. However, in the context of HIV/AIDS and its trajectory of almost four decades, heterosexuality has not been understood as the paradigm. The concentration of the HIV epidemic among men who have sex with men (MSM) in the Americas and Europe created a biopolitical apparatus that allowed the articulation of a global medical response that was deeply intertwined with the gay rights movement. I argue that this intertwining created a biopolitical apparatus crafted mostly by gay men for gay men. I am aware of the importance of this synchronous movement in the development of progressive medical and political agendas around the globe as well as in Colombia, yet I believe that it is also important to critically evaluate its trajectories.

Through my research project, I argue that the HIV biopolitics of Colombia have systematically excluded self-identified heterosexual men and that is why I focus on their life experiences traversed by HIV/AIDS. In this sense, I have decided to use the label of 'heterosexual men' throughout this document and my research because I want to call attention to how the intersection of heterosexuality, masculinity, and HIV develops from the perspective of heterosexual men living with HIV, their female partners, NGOs, and the medical system. I could have used labels such as MSM? men who have sex with women (MSW), or heterosexually active men (HAM) but I chose not to for two reasons. First, because the great majority of men I talked to

self-identified as such, and I wanted to respect that. And, secondly, because even though I understand the logic behind labels such as MSM, MSW, or HAM allows including men who do not identify as homosexual or gay but may have homosexual encounters, the scope of my research does not focus on the hidden sexual practices of heterosexual men, but rather in the meanings of living with HIV/AIDS as a self-identified heterosexual man in Cali, Colombia. My research scope is wider, and I aim to provide a broader panorama on the effects of HIV/AIDS on the lives of these men, instead of focusing on means of infection.

Furthermore, I understand and use heterosexuality as a non-rigid category, and rather assume it as part of a spectrum of possibilities to which people can cling to in moments of their lives in temporal or more permanent ways. Additionally, there is a common belief among HIV professionals in Colombia that all HIV-positive heterosexual men are homo or bisexual men in the closet. And even though I found cases in which this was true, most of the cases I encountered in my fieldwork do not exactly fit this stereotype. Thus, the use of the term HIV-positive heterosexual men becomes in this case political in the sense that I want to call attention to a growing component of the HIV epidemic in Colombia which is hitting the heterosexual population.

With the data I collected in Cali I demonstrate that dynamics of HIV infection among heterosexual men do include homoerotic sex but expand way beyond this monolithic impression. I also found that heterosexual men living with HIV are not all active virus spreaders and womanizers who bring HIV into their families. I argue that both of these stereotypes of HIV infection and transmission have created a bias in the administration of medical care and social support anchored in the HIV politics and epidemiological dynamics of the '80s and '90s, when the epidemic was intrinsically linked to MSM and the Gay Rights Movement, which negatively affects

the incorporation of heterosexual men into adequate networks of HIV medical care and social support.

Furthermore, HIV-positive heterosexual men very often end up coping with an unexpected diagnosis in silence. I found that the HIV-positive diagnosis for heterosexual men is a moment of profound rupture, which leads men to experience something unknown; thus, for them, HIV works as an affective intensity which not only dislocates male privilege, but also reveals men's vulnerabilities, and holds the possibility for transformation towards new masculinities (Bordo, 1994; Reeser & Gottzén, 2018).

This being said, I use Connell's idea of hegemonic masculinities (R. W. Connell & Messerschmidt, 2005) to initially address how the HIV biopolitical apparatus has built an hegemonic type of man who incarnates the HIV experience and therefore the deservedness of care—the gay-male body—while other forms of masculinity and femininity are left aside or subordinated. HIV in Colombia today is still synonymous with a gay disease, and HIV-positive men who do not self-identify as homo or bisexual are often stigmatized for not being open to their closeted hidden desires and identities and are commonly excluded from social and medical support. Additionally, there is a paradoxical transition from a negative HIV status to a positive one for most of the heterosexual men I talked to. Their HIV-positive diagnosis rescinds many of the privileges that a *caleño* or a Colombian patriarchal society provided them. Men I spoke to told me that HIV became a barrier for having multiple sex partners, implied the use of condoms, and often obliged them to diminish their consumption of drugs and alcohol. Furthermore, HIV posed as a barrier for reproduction and family formation. Thus, HIV in the lives of these men became a force that undermined privileges and desires ascribed to heteronormative male roles in Colombia.



HIV has created a biopolitical infrastructure that gay men today in Colombia can navigate relatively at ease. For example, the support groups I know of that include men are usually run by and for gay men. Most of the top bureaucrats of HIV/AIDS in the country are gay men and most of the NGOs with longer and established trajectories in the country are also run by gay men. Plus, many health professionals devoted to working with HIV patients are gay men too. Hence, the HIV infrastructure in Colombia is one that contrasts with a patriarchal and homophobic society, and that is indeed a very positive aspect, however with my research approach I have found that the Colombian HIV-biopolitical apparatus has inherited bias.

As an example of how strong the ties between HIV and the male gay community in Colombia are, in many conversations I have had with HIV-positive women in Colombia I have learned that the positioning of their experiences, needs, and organizations has not always been easy or welcome. HIV-positive women's struggle to become visible has been difficult, and even more so when economic resources for HIV have become scarcer as the disease is progressively thought of as a chronic disease instead of an acute and mortal one.

In this context, it is key to imagine that the positioning of heterosexual HIV-positive men in the HIV map in Colombia is problematic, clearly for the men themselves but also for the HIV biopolitical apparatus. For most of the heterosexual men and women I talked to, HIV is an unexpected presence, and when they know of its presence in their bodies, death is the first thought that crosses their minds. On the other hand, the Colombian HIV biopolitical infrastructure is not prepared to provide services and support to heterosexual men. Institutions do not know their fears and anxieties and rarely offer tailored and accurate support to these men. Subsequently, heterosexual men's ghostly existence within the HIV apparatus leads them to take distance from

services and many times become non-adherent to ART treatment, negatively affecting the possibility of transforming their HIV diagnosis into a chronic experience.

From the perspective of the HIV biopolitical apparatus, HIV-positive heterosexual men's heterosexual path of infection and "true" heterosexual identity is often questioned, and often leads to uneasy situations where important facts about transmission and aspects of living with the virus are not shared effectively with these men. For example, many of them do not know that they can become parents after being diagnosed with HIV. There are no support groups for heterosexual HIV-positive men, nor protocols that include advertisement about preventive methods and tests tailored for them. HIV-positive heterosexual men are very often left on their own with important questions unanswered. In sum, their gender self-identification leads them to become subordinate subjects of the HIV biopolitical apparatus.

In a further attempt to grasp the complexities of the impact of HIV among heterosexual men, I argue that the irruption of the virus in their lives acts, initially, as an unknown potency or force that puts their existence in jeopardy. I use affect (Wetherell, 2012) as an entry point to understand this phenomenon. Medical anthropologists have discussed how chronic diseases transform the life experiences of people, sometimes in positive ways, highlighting how linguistic constructions based on accurate information and social and medical support help to create narratives and feelings of hope and well-being (Das, 1997; Good, 1994; Ruiz Sánchez, 2007). In this sense, I want to put my work into dialogue with studies of emotions and, more specifically, with the notion of affect to bridge experiences of disease, gender, and chronicity in the context of HIV-positive heterosexual men in Colombia.

Throughout my fieldwork I found in the narratives of men and women repeated examples of how the appearance of HIV/AIDS in their lives marked an unprecedented set of experiences,

feelings, and ideas. The breaking of HIV/AIDS in their lives created horror and terror, usually intensified by the news of a newborn on its way or the existence of an AIDS related disease. I also learned through dialogues with medical experts that today, very often, self-identified homosexual or bisexual men in cities like Cali are emotionally well-prepared to receive and cope with an HIV-positive diagnosis. The four-decade trajectory of the male gay communities dealing with HIV has led homosexual men to acquire excellent information about the facts of living with HIV and the efficacy of ART. Thus, in a way, homosexual communities in urban Colombia have developed a cognitive and emotional capital that allows newly-infected MSM to better navigate an HIV-positive diagnosis.

On the contrary, for heterosexual men the unexpected appearance of HIV into their lives arrives, and men have none of the emotional capital necessary to deal with the diagnosis. More importantly and dramatically is that this horror can be extended indefinitely if men do not receive accurate support and information, which is what I often found. Thus, I argue that heterosexual HIV-positive men in Colombia are lost in translation because they don't know how to interpret the HIV-positive diagnosis into a chronic experience detached from the idea of death. They lack the categorizations and descriptions to make sense of their HIV-positive diagnosis (Wetherell, 2012). Furthermore, I argue that heterosexual men continue to lack access to affective emotional capital that allows them to embrace their illness in more positive ways due to the stigma associated with HIV, still linked to "deviant" sexual practices, reducing their chances to seek support.

In the interviews I had with HIV-positive heterosexual men, female support coming from romantic partners and mothers emerged as a force that transformed the uncertainty of the HIV-positive diagnosis into feelings and knowledge that allowed men to comprehend and transform their HIV-positive experience into a more positive one. Some of the women who supported these

men were HIV-positive too, but not all of them. Their support came from emotional labor, care, and many times the possibility of forming a family or continuing to have one. These efforts, however, added burden to the lives of women, and caring for their men and their HIV-positive diagnosis became sources of emotional labor and often anguish, despair and sorrow. I argue that even though some of these women were not HIV-positive, they experience the affectivity of the HIV-positive diagnosis through their partners and the institutional vacuum that leaves heterosexual men without adequate medical, social and emotional support.

Men, too, enter into processes of emotional labor trying to give sense to their HIV-positive diagnosis, though unfortunately it often happens after a period of denial and a subsequent fall into acute illness linked to AIDS. This emotional labor I refer to is often coupled with a deep questioning and, sometimes, the reshaping of men's individual trajectories anchored in what the literature in Latin America on masculinities has often labeled as *macho* gendered roles (Fuller, 2012).

The use of drugs and alcohol appeared as a recurrent component in the life trajectories of men I talked to, which is deeply connected to a second aspect of my research, heroin in Cali. As I mentioned before, initially I did not plan to do research this matter but the presence of the heroin epidemic during my fieldwork was strong and the overlapping of intravenous drug use and HIV pushed me to follow this thread.

Here I want to frame a scenario in which heroin addiction, HIV, and masculinities can begin a dialogue in the context of urban Colombia where the heroin epidemic is invisible. The main point of connection that I find with the HIV epidemic is that it is primarily hitting men. According to conversations with specialists, 90% of heroin users in Cali are men, and among the group of people I worked with, twelve out of thirteen participants were men. Furthermore, all the

men I talked to in Cali were poor men, most of them affiliated to the informal job market, a few had stable jobs that gave them more financial stability, but perhaps the main differences between both groups of men were that those affiliated to the methadone clinic were younger and closer to homelessness.

The heroin epidemic in Colombia is a new one, and the biopolitics of heroin addiction are almost inexistent in the country. The global biopolitics of illegal opioids in Colombian territory are focused on eliminating or, more accurately, reducing the production and commercialization of heroin to the Global North. Addiction in places where heroin is produced is not contemplated as a public health matter. As an example, Colombia has been immersed for decades in a *basuco* (a cocaine derivative) epidemic that has been poorly dealt with by private and charitable organizations, and the same scenario is repeating with heroin. Thus, in a similar way to how HIV is silently affecting heterosexual men, heroin is clinging to the lives of men in Colombia, and the country is not prepared to deal with it and its repercussions in the new shaping of the HIV and Hepatitis C epidemics. In Latin America, the HIV prevalence among people who inject drugs (PWID) is 35.7%, in South Asia 19.4%, in Eastern Europe 24.7% while the global average is 17.8% (Beletsky et al., 2018). In fact, one man that initially wanted to participate in the PhotoVoice project decided not to after getting an HIV-positive diagnosis.

Addiction to heroin and other opioids is biologically powerful, hence allopathic medicine today deals with it pharmacologically through synthetic opioids with non-psychotropic power. Methadone is one of those synthetic opioids, and it is the substance chosen by the Colombian ministry of health to deal with opioid addiction in the country. Thus, for heroin addicts in Colombia, methadone is a lifeline and the only pharmacological option addicts have to overcome their opioid addiction by legal and allopathic means. The methadone treatment, however, is long;

it is initially programmed for two years and is in essence an opioid replacement that relieves withdrawal symptoms without the heroin high. Nonetheless, access to legal methadone in Colombia is difficult and scarce, and there are few harm reduction therapeutic approaches.

The group of people that participated in the PhotoVoice project belonged to a pilot methadone clinic framed as a harm reduction program. In general, harm reduction is directed towards decreasing adverse health, social and economic consequences of drug use even if clients continued using heroin (Single, 1995). This is important to note, first, because the approach was rare and novel in Colombia, where abstinence-oriented programs often framed under religious terms and the criminalization of the poor addict have been the norm. Secondly, and more importantly for my arguments, harm reduction addiction biopolitics understands addiction as a chronic disease. In this sense, heroin addicts in Colombia are experiencing a chronic disease, which can become chronically tolerable with access to legal opioids.

HIV in the last decade has been relabeled as a chronic disease due to the effectiveness of ARTs in controlling the reproduction of the HIV virus. Chronic diseases are known to create or maximize situations and experiences of awkwardness, discomfort, inequality and instability because they “recast reality in relation to the unexpected, the non-ordinary, the mysterious” (Good, 1994, pp. 164–165). In the case of HIV, after being an acute fatal disease, its transitioning into a chronic disease has transformed the lives of people all over the world by allowing the prolongation of their lives, in many cases for decades. However, my research findings show that the people I interacted with in Cali, most of them working-class people, do not always experience HIV as a chronic disease or have steady access to methadone and support to addiction. In both cases, my interlocutors often told me of repeated near-death experiences due to lack of access to adequate medical and social support.

Chronicity, as we now understand, is achievable only if multiple structural and individual variables coincide (Smith-Morris, 2010). In this case study I found that the intersection of heterosexual masculinities and HIV is a deterrent to experiencing HIV as a chronic disease in Colombia because these men have to overcome barriers not only related to the Colombian healthcare system, but also to position themselves as outliers within a geography designed by the HIV biopolitical apparatus which denies their existence and therefore questions their deservedness for care. In other words, the HIV biopolitical apparatus turns a chronic disease into a terminal one.

I also show and argue that the lack of access to legal opioids for heroin users in Cali, in the context of harm reduction programs, deters heroin users in need of treatment for their addiction from the possibility of treating it as a public health matter linked to a chronic condition. Colombian policy makers have not yet accepted that the country is going through a fast-expanding heroin epidemic, a fact evidenced by the paucity of epidemiological data and social and medical support. Colombia has been an active producer of heroin in the continent for at least four decades now, but it never prepared for a heroin epidemic after decades of chronic civil war, fueled in part by the juicy dividends of the illegal drug trade and rooted in yet unresolved critical structural inequalities. The scenario could not be more perfect for a heroin epidemic that was ignited due to a US illegal opioid market saturated with legal opioids and more Mexican heroin, which left heroin without a market within Colombia.

The heroin epidemic in Colombia spread through an infrastructure of drug dealing points located in downtown neighborhoods of many cities which have historically allocated displaced people, poor communities, and the homeless population. *Basuco* has conquered these strategic places in urban Colombia since the '80s, garnering little attention aside from that given by the police through the lens of criminality. Heroin is now deeply entrenched in these urban settings,

affecting thousands of mostly young poor men. Cali today has a street, called H street, which is the epicenter of heroin selling and consumption in the city. Colombia, through its immersion in the global drug war, has quite unsuccessfully implemented countless and very expensive efforts to control the production and circulation of illegal drugs, pressured by the negative effects on addicted people in the Global North. However, in this picture, Global South addicts do not exist, or better, seem to not deserve attention or resources.

Finally, my research project also shows the dramatic consequences of the deep privatization of the Colombian healthcare system which has created a free market-based health economy since 1991. As a result, private health insurance companies have taken control of almost all the healthcare services in the country, fragmenting strong HIV programs that were anchored in the public health network and asphyxiating non-profitable initiatives, such as the pilot methadone clinic. Furthermore, in its current neoliberal shape, the Colombian healthcare system has created a battery of small, cost-effective HIV clinics detached from medical centers, distancing HIV care from holistic medical approaches, medical research, and patients' grass-roots organizations which made the HIV response in the '80s and '90s so effective.

In sum, this dissertation tackles two pressing matters of men's health in Cali, Colombia: the HIV epidemic among heterosexual men and the heroin addiction of a vast number of poor, young, Colombian men. The shapes of both epidemics are starting to overlap and are already changing the form of the HIV epidemic in Colombia in various ways that we need to understand in order to better tackle each one. This dissertation project is a step towards the comprehension of these two connected yet largely unseen epidemics.



## 1.6 Dissertation organization

My dissertation has eight chapters, including this introduction in which I have laid out a map that allows the reader to have a conceptual, methodological, geographical, and demographic context for my research project. The second chapter provides a critical panorama of the privatized Colombian healthcare system, presents epidemiological data about the HIV and heroin epidemics, and closes with data on and a broad overview of men's health in the Americas. I focus on providing the reader with a critical description of the Colombian healthcare system, which has undergone a deep privatization process since the '90s and which is key to contextualizing the rest of the dissertation's chapters.

In chapter three, I discuss masculinity theories and approaches with an emphasis on Latin America and the malfunctioning male, which refers to stages, moments or processes of broken masculinity, especially while men are going through chronic diseases. I map the way medical anthropology has used this fracture as a window to understand contemporary dynamics of men around the globe. In this chapter I also reflect on the history of HIV biopolitics in Colombia. I argue that the Colombian HIV apparatus has been created by entrenched histories of the HIV and the gay rights movements in Colombia. I discuss how this liaison between the movements has created a bias for the implementation of the HIV biopolitical apparatus in Colombia in which heterosexual men are invisible. I close the chapter with a description of my methodological approaches, paying attention to how one does ethnographic work with hard-to-reach *machos*.

Chapter four is the first of my data chapters and focuses on the moment at which heterosexual men first come to terms with their HIV status and describe their infection itineraries. I present an array of profiles and trajectories with the aim to illustrate continuities and differences in how men in Cali end up becoming infected with HIV and how they make sense of an unknown

force and presence in their bodies. In this part I also identify trajectories of HIV infection and the difficulties men experience in translating the presence of the virus in their bodies. I show how men struggle to categorize the post-hoc experience of their HIV-positive diagnosis.

In chapter five, with the aim of triangulating men's perspectives, I introduce narratives of their female partners, emphasizing pregnancy as a nodal point of conflict and hope when HIV becomes part of kinship. In this chapter I also introduce the perspectives of medical and NGO experts on the matter of HIV-positive heterosexual men, showing how few experts manage to grasp or at least try to understand the complexities that the virus brings to the lives of these men and the challenges that their existence brings to the HIV biopolitical apparatus.

In chapter six, I focus on the lives of men after their HIV-positive diagnosis, focusing on three aspects. First, I review access to healthcare and question the possibility of HIV being a chronic disease in Colombia, building an argument in which gender plays a crucial role in the chances to get access to information, be part of support communities, and build emotional capital to cope with the diagnosis. Second, I discuss the case of a man's return after migration from Chile to Colombia caused by an HIV-positive diagnosis, underlining the tensions between breadwinning, migration, and the cruciality of gendered care provided by female partners to heterosexual men living with HIV. Finally, I touch on sero-discordant couples as a way to speak to romance, love, unprotected sex, and reproduction as technologies of hope and endurance.

In chapter seven, I shift focus to the heroin epidemic in Cali and its effects on the city's youth through a PhotoVoice project I conducted with members belonging to the first state-run methadone clinic in the Colombian southwest. The chapter focuses on the effects of methadone as a palliative for youth addicted to heroin and explores how heroin and methadone connect these youth in different ways to their families, bodies and the city. The chapter ends with a reflection on

people addicted to heroin circulating within legal and illegal opioid markets that are reshaping the opioid and HIV epidemics in the Americas.

Lastly, in my conclusions, I tie up my findings with further theoretical analysis, propose suggestions for policy change, and close with possible futures for this research project.

## **2.0 The Colombian healthcare system, HIV and heroin use data, and men's health**

In this chapter I provide a brief history of the privatization of the Colombian healthcare system over the last three decades. This context is key to understanding how HIV services are administered today under a market-driven and stratified healthcare system, which extinguished a public system that had been consolidated over decades under welfare state principles of care of life. The system that exists today has managed to enroll almost every Colombian citizen into a private health insurance network that administers healthcare under a neoliberal logic. Next, I provide a general overview of the most current HIV epidemiology data available in Colombia, which reveals class disparities in how the HIV epidemic is primarily affecting poor Colombians. The data I collected shows how the HIV epidemic is no longer concentrated among men who have sex with men. I also give some brief context on epidemiological data on heroin, which is very scarce. The chapter ends with a reflection on men's health, heterosexual masculinities and HIV viewed through the lenses of current research in public health and medical anthropology.

### **2.1 A glimpse at the Colombian healthcare system**

All through the 20<sup>th</sup> century, Colombia struggled to create a stable and centralized state. Part of this project consisted of building health infrastructure inspired by welfare state ideologies. By the 1990s, Colombia had built a public healthcare system divided into two subsystems: one designed for the formal labor workers, the Instituto de Seguros Sociales (ISS), funded by workers' and companies' payments; and a second one built on charity services that have existed since the

Spanish Colony, designed for the poor.-Simultaneously, Colombia had a private network of clinics and practitioners that operated individually and externally from the public network, sometimes under the umbrella of health insurance companies.

The charity branch of the Colombian healthcare system created alliances with public universities, which used the public network of hospitals for training and research. Funds for this branch of the system came from national and local governments and from payments made by patients according to a sliding scale. Importantly, anybody could access these services. The public model of the Colombian healthcare system was not perfect. It did not have national coverage, resources were very often scarce, and corruption existed, but the model was based on a conception of care of life which was not entirely mediated by efficiency, cost reduction, and revenue (Giraldo, 2007). Private clinics and health services also existed and served those who did not want to use the public network, but most healthcare was administered through the public system.

That changed in the last two decades of the 20<sup>th</sup> century. In the mid-1980s, the International Monetary Fund and the World Bank lent new funds to the majority of Latin American countries conditional on their implementation of certain structural adjustment policies. These conditions implied fundamental shifts in the role of states: the contraction of public expenditures, the control of monetary expansion, and the reform of the state itself. Under this new logic, states were seen as inefficient and incapable of managing productive enterprises, services, and social expenses (Iriart, Merhy, & Waitzkin, 2001). As a result, many public services became privatized. In the 1990s, public utilities such as electricity, telephone lines, water, and gas were sold by the state to the private sector. The rationale was that competition between companies would raise the quality of services while relieving the Colombian state of these ‘resource draining’ entities, which often came with financial losses and were seen as the foci of corruption. The reframing of public services

opened the door to a neoliberal reshaping of Colombian public infrastructure more broadly – including the healthcare system (Vega-Vargas, Eslava-Castañeda, Arrubla-Sánchez, & Hernández-Álvarez, 2012).

The privatization of the Colombian healthcare system began in 1993 after the 1991 Colombian constitution stated that access to healthcare was a public utility, rather than a human right. In the previous decades, under the ideological framework of the welfare state, health and pensions had been considered a public good and a state responsibility (Homedes & Ugalde, 2005). The shift away from state responsibility for healthcare, which allowed private insurance companies to access and administer social security funds, has been referred to as neoliberal managed care, market-based health care reform, and the financialization of the welfare state (Abadia, 2014).

In the early 1990s, Colombia was going through deep social and economic changes amidst a decades-long civil war and a more recent, but no less traumatic, global drug war. The 1991 Colombian Constitution, which replaced the outdated 1887 one, recognized Colombia as a multi-ethnic, pluricultural, and pluri-religious nation. The new constitution provided autonomy to minorities, which gave rise for the first time to indigenous and Afro Colombian political parties and autonomous territories. The 1991 constitution also recognized LGBTQ+ rights, known at the time as gay rights, crucial for the consolidation of a national HIV agenda. The M-19, a political party born out of negotiations between the government and the M-19 guerilla group, was key in the construction of the new constitution. In 1991, Colombia had a pause to breathe and imagine a new future. Under this new route, Colombia shifted toward decentralization, granting individual regions more space for economic growth and autonomy, and shifted from a bipartisan to a multi-partisan political system.

At the time of its publishing, the 1991 Colombian constitution was praised as a progressive one. However, neoliberal economic adjustments were happening all around the world, and while the country was moving towards a more inclusive social and political landscape, its economy was adjusting to insert itself into a shifting neoliberal global market. The argument that supported opening national economies to the international trade market was that it would create an optimal environment to pull non-developed countries from their “pre-modern” stages into modernity (Londoño Rendón, 2009).

Within this context, in the years following the new constitution, Colombia began an aggressive privatization of its national healthcare system. The legal precedent that allowed this was framed under Law 100, which established the following:<sup>3</sup>

*Social security is a mandatory public service whose direction, coordination, and control are the state’s responsibility. Services will be provided by public or private entities under the terms and conditions established by this law.*<sup>4</sup>

Law 100’s phrasing of social security, including healthcare, as a mandatory public service that could be provided by private entities in the neoliberalized Colombian economy rapidly changed the Colombian healthcare system. With the public announcement of Law 100, ACEMI (the Association of Enterprises of Integral Medicine), a conglomerate of private health insurances, commended the reform since it promoted freedom to choose services, decentralization, focalization of resources, and the separation of financial administration and services (Vega-Vargas et al., 2012). In a matter of two decades, public health entities became almost inexistent, and the

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<sup>3</sup> [http://www.secretariassenado.gov.co/senado/basedoc/ley\\_0100\\_1993.html](http://www.secretariassenado.gov.co/senado/basedoc/ley_0100_1993.html)

<sup>4</sup> Translation mine.

private sector became the administrator of the majority of health services in Colombia through compulsory private health insurance.

In this context, public entities, which for decades had functioned under non-profit schemes, tried to adjust to the new market dynamics under the legal name of State Social Enterprises (Vega-Vargas et al., 2012). However, most of them fell into bankruptcy, leaving thousands of workers unemployed, patients without care, and public medical research and training without an institutional home (Abadía B., Navarrete, Martínez P., & Pinilla A., 2006). Just a few public entities managed to adjust to the new market by selling profitable services, like the treatment of cancer, heart disease or psychiatric care. Over the years, the vast network of public hospitals and clinics that was left behind by the neoliberal mercantilist wave was bought or repurposed as outsourcing entities by private health insurance companies.

By the 2010s the welfare infrastructure that Colombia had built over decades had almost completely vanished in the hands of national and international health insurance companies. The privatization of the Colombian healthcare system did not bring more equality in access to healthcare, it just restructured its already existing divisions into a more unequal system divided into the following five subsystems, each with stark differences in the quality of attention.<sup>5</sup>

1) *The Subsidiado* (subsidized) is designed to support the poor and waives its monthly fee for its clients. Nevertheless, it has co-payments stratified in three levels, dictated by a survey conducted in people's homes by an entity called SISBEN, designed to identify

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<sup>5</sup> Colombia is well known for its structural inequality; in 1996, the Gini index was 56.9, and in 2017, 49.7, one of the highest in Latin America.



beneficiaries of social programs through a poverty score. This sector is similar to Medicare in the U.S.

2) *The Contributivo* (contributive) is designed for the formal labor market workers who pay a percentage of their monthly income to the healthcare system. If workers are freelance, they pay the whole amount of the fee, while if they have permanent contracts their contractors pay part of it. *The Contributivo* also mandates out-of-pocket co-payments for certain types of medical services, according to their complexity, scaled in medical guidebooks based on cost-efficiency analysis.

3) *The Vinculado* (linked) is the part of the system that administers the services for minorities (Afro Colombians and indigenous communities), displaced people, and the homeless. It does not have monthly fees or co-payments. Initially, services were provided by the public health network, but with its shrinking, this segment of the market has been taken over by the private sector. How/why is this different from the first one?

4) *The Regimen Especial* (the special regime) is the part of the system that administers healthcare for specific populations such as the military, the police, or public teachers. These groups have autonomy in their payments; this is the closest to what the ISS had been.

5) *Prepagadas* (pre-paid) is a market tailored to the upper and middle classes to access premium quality services. Clients enrolled in this health market adhere to different plans with different coverage, with the advantage of avoiding long waits or extensive bureaucratic procedures, but still have to pay monthly fees to the *Contributivo*.

The reform of the Colombian healthcare system has been praised as one of the most successful health reforms in the Americas. The WHO in its 2000 World Health Report tilted *Health Systems: Improving Performance* makes several references to the achievements of the Colombian

healthcare system. Yet critiques have shown that the so-called universal access to healthcare in Colombia can be better described as a state policy of compulsory affiliation to a stratified market of health services, where the poor are at a clear disadvantage because different affiliations lead to different qualities of service (Vega-Vargas et al., 2012). In fact, the Colombian healthcare system has created a model in which each Colombian citizen is obliged by law to be part of a privatized health insurance market, which works under a demand subsidy logic that values not only the efficient use of resources but also the accumulation of capital. Under this logic, the privatization of the Colombian healthcare system has deepened health inequities, significantly reduced primary and preventive healthcare, and has shown meager results in public health indicators. In sum, it is a lucrative scheme for all those involved in an insurance market that openly benefits and profits from the perverse financialization of the human right to health (Hernández & Torres-Tovar, 2010).



**Figure 4. “The hospital closed, and neonatal death rose. Let’s tear down neoliberalism”. Photo by the author, 2010.**

I took this photograph in 2010 at the Instituto Materno Infantil (IMI), the most important maternal hospital in Colombia's history, which closed in 2006 after being strangled by the privatization of the healthcare system. The IMI had been the maternal division of the Hospital San Juan de Dios (HSJD), and for centuries both institutions were the core of the public health network for care, treatment, research, and training in Colombia. Both institutions were intrinsically linked to the National University; medical students did residency rotations in both hospitals and they served the whole country. When they closed, the country and Latin America lost a top-level institution that served mostly the poor (Abadía Barrero & Ruiz Sánchez, 2018). It is no surprise that the closure of the hospital negatively affected neonatal death rates in the country, as the graffiti mentions. This massive and beautiful public hospital has been largely abandoned since its closure, used solely by a primary level private? maternal hospital that occupies one floor of the 4-story building. Until 2016, it had continued to be used by a few workers, who fought without success its closure and the unfair termination of their labor contracts; they were given no severance pay.

With the closure of hospitals such as the IMI and the HSJD, huge numbers of health workers were suddenly forced to join a precarious healthcare job market. Being an MD in the new millennium in Colombia was no longer a sign of economic status. In her extensive research on the effects of the privatization of the healthcare system in Colombia from the perspective of healthcare workers, Adriana Ardila points out that medical work in Colombia under the lens of productivity and cost-efficiency became precarious and a tool to create revenue by treating human suffering in a dehumanized way (Ardila, 2016). In 2014, doctors looking for a job in any of the 32 Colombian states found positions with salaries 1.5 to 6.5 times the minimum wage, while two decades earlier salaries for the same positions had been 20 times the minimum wage. Flexible contracts with hourly wages pushed doctors to have several jobs, forcing them to work 12-hour shifts to make

ends meet. Unsurprisingly, the quality of medical practice was affected too. For example, the length of medical visits was shortened to 20 minutes, from which several minutes are dedicated to filling out forms, leaving precious little time for the patient-doctor interaction (Ardila-Sierra, 2017).

These issues have shaped the administration of healthcare in Colombia into a privatized hierarchical system where class, cost of care, type of health insurance, and the stability of the healthcare market have become variables that inform public health policies and affect the quality of the services provided. For example, Colombia administers HIV care through an institution called the *Fondo Colombiano de Enfermedades de Alto Costo* (the Colombian Fund for Expensive Diseases.) This institution is a branch of the Colombian healthcare system, whose function is to offset the disproportionate financial burden of healthcare that costly diseases generate to the healthcare system. This entity was started in 2007, two decades after the privatization of the Colombian healthcare system, to administer resources, provide guidelines, and collect data for the treatment of high-cost diseases such as arthritis, chronic kidney disease, opioid addiction, cancer, hemophilia, rare diseases, and HIV.

Colombia has different entities providing healthcare services to HIV patients depending on the kind of healthcare services to which they have access, which is largely determined by the patients' class and area of residence. For example, a worker in the formal labor market that lives in Buenaventura, Colombia's most important port in the Pacific, can be affiliated with the *Contributivo* which, in theory, guarantees access to healthcare. However, despite its population of 415,800, the city does not have medium or high-level health care services. Thus, people living with HIV in Buenaventura must go to Cali – a trip of 3 hours – to get medical check-ups and ARTs

at least once per month, and while some health insurance companies cover transportation, many do not.

When the HIV epidemic emerged in the country in the 1980s, the most critical responses to support people living with HIV came from the *Instituto de Seguros Sociales* (ISS). This was the national public entity in charge of the health services and pensions of all formal workers in the country. Over decades, its medical personnel, mostly trained at public universities and public hospitals, managed to build a good infrastructure. In the largest Colombian cities, the ISS had at its core a hospital. In Cali one of the oldest and most well-known support networks for people living with HIV/AIDS emerged from the ISS San Pedro Claver Hospital. By virtue of being part of a hospital, these programs had the support of the entire clinical apparatus, and this attention was centralized. Similar programs emerged all over the country and were vital not only to create an expert and multidisciplinary view of the HIV epidemic in Colombia but also to support and activist organizations for patients, which played critical roles in fighting for rights to access to healthcare. Sadly, with the aggressive privatization of the healthcare system, the clinical view and robust patient organizations developed over decades in this hospital setting became fragmented and eventually dissolved.

The neoliberal economic restructuring of the Colombian healthcare system has also reshaped the physical architecture of healthcare centers. HIV clinics all over the country have adopted a “cost-effective” model in which a nurse, an infectious disease expert, and a psychologist are in clinics only when there is a demand for their services. This model operates both within and outside hospitals and helps health insurance companies maximize their resources and profit while checking the boxes of the HIV medical protocol guide. Yet this model is in direct opposition to the holistic approach that an HIV clinic within an infectious disease department within a hospital

must provide. For example, important ties with other departments such as gynecology or psychiatry are broken with the creation of hyper-specialized and financially independent for-profit clinics. And even though patients can arrange appointments with other medical specialists, these are managed by health insurance bureaucrats and often take weeks or even months. Today, few HIV clinics still reside within hospitals; the majority are located in houses in former upper-middle-class neighborhoods. In fact, many hospitals in Colombia today function more as a cluster of independent clinics that independently provide services to health insurance companies.

The Colombian shift from a welfare approach to healthcare into a market-oriented one destroyed a public system that fed from a symbiotic relationship between public universities and public hospitals. This undid a legacy of healthcare services, research, and education that, while imperfect, was ethically and pragmatically superior to its successor. Today almost all Colombians have insurance cards in their pockets, which has been praised as a positive shift towards health coverage in the developing world. IDs, however, have not translated into access and quality of care, and I will show how this transformation has affected HIV and addiction biopolitical policies.

## **2.2 HIV epidemiological data**

According to the 2015 Colombian Health National Survey, the percentage of people that got tested at least once for HIV in the age range of 13 to 49 was 30.2% among men and 50.9% among women (Ministerio de Salud y Protección Social, 2017). This percentage is low by all accounts and speaks to an HIV testing policy that is not carried affectively. From the total of people tested, only 6.5% of the men received their results (HIV-positive or negative), compared to 9.6% of the women. These alarmingly low figures speak to a very poor follow-up system, which leaves

close to 84% of the population tested without after-test information. In 2018, among people living in the AIDS phase, 53.3% were women, 57.7% were men, and 61.7% belonged to the *subsidiado*. This epidemiological framework shows that in Colombia, the poor (i.e., the *Subsidiado*, *Vinculado*, and unaffiliated) are those most affected by AIDS.

**Table 1. HIV prevalence.**

<b>HIV Prevalence in January 31, 2018<sup>6</sup></b>
Including dead, alive, affiliated, and unaffiliated to the healthcare system as <u>95,745</u> .
The male to female ratio is 3:1
Median age among women: 40.2
Median age among men: 40.5

**Table 2. HIV incidence.**

<b>HIV incidence February 2017 – February 2018<sup>7</sup></b>
<u>10,246 new cases</u>
85.4% of HIV new infections happened via sexual transmission, 13.8% of people did not know the route of infection, and the remaining cases happened through blood transfusion, injections, sexual abuse, work-related accidents, and mother-to-child transmission.
80.7% of the incident cases occurred among men, showing the epidemic has a male to female ratio of 3:1.

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<sup>6</sup> Data retrieved from (Fondo Colombiano de Enfermedades de Alto Costo, 2019).

<sup>7</sup> Data retrieved from (Fondo Colombiano de Enfermedades de Alto Costo, 2019).

Median age among women: 35.6
Median age among men: 33.4
Population affiliation to the healthcare system  55.8% Contributivo  41.9% Subsidiado  2.1%. Special  17% Unaffiliated

Thus, if 85.4% of transmissions happen via sexual intercourse and women report they become infected mainly through sex with men (UNFPA & Universidad Nacional de Colombia, 2008), then 20% of cases are active heterosexual men who are playing a pivotal role in the epidemic. Moreover, the fact that 17% of new infections happened among people without insurance speaks to the failure of the Colombian healthcare system in testing and preventing the expansion of HIV and AIDS, especially among the poor. Moreover, the data shows that the data is severely undercounting the HIV epidemic.

### **2.3 Injection drug use epidemiological data**

Heroin use has risen in Colombia by 200% between 1996 and 2008 (Observatorio de Drogas Colombia, n.d.), following a recent upsurge in local cultivation and illicit sales of heroin in Colombia. The phenomenon is new, and the epidemiological response in collecting and publishing data on heroin use has been very slow, to say nothing of the inexistence of public health



policies on the matter. The heroin epidemic is affecting the incidence of HIV and hepatitis C, which is the leading cause for cirrhosis and hepatocellular carcinoma (Ly, Hughes, Jiles, & Holmberg, 2016; Mateu-Gelabert et al., 2016; Ministerio de Justicia y del Derecho - Observatorio de Drogas de Colombia, 2015).

Nearly half (41%) of people who inject drugs (PWIDs) in Colombia have shared syringes with actively using peers in the preceding 6 months and at least 10% of PWIDs reported sharing syringes during their last injection event (Dedsy, Berbesi-Fernández, Segura-Cardona, Montoya-Velez, & Santamaría, 2017). In Pereira, one of the Colombian cities with the highest rates of heroin use, the prevalence of HIV among heroin users, increased from 1.9% to 8.4% in less than three years. Medellín, another urban center with a high prevalence of heroin use, experienced an increase of HIV prevalence from 3.8% to 6.3% (Ministerio de Justicia y del Derecho - Observatorio de Drogas de Colombia, 2015).

Epidemiological data on the prevalence, incidence, and comorbidities related to injected drug use in Cali are still unavailable. However, in a conversation with Cesar Londoño, the peer coordinator of *Cambie*, a needle exchange program in Cali, he told me that with financial support from the Global Fund, data started to be gathered in July 2020. The results, however, were not still available when we talked.

One of the few studies published on heroin use in Colombia was conducted with PWIDs in Pereira and Medellín. The study was published in 2016. Using respondent-driven sampling, the research team recruited 540 participants over 18 years old. 93% of the population was in the age range of 18-34, 77% were classified as low socioeconomic status, and 93% were male. Regarding HIV risk transmission behaviors, 43% of participants shared needles on a weekly basis; 49%

shared cookers, filters or rinse water; and 22% injected prefilled syringes (Mateu-Gelabert et al., 2016, p. 232).

These data resonate with what I heard from heroin users and staff members in Cali, however more epidemiological data is needed in order to map the state of the epidemics that convene around heroin use.

## **2.4 Men's health in the Americas**

*“More than 20% of men die before the age of 50; in other words, one out of five men die long before reaching their life expectancy at birth.”*

*Masculinities and Health in the Region of the Americas (PAHO, 2019, p. 8).*

Although there are 105 boys for every 100 girls born in the world, this proportion is inverted in the 30-to-40-year-old population and increases from the age of 80 onwards (with 190 women for every 100 men). Women constitute the majority of older adults in all countries. In the Americas on average, women live 5.8 years longer than men. The age-adjusted mortality rate for men is higher than for women (718.8 deaths per year per 100,000 people among men versus 615.1/100,000 for women) (PAHO, 2019). The most common causes of male mortality in the Americas are ischemic heart disease, interpersonal violence, and road injuries. Three of the leading causes of death are associated with behaviors that are frequently linked to the exercise of masculinity, namely interpersonal violence (homicides, with a 7:1 male/female ratio), road injuries (3:1), and cirrhosis of the liver (more than double), of which the leading cause is alcohol use.

Furthermore, due to premature death, there are 18% more years of life lost among men than among women (PAHO, 2019).

Men's socialization within dominant masculine roles underpins a triad of risks toward: 1) women and children, due to violence, substance abuse, sexually transmitted infections, imposed pregnancies, absent paternity, and lack of shared responsibility in the home; 2) other men, due to accidents, homicides and other violence, and transmission of HIV/AIDS; 3) toward themselves, due to suicide, accidents, alcoholism and other addictions, and psychiatric illnesses (PAHO, 2019, p. 4). Assuming dominant masculinity roles contributes to men taking risks in the workplace or when driving, excessive alcohol and drug consumption, unprotected sexual practices, violent interpersonal relations that result in homicide, and inability to manage emotions (PAHO, 2019).

With respect to men assuming parenting and family roles, men's connection with pregnancies and their participation in contraceptive strategies are topics largely absent in both international and national reports. Boys tend to be raised without parenting responsibilities, and little or no effort is made to teach them about caring for and raising children, responsibilities that fall to women. Through conscious or unconscious actions, families, schools, and the health system support this view, at times punishing girls—but not their partners—for early pregnancy. One country in the Americas reports that of the 7,000 births to mothers under age 15, only 40% of the fathers were under the age of 20. In a large proportion of such cases, the age difference between mother and father is so great that it is hard to imagine that the pregnancy is not the result of sexual abuse perpetrated by an adult (PAHO, 2019, p. 13).

“Frequently, men are not seen as allies, but rather as obstacles to gender policies. As a result, initiatives for men's health tend to be marginal, insufficient, and late” (PAHO, 2019, p. 17). However, efforts to highlight the effects of *machismo* and its impacts on public health are emerging

around the globe. Many of these initiatives have been framed under the label of new masculinities and gender violence prevention programs. For example, MenEngage,<sup>8</sup> an international alliance that fights for gender justice and has strong support from the United Nations, recommends developing, implementing, and following-up on policies that involve men, states, and societies at large in working towards gender equity. The specific recommendations are: men's participation in the prevention of gender violence; the promotion and socialization of gender equity at all educational levels; the participation of men in parenting and caregiving; the involvement of men in women's economic empowerment; men's roles as supportive partners and agents of positive change in sexual health and rights; and men's positive involvement in maternal, newborn, and children's health (MenEngage, 2014).

More specifically, Cali has two organizations that have been working on the issue of new masculinities: *Taller Abierto* (Open Workshop) and *Círculo de Hombres* (Circle of Men). The first is an NGO that was started in 1997 and was one of the pioneer organizations in the promotion of alternative masculinities and the prevention of gender-based violence in Colombia.<sup>9</sup> This NGO has ample experience in working with peasant, afro, and indigenous communities in the Colombian southwest. The latter focuses its work in Cali and advocates for dialogue to reflect about masculinities in their experiential, spiritual, intellectual and political realms, to rethink the dominant masculine model, and to promote alternatives anchored in equity, care, and non-violent relations (Pinto, 2016). They have a branch at Universidad del Valle in Cali and have developed a program to work with perpetrators of violence against women who are incarcerated in Cali.

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<sup>8</sup> <http://menengage.org/>

<sup>9</sup> <http://tallerabierto.org>

I have had the chance to meet with members of both organizations for almost a decade now. In 2013, when I started this project, I interviewed Wili Quintero, a member of Taller Abierto, and when I inquired about heterosexual men living with HIV, he mentioned that they were typically diagnosed late, died soon, and were very often without support. His work on reproductive and sexual health since the '80s connected him with the reality of HIV. He recalled encountering heterosexual men affected by the HIV epidemic in very bad conditions, and often receded from organizations and support networks because the ones that existed were for gay men.

Wili recounted the story of a poor woman in Cali he ran into once. She worked picking up material to recycle in the streets of Cali and she had a loving partner who did the same job. At one point, her partner suddenly changed his attitude towards her and became hostile and violent. When she decided to end the relationship, she asked why he had changed. The man was very sick and told her he was diagnosed with HIV and died soon after. Wili told me that after that the woman struggled a lot, imagining the battle of her partner in silence, and suffered because she was not able to support him and saw him dying in that way. After his death, she tested positive for HIV. Wili added it was also common among women in Cali to find out about their HIV-positive diagnosis after their partners' deaths to AIDS.

Wili also mentioned that there are two patterns at the intersection of heterosexual masculinities and HIV. The first one is guilt, which often mutates into violence, abandonment, and silence. The guilt is founded on infecting their partners, the possibility of having had sex with other men, and the difficulties of living with the stigma of a "gay" disease. The second pattern is the reproduction of chains of HIV infection that heterosexual men often perpetuate even after knowing of their HIV-positive status.

*Taller Abierto* and *Circulo de Hombres* have invested time and resources in beginning the challenging project of talking to men about their gender identities, sexualities, and different possibilities for being men. CDH keeps building and expanding its presence in Cali, yet it remains the only entity that navigates gender-woke spaces in the city. They hope to expand their work within the prison system because, as Natalio from CDH told me, jails end up holding the men who have been in structural disadvantage and have rarely had a chance to rethink their gender roles. *Taller Abierto* now has a wider focus on the support of rural and urban poor communities and their development under an agenda of social, economic and gender equity in harmony with the environment.

In this chapter, I provided the reader with a panorama of the Colombian healthcare system highlighting its transformation and its shaping into a neoliberal market in which different populations get different types of access and qualities of healthcare services under the slogan of universal healthcare, which in fact is a total fallacy because universal health care means equal access to healthcare for all and that is not the case in Colombia. The new system has classified HIV/AIDS and opioid addiction into high cost diseases and created a fund to administer these, based on cost-effectiveness rather than quality of care, epidemiological surveillance, and research. In this sense, I show how the scientific blindness of the current Colombian healthcare system to the transformations of the HIV and opioid epidemics has kept under the epidemiological radar both the presence of heterosexual men in the HIV epidemic and the emergence of a heroin epidemic that is hitting mostly poor men. Finally, by showing a few statistics of men's health disadvantages and family roles, I highlight that men need to be included in policies of health and processes of gender-roles transformation in order to achieve more equitable and healthy societies;

women cannot be the only people responsible of these changes. In sum, men are vulnerable too, and they need and deserve attention and care.

### 3.0 (in)Vulnerable *machos* & the Colombian AIDS landscape

In the summers of 2013 and 2014, while doing exploratory fieldwork in Cali, Colombia, I visited different HIV clinics to inquire about heterosexual men living with HIV/AIDS in the city. I approached HIV clinics and NGOs to introduce my research project, interview their staff members, and recruit participants. In all the institutions, even though professionals were usually very busy, they were generous with their time and eager to talk and share their knowledge and experiences regarding HIV. However, when I asked if they could refer me to heterosexual men living with HIV, very often, there was a pause. I could see my interlocutors struggling in their heads with my request, and they usually came up with intricate ways to think of heterosexual male patients with whom I could talk. Comments about the men's behaviors and mannerism emerged, evaluating whether those were heteronormative enough or not. My interlocutors talked about the trust the men inspired, often referring to their stories of infection and how believable those were. Also, the marital status of the men, and if they were fathers or not, including the number of kids they had, were frequent topics in these classification attempts. Health professionals frequently did not believe their clients. Anecdotes about men claiming they were heterosexual that ended up being homo or bisexual were common. Men's mannerisms were put into consideration; for example, health professionals would question if they were too effeminate. Sometimes, if a colleague were around, they would ask them what they thought about this or that specific man. However, two facts washed away suspicion of the non-heterosexuality of men: being born with HIV and fatherhood.

The exercise was fascinating in many ways because it revealed the deeply ingrained idea of the virus inhabiting the bodies of men who have sex with men (MSM) solely. This sense still permeates conceptions of the HIV epidemic in Colombia and across Latin America even though it



is an outdated one, since today 20% of new infections happen among women and 20% of men claim their HIV transmission occurs through heterosexual sexual intercourse. It is true that since 1983 and for almost two decades, the HIV epidemic was concentrated mostly among MSM. However, the epidemic's shape had changed over the last two decades, and HIV specialists in Colombia have not updated their maps to better navigate the new silhouette of the epidemic.

At the beginning of the formulation of my research, I framed this research project under heterosexual HIV-positive masculinities. Yet, while doing exploratory fieldwork, it was challenging to reach the men I wanted to talk to, because of the problematic conceptualizations around heterosexuality and HIV. A couple of times, I ended up interviewing men who, after starting the interview, recognized they had mixed up the concepts and indicated that they felt sexually attracted to men. Heterosexuality, apparent for me and the literature, became blurry and non-practical as a discrete category in the fieldwork. Thus, after some thought, I decided to tackle the intersection of fatherhood and HIV, which would allow me to reach out to active heterosexual men and also explore fatherhood. Accordingly, for the remaining part of the research project, I mainly recruited and talked to HIV-positive fathers who self-identified as heterosexuals.

The idea of focusing on fatherhood also stems from reading Latin American literature on masculinities, where fatherhood has emerged as an essential topic of discussion as it represents a unique arena in which to explore the repositioning of men. It is at once a public and an intimate matter that requires constant siftings due to structural and private elements such as unemployment, addiction, changes in gender roles, or sickness. In this sense, following the work of Latin American scholars and my findings in my exploratory fieldwork, I decided to shift my approach to studying HIV-positive heterosexual men by recruiting HIV-positive fathers.

### 3.1 The challenge of understanding *machos* beyond the stereotype

*Machismo* has been a pivotal point to the understanding of hegemonic forms of behavior and socialization of men in Latin America and the Caribbean. It has been criticized as a singular term, but it remains a proxy to refer to multiple arrays of masculine behaviors and identities. The idea of the *macho* and the concept of *machismo* were built by the US and Latin American elites to refer to working-class, non-north-American men. The *macho* emerges as a masculine stereotype of a brown, hyper-sexual, manipulative, and violent subject incapable of self-control. In *The Labyrinth of Solitude* (1969), Octavio Paz reflects on the tense relationship between Mexico and the US and explains that the US white elite started using the concept of *macho* to refer to Mexican immigrant men in the early 20<sup>th</sup> century. Carlos Monsiváis adds that the idea of macho was later embodied and embraced by Mexican *Braceros*<sup>10</sup>, who became a vital force for the economic growth of both countries. On the Mexican side, they were "heroes" because of the high volume of remittances, while on the US side, they were the base of the economy through the provision of cheap labor (Monsiváis, 2004). With the growth and expansion of the Mexican and Argentinian film, music, and print industries in the second half of the 20<sup>th</sup> century, two proto-images of the *macho* spread, the *Charro* and the *Malevo*, which embodied an always-stoic, courageous, generous, and seductive man.<sup>11</sup> These images conquered Latin America and the rest of the world

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<sup>10</sup> This term refers to labor force that came from Mexico to the US in a political agreement in 1942 to work in crop fields. The term expanded later to other manners of low wage labors made by Latino immigrants in the US.

<sup>11</sup> The *Charro* is the classical image of the Mexican singer who wears a cowboy outfit and a big hat, a symbol of Mexican national identity.

and became the key term to address the bodies, roles, and intimacies of working-class men in Latin America (Viveros, 2002, 2006).

In the 1990s, anthropology in Latin America began paying particular attention to the matter of masculinities. The topic was previously addressed among family and kinship studies in more functionalistic ways. Still, it was after the rise of feminist studies that men were seen as engendered and engendering subjects. This shift caught the attention of anthropologists such as Roger Lancaster, one of the pioneers in masculinity studies in anthropology and Latin America. In his book *Life is Hard*, Lancaster describes family and gender dynamics in Nicaragua during the Sandinista revolution in the 1980s and 1990s. Within this specific context, in which the country attempted to create new gender dynamics policies and practices, Lancaster sees changes towards a more gender-equal society, yet only while the revolution was triumphant. Thus, Lancaster sees *machismo* as a force deeply embedded in the social structure of capitalism. Lancaster says that *machismo* exists and is reproduced within networks of uneven social and intimate interactions (Lancaster, 1994, pp. 19–20). For Lancaster, *machismo* is not a culturally or geographically bounded phenomenon; for him, it is an expression of patriarchal and capitalist structural inequalities naturalized in gender, class, and race dynamics. With this tweak given by Lancaster to the concept of *machismo*, there is a way to link the experiences of working-class Latin American men with similarly classed men in other parts of the world.

It is within this context that masculinity studies in anthropology emerges as a series of research projects that examine men immersed in networks of power, showing that their masculinity was never wholly given and that their gender identities were under permanent construction (Gutmann, 1997, p. 385). This change in perspective allowed the exploration of male's subjectivities and worlds under new lenses. In this context, Ryan Connell's idea of hegemonic

masculinity became pivotal for further reflections on masculinity studies in academic and applied work because her theoretical framework broke male dominance in two big sets, hegemonic and subordinated masculinities. Connell states that the 1990s was the decade in which masculinity studies entered the realm of specialized journals focusing on the discursive constructions of masculinity and on the many interactions that men had with modern aspects of life such as globalization, urban labor, or the fight for gender equality and freedom (R. Connell, 2015).

Connell coined the term “hegemonic masculinity,” as a way to understand the social dynamics of masculinity. She proposed it as a way to surpass patriarchy as a homogenous, structural, and all-mighty explanatory model of gender inequality, as had been primarily promoted by first-wave feminist scholars. Her analytical framework is inspired by the Gramscian idea of social agreement as a practice of power. For Gramsci, individual daily practices are in constant dialogue and negotiation with collective desires and expectations. Thus, when there are structural changes, changes in the everyday and intimate life happen too, and new social agreements that reflect the structural in the daily life emerge (Gramsci, Hoare, & Nowell-Smith, 1971, pp. 364–365). Hegemonic masculinity is distinguished from subordinated and other forms of masculinities because it embodies the “most honored” style of being a man. Hegemonic masculinity requires all other men to position themselves in relation to it, and it is ideologically legitimized by the subordination of women and subordinated men to hegemonic men. Hegemony does not mean physical violence, although it could be supported by force; it means ascendancy achieved through culture, institutions, and persuasion (R. W. Connell & Messerschmidt, 2005, pp. 832–833).

In this context, what emerged with the advent of the concept of hegemonic masculinity was a widely used model that invigorated gender studies by including men differently in three ways: 1) it dislocated a quasi-unique gaze of gender studies on women. 2) it identified men as subjects

of potential subordination 3) it positioned masculinity as a gender construction intertwined with economic, political, and historical forces.

Very rapidly, hegemonic masculinity became widely used and diversified (cite?). For example, in health-related studies, the concept opened the possibility of adding different categories to masculine identities —coined as masculinities (in plural)—allowing assessments of the ways various health risks relate to specific behaviors without rigid gender labels (cite). In gendered violence approaches, it permitted the inclusion of men as actors with agency that could embrace positive change (cite). In the studies of economic landscapes, it allowed the exploration of the masculinization of the financial elites (R. Connell, 2015; R. W. Connell & Messerschmidt, 2005).

The idea of hegemonic masculinity influences Matthew Gutmann, anthropology author in the field of masculinity studies in Latin America and his work. In *The Meanings of Macho* (Gutmann, 1996) he addresses fatherhood and men's social dynamics and representations in a blue-collar neighborhood in Mexico City. In his ethnographic work, he explores the contradictory roles and identities of being a man in that neighborhood. In his analysis, he examines men's roles and patterns concerning child-rearing, house chores, infidelity, and alcohol consumption, finding that men often defy the macho stereotype. Thus, Guttmann argues that *machismo*, rather than explaining Mexican men's behaviors, is a hegemonic discourse that Mexican men and society have to negotiate with continually.

Colombian anthropologist Mara Viveros, in her ethnography of middle and working-class men in Colombia, *De Quebradores y Cumplidores* (On Conquerors and Breadwinners) (Viveros, 2002), found that men's roles and identities transit between two stereotypes. The first corresponds to the *Charro* character and the second to the responsible breadwinner. She argues that as in a pendulum, men move from one aspect to the other, depending on different moments and situations

of their lives. She explores men's narratives in three different stages of their lives: a) men's relationships with their mothers and fathers; b) Masculine competition and responsibilities, education, and male socialization; and c) the exercise of paternity and the displacements of traditional masculine definitions. Viveros argues that due to the pressure imposed on men to be active providers and affective and attentive fathers, men are experiencing a double burden because of both everyday precarious economic contexts and not knowing how to behave as caring fathers and partners (Viveros, 2002). For Viveros, race, family, class, geographic settings, and structural factors are in constant dialogue with men's performances and trajectories. Within this matrix, there are chances for men to re-signify and sometimes critique hegemonic models of masculinity.

In Peru, anthropologist Norma Fuller's research focuses on how men cope with the ideas and realities of being fathers while exploring the existence of *machismo* as an actual practice as well as a solid framework to explain contemporary men's behaviors. In her book *Masculinities: Changes and Permanencies* (Fuller, 2001), Fuller addresses and compares three cities located in different regions of Peru. She focuses on the life cycle of working and middle-class men. Fuller digs into how these men have constructed their male identities by paying attention to childhood, male bonding, school, their erotic life, work, marriage, and fatherhood. She simultaneously pays attention to structural neoliberal policies and flexibilization of labor, arguing that these factors have profoundly transformed traditional men's and women's roles in Peru (Fuller, 2001). Fuller also looks at the inputs of masculine identities that different scholarly regimes (private, public, laic, military, catholic) impute to young men, emphasizing how these institutions are important nodes for the reinforcement or changing of hegemonic masculinities. She also explores sexuality, which seems to be expressed differently in each of the studied cities. For example, in Cusco, women have more control over sexual exchanges than in other parts of the country. In Iquitos, men

from whitened and upper classes have more access to polygamous relationships with women of lower classes. In Lima, men seem to be more volatile, flexible, and adaptable to discourses and practices of sexuality (Fuller, 2001, pp. 471–473).

Fuller also explores the etiological route of *machismo*, stating that it has become an ideological and discursive apparatus comparable to that of hegemonic masculinity, which coexists with other forms of masculinity (Fuller, 2012, p. 122). According to her research, fatherhood emerges as a desired and valued stage among men, yet it is a source of tensions and contradictions. This is due to two things: first, the difficulties of accomplishing fatherly and husbandly duties with success in contexts of chronic and acute material constraints, and second, the menace that fatherhood represents for social and sexual independence (Fuller, 2000b).

Chilean sociologist Jose Olavarria, in his book, *Men Adrift? Power, Work, and Sex* (Olavarria, 2001) interviews men from Santiago de Chile to explore their identity constructions. His approach connects to David Gilmore's work (Gilmore, 1990), and Pierre Bourdieu's *The Masculine Domination* (Bourdieu, 2001). Olavarria creates a teleological analysis in which men start constructing their gender identity in childhood and achieve it through rites of passages, such as the first heterosexual sex encounter, getting a paid job, or becoming a father (Olavarria, 2001, pp. 25–26). Olavarria's argument is a functionalistic one with sharp gender divisions. Men rarely mention dissonances with their male project, and actions against the hegemonic model of masculinity seem to be absent.<sup>12</sup> These results align with David Gilmore's psychoanalytical model,

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<sup>12</sup> Probably the results obtained are due the methodology of the research, which is only based in interviews and not in ethnography, so the only data available is the men's narratives. Also, Augusto Pinochet's dictatorship is a historical moment to Olavarria's work, and it might strongly affect his results.

in which patterns of manhood are meant to be fulfilled, not transformed (Gilmore, 1990). This work connects particularly with Pierre Bourdieu's structural analysis of male power in society, whereby the naturalization of gender difference ensures that men will always be the dominating power given the connection of the male body and self with the existing powers in society. For Olavarría, Chilean men expect their male children to reproduce male power, display and have warrior-like bodies, be heterosexual and refrain from doing what women do (Olavarría, 2001, pp. 30–34).

One of Olavarría's more recent projects studies the impact of structural economic changes on men's lives, their identities, and their affective lives (Olavarría, 2008). He approaches men who work in corporations in Chile. He finds that corporations offer men a unique, specific language, a work routine and environment, and technological isolation that creates a self-sufficient social world in which the profit logic can expand without limits. These factors are condensed into the masculine corporate self. These corporate landscapes, according to Olavarría, tend to ostracize individuals from their original social networks and build modernized forms of masculinity, while reinforcing sexual divisions of labor. They are alienated (Olavarría, 2008, p. 83).

To review, from Lancaster to Olavarría, it is possible to see a group of scholars that found a research niche in the crises of Latin American men, and who produced a prolific body of scholarship that would constitute the foundations for masculinity studies in the region. One of the main contributions of this group of scholars was the questioning and decentering of the idea of the Latin *macho* as the pivotal Latin American men stereotype. This epistemic turn transformed feminist and family studies by giving men a space to speak and reflect on their own lives and interactions with peers, family, and partners. Second, it applied a constructivist gaze to male bodies and identities, giving men the chance to change and transform. Third, this group of scholars opened



new avenues for exploring men's life trajectories and connecting these with broader structural factors distinct from *machismo*, thereby creating more dynamic, intersectional, critical, and creative analyses.

These authors' interrogations of men's identities along with class, race, cross-generational dynamics, regionalisms, and individual life characteristics identify new masculinity roles that resist *macho* classifications. In so doing, they pay attention to processes that have changed Latin America in the last half-century, such as the massive rural migration into cities, changes in gender roles, daily economic strains, and the lack of time for family and parenting. Thus, for these authors, modernity and its contradictions are fundamental forces that kindle profound and palpable dilemmas and anxieties for men in the region.

In this context, *machismo* becomes a vital referent for men, sometimes assumed as positive, when it refers to being responsible and a good breadwinner, but most of the time, as a negative one, mainly when it implies womanizing, irresponsibility, or violence. *Machismo*, then, seems to be part of a web-like net in which other forms of masculine selves can exist. Ultimately the work of these scholars challenges *machismo* as the inherent essence of the body, soul, and social subject of the Latin American man. Yet they acknowledge that traits attached to it are always present in men's lives, especially in moments and spaces where structural gender, class, and race inequalities are more vivid.

### **3.2 The “malfunctioning” man: A fracture to explore new masculinities?**

Intimacy, sexuality, and reproduction are matters that have interested medical anthropologists as lenses through which to understand the regulation, administration, and control

of life and death, along with the construction of subjectivities and desires. Michel Foucault planted the seed for this kind of approach in his essay “Right of Death and Power Over Life” (Foucault, 1978), where he explains how modern states have generated, incited, reinforced, controlled, monitored, optimized, and organized the forces of life, through instruments of biopower.

Influenced by this line of thinking, medical anthropologists have approached men by focusing on grey, liminal, or emergent moments in which the male body and self are clearly at an uncomfortable intersection. These include studies on infertility (M. Inhorn, 2012), male impotence (Wentzell, 2013b; Zhang, 2015), vasectomy (Gutmann, 2007), and homosexual sex work among heterosexual men (Padilla, 2007). These analyses share interests in analyzing and questioning sexualities and gender roles through biological and social “abnormalities,” which are often associated with uncanny, awkward, and uncomfortable emotional landscapes, not only for men themselves but for their social networks too.

In general, these fractures in the emotional, sensitive, and affective aspects of life create, delineate, and shape pain, anger, frustration, and difficult dialogues with society and the self. As Byron Good puts it in relation to chronic diseases, these are known to create or maximize situations and experiences of awkwardness, discomfort, inequality, and instability because they “recast reality in relation to the unexpected, the non-ordinary, the mysterious” (Good, 1994, pp. 164–165). Still, these situations can create spaces for reflection in which bodies, attitudes, and structures might be questioned, reframed, and maybe re-structured.

Anthropologist Marcia Inhorn has done extensive research on male infertility among men in the Middle East. She finds what she calls “a new emergent Arab man,” which in many ways defies the classical depiction of a patriarchal, patrilineal, patrilocal, and polygamous Arab man (Inhorn, 2012). Infertile men are in socially difficult positions when they discover the impossibility

to procreate lies in them. The cultural shock of being infertile does not only affect men but their nuclear and extended families as well, creating stress and frequently the pouring of time and resources into artificial fertility technologies. Inhorn discovers a significant number of men willing to undergo medical procedures to overcome infertility caused, according to them, by hereditary transmission, illicit sex, war PTSD, daily stress, and pollution. This “disability” opens a route for men to be vulnerable and explore and sometimes assume non-traditional Arab masculine roles in relation to love, family and society (Inhorn, 2012). Inhorn, as scholars in Latin America, finds that hegemonic forms of masculinity are stereotypes that men are questioning.

Mark Padilla’s ethnographic work on heterosexual men who do homosexual sex work in the Dominican Republic shows how the emic concept of *tigueraje* allows these men to articulate the paradoxes of their work with their lives and their identities (2007). The concept refers to the ability to take advantage of others (M. Padilla, 2007, p. 135), and it allows these men to conceptualize their commercial sexual practices without losing masculine capital. It gives them a sense of practicality to perform well with clients, as well as with peers, family, and heterosexual lovers. This type of personality becomes a useful tool of self-entrepreneurialism in the context of a globalized sex-scape, in which tourism has shaped many aspects of daily life. Sex work provides these men material and symbolic benefits, though not without tensions concerning love, heterosexuality, STIs, and economic stability. In this sense, masculinity, for these men, becomes a balancing act between their private and public life in a context where sex work is illegal within a depressed local economy that is highly dependent on seasonal tourists seeking and paying for “tropical” intimacy and affection (Ardt, 1999).

Emily Wentzell's ethnography of male sexual impotence in Mexico explores the responses and coping strategies of men who attend a public clinic seeking treatment for erectile dysfunction

after the appearance of Viagra (year). The drug promises a never-ending sexual life to men regardless of their age and has become the primary therapeutic allopathic alternative to address erectile dysfunction. In her research, Wentzell finds troubled men dealing with erectile dysfunction (ED), making sense of it, and tracing its causes. For example, one man thinks he began experiencing ED due to the stress caused by constant fears of layoffs in the auto factory where he worked. At the same time, line workers were gradually being replaced with robots (Wentzell, 2013b), a fact that shows how masculinity adheres to enhancers, such as Viagra, or is threatened by external agents such as robots. Even though many of Wentzell's informants take Viagra as a possibility to “reset” their “disabled” masculinity, many others decide to engage in new non-penetrative sexual practices. In this sense, for some men, ED becomes a chance to rethink and redo their masculine roles and identities and reflect on the process of aging. In Wentzel's analysis, Viagra has the potential to reduce social suffering. Still, it can also naturalize the rejection of 'non-ideal' bodies and the need to alter them medically (Wentzell, 2013a, p. 3). Thus, if the drug becomes adopted as routine, it also becomes a necessary aid to be a man.

In another example based on fieldwork in Oaxaca city in Mexico, Gutmann (2007) explores the ideas and perspectives of men undergoing a vasectomy. He finds that men have discussed with their partners how having a vasectomy can alleviate economic stress, avoid women's physical burden due to pregnancy and use of contraceptive methods, and increase the odds of offering a better future for existing children. However, having a vasectomy is often kept a secret to avoid gossip. This shows that more active participation of men in family planning requires the reshaping of family planning programs that have historically focused on the female body as well as challenging cultural pillars that punish male infertility, even when desired.

In sum, by paying attention to the male “malfunctioning” body or self, these authors find a point of convergence that allows a more in-depth exploration of tensions in men's lives with their bodies, beliefs, social networks, and societies. As Susan Bordo proposes, “far fresher insights can be gained by reading the male body through the window of its vulnerabilities rather than the dense armor of its power” (Bordo, 1993, p. 266). Anomalies, then, seem to generate self-reflection and awareness among men, often triggering the emergence of “new” masculine selves that break with classical manly stereotypes. Under this perspective, concepts anchored in labels such as “traditional” men's roles or *machismo* lose their explanatory power and open routes to exploring men's lives within their contexts. They also point out that “traditional masculinity” is socially constructed, and thus there are multiple “traditional masculinities” (Everitt-Penhale & Ratele, 2015). This new wave of cultural anthropologists has reshaped the concept of masculinity, making clear that it exists within a gamut of gender identities, which coexist in stratified and hierarchical settings where differences are dictated by class, race, sexuality, or ability. And, more importantly, these works recognize that men can transform themselves over the course of their lives (Rehiling, 2020). Ultimately, men's histories, bodies, material, and affective worlds find themselves in a constant reshaping of their past, present, and future. And, under this logic, events such as HIV/AIDS represent a challenge to men's lives but can also be understood as an opportunity to rethink and recast their trajectories.

### **3.3 Anthropologies of HIV/AIDS**

Overall, the anthropology of HIV/AIDS has revealed complex social dynamics associated with the HIV epidemic. Critical medical anthropologists have examined the relationship between

the HIV epidemic and structural factors such as poverty, war, and corruption. They have shown how disadvantaged regions of the world and their people are more prone to become infected and die of AIDS as part of a continuum of historical structural violence (Bourgois & Schonberg, 2009; Farmer, 2004; Singer, Mirhej, Santlelices, & Saleheen, 2009). These approaches have been key in pushing forward HIV treatment policies and applied agendas to improve the lives of many people around the globe while showing that epidemics are deeply intertwined with politics and economics.

Studies on the biopolitics of HIV have revealed political tensions at the national and global levels. For example, both South African President Mbeki's policies against western HIV treatment (Fassin, 2007) and the Brazilian response to the epidemic—where generic antiretroviral medication was produced, breaking international patent laws (Biehl & Eskerod, 2007)—have had deep consequences for the local populations, as well as international politics and policies.

The methodological approach of syndemics proposed by anthropologist Merrill Singer has been useful to understand how the interaction of many different factors affect biological outcomes (Singer et al., 2009). This multifactorial perspective assesses risks and vulnerabilities in ways that fruitfully bridge epidemiological and social sciences perspectives (Ventura-Garcia et al., 2013), usually in applied work. Interdisciplinary HIV studies have bloomed under this gaze (Surratt, Kurtz, Buttram, & Stall, 2012), showing that besides structural factors, variables such as desire, the co-existence of other viruses or bacteria, and aspects of mental health are key to understanding routes of HIV infection. Interrogation of these variables can also lead to new preventive measures, reframed as harm reduction, which is an outcome aligned with the philosophy of syndemics. In this realm, masculinity has often been understood as a 'risk factor' for acquiring HIV and AIDS, an argument based on the scarce contact of men with medical health care systems, and the “fact” that men are more prone to self-destructive attitudes (Dworkin, 2015).

Anthropologies of HIV and the family have repeatedly overlooked heterosexual men and have focused on the experiences of mothers and children, especially since the advent of antiretroviral treatment and the recognition of the profound and growing effect of the HIV epidemic on women around the world. Studies of HIV-positive mothers have addressed the tensions of reproduction, prevention of virus transmission to the child, anxieties of breast vs. formula feeding, childcare (Blystad & Moland, 2009; Hollen, 2013; Liamputtong, 2013), and women's social organizations that confront the impacts of the epidemic on themselves, their kin, and their communities (Susser, 2009). Studies on foster care among HIV-affected children and absent parents have addressed the questions of orphanhood, social parenting, and AIDS (Abadia, 2011; Dilger, 2008). These analyses have unpacked difficulties and tensions endured by HIV-positive orphans, the role of private and public foster care, and the experiences of being born and growing up with HIV. Yet, in general, these studies have overlooked the voices and experiences of men as fathers and have mostly shown them as a homogenous harmful entity of self and family destruction or as an absent figure.

In a similar vein, in studies on migration, family, and HIV, unfaithful migrant men appear as vectors of the disease and as the main problem that must be addressed to prevent the infection of women (Hirsch, Higgins, Bentley, & Nathanson, 2002; Liamputtong, 2013; Lippman et al., 2007). Men here are seen as victims of structural violence and obliged to find jobs abroad in unfair conditions, but they also appear as individuals unable to control their sexual desires, and thus are commonly depicted as victimizers of their partners.

In more recent critical perspectives, aspects such as concurrent multiple sexual partnerships have become a productive way to understand HIV infection among couples, showing that women bring HIV into their couples and families too. This new gaze is focusing on closed sexual networks

of underprivileged communities as the main source for HIV infection among heterosexual populations (Dworkin, 2015). This shift in thinking has been criticized for its embedded risk of homogenizing and stigmatizing whole communities, yet it represents a step towards opening more frank dialogues and analyses regarding the role of men and women in the contemporary shaping of the HIV epidemic.

HIV is profoundly intimate because it is transmitted through direct contact with infected blood and sexual fluids. Its appearance reshapes intimacy. Intimacy studies have approached love, romance, and sex as a productive lens to reveal how "human societies organize social life, meaning, and intimate experience, as well as how individuals enact, resist, or transform social discourses of love" (M. Padilla, Hirsch, Muñoz-Laboy, & Sember, 2007, p. ix). Under this lens, the family setting becomes simultaneously a place for pleasure, intimacy, exploitation, and inequality.

Some studies have focused on the political economy of romance, examining how love, desire, and affection shape the distribution of resources, hierarchies, and power in local and global contexts. These have focused on sex work in transnational spaces such as the Dominican Republic (Brennan, 2004) and South Korea (Cheng, 2010), or international "swingers" conventions (Frank, 2007), showing how the circulation of desires intersects with class, race, and gender in ways that shape new economic panoramas along with new pleasure landscapes around the world. Cali is indeed a pleasure landscape with well-known musical, sex, drugs, and party industries.

Affect theory and related studies propose investigating how emotions circulate between people and objects, by examining how they "stick," move, and mutate (Ahmed, 2004). In these circulating trajectories, emotions transform the ways we feel. Thus, emotions maintain a deep and strong connection with class, race, and gender, which demonstrates why they are key to



understanding the experiences and reproduction of difference (Wetherell, 2012). With this in mind, I situate HIV as an agent, or force, of affect that has the power to transform landscapes of feeling and affection, and also to reveal mutations within different actors' relationships and their selves.

Within this context, I see HIV as a vulnerable window to look through males' identities and intimate interactions. HIV highlights the tensions and frictions within men because they get questioned, challenged, and transformed by the HIV-positive diagnosis, especially in a historical moment in which men are being asked to perform more caring, attentive, and loving practices as parents and couples.

Using the interaction, presence, and potency of HIV in the lives and emotions of men as continuum of affect, I critically observe and analyze manifestations of masculinities, while keeping in mind the tensions between traditional and emergent forms of masculinity. HIV becomes a fracture and a friction that facilitates reflection on the idea of *machismo* and moves us towards a critique of this totalizing and homogenizing concept that has been widely used to (mis)understand men, their roles, and their identities in Latin America.

Labor, breadwinning, an ideal sexual life, and the achievement of fatherhood have been understood as critical foundations for the construction of working-class masculinities in Latin America (Fuller, 2000a). HIV adds a burden to men's lives by exposing their sexuality to biomedical surveillance and by potentially diminishing men's health, work capacity, and means to provide. This whole panorama reconfigures the position of HIV-positive heterosexual men within their social networks, creating potential changes in their interactions with friends, co-workers, lovers, and family.

In addition, an HIV-positive status today in Colombia contests the notion of invulnerable heteronormativity because of the many stigmas associated with the disease –including the

assumption of homosexuality—and because men become a risk of infection to partners and offspring. These issues foster a difficult atmosphere in which finding support and sympathy among kin and friends is not always an easy endeavor, as would happen in the context of a less-stigmatized diagnosis like, for example, cancer. The sum of these situations creates a panorama of an experienced crisis lived in silence, in which emotions, objects, histories, and images attached to the HIV virus challenge the existence and daily life of men, their families, and their extended kin.

In this sense, exploring HIV-positive heterosexual masculinities is a critical case study to investigate the construction and practices of masculine selves at the crucial point of reproduction. This exploration connects public and intimate spheres, and thus critically analyzes structural factors that have repercussions on gender inequality and intimate relationships. HIV/AIDS is a chronic disease that carries a heavy burden and creates a series of uncomfortable situations in the individual and social corpus.

Finally, and from a broader perspective, as Carina Heckart has pointed out in her ethnography of HIV in Bolivia (Heckert, 2017), focusing on the experiences of heterosexual men living with HIV in Latin America opens a question about deservedness of treatment. Didier Fassin (Fassin, 2009) has described contemporary global health interventions as politics of life that function as mechanisms that produce inequalities by deciding whose lives are worth saving. Under this logic, heterosexual men living with HIV in Colombia often fall into a category that does not raise empathy.

### **3.4 The silencing of heterosexual men from the Colombian AIDS landscape**

In Colombia, because of the persistence and spread of the idea that links the HIV epidemic to men who have sex with men, self-identified heterosexual men assume they are out of the risk pool, and their sexual behaviors exclude precautions to avoid contracting HIV. But also, for decades, responses from activists and health policymakers have left heterosexual men out of the picture in HIV prevention and treatment services. As an example, in 2010, when I was conducting research on the effects of HIV/AIDS on families in Bogotá, I approached a well-known HIV organization in the country to inquire about their perspective on this matter and possibly set an agenda for referrals. I ended up having a very short conversation with the director of the entity who mentioned that my point of wanting to know about the lives of heterosexual men living with HIV was aimless since all of them were gay men in the closet. I was shocked, especially since by then it was epidemiologically clear that the number of women affected by HIV in the country was without a doubt rising and they mainly became infected through their male partners.

Later in 2018, I met with a person in Cali that played an important role with the operationalization of funds in the fight against AIDS in the city. When I asked her about the role of heterosexual men in the shape of the HIV epidemic there, she responded that they were invisible, because they were bisexual men. Her contact with them happened in saunas designed for homoerotic encounters while she conducted in-situ rapid HIV testing. This is undoubtedly part of the story, as the literature shows that homoerotic encounters among self-identified heterosexual men are common in Latin America. However, HIV biopolitics must consider the heterosexual face of the epidemic as heterosexual men are populating the HIV/AIDS scenario in Colombia. Similar data is emerging in other parts of the world, reflecting similar issues (Kou, Djiometio, Agha, Tynan, & Antoniou, 2017).

In Colombia, HIV bureaucrats working in agencies and NGOs are very often middle or upper-middle-class gay men who were impacted by the '80s and '90s AIDS epidemic. They were also often public figures in the Colombian gay movement, which moved forward progressive policy and ideas in a conservative country that until 1989 put in prison men for showing same-sex affection in public. The Colombian gay movement found an anchor in the AIDS epidemic to create a public debate on the gay matter, a symbiosis that worked well, as the gay rights agenda gained power and visibility alongside the fight against AIDS. In 1991, the Colombian government changed its previous constitution written in 1887 and included gay rights and mandatory health care to AIDS patients in its new version. Since that era, the most visible Colombian HIV activists belong to the gay rights movement.

My aim here is not to contradict HIV specialists or the studies that have consistently shown that in Latin America men have difficulties in disclosing sexual identities and orientations that are not heterosexual (Cáceres, 2002), and that in fact part of the heterosexual population of men indeed does have hidden sex with other men. Yet I found throughout my research that heterosexuality, masculinity, and HIV must be understood as a case of intersectionality. Therefore, the monolithic answer, that all HIV-positive heterosexual men are bisexuals in the closet, obscures more than clarifies. Epidemiological data on new HIV infections in Colombia shows that between February 2017 and January 2018, 20.3% (n=1980) of new cases happened among women, with a male to female ratio of 3:1. In regard to routes of infection, 85.4% of the new cases reported sexual transmission as the means of infection (Fondo Colombiano de Enfermedades de Alto Costo, 2019). We also know that the main route of HIV in Colombia among women is through their male partners; thus, there is room to epidemiologically think about HIV-positive heterosexual men. Plus, there is generation of adults that was born with the virus or contracted it early in life, and there is

a heroin epidemic that even with the scarce data available already shows big shifts in the AIDS epidemic.

On the other hand, we know that gender is fluid, and that the long-used, and today very present dichotomous gender model is not useful to address the complexities, variations, and processes of our sexualities and our gender identities. In my fieldwork, I found out that the great majority of men do not exactly know when and how specifically they became infected with HIV. Most of the men I talked to think they became infected with HIV while having drugs and alcohol, paying for sexual favors, being in jail, or being involved in the long-standing Colombian civil war. A few of them identified a female partner as the source of their HIV infection. One was born with the virus. And another few men mentioned having sex with other men and that trans women might have been the source of their HIV infection. What I found is an ample gamut of possibilities on how HIV, masculinity, and heterosexuality intersect. Moreover, the great majority of men I talked to self-identified and assumed heterosexual roles, and I think an updated approach to the epidemic should take this into account as a fact and act accordingly.

The history of the fight against AIDS in Colombia is deeply intertwined with the fight for gay rights. In 1983 the first case of HIV/AIDS in Colombia was detected, the patient was a female sex worker who lived in Cartagena, the most touristic spot in the country and a well-transited port in the Caribbean since colonial times. Soon after, the epidemic took a similar shape as the ones in the US and Europe and concentrated among men who had sex with men (MSM) and female sex workers. For the latter, HIV/AIDS became another occupational hazard, a deadly one, which empowered biopolitical surveillance offices to further control their bodies and their work. While for gay men and emerging gay rights organizations AIDS often became a way to support each other in a moment in which the virus was lethal, ART therapy barely existed, and gay individuals

struggled to dignify their presence in Colombia. For Colombian society at large, and surprisingly until today, HIV is understood as exclusively inhabiting the bodies of gay men and female sex workers. This enduring assumption has stigmatized people living with the virus with "deviant" sexual orientations or practices, and it is an idea that blurs the actual epidemiological dynamics of HIV in Colombia that show that the virus lives in many other bodies beyond these two stereotyped populations.

I argue that the appearance of HIV was foundational for the LGBTQI+ movement in Colombia, but more specifically for the gay movement because of the impact of the virus among MSM, but also because of the synergies that were assembled globally between the gay rights movement and the fight against HIV/AIDS. Furthermore, I think, this creative way to reconceptualize AIDS shaped a novel biopolitical apparatus which allowed the positioning of gay leaders, bureaucrats, medical experts, activists, academics, and so on into a public and global arena in which huge amounts of economic, social, political, and symbolic capital circulate.

This global AIDS landscape has been strategic for the development of movements and policies to address the impact of HIV/AIDS among various populations and the positioning of progressive LGBTQI+ policies around the globe, allowing the entering of openly gay men into public arenas of knowledge and power, that had previously been closed to them because of their queerness. Ralph Bolton, an anthropologist in the AIDS landscape, describes the difficulties of conducting anthropological research focused on the "gay matter" before the AIDS pandemic, and describes how "the plague" accelerated the consolidation of groups and chapters of gay anthropologists worried about "gay matters" in which AIDS became a priority topic (Bolton, 1996). Anthropology was no exception to many other fields that found in AIDS a path to bring out to the public arena gay experts that in many ways had first-hand experiences with the AIDS

pandemic. In this sense, I argue that these intersections have shaped a gay biopolitical lens that has historically molded the fight against AIDS in many parts of the world, including Colombia, in a way in which non-gay men have difficulties of incorporation.

Colombia's early nexuses in this global landscape were Bogotá, Medellín, and Cali, which speaks to the urban character of the AIDS landscape and the gay rights movement, at least in its early stages. At the beginning of the 1980s, outlets from Europe and the US arrived in Colombia with information about gay rights and HIV/AIDS, kindling the beginning of the Colombian social movement of gay men living with HIV (Prachniak-Rincón & Villar de Onís, 2016). In a meeting in the Amigos del Norte bar in Bogotá during International Gay Pride Day in 1983, Manuel Velandia, a prominent Colombian HIV activist, proposed making AIDS the main focus of attention for the gay rights movement in the country (Velandia Mora, 2011). Even though the theme was not enthusiastically accepted, and many people disagreed, in 1984, in that same bar, Colombia had its first AIDS conference.

The explosion of the HIV epidemic in the early 1980s coincides with the awakening of the gay rights movement in Colombia. In 1977 the Movimiento de Liberación Homosexual Colombiano (Colombian Homosexual Liberation Movement) was founded; in 1979 Leon Zuleta prints “El Otro” (The Other) an iconic gay magazine; in 1980 the magazine “Ventana Gay” (Gay Window) was printed; in 1981 homosexuality was constitutionally decriminalized; and, in 1991, the Colombian constitution issued four articles that defended the civil rights of sexual minorities.

In 1985, Velandia, along with Luis Moreno, founded GAI (an AIDS support and information group), which initially aided homosexual men and was the first one of its kind in Colombia. In 1989, GAI became FIASAR (front for research and social anticipation of risk) which opened its scope of work to other populations. In 1986, Velandia created the first AIDS hot line in

Colombia, located in his own house, dedicated to support, initially, homosexual men coping with AIDS. In 1992, *Fundación Apoyemonos*, initially funded by USAID and FHI-360, emerged as a non-only-gay organization, which became a hub for the promotion of human and sexual rights and was a spot for the creation of material for AIDS prevention targeting gay men and the trans population (Velandia Mora, 2011).

By the end of the 1980s and the beginning of the 1990s, there was a boom of HIV/Gay organizations in urban Colombia that consolidated into a national network of research, support, and activism. These organizations served as platforms for key actors in the Colombian HIV scene, many of whom are still active today in many fronts. These key actors often had in common upper and middle class, educated, urban, gay personal trajectories that allowed them to bond and build long-lasting connections with HIV and gay research, social, and activist communities in western Europe and the United States.

For example, in a conversation that I had in 2017 with a top-ranking HIV bureaucrat in Colombia, he told me that after being in San Francisco, CA for a season in 1988, he, as a gay man and physician, came to understand that he had to do work related with HIV in Colombia. When we talked, he asked me if I was gay, and he told me he asked because he believed I could better grasp the true dynamics of the epidemic if I were. And I agree with him, my positionality as a heterosexual man blinds my perception to many of the aspects ingrained at the intersection of gayness and HIV. However, it felt really awkward that in 2017 I still had to validate my interest on the intersection of HIV and heterosexual masculinities, and my positionality as male heterosexual HIV researcher, especially when epidemiological data clearly shows that heterosexuals are affected by HIV. Furthermore, when I interviewed this top-ranking HIV bureaucrat, I had over a decade of research experience with HIV in Colombia, I had heterosexual



and non-heterosexual friends living with HIV, and I was and am an anthropologist, in theory trained to deal and understand otherness. This is not unique to the Colombian context; a similar encounter happened to me with a well-known HIV researcher in the US when I approached him with a premature version of my research project early on during my doctoral studies. In our meeting, I explained to him I was interested in working with heterosexual men living with HIV/AIDS. He answered that heterosexual men were not statistically significant within the HIV epidemic, and thus they did not deserve the same level of attention. For him, HIV research had to highlight the vulnerabilities and risks of MSM towards HIV/AIDS; his agenda was clear.

Now, to be clear, my aim with presenting these interactions is not to judge the work done by LGBTQI+ and HIV activists and researchers. My own history as a researcher is intertwined with these efforts, which have changed societies around the world in many positive ways. I have worked on many projects led by gay HIV researchers and activists, among whom I have many friends and colleagues. However, I also think that this intrinsic bond between HIV and MSM has created an HIV/AIDS biopolitical apparatus that is blind to other populations affected by HIV. This apparatus has created a regime of truth mostly founded on the epidemiological intersection of HIV and MSM: the positionality of gay men, their first-hand experiences with the pre-ARTs AIDS epidemic, the international HIV/AIDS research and activists networks, and funding agencies, and the social recognition based upon their work with HIV and LGBTQI+ rights.

I argue, then, that this HIV regime of truth is based on a biased and outdated gay male-centric perspective. In this research project, I show that HIV-positive heterosexual men exist in Colombia, and that they have difficulties in fitting within the medical protocols and the support networks that exist for people living with HIV. For heterosexual men assuming an HIV diagnosis is in many ways problematic. HIV is a chronic disease, ARTs are for-life drugs, and the virus poses

critical questions towards men's sexual and romantic lives, their desires for family formation, and fatherhood. This is compounded by the fact that the HIV landscape in Colombia today has a gay-gender dynamic attached to it that creates noise and rejection within a structurally homophobic society, and among most of the men I talked to in this project. HIV-positive heterosexual men who live with HIV in Colombia are trapped within a limbo in which seeking medical assistance and peer support becomes a trajectory in which their heterosexuality is constantly questioned and frequently undermined, facts that often create fractures and ruptures between the men and the healthcare system, putting in danger the men's adherence to HIV treatment.

Throughout my research, I show that there is a real intersection of HIV, masculinities, and heterosexuality, that certainly needs to be addressed to better understand and cope with the current shape of the HIV/AIDS epidemic. In the last two decades, HIV scholarship, policy, and activism have been able to recognize the vulnerability of women to the epidemic. For example, research on gender and AIDS stigma around the world has largely focused on the discrimination and stigma experienced by women and its effects on HIV testing, access to care and social support. Such studies are of vital importance, but I agree with Robert Wyrod (2016) and Shari Dworkin (2015) in saying that these approaches do not fully grasp heterosexual men's experiences of HIV vulnerability to HIV/AIDS, and their experiences of stigma, which are different.

Part of my argument is that the HIV movement in Colombia is still today an enclave of the gay rights movement, a fact that has created a bureaucratic apparatus. This apparatus has been successful in promoting an HIV & Gay rights agenda, yet it has not been very successful in acknowledging and recognizing other communities affected by the HIV epidemic. I argue that this has created a type of hegemonic HIV masculinity in which, paradoxically, heterosexual men are

subordinated by the discourses and practices of HIV activism and medical practices tailored for decades for men who have sex with men.

As Dworkin suggests, in many cultural contexts, men are erroneously constituted as invulnerable subjects despite the fact that they suffer physical and health trauma and die more often due to violence, suicide, drugs and alcohol, occupational hazards, and HIV/AIDS. She also suggests that heterosexual men are usually conceived of as powerful in the gender order without recognizing that they may be marginalized by class, race, and the disjuncture between sexual identities and sexual acts. An example of this phenomenon is clearly shown in the HIV prevalence among African-American men in the US, the highest among heterosexual men in this country (Dworkin, 2015).

Furthermore, I argue that heterosexual men in the context of HIV in Colombia belong to a non-formal world. Neither do they belong to the communities who hold the policy discourses, nor to the activist communities. They are invisible to the health public policy protocols and do not count on support networks. Men, who throughout the course of their lives have often embodied privilege, transit to moments, places, and experiences of subordination and marginalization after becoming infected with HIV/AIDS. In Foucauldian terms, they are outside of the HIV discourse economies and outside the HIV regimes of truth, therefore they cannot or do not exist. This creates a gap in the understanding of the contemporary silhouette of the HIV epidemic in Colombia.

### **3.5 What's the local time? The entanglements of chronicity of HIV and heroin addiction in Colombia**

Even though the medical time-based concepts of chronic and acute allow us to communicate across disciplinary boundaries, their use today produces tense ambivalences, since their classificatory boundaries are always changing, especially when at play in contexts different from the ones in which they were conceptualized or produced. Lenore Manderson and Carolyn Smith-Morris, in the introduction of their edited text *Chronic Conditions, Fluid States*, invite scholars, and especially medical anthropologists, to destabilize not only the dichotomy of chronic-acute but also that of communicable-noncommunicable, since both have framed our understanding and representations of disease (Smith-Morris, 2010). And HIV and heroin addiction today coexist in problematic ways at the intersection of both of these dichotomies, according to and depending upon economic, social, and political environments.

Anthropological phenomenological approaches to experiences of chronic diseases suggest that these long term processes reshape people's lives from a place of "abnormality" because their bodies are separated from the ideal healthy standardized body, which obliges people to reconfigure their daily lives (Good, 1994). Experts seem to agree that those with more tools and resources to understand the changes that chronic disease imposes are better at grasping and inventing solutions and situations to cope with their disease. In opposition, those who don't have access to these resources consequently end up in situations that worsen the chronic conditions. Anthropology has shown that a powerful thread exists in the narratives of the people with chronic diseases that can guide researchers through the understanding of the complexities of chronic states of illness.

As I have stated, this research project belongs to a wave of medical anthropologists who have approached the male body under often chronic and uncomfortable situations, showing

complexities at the intersection of health, gender, family formation, and the male body. This body of research simultaneously inquires as to how chronic illnesses are lived in different parts of the world by men in varied environments and scenarios. Thus, in this sense, my research follows Manderson and Smith-Morris' invitation, as I inquire about the chronicity and communicable diseases in Cali, Colombia.

In Colombia, the latest data on HIV shows that 67% of people living with AIDS belong to the *subsidiado* and 17% have no affiliation with the healthcare system (Fondo Colombiano de Enfermedades de Alto Costo, 2019). Essentially, the majority of people who are HIV-positive and are experiencing the disease as acute are poor. Furthermore, my research suggests that heterosexuals, and especially men, in an urban context like Cali, are more prone to experience HIV in the form of AIDS. I argue that this happens for three reasons. First, the majority of HIV models (knowledge and power) state that HIV is not a transmissible disease among this specific population. Second, the environment of care and support does not provide a milieu in which heterosexual men can acquire the resources necessary to potentially transform HIV from an acute disease into a chronic one. Third, the privatization of the Colombian healthcare system has created a for-profit market that has destroyed grassroots community-based organizations of HIV-positive patients along with holistic HIV clinics, which were key in the advancement of successful HIV policies and programs in the '80s and '90s. This process ended in the creation of the Cuenta de Alto Costo (a high cost account) which administers the epidemiological data, policies, and budget of the treatment of diseases such as HIV or opioid addiction. I argue that by labeling these diseases as "high cost" a question of deservedness of care is at stake, putting universal access to healthcare in jeopardy.

In the case of addiction to heroin, the panorama is even more complex, because it is a relatively new phenomenon in Colombia, but mostly because the issue is invisibilized even though the drama is quite visible. It might be possible to think of the contemporary heroin epidemic in Colombia in similar terms as the '80s AIDS epidemic, in which the society questions the deservedness of care. In this case, that questioning comes not because the majority of people affected are not heteronormative, but because they are addicts—deviants, in Foucauldian terms. In addition, opioids have a paradoxical relationship with chronic diseases. On one hand, opioids are effective drugs to treat the pain associated with chronic or acute diseases. However, opioids might be very addictive, and therefore they can become the source of chronic dependency—addiction—and the route to potential HIV or hepatitis C infection, which might be chronic or not, depending on the social, economic and political environment.

Furthermore, Colombia has had a bipolar approach to the matter of substance abuse and addiction. For example, *Plan Colombia*, the United States' \$7.5 billion initiative to combat drug cartels and left-wing insurgents and foster economic growth in Colombia for 6 years (2000-2006), only reduced cocaine production by 5.3%<sup>13</sup> and did not allocate a single dollar for the treatment of *basuco* addiction. *Basuco* is deeply embedded in urban Colombia, devastating generations, and leaving many in a state of homelessness. *Basuco*, like heroin today, is a drug that circulates broadly among the very poor, again raising questions of deservedness and suggesting that Colombian society has to start dealing with it more seriously.

Thus, in this sense, opening the discussion of chronicity to discuss the HIV and opioid epidemics among hidden and neglected populations brings my research into dialogue with what

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<sup>13</sup> <https://www.oxfordresearchgroup.org.uk/blog/the-legacy-of-plan-colombia>

chronicity means at its intersection with gender, deservedness of care, and “situated biologies,” or the processes by which bodies get embedded in specific temporal, spatial, and cultural contexts (Niewöhner & Lock, 2018). Material bodies are immersed in evolutionary, environmental, social, and individual trajectories whose representations make sense within local categories of knowledge and experience. Bodies, therefore, are in constant action, mutation, and change, and the constant disintegration and recomposition of their boundaries has to be taken into account (Lock, 1993).

Having reviewed the theoretical background on masculinities, HIV/AIDS, and medical anthropology, I will now transition into three chapters based on my fieldwork in Cali, Colombia, aiming to transmit the complexities of the daily lives of working-class men going through processes of illness and disease who receive little structural support and empathy for their struggles and desires in contemporary urban Colombia.

#### **4.0 It hits men like a bomb: How heterosexual men discover their HIV-positive status**

Today in Colombia, there are 2.5 HIV-positive men for every HIV-positive woman. Men are considered the main route of infection among women, yet we know little about how heterosexual men become infected and how they live with the virus, especially in contexts where HIV is still broadly considered a “gay disease.” To move towards a better understanding of the relationship between men, HIV, and women in Latin America, this chapter focuses on the experiences of HIV-positive men and fathers in Cali, Colombia. I examine how HIV enters and disrupts the lives of heterosexual men by considering how men become infected with HIV and learn of their HIV-positive diagnosis.

Because of the invisibility of HIV infection among heterosexual men, many believe their heterosexuality is a safety barrier against the virus and find it hard to navigate the HIV therapeutic itineraries, which are mainly tailored for gay men. In this chapter, I show that working-class heterosexual men often discover their HIV-positive status through AIDS episodes that manifest in tuberculosis, toxoplasmosis, and other episodes of acute infections. I argue that men’s heterosexual status enters in conflict with a trajectory and history of HIV bio-policies that does not recognize the intersection between heterosexual men and the virus and therefore neglects their specific needs, which exacerbates negative individual responses such as denial of diagnosis, lack of adherence to treatment, isolation, AIDS, and oftentimes more spread of the virus. The chapter ends with the story of a man born with HIV, who today is in his 30s. His story highlights his personal difficulties as well as those of a whole generation in building and keeping romantic relationships and building families, which raises questions about reaching adulthood when born with HIV and the arrangement of kinship based on HIV serological status.



In this chapter I introduce five men I met in Cali, three of whom found out their HIV-positive status when they got critically sick due to a serious immunological suppression associated with AIDS, and one of whom has known about his HIV-positive diagnosis since childhood—he was born with HIV. Three of these men relate their HIV infection with moments of high alcohol and drug consumption and interactions with multiple sex partners, including trans-gender women. Except for César, who was born with the virus, none of these men had received an HIV test in regular medical check-ups prior to their diagnosis, even when they sought consultation for other STIs. It seems that their gender status as heterosexual men was assumed by medical staff as an effective barrier against HIV.

The emergence of HIV/AIDS in the lives of these men creates ruptures of large magnitude. Today, HIV is treated as a chronic disease; however, the aura of death that the virus carries is still vivid in the collective images of the Colombian society at large. As I will show, HIV for heterosexual men is a completely unexpected disease, and that component of unfamiliarity transforms the virus into an agent of death that creates fear. When men learn of their HIV-positive status, they immediately think they are going to die soon, and in a horrible way. This closeness to death, which is often experienced in the form of acute AIDS syndromes, brings men into the realization of how finite life is, and while some decide to abort life and wait to “die with their boots on,” others decide to reshape their lives in ways that will allow them to live longer. HIV in these cases becomes almost like a new pedagogical tool that helps men explore their bodies, attitudes, and roles in unprecedented ways, often bringing epiphanies to their lives. The stories that I present here are all from men who want to live longer. Nevertheless, it is important to acknowledge that many times I heard from professionals and HIV-positive women that those men who refuse to cope with HIV end up dying alone in very bad conditions, often spreading the virus to others.

The majority of men report having difficulties at some point with adherence to antiretroviral treatment (ART), and many feel uncomfortable attending HIV clinics, support groups, NGOs or support networks for fear of losing anonymity, being labeled as HIV-positive or gay, and because of the almost inevitable interactions with male gay patients in these spaces. This reluctance to engage with HIV professionals and communities lead these men to live their HIV-positive diagnosis in silence and often ignorant of basic and accurate information about HIV and how to live with it. As an example, some of the men I talked to referred to wanting to become fathers, but they lacked information about their reproductive rights; thus, many believed they were not able to become parents, even though HIV protocols say it is a right, and perfectly plausible and safe for all the parties involved when done correctly.

Romantic relationships after men know their HIV-positive diagnosis is a topic that men find difficult to navigate, understand, and share with partners. Most of the men I present here say they would prefer to have romantic relationships with HIV-positive women, and in fact César recounts how he fell in love and created a family with an HIV-positive woman who was the mother of a HIV-positive child from a previous marriage. This story raises important questions about HIV and kinship, rarely discussed in the HIV literature in the Americas. The diagnosis also brings questions and fear of resuming sexual life. For example, among the majority of men I talked to, condoms were not part of their routines and became an element of concern related to their newness, sometimes their discomfort, and their quality. Other men disclosed experiencing erectile dysfunction due to ART and “mental blockages” which deeply affected their egos. In many instances, men disclosed these traumas during our interviews, and when I asked if they had asked questions about these matters with the health professionals they meet, they typically told me they did not feel comfortable asking these questions at HIV clinics.

We know that viruses do not care about sex or gender and that they mutate rapidly over time, often succeeding in spreading more successfully from one host to another. Latin America's HIV epidemic today is different. It affects a more diverse population that goes beyond the traditional "at risk" populations who have received attention in the region, such as MSM, sex workers, and more recently trans-gender women. On the contrary, health policies in the region have not updated their actions or protocols. It seems that the biopolitical apparatus for the prevention and treatment of HIV/AIDS in Colombia is still one tailored for men who have sex with men and recognize themselves as such. Thus, with this research, I show that men and fathers do in fact have a lot to do, say, and challenge in regard to the new faces of the HIV epidemic in the context of a urban landscape in Latin America, but I also show that these transformations need a strong social backup that recognizes men as subjects of HIV preventive care and treatment, in ways that better account for their gender and cultural needs. Having this social backup would mean that men and their families would live healthier lives.

#### **4.1 Sex, drugs and salsa**

I interviewed Juan on the back patio of an HIV clinic in Cali. At the time, he was 52 years old. He fit well the stereotype of the *Caleño* man—a man from Cali. He had brown skin, like mine. He was wearing a tropical shirt with short sleeves, elegant pants, and moccasins, an outfit common in Cali's salsa scene, which bloomed in the 1970s. He had that *caleño* accent, which mixes two versions of second person conjugation in Spanish, *tu* and *vos*, all the time. As an example, he would tell me: "mirá ve Camilo, lo que te voy a contar a vos es muy personal" (look Camilo, what I am going to tell you is very personal). Juan was part of a generation that grew up with the

aesthetics of the 70s and 80s salsa scene, and he kept that look with him. In the 70s, Cali entered the global circuit of the salsa record industry that had New York City as its main epicenter. Salsa records printed in the US travelled in cargo boats all over the world and found welcoming audiences in places like Cali through Buenaventura, the main Colombian port in the Pacific. Cali in the 1970s also became an important knot in the airplane route map in the Americas. Cali was often a mandatory stop for planes traveling from North to South America and vice versa, which usually had a one-night layover to refill fuel, food and do mechanical check-ups. Cali entered the global party scene at the time, with travelers from the world having transitory days and nights to spend during their long airplane trips. By the same time, Cali's local elites managed to attract international capital to set up factories seduced by Cali's privileged location and a vast amount of cheap labor fueled by a massive rural migration into the city composed of people escaping violence and poverty. Goodyear and Colgate, for example, had factories in the city for decades (Martínez, 2012).

This rapidly growing population of urban proletarians adopted salsa, an urban musical beat with lyrics that often talked about the social and political hardships of Caribbean countries and their diasporas in places like New York, which resonated with Cali's migrants' own experiences. Within this vibrant scene, local DJs in Cali started playing the 33 RPM records at 45 RPM, speeding up the way of dancing salsa in a unique way that captured the attention of the whole salsa industry (Ulloa, 2009). This shift revolutionized salsa, and Cali became the Global Capital of Salsa, a place where music, party, and sex industries boomed. On top of this, in the 80s the Cali Cartel anchored the city as one of the global cocaine-escapes of the world. This story is important because the transformation of Cali into what Brennan calls a pleasure landscape (Brennan, 2004)

promoted masculinity roles deeply permeated by salsa, drugs, and sex, which clearly influenced Juan and the other men I talked to.

Juan had a hectic and intense life. He grew up in one of Cali's traditional red zone areas, and he described his life as a roller coaster of precarious jobs, sex, drugs, and alcohol. Juan learned that he lived with HIV through a tuberculosis (TB) infection. He thought he became infected with TB by sharing drinks from the same cup with a friend of his who guarded cars in the street in downtown Cali. Juan recalled how he found it odd that his friend, despite the tropical weather of Cali, would usually wear not only one, but two jackets, and was always coughing; however, he never made the connection until he got sick. He recalled that he started sweating a lot, lost energy, felt tired, and had difficulty climbing upstairs. Juan decided to visit a clinic. There he found out he had not only TB but also HIV. Juan never expected it even though, as he told me, he had had every single possible venereal disease. When he knew he was HIV-positive he thought he would die in a month.

*I got tested for tuberculosis and HIV at the Carlos Holmes Trujillo [a city Hospital] and at that moment I knew I was positive for both.*

*c. did you expect that you could get it [HIV]?*

*j. no, no, no, no, never!*

*c. what did you imagine when you knew?*

*j. uff, I thought everything, I thought I was going die in a month, which is the first thing you think... in that moment you think you are going through the worst moment in your life.*

*Juan*

The day we met, Juan looked healthy. He was in his third month of treatment for TB and HIV and seemed in good spirits; he was thinking positively about his life, and he had useful

information about his medical condition. He was lucky—Diego Correa, a long-time HIV expert and activist was his psychologist.

When I met Juan, he had a female partner, Gina, with whom he had been together for fifteen years. He considered her daughters and sons his stepchildren. Until that moment his partner had tested negative, a fact that made him tranquil. Gina, her daughters, and even her mother knew Juan was HIV-positive and were supportive of him. However, his partner's sons did not know. Both were in prison and Juan said they could take violent revenge if they ever knew Juan lived with HIV and could put their mother at risk.

Juan and Gina used to manage low budget motels in downtown Cali called *residencias*, in which people can rent cheap rooms by the hour or day. *Residencias* offer temporary and cheap refuge and are often tolerant of clients who check-in to have sex or use drugs. Juan and Gina used to work from Monday to Friday administering a *residencia*, and on Fridays they reserved a room in a different one where they spent one or two nights watching TV, smoking *basuco* (cocaine paste) and cigarettes, and drinking alcohol. It was their time to be alone and enjoy each other's company and intimacy. Juan told me that he never enjoyed consuming *basuco* in the streets—he liked to do it in private. On Sundays, if they could, he and Gina sobered and would do a Sunday family trip with her sons and daughters to Pance, a river that flows cold and clear from Cali's western mountain range and which Caleños love to visit to freshen up, eat a barbecue or a picnic, and enjoy nature.

During the time when he was working at the *residencia* is when he met his friend, the one who he thinks infected him with TB. This man died a month before our interview. It is also during this time that he thinks he became infected with HIV. He thinks it was through a woman he and Gina kept running into in Cali's downtown *residencias*. The woman liked to consume cocaine but

she did not like to buy it, so Gina would get it for her and get a tip. One night, Juan told me, she knocked on their hotel room door and they ended up having a threesome with no protection. Juan told me they never saw her again.

Juan, like many men I talked to, embraced a masculine identity in which pleasure is deeply intertwined with alcohol and drugs. Studies show that drugs, including alcohol, play key roles as risk factors for HIV infection (Nødhjelp & Norwegian Church Aid, 2016; M. B. Padilla, Guilamo-Ramos, & Godbole, 2012). Juan spent his life in Cali's downtown, an area of town known as a working-class pleasure landscape where sex and drugs are openly available businesses. Cali's downtown has not gone through a deep process of gentrification like many other downtown areas in Latin America, so today it continues to have a large portion of impoverished blue-collar inhabitants in an area of the city with little public investment. This gradually allowed the drug dealing business to occupy entire blocks in the downtown area, with heroin being a new product that added to the now-traditional selling of cocaine, *basuco*, marihuana, and synthetic drugs. While he was telling me how HIV changed his life, Juan told me about the transformation of pockets of the Sucre neighborhood—located in Cali's downtown, where he was born and raised, into *Ollas*, a word used in Colombia to refer to places to sell and consume drugs. Juan and many of his family and extended family members had consumed drugs for long periods of their lives. In fact, one of his stepdaughters was at the time of our conversation homeless due to her addiction to *basuco*, the same substance Juan used in Cali's downtown *residencias*.

Cali in the 70s was attractive to an urban proletarian group of people who found jobs in the sugarcane industry that still surrounds the city in the north, east, and south flanks, as well as other national and multinational industries, many of which are located close to downtown where the bus terminal and the train station are still located. Back then, the Sucre and Obrero neighborhoods

were working-class spaces where many people had jobs. However, over the last four decades many of Cali's multinational companies have moved their factories to places with fewer taxes, such as Panama, and the sugarcane industry has unemployed many people by acquiring automated technologies. Neighborhoods like Obrero and Sucre have become systematically poorer, and illicit drug markets are taking over the landscape of a big chunk of Cali's downtown. A few salsa bars that emerged in the 70s still open their doors, especially on Mondays, in memory of those days in which factories' most common day off was precisely on Mondays. When you go on a Monday night to *El Chorrillo Antillano*, one of those salsa bars, you can see men like Juan, elegantly dressed, dancing with equally well-dressed women in a Cali totally immersed in the '70's nostalgia scene.

#### **4.2 A womanizer surrounded by female support**

Carlos was referred to me through an infectious disease specialist. We arranged our meeting via telephone; he wanted to meet in private, at his place, not in the clinic, nor in a public space. Carlos lived in a working-class neighborhood filled with colorful self-built houses. When I got to his place, he invited me to his room, located within a first-floor apartment that he shared with his sister, brother, and sister-in-law. In his bedroom, he had a bed, a big TV screen, and a set of prominent speakers. Carlos was 34 when we met in 2018. He worked driving a taxi that was parked outside his house and rented a few more. He was the father of a 12-year-old child that lived with her mother.

Carlos said to me his line of work allowed him to earn enough money to be attractive to women. He enjoyed being a womanizer and having casual sex. Yet he acknowledged that the



diagnosis had changed his sexuality because there was now a latent risk of infecting someone. Carlos had a daughter and knew what it was to be a father, but sometimes thought about having another one or suspected that at some point a woman would ask him to have one but thought it would be dangerous and risky.

In 2012, Carlos went to Cali's University Hospital (the Hospital Universitario del Valle HUV), seeking urgent care for severe inflammation in his neck. He had a pus agglomeration, which made the doctors suspect an immunological problem. After getting surgery and a set of different exams, he was tested for HIV and found out he was living with HIV. Carlos told me he had been a womanizer, and even though he knew about other risks, he did not always wear condoms. He never thought he could become infected with HIV.

I asked him how he thought he became infected with HIV and he told me it was clearly a sexual transmission. When I asked him if he suspected someone, he said, no. I asked again, and he said,

*well maybe it was this pelada [young woman] that I used to hang out a lot with. And imagine that every time when we were about to get intimate she always ended up giving me oral sex, and there was no penetration. Until one day, in which we were enrumbados [drunk or high and in a party mood] we had intercourse. That is the only person I can think of.*

*Carlos*

When I asked him if he knew of the whereabouts of this woman, or if she had become infected, he responded that most of his relationships were casual and that he did not like to get involved, so he did not know anything about her. He told me he usually did not like to meet his

sexual partners' intimate circles or family nor introduce them to his. As he said, he liked his sexual life to be very casual.

Carlos became a father years before he knew about his HIV-positive diagnosis. When he learned of his diagnosis he shared it with his mother, his ex-partner and his ex-mother in law, who used to be a nurse and was key in supporting Carlos and connecting him with staff at the HUV. At that moment he had a girlfriend that worked in the health sector with whom he was having unprotected sex. When he told her he had been diagnosed, she broke down, but stayed with him and supported him. She tested negative for HIV twice, the first time soon after she learned of Carlos' diagnosis and the second time after they had sex *enrumbados* without a condom. Carlos told me that after he got diagnosed, another one of his sex partners, to whom he did not reveal his diagnosis, donated blood every six months to get checked for HIV, and she had tested negative as well. And another sex partner, to whom he did not reveal his diagnosis either and to whom he referred as a *prepagado fina*—the Colombian name given to women enrolled in sex escort services—routinely had HIV tests, and she also tested negative for HIV. Carlos had never had this conversation with a specialist before, and he wanted me to explain to him why he had not infected his sex partners. After the interview we talked about it, and I gave him information about the virulence along with specific sexual practices that lead to situations of more or less HIV infection risk. Carlos did not have this information, and I felt it was important he knew it, but certainly I felt the whole conversation needed the support of a professional.

Carlos told me his HIV status took him by surprise, yet it felt like kind of a natural response to his sexual life. He clearly remembers that when the psychologist called him to the office to give him the HIV result, he knew it was because it was positive because, as he told me, when a result is positive there is a lot of mystery around it. When he left the psychology office he felt deeply

sad, he was with his mother and he cried. Fortunately, he said his mother had been supporting him from the very first moment, which again reaffirms how a big part of the emotional support that he received came from women close to him.

Carlos told me that it took him a few years to accept his HIV-positive diagnosis in a practical way. It was after a critical health relapse that he started taking the ART treatment daily and going to monthly medical check-ups despite his reluctance to spend time in the clinic. At the clinic he felt annoyed and uncomfortable because of the long waits and the possibility of running into someone who might know him. He also told me that in the pharmacy, located in the upper floor of Clinica Colombia, a 9-story hospital, HIV patients received their ART in black plastic bags, which was awkward because no other patient's drugs were packed in this way. He also highlighted how he felt out of place in the notably gay environment of the clinic and the waiting room; he disliked male gay patients trying to establish conversation and flirting with him. In sum, when he went to the clinic, he told me he tried to focus on his cellphone and WhatsApp, avoided any conversation with patients, and tried to do everything as quickly as possible.

Clinica Colombia held the HIV clinic where Carlos had his medical check-ups. The HIV clinic rented the space from the hospital and was in a little-transited area on the ground floor of the clinic. The clinic was exclusively an HIV treatment clinic, like many others in the city and the country, which meant that being in the waiting room had no other explanation other than being an HIV patient. I visited the clinic many times and it was always crowded, a couple of TVs were always on, and the staff members were always very busy. The waiting room was small so patients would also sit on chairs on the only hall in front of the 2 doctors' offices or sit in an empty room that had a few abandoned dialysis chairs. Often, patients would knock on the nurse office door while opening the door in case other patients were inside. Carlos told me, with reason, that it

bothered him that there was no privacy at the clinic even inside the clinic's offices, and he blamed it on the "gossipy" behavior of male gay patients rather than the precarious infrastructure of the clinic.

Carlos also did not feel comfortable being open about his serological status with a girlfriend he had at the time. He liked her, yet he told me there were times when he thought it was better to end the relationship because he felt that a long-term commitment implied revealing to her his HIV-positive diagnosis. He told me:

*Imagine she proposes to establish a more stable relationship and suggests moving in together. I would become the husband and she would obviously want to have sex without condoms. Decíme yo con qué le salgo? [Tell me, what do I tell her]?*

*Carlos*

He said that living with HIV made him constantly think about terminating relationships he felt comfortable with. When I asked him if he thought his partner would leave him if she knew about his diagnosis, he responded that she would dump him without a doubt. He was also anxious because his girlfriend had insisted on him getting a vasectomy. She was a mother and she did not want to have more children. Carlos was a father, and he was considering not having any more children, yet her suggestion made him think she was getting tired of using condoms, and he felt anxious about the implied non-condom use after the vasectomy. In his head he had imagined suggesting getting a mutual HIV test and reacting as though his diagnosis was new, and in this way setting the relationship straight. Carlos had never discussed this plan with his psychologist or anyone else.

Carlos also believed he could not be a father for fear of transmitting the virus to the child. After the interview, we discussed the fact that he could indeed be a father with adequate medical

support and with minimal risk for the baby. He was surprised to learn he could be a father; he had never had this conversation with any of the health professionals at the HIV clinic. He also felt stuck in Cali due to his diagnosis. He had friends, ex-lovers, and family that migrated to Chile and Spain and found better lives abroad. People had invited him over and even suggested that he migrate, but he felt and regretted that he could not travel because he did not know how to deal with accessing ART abroad.

Carlos' relationship with the ART treatment was not ideal at the beginning. He remembered he did not like the idea of taking pills every day. Instead, he decided to keep partying hard, indulging in long weekends of bars, alcohol, cocaine, and sex. For almost four years he thought that he would not pay attention to the HIV matter; taking the ART pills reminded him each time of his HIV diagnosis, and he disliked it. He thought the best way to cope with HIV was to wait for the arrival of death, and in the meantime to enjoy life as much as he could. He kept on with this routine until he had a relapse and got so sick that he had to stay in the hospital for fifteen days. After that traumatic moment he began taking the treatment again, but the virus had developed resistance to the initial treatment. After genotyping his strain of the HIV virus, he got a new ART cocktail that was working well, except for the Kaletra, which sometimes gave him diarrhea, but fortunately doctors were looking into it. By 2018, he had stop consuming cocaine and reduced his alcohol intake significantly. He said he felt better. His viral load was undetectable, and his CD4 was 200—not great, but better than zero like when he relapsed.

After his health crisis, Carlos began taking his ART, quit his cocaine habit, and diminished his alcohol consumption. His approach to the use of alcohol and cocaine changed, along with his desire for intense and prolonged partying. In previous research with female patients suffering from chronic pain and arthritis (Ruiz Sánchez, 2007) I found that the experiences of chronic pain over

time, treatment, and reflection became pedagogical experiences for the sufferers. They explained to me that pain had allowed them to communicate better with their bodies. They understood much better what their bodies needed and engaged in healthier diets and habits. Similarly, men I talked to in Cali told me their HIV-positive diagnosis made them rethink and transform their intake of drugs and alcohol and also made them think more about ways to take better care of their bodies.

Carlos was not alone in feeling that he did not fit the landscape of the HIV clinics in Cali. Most of the men I spoke with recounted that HIV clinics and support networks were spaces not tailored for them, and they felt out of place. Most of them had crucial questions about their bodies, sexualities, and relationships that they did not feel comfortable bringing up in their medical appointments. They often raised these questions in our interviews and even though I have a good amount of knowledge on HIV matters, I did not always feel our conversations were the best space to address their concerns. However, I always provided the information I had at the end of the interviews, referred some of them to specialists that I knew could support them, and always pushed them to ask these questions and open up dialogues with the health staff in charge of their healthcare.

For example, it was very common among the men I spoke with to believe that once they had received their HIV-positive diagnosis, they could not be fathers. They thought fatherhood was inherently risky for the offspring and their partners and did not know it was possible to become fathers safely, especially if they had undetectable HIV viral loads. Planned fatherhood was not openly discussed in the HIV clinics in Cali. This absence resonates with findings in other part of the world. For example, on their research with 32 HIV-positive heterosexual men in Britain, Sherr and Barry (2004) found that men were rarely given medical advice on reproduction (only 9.4%) while nearly half had considered having children. Almost half believed they would experience

discrimination if they conceived a baby and a quarter would withhold their HIV status when attending antenatal clinics. The majority (81%) believed that a child gave meaning to life and was something to live for.

Similarly, in their research with 250 HIV-positive men in Sao Paulo, Vera Paiva et al (2003) found most participants did not consider health professionals to be supportive enough or even impartial about HIV-positive people having children, and paid little attention to men's fathering roles. 80% of these men had sexual relationships, and 43% wanted children, especially those who had no children, despite expectations of disapproval. Few of the men received information about treatment options that would protect infants, however. In previous studies with HIV-positive women attending the same clinics, by comparison, greater knowledge about prevention of perinatal HIV transmission was reported, but women had fewer sexual relationships, fewer desired to have children, and they expected even more disapproval of having children from health professionals.

In Cali, HIV-positive parents generally receive information on how to avoid the transmission of the virus to offspring and sexual partners, but the right that people living with HIV have to become parents is rarely discussed. This exclusion has a history within the healthcare regimes of truth in which HIV-positive people that become parents after their diagnosis are seen as irresponsible people, even more so if they are men. In this sense, the intersection of HIV with fatherhood becomes a socially and medically stigmatized space that men often have to navigate alone in silence.

### 4.3 From Buenaventura to Cali: A monthly therapeutic journey

Darío lived in Buenaventura, a city of roughly half a million inhabitants that holds the most important Colombian port on the Pacific coast. The city is an urban enclave located on the shore of a deep and ample bay surrounded by thick rainforest, equally distant from the ports of Vancouver in Canada and Valparaíso in Chile, and very close to the Panama Canal. Its population is 85% afro-descendant, and it is a city with profound and acute inequalities.

Buenaventura is a city divided in two. The port, protected by fences, checkpoints, the police, and the army is characterized by its high-quality infrastructure, built to accommodate the entry and exit of containers, whose flow never stops. The rest of the city, with the exception of the neighborhoods that surround the port, is self-constructed with very little public infrastructure and almost no urban planning, and accommodates a large poor population attracted by the wealth that the port creates and its relative safety against violence.

Buenaventura is the largest county of Valle del Cauca, the same state that contains Cali. According to the DANE (the Colombian National Statistical Bureau),<sup>14</sup> Buenaventura has an index of multidimensional poverty (IMD) of 41% while the Colombian IMD ranges from 4.4% to 65%. Cali's IMD is 15.5%. The IMD calculates the prevalence of multidimensional deficiencies in health, education, and quality of life, as well as their intensity, meaning how many deficiencies individuals experience at the same time. Poverty in Buenaventura is obvious, and the Colombian civil war has moved into the daily life of this city. All the actors involved in the Colombian armed

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<sup>14</sup> Visited on June 18, 2020.

<https://dane.maps.arcgis.com/apps/MapJournal/index.html?appid=54595086fdd74b6c9effd2fb8a9500dc>



conflict want to have a piece of Buenaventura. The killing of social leaders, the discovery of houses where paramilitaries would literally chop and disappear people, and the displacement and privatization of land within the city has in the last decade sparked a series of public discontent with the policies that keep the city and its population in critical poverty while the levels of violence have become intolerable (CNMH, 2015). Within this context, the city's healthcare network has kept shrinking. And more specifically in the case of HIV, there is a high prevalence and incidence of cases, in big part connected to the sex industry that circulates around the port.



**Figure 5. Buenaventura. H Camilo Ruiz S, 2018.**

Darío had to travel monthly from Buenaventura to Cali to get antiretroviral treatment and medical attention for him and his daughter, who was also HIV-positive. Darío and his daughter received attention at different HIV clinics, and usually on different days because they had different health insurance companies. Darío's therapeutic journey meant commuting of 3 to 4 hours each

way and paying 35.000 COP (15 USD) per person each way. The roundtrip journey can take a full day, if there are no roadblocks due to avalanches which might even create delays of days.

Despite the wealth that flows through Buenaventura—60% of Colombian international trade goes through it—the city lacks an efficient healthcare infrastructure to serve its population. Health insurance companies have decided to provide essential services in the city and more complex ones in Cali. I talked with many people coming from Buenaventura in different HIV clinics in Cali. Those who belonged to the *Contributivo* often came on their own with their own money, while others belonging to the *Subsidiado* and *Vinculado* had transportation and sometimes food. I frequently heard how the health network in Buenaventura was in total decay and getting worse every day. However, there was a positive aspect to commuting to Cali—anonymity. I often heard that gossip in Buenaventura travels fast and keeping an HIV diagnosis anonymous was difficult; thus, at least after all the effort and annoyance of the long commute, there was the tranquility of having the chance to deal with their secret in another city. Once I asked a woman who traveled monthly from Buenaventura to Cali in a van with other HIV-positive patients how they dealt with keeping the secret. She told me that once they met in the van, there was a tacit agreement of not disclosing each other's diagnosis or identities. Sometimes she would even run into other patients in the streets of Buenaventura and she told me they usually ignored each other.

I met Darío through an institution that takes care of children living with HIV which hosted his daughter. His daughter spent eighteen months institutionalized, according to him, due to the irresponsible attitude of his partner. “She just partied too much,” he said, a fact that brought difficulties for both of them, making them split. Their daughter ended up in foster care and, ultimately, in the aforementioned institution located in Cali's suburbs. Since the child was there, Darío visited as much as he could. The institution personnel referred to him as a caring father, and

since the start of my project, he had been a candidate to interview. Yet it took us months to meet. I even offered to go to Buenaventura to interview him, but he told me he would prefer to do it in Cali. Darío's daughter went back to live with him because of his reputation as a good parent and also because there was a wave of de-institutionalizing HIV-positive children that were living in orphanage environments and had family that could take care of them. Darío gained back the custody of his daughter with the promise of the institution's remote support, which explained why Darío's daughter had a different health insurance.

I interviewed him in a coffee shop close to the Hospital Universitario del Valle (HUV) before he and his daughter went back to Buenaventura; it had been a long day for both of them and they were exhausted. Fortunately, Teresa, my mother, was visiting me in Cali and Darío agreed my mother could take his daughter for ice cream in a park nearby while we talked. Darío did not want to talk about his diagnosis in front of his daughter; she did not know that she or her parents lived with HIV.

When I asked Darío how he got to know about his HIV diagnosis, he told me that the first person that showed symptoms was his partner, who was tested for HIV after having an acute case of pneumonia. After that, he and his daughter also got tested for HIV and found out that all three were living with the virus.

When Darío learned of his diagnosis he thought he was going to die soon, yet at the HUV he found useful information on the importance of ART in controlling the virus. In a practical way he got the message and became adherent to the treatment immediately. He wanted to be healthy to be able to take care of his daughter. The day we met, his daughter was 9 years old and he was 42. Both looked healthy. His ex-partner had migrated to Chile—like many other people from the Colombian southwest—and there she found a partner with whom she had a baby. Darío told me

the diagnosis had reoriented his life; he basically worked and took care of his mother and daughter. He mentioned that he had occasional sex encounters with friends, always with condoms, but that he was not interested in establishing a new romantic relationship. He did not feel he was ready to be open about his HIV-positive diagnosis.

Darío had a stable job at the port of Buenaventura, so he had resources to provide for his daughter. He also was a caring father who with the help of his mother was raising his daughter. However, he confessed it was harrowing for him having neither the courage and nor the tools to talk with his daughter about his and her HIV diagnosis, and he felt paralyzed and deeply anxious about this. Darío was on his own on the task of revealing to his daughter her HIV diagnosis, a terrible paradox since both of them were under the vigilance of two HIV clinics and one foster care institution.

Darío, in the context of Colombia, is outside of the norm with respect to single fatherhood. He was a single father taking care of his only child, and everyone I knew that knew him had a good impression of him. However, Darío had no support from the medical staff to explain his diagnosis to his daughter and help her know she lived with it too. Studies show that children under appropriate guidance are able to understand and cope positively with an HIV-positive diagnosis (Guerra & Seidl, 2009; Trejos, Reyes, Bahamon, Alarcón, & Gaviria, 2015). Access to ART therapy has changed the landscape of children that were born with HIV: their lives have been prolonged, and with that had emerged the dilemma about when is a good time to talk openly about the diagnosis. In most cases this conversation emerges when children reach puberty because of the sexual component that is attached to HIV. However, as Darío explained, it was hard not to tell his daughter openly why they had to go to the doctor every month, why she had to take pills daily, and what was the matter with their health. The biopolitics of HIV seem to keep their focus

on an adult population that very often have no children, but that landscape is changing and men like Darío need tools to better do their jobs as fathers of HIV-positive children.

Darío is part of a growing number of HIV-positive men who are pushed to assume single fatherhood, in this case due to the migration of his partner, but in many other cases it happens due to the death of their partner. Left with the responsibility of parenting, some men like Darío seem to transform their gender roles enormously, becoming caring and responsible parents. Nevertheless, these transitions are not always easy and these men should be provided support. They have a lot of questions and anxieties connected to their diagnosis that go beyond adherence to treatment and ART. All the men I talked to for this research project had questions about how to proceed with their romantic and family spheres, but rarely had a space or a trusted person to share their concerns.

Darío told me at the end of our conversation that even though he was not planning on resuming his romantic life, he had thought that doing so with someone that lived with the diagnosis would be easier. He felt that disclosing his HIV-positive diagnosis was just too big of an issue. Thus, he preferred having occasional non-committed protected sex. Darío's situation, however, represents a big contradiction in the Colombian HIV to the Colombian HIV biopolitical apparatus. He was one of those good and responsible HIV-positive patients who everyone referred as an exemplar father, but somehow, he was alone with his thoughts, his ideas, and his fears because none of the three institutions that were responsible for his and his daughter's well-being invited him to ask these questions.

#### 4.4 A man's hetero(flexible) sexual desires

I met Alvaro at an HIV Clinic after he was referred to me through the clinic psychologist. I interviewed him at the clinic. It was a warm Cali afternoon, and we sat in the back-patio clinic of an old two-story house located in an upper middle-class neighborhood. When I asked him for a short biography, he told me he was 62 years old and that he was an alcoholic and drug addict in recovery. He had not consumed any of these for 16 years. He had a small street food business—he sold *arepas* in the morning—and was an electrician too, a job that he did in the afternoons whenever a gig appeared.

Cali has a strong bond with the Colombian coffee growing region. Today you can travel from Cali to Pereira, one of the main cities in the coffee circuit, by bus in two hours. So *arepas*, a ground maize kind of pancake and a staple food in the Colombian coffee-growing area, are everywhere in Cali. Most commonly, you can see people in the mornings setting up small barbecues in the streets of Cali to roast *arepas*, sometimes filled with cheese or scrambled eggs, sold with coffee or orange juice. Alvaro had one of those *arepa* businesses, and he had a bit of a *paisa* (coffee-growing region) accent. In our interview I realized I knew him: I had eaten a few times at his business, located close to one of the places I lived while doing fieldwork in Cali.

Alvaro found out he was living with HIV in 1994, when he got an infection in the groin. The doctor suspected he had syphilis, but he doubted that was the issue, as he had had it before, along with other STIs, and to him this felt different. So, he suggested the doctor order him an HIV test, and it came back positive. Alvaro told me when he was young he was a handsome man, and that for a while he made a living doing sex work. He also told me he enjoyed engaging in romantic relationships with sex workers. Thus, in his social circles STIs and HIV were a reality; in fact, people he knew had become HIV-positive and others had died because of AIDS. HIV was

spreading, along with its stigma. When he told me this he said, “you know, like in the song,” and sang a bit of Willie Colon’s famous salsa song *El Gran Varón*, which tells the story of a trans-woman named Simón who her father never understood and who dies of a rare disease in ‘86 with no one to cry for her. Despite of this evidence around him, he never imagined he could become infected with HIV. When he suggested to the doctor the HIV test he was simply ruling out options, but he never thought he could actually get it.

In Alvaro’s words, he was very promiscuous, and even though he had long-standing relationships with women, he hung out and had sex with female and trans-female sex workers. He identified himself as bisexual but emphasized that he felt sexual desire for women and trans-women, never men. Alvaro admitted he had had plenty of HIV risky sexual encounters, so figuring out who might have been the person that infected him was pointless. Nevertheless, when he learned of his diagnosis he felt depressed and started heavily consuming drugs and alcohol until the year 1999, when he enrolled in a detox program with the help of his family. In the year 2000, Alvaro got a meningitis infection that put him in a coma for seven months. Meningitis is common in at least 10% of the population that reaches an AIDS phase.

When he learned of his diagnosis, Alvaro went to share an apartment in Cali’s red zone area with four women and two gay men in sex work who were party friends of his. He remembered this time as a very intense one. He told me he started selling *arepas* to bring in money for the apartment. He worked daily from Monday to Friday in the afternoons, and that allowed him to pay rent, get money for food, and most importantly buy drugs. He remembered having enough money to buy in a single day 5 grams of *basuco*, 5 grams of cocaine, half an ounce of marijuana, one packet of cigarettes, and a bottle of brandy. And brandy was essential, because he needed it for his good morning coffee the next day. Alvaro described the apartment as a *comunidad de consumo*

(community of drug use). He said everybody worked to keep on the non-stop party, which included a lot of sex too. I asked him if his roommates knew of his HIV-positive diagnosis and if they used condoms, and he said they knew and condoms were not used. He remarked that in the climax of consumption people did not care. In his words:

*yes, sometimes with and sometimes without it [condom], anyhow we kept on. When you are high you don't think about that. The thing is that when you consume too much basuco or cocaine, in the moment you have an erection you have to take advantage of it because often times it is hard to get an erection when you are high on those things.*

*Alvaro*

Alvaro told me he was the only one who was still alive from that group of roommates, and that while he was there everybody knew he and two more people were HIV-positive and the other ones did not care about it. He told me that when he learned about his HIV diagnosis he wanted to vanish. He never told his partner and the mother of his only son about it and he abandoned their household. He wanted to disappear, and he kind of did so by becoming a member of this *comunidad de consumo*. He told me that the mother of his son realized he lived with HIV because of medical paperwork he left at their house and even though they reunited later in life they never resumed their sexual life again; he said there was too much between them—fear, cheating, and of course his HIV-positive diagnosis.

When I asked Alvaro about his adherence to ART treatment, he told me he went to support groups where he had learned about the importance of being consistent with ART treatment, among many other things. He enjoyed attending the group sessions. He did not feel uncomfortable with the presence of gay men or trans-women, which deeply bothered some of the other men I talked to. Clearly, his own trajectory allowed him to fit in well in those spaces. Alvaro also valued his



son and found in his existence comfort, support, and a reason to live. His son knew very early on about his diagnosis and was one of the first people in his family to bring information about HIV to the household to avoid for example the use of different silverware for Alvaro. His son was always asking him about his medical appointments, and at all the critical moments related to his health his son was always present. His son was a father at the time of our interview and Alvaro's eyes shined when he told me how he loved to spoil his granddaughter.

After his HIV-positive diagnosis Alvaro found refuge within a community where HIV, sex work, non-binary gender expressions, and the use of drugs were not stigmatized. Finding out that you were HIV-positive in the 1990s had harsher connotations than today—back then it was more lethal. Thus, Alvaro's response was a way to cope with death. I can imagine him trying to make sense of his life and death in a utopia materialized in that apartment in downtown Cali, living with peers that had gone through exclusion, pain, and despair, and who were living at the margins of society. Their experiences of marginality allowed them to create strong bonds which translated to solidarity and support.

It seems to me that Alvaro spoke of this apartment as a Victor Turnerian *communitas* (Turner, 1995), a long and extended ritual of communion, sex, and intoxication where this group of people exorcised the biopolitics of AIDS, sexuality, and sobriety. Perhaps in this liminal period of his life, Alvaro and his *communitas* friends were also trying to cope with their imminent death, which eventually did come to everyone else, except him, who survived the rite of passage.

Alvaro's explicit sexual desire for trans-women also speaks to a well-described phenomenon in the Latin American masculinities literature (Fernandez-Davila et al., 2008; Sternberg, 2000) in which technically homoerotic encounters are culturally not assumed as gay when the man is the penetrator or, as in Alvaro's case, the other person involved is a trans woman.

The HIV biopolitical apparatus expects heterosexual men to disclose their homosexuality in order to be entitled to receive support. Alvaro's case shows that his life trajectories of sexual desires and openness to all types of genders allowed him to navigate more easily the HIV support networks and services than the other men presented here; however, his heterosexual identity denied him HIV preventive tests. Diagnosis in the early stages of HIV infection reduces the chances of people wearing out their immunological systems and of course of reaching AIDS phases, which as we have seen put people in harsh medical situations, oftentimes for months. But preventive conversations about the risks of HIV infection also make people more aware of their vulnerabilities to HIV and have the potential to prevent transmissions.

Alvaro, Carlos, and Juan all had lives immersed in the party scene where alcohol and drugs were keystones in building their personalities and masculine identities. The HIV biopolitics in Colombia rarely talk about the intersection of alcohol and drugs like cocaine or *basuco* and HIV. An emerging heroin epidemic is introducing intravenous drug use as another variable in the Colombian HIV panorama, as well as the open use of drugs in sex parties among MSM, known as chem-sex. However, these approaches to understanding HIV leave most of the male profiles presented here out of the picture, as well as substances widely consumed by men in Colombia, namely alcohol and cocaine derivatives.

#### **4.5 Building a family as a way to normalize a life with HIV**

*I see that my treatment is experimental; I say that my life is a science experiment; until now I have not met any person like me that has lived this many years with HIV.*

*César*

I met César in 2009 in the first Colombian meeting of children and teenagers living with HIV/AIDS in Colombia, held in Cali and organized by Fundamor, an institution in charge of taking care of children living with HIV/AIDS in Cali. Back then, a group of colleagues and I were in charge of producing the visual and written records of the event. This event was a landmark in the history of HIV/AIDS in Colombia because it was the first national conference that brought together NGOs, state bureaucrats, parents, and children and youth to talk about the future of a generation of children born or infected early in life with HIV who were becoming teenagers and adults. César was there, actively participating in many activities. He was talkative and open, and he seemed to be a happy teenager. César and I ended up meeting again by chance in 2013 through a social worker who referred us, and since then, we have stayed in touch. He was born with HIV; he became infected through his mother at birth. His mother died when he was two and his father when he was three years old, both due to AIDS, and since then his grandparents took care of him.

César was born in the '80s, early on when HIV meant AIDS and death, yet he was lucky to get ART treatment as soon as it was available in Colombia. César received constant support since he was a child, and very early in life, he understood the importance of being consistent with the ART treatment and how important it was to have high levels of CD4 cells and low HIV viral loads. He recalled how he learned that the virus was like a guerrilla that the CD4 army had to kill and keep in control—the analogy fit the context of the Colombian civil war. However, he told me he felt somehow overprotected and hyper-aware of his diagnosis while growing up. He remembered that thinking about love, sex, and family was not easy because of the omnipresence of HIV. For example, he told me that whenever he got a cut or a wound at school, he would avoid any contact with other people and tried to cure himself, because that was what he was told to do. He also said to me that he was very young the first time he felt his romantic life was affected by

the HIV diagnosis. At school, a girl asked him to kiss her, to which he responded, “I can’t, maybe another day, I have the flu.” He said he felt bad because the girl most likely felt rejected, but he even felt worse when he got home and realized in tears that had missed a big opportunity because of his HIV diagnosis. At that point, he was told that he had to be very careful with kisses because they could be a means of infection.

César is one of the few men I have been able to follow-up with and who has been willing to talk with me routinely over the years. He said to me the first time we met in the context of this project that he valued it because people needed to understand that HIV was not such a special condition anymore, like when he was growing-up. Almost since he was born, César received outpatient care from the foster institution Darío’s daughter lived in for 18 months. Children affiliated to this institution for years lived in a unique space of care where they received housing, care, good education, and good food, within a beautiful countryside landscape. A well-known wealthy family in Cali that led the project attracted good financial support to the cause, and children grew up in conditions that many times contrasted the socio-economic realities of their families. However, things became more complex when children started to become teenagers and eventually adults, challenging the foundation of the organization, which had emerged among many other institutions to provide the most humane death to people. This generation proved that ART was effective in prolonging the lives of children born with HIV.

After the death of his parents, César lived with his grandparents, who have been a tremendous source of support in his life. But he was intrinsically linked to the foster care institution: he would go to school there, had godparents who would give him economic support and gifts, and attended all the institution’s activities, including the one I met him at in 2009. And even though César had appreciation for the institution and the personnel that work there, he thought

that somehow the institution with its hyper-caring profile made children believe they were special, and he disapproved of that attitude. I remember that since I met César, he was always looking for a sense of normality. Since that first conversation we had he mentioned that he had always wanted to be a father and to have a family, and he made this desire clear to medical and institution staff, to which professionals reacted not in a completely discouraging way but not in a supportive way either.

When César was 14, he asked a doctor about his possibilities of becoming a father. He learned that it was possible through artificial insemination after getting his semen washed, and of course, he had to find a partner willing to do so. But he wanted to be a father in a “natural way, not in a scientific one,” he said. He tried to find a girlfriend when he was a teenager. Still, he always felt dealing with the diagnosis was very difficult; even though he tried to establish relationships without focusing on his diagnosis, he found it challenging to develop romantic relationships. For years, he was in love with the daughter of a woman living with HIV that he met in an event, and he thought she would have a better understanding of the situation. He tried, but the relationship never came to fruition.

*It generates very high responsibility and fear of infecting others; with the girl you like, there is a halt, it is the fear of affecting the other person's life. I think that to be accepted by a person it is a blessing. It is not easy to say to a person: I have HIV, do you accept me? There comes the risk, fear, controversy, about having or not having an HIV-positive partner; I was lucky because my wife lives with HIV too.*

*César*

In 2013, he was 26 years old; he was working in a communications company hired on yearly contracts. He had met Milena while he was working at a different place. She had moved to

Cali years before due to the aggravated illnesses of her daughter, and doctors advised her to stay, at least temporarily, so her daughter could access proper treatment. She decided to live in Cali. She and César fell in love and she became pregnant with twins after a condom broke. When they found out that she was pregnant, she was worried, and he was joyous. In the end, both decided to continue the pregnancy. Their pregnancy was not entirely supported by the medical staff, and they often felt stigmatized for taking the risk of becoming parents. Still, they went through the very straightforward medical protocol to avoid mother-to-child HIV transmission, and their twins were born HIV-negative.

Both admitted their relationship built more quickly because they shared a positive HIV-status, and it was reassuring for both of them to focus on their relationship rather than the tensions of diagnosis disclosure. César even pointed out that the achievement of having a partner and a family led him to embrace a “normal life.” He also decided to quit his desk job to enroll in a heavy-lifting job in a department store because he wanted to separate himself from the omnipresence of HIV. He also stopped going to an HIV-positive support network he had attended for many years. He wanted to feel he could go beyond the limits imposed by the HIV diagnosis and ART. He decided that ART and his HIV diagnosis would not be a barrier to do any job. The heavy-lifting job ended up being a source of exhaustion and César ended up being fired for his medical absences. César said that as soon as he got hired, there was a personnel cut, and there were not nearly enough people to do the 80 daily tasks, which took at least 30 minutes each, and he only had one more workmate. His monthly visits to the clinic were the reason for his firing.

César managed to build a family even while contradicting all the prognostics. The first time we talked he was ecstatic about his relationship with Milena—he was in love. The second time, 5 years later, he was focusing on the future of his daughters and told me about some difficulties they

were going through with his partner. He told me they had gone through a couple of very difficult health situations with his stepdaughter and Milena, both due to inconsistencies with ARTs. Both almost died at the hospital after reaching the AIDS phase. For a while, the three of them stopped taking ART. César and Milena believed the efficacy of ART was not proven, and they were concerned about ART's side effects. And furthermore, César had never experienced AIDS firsthand, which reaffirmed his position of not taking ART.



**Figure 6. Toys and ART, 2018. César.**

In this picture, César wanted to capture a new commitment he and Milena had towards ART. In the image there are a couple of plastic bottles with ART pills, a glass filled with water, and their daughters' favorite toys, the kind that children take to bed, on trips, and everywhere they can. César took this picture on a weekday in the morning after the two children had left to school, and he was about to take his daily ART pills. He said with some pain in his voice that they had to

learn this lesson the hard way. He said that during the four months that Milena was very sick, he did not know how he got through it because he felt he had to split into different selves; he had to be a father, he had to work, and he had to be at the clinic, dealing with Milena's health issues. They thought many times that Milena was not going to survive and the idea of raising the children without her made him feel very bad. Thus, when Milena recovered, they decided to take ART again in a sacred manner, for the sake of their children. They even visited *El Milagroso*, a statue of a black Christ that inhabits a catholic basilica in Buga, a town one hour north of Cali. The statue has been revered for hundreds of years and it is famous for conceding worshipers wishes and miracles. Thus, as soon as Milena could make a trip to Buga, the family, including these toys that appear in the picture, went to ask for the total recovery of Milena.

Relationships with ART are not easy. People have to take these drugs daily and for the rest of their lives, frequently coping with a gamut of side effects that range from nightmares to diarrhea to lipodystrophy (body dimorphism due to fat reallocation) to hepatotoxicity (intoxication of the liver). However, ART has evolved enormously in the last three decades and people today can take three pills per day in comparison to the thirty pills necessary in the '90s. Today ARTs are cheaper, more people have access to them, and every few years new treatments emerge that add to an already diverse set of options. When HIV-positive patients have access to an accurate ART cocktail that can effectively attack the reproduction of the specific strain of HIV that the person carries, it is expected that HIV viral loads get low and CD4 or white cells numbers increase. A person who reaches a count of less than 50 of viral load per mm<sup>3</sup> of blood is considered undetectable, and thus assumed to be someone who has the virus under control and is very unlikely to transmit the virus. People diagnosed with AIDS are considered to have fewer than 200 CD4 cells per mm<sup>3</sup> of blood and are considered to have a compromised immunological system. When I



met with Milena and César that Sunday afternoon, both were undetectable and their CD4s were on the raise. César wanted to take a picture about the meaning and value of the ART, because without these, as César said, there is no life.

César and Milena were two of the three people that agreed to participate in a PhotoVoice exercise to inquire about people's daily lives with HIV. The rest of male participants were reluctant to engage in taking pictures of themselves and their lives. Considering how hard it was for them to even arrange a meeting with me, taking pictures of themselves and leaving images or traces of their lives with HIV was too risky; it meant too much information out there. Nevertheless, César and Milena agreed to do the exercise. In the end it was César who took pictures, but both of them joined in the conversation around the pictures that he took. They had the camera for a month and we met at their apartment on a Sunday. We picked up a tasty roasted chicken in a nearby restaurant and had lunch together. Afterwards they shared the set of pictures with me over a couple of hours seasoned with an after-lunch coffee.

César was a devoted father. He invested most of his time working often from Monday to Saturday to provide money for the household, and whenever he had a bit of free time he liked to spend it with his children. Yet the long work hours and the family needs had absorbed him in a way that he had not expected and made him cut his ties with friends and social networks, like the one he had built with other HIV-positive people that were born with HIV. In one of the interviews we had, I asked him about his social life, and he responded that he had none, and added that he dreamed about being able to grab his motorcycle and go for a trip for days, on his own. He told me that things with Milena were not going very well lately, and that a separation was something that had been discussed. In fact, in 2019 when I was back in Pittsburgh, we chatted via telephone

and he told me that he and Milena had gone through a divorce. He told me everyone was doing OK.

#### **4.6 Undoing HIV's gender**

Juan, Carlos, and Alvaro, like the majority of men I talked with, never imagined that they could become infected with HIV. Juan, like almost every other man I talked to, never got a routine HIV-test prior to experiencing an acute infection related to AIDS such as TB, toxoplasmosis, or pneumonia, among others. Juan had to experience a severe case of TB to later know he was also HIV-positive. In Colombia, heterosexuality in HIV matters has been read as a safety barrier against HIV not only among the general population but also among medical and NGO staff members. Heterosexual men in Colombia are not “at risk” populations for HIV, and thus they are ignored by prevention measures, treatment protocols, budgets, and policies. It appears that HIV-positive heterosexual men are not only invisible to the biopolitical apparatus, but also are not considered deserving of receiving accurate and tailored care, which is very much needed.

As I showed in this chapter, most of the time these men end up ruminating on their questions and anxieties about how to live with HIV on their own, and refusing to take ART until they reach an AIDS phase, which is often the route of detection of their HIV infection to begin with. I often found that men awaken to the reality of living with HIV after an acute health crisis, often related with AIDS. What Carlos said about his initial denial to take ART because its daily intake reminded him of living with HIV is not rare. I have heard similar narratives from various men in different parts of Colombia. Sadly, facing near-death experiences seem to be a common denominator among men who are reluctant to seek treatment to embrace adherence to ART. After

this type of “shock therapy”, men often adhere to ART and also reformulate other behaviors that they believe are harmful.

Within this context, the appearance of an HIV-positive diagnosis in the life a heterosexual man is a bomb that arrives from nowhere—when men receive their diagnosis, they assume that death is around the corner. Often, it is the men’s mothers and female partners who are the ones that counterbalance the impact of the HIV-positive diagnosis through practices of care and love, allowing men to resituate and signify their existence and cope with the virus. For example, Juan’s mother, who, due to issues with addiction, was absent in his upbringing, invited him to live with her because of his diagnosis so she could take care of him and feed him well. Juan told me his mother was key in supporting and accepting his new life with HIV, and paradoxically, he said to me that thanks to the virus, they were able to reconnect after years of mutual absence, which he seemed genuinely happy about.

Throughout the stories of these men and women, it is clear to see that women become key care and support givers for men who become HIV-positive, even though men often react reluctantly to the diagnosis. In Colombia and Latin America more broadly, it is common to see women engaging in what some scholars have called *marianismo*, or gendered female practices of altruistic care based on moral and spiritual superiority cemented on men’s sexual misconduct (Dasen, 2018; Jarrett, 2011; Stevens, 1973; Wood & Price, 1997). The data I collected certainly reiterates this phenomenon. Gendered care coming from mothers and female partners exists and becomes key in counterbalancing the negative effects of men’s limbo situation in the current HIV-positive panorama, which does not give them a legitimate HIV/AIDS bio-citizenship due to their sexual orientation and gender status. Women often fill the gap that the HIV biopolitics in Colombia

have left empty for heterosexual men and, through care and support, manage to revert the men's falling into AIDS.

This liminal position for heterosexual men in the biopolitics of HIV/AIDS in Colombia leaves men without preventive testing. As I showed, men typically find out about their diagnosis when their immunological systems collapse and diseases such as tuberculosis or toxoplasmosis subsequently emerge, denoting that they are in an AIDS phase. This is unfortunate because the therapeutic technologies that exist today in Colombia to treat HIV can prevent patients reaching an AIDS phase. By the time heterosexual men are diagnosed in an AIDS phase they might have already lost valuable time to prevent their immediate death or future relapses into AIDS phases. Routine HIV-tests are key to transform HIV into a chronic experience because the sooner the diagnosis is made, the more life expectancy increases.

I argue that Colombian HIV biopolitics have to become ungendered. The data I collected for this research project resonate with other research that clearly states that HIV also affects heterosexual men (Higgins, Hoffman, & Dworkin, 2010; Kou et al., 2017; Robert Wyrod, 2011), and thus in order to achieve effective public health policies, heterosexual men should be included, with the acceptance that heterosexuality is part of a fluid gender spectrum and that there are other risk factors for HIV infection among heterosexual men, like drugs and alcohol.

Furthermore, when heterosexual men get to know their HIV-positive diagnosis, HIV-clinic protocols and support networks do not meet their needs, desires, questions, and experiences. In fact, there seems to be a halo of suspicion and doubt among a majority of health and NGO staff members about the true sexual orientation of heterosexual HIV-positive men, and this mistrust just digs deeper the abyss that already exists between heterosexual men and sexual and reproductive healthcare services.



**Figure 7. One of the many Hector Lavoe murals in Cali. Laura Puerta, 2020.**

The men I talked to grew up in contexts in which masculinity means heavy drinking, having sex with different sex partners, and using drugs, all aspects connected to Cali's *rumba* (party) scene and to routes of HIV infection among the vast majority of heterosexual men I talked to. Cali's aura of a city of pleasures permeates the ideas and praxis of masculinities to the *quebradores* side of the spectrum, to use Colombian scholar Mara Viveros' terminology, which refers to womanizing men, but in this case with added layers of parties, drugs, and alcohol. A city hero, the Puerto Rican salsa singer Hector Lavoe, who spent time in Cali and who is known for his depressing songs, abuse of drugs, endless partying, suicide attempts, and death due to AIDS, is omnipresent all around the city. He exists all around Cali in murals and as a ghost; people always talk about a time they saw him, a time they partied with him. The *salsero* masculinity roles of the '70s have

impregnated Cali and its men, and many of the behaviors associated with it have connected men's lives with HIV.

Moreover, the privatized healthcare system that now rules Colombia has eroded more communitarian ways of coping with HIV, where for example support groups were key for HIV patients to exchange information and mechanisms of survival. This communitarianism, which oftentimes was centralized in public infrastructure, has been replaced by fragmented clinics where attention is vastly focused on adherence to ART, and nothing more.

Finally, HIV represents a large rupture in men's lives, though its affective discomfort and death mirroring effect creates spaces for men to reflect on their life trajectories and the uncanniness of its presence, and sometimes becomes a detonator of new pedagogies about their bodies, sexualities, and relationships. However, this only happens when men are able to translate HIV into a more comprehensible experience and yet most of the times men cannot do it on their own.

## **5.0 HIV-positive heterosexual men in the eyes of their female partners and HIV professionals**

In this chapter, I examine in more detail the voices of health care and NGO staff members in regard to heterosexual HIV-positive men. Heterosexual HIV-positive men in Colombia appear only tangentially in the narratives of HIV experts and when they do, often illuminate the frictions that men's heterosexual HIV-positive status pose to a trajectory and history of HIV policies that do not recognize their existence and their specific needs. The HIV biopolitical apparatus in Colombia often uses the MSM acronym to describe males' sexual fluidity and to simultaneously tackle what is considered the riskiest sexual intercourse practice, unprotected anal sex, often wrongly ascribed solely to the homoerotic realm. Even though in a practical sense MSM covers heterosexual men who have sex with men, it does not fully acknowledge the cultural construct of Colombian heterosexual masculinities. In my research I found that NGOs working with women and families are closer to an understanding of HIV-positive heterosexual men compared to the medical apparatus and more traditional gay-oriented NGOs.

In the previous chapter I presented the narratives of men as they recalled the ways in which they received the knowledge that they were infected with HIV. One of the key themes in that chapter was the ways in which their HIV-positive diagnosis affected their lives and relationships with women they were romantically involved with. In this chapter, I examine the narratives of women who, along with their partners, received the knowledge that they were HIV-positive through pregnancy and prenatal care. I decided to highlight this moment given the high frequency heterosexual men and women in Colombia realize their HIV-positive status through pregnancy, but also because of the social implications and powerful social meanings of pregnancy and

HIV/AIDS converging into dynamics of family formation. HIV in this context acts as a force of chaos, distress, and despair, creating new affective dimensions which question, undermine, and sometimes promote changes among men and their masculinities. Furthermore, the narratives of women and partners of HIV-positive heterosexual men present a more intimate look at the experiences of HIV-positive heterosexual men that highlight women's crucial roles in supporting these men with coping with their HIV diagnosis.

### **5.1 *Machos* live their HIV-positive diagnosis in silence**

The perspectives and narratives of health professionals and activists on heterosexual men living with HIV provide pieces of the puzzle of how heterosexual men react when they get to know their HIV-positive diagnosis, routes of infection, and cultural and structural issues that create barriers for heterosexual men to embrace their diagnosis in more positive and healthy ways. Throughout conversations, some professionals did stick to the idea that heterosexual men acquire HIV solely through sex with other men, while others gave space to the possibility of women as the source of HIV transmission. Some professionals touched on family dynamics and the role of men and HIV, while others touched on the importance of recognizing the flexibility of sexual behaviors among heterosexual men, which often includes undisclosed sex with other men. Heterosexual HIV-positive men appeared in professional's narratives in diverse ways but often through their family ties or their bisexual behaviors, not as a population with specific needs and characteristics. Alcohol, drugs, and sex work still emerge as pivotal variables that intersect with HIV infection among heterosexual men, as well as structural aspects, such as poverty and violence.



In 2014 I talked to Yessid, the psychologist of *Fundamor*, a foster care institution located in Cali specialized on children living with HIV. Yessid and I talked about an assessment on parenting HIV-positive children made in six Colombian cities and led by *Fundamor*. Yessid traveled around Colombia talking with mothers and fathers living with HIV, and he told me that even though the majority of people he interacted with were women, he was surprised to encounter self-identified heterosexual men in each one of these cities taking care of their children in ways that he described as maternal and caring. Yessid clarified that when he encountered couples that were together, women often assumed a more important role in interacting with NGOs, health staff, and support networks, while men were in the background, present but not engaged, and many times not even coping well with their own HIV-positive diagnosis.

However, Yessid highlighted that most of the men he perceived as engaged in their parenting role were usually single fathers. Yessid hypothesized that the crisis of being alone with offspring pushed men to reshape their ideas of household, care, and fatherhood. The death or the absence of these men's partners reconfigured in drastic ways their gender roles and even pushed men to assume maternal roles. Instead of checking out, as assumed by the *macho* stereotype, some men cling to alternative articulations of gender that include parenting. Gutman, in his research on working-class urban Mexican masculinities (Gutmann, 1996), finds similar patterns in less extremes contexts when men are for example simultaneously at work and taking care of their offspring. What Yessid found also resonates with my own findings. In my research I encountered three single fathers who, due to the absence of their female partner, reconfigured their gender roles and became caring and maternal fathers, such as Darío, who I introduced in the previous chapter and who has an HIV-positive child and lives in Buenaventura.

Yessid told me that heterosexual men struggled to fit in the HIV world because attention in Colombia for HIV-positive families circles around mothers. This fact, according to Yessid, made men feel like outsiders with no right to receive services or ask for answers or help. Yessid told me that men were in clear need for judgment-free information, but many times when they approached HIV services, professionals were distant or even rude to them. Anthropologist Carina Heckert (Heckert, 2017) found that heterosexual men in Bolivia struggle to reach HIV services because monolithic ideas of heterosexual masculinities anchored in *machismo* stereotypes act as a deterrent for men to approach healthcare services, and vice versa. Studies have shown how marriage in some Latin American contexts represent “the single greatest risk for HIV infection among women” (Hirsch et al., 2007, p. 986) because marriage means a construction of trust where infidelity is rarely discussed, and men assume that not disclosing affairs is a way to protect and respect their partners. So, one perspective, and I believe the most broadly accepted one, is that love is an HIV-risk for women, and under that logic men are commonly depicted as victimizers.

What Yessid shared with me in our interview fits well with what I have found in years of research on HIV in Colombia. Men are treated poorly because they are commonly suspected of infecting their female partner and families and thus are seen as foci of disease and corruption, as research on HIV in Mexican men immigrating into the US (Hirsch, 2009) and truck drivers in Brazil (Lippman et al., 2007) has shown. In this sense, many times I saw health staff members and NGOs taking the side of women and putting men in a difficult position to ask for support. Paradoxically, when *machismo* intersects with HIV it serves as an element that strips men from their privilege and functions as a marker of stigma, which puts heterosexual HIV-positive men in a not-deserving-of-care category.

In repeated occasions I talked with HIV-activist Ligia Lopez who directs Casa Gami, an NGO based in Cali which for two decades has worked with women and families living with HIV in Cali. Ligia told me that in the '90s she started organizing support groups for women because this specific HIV-positive population was growing and the organizations that existed back then were tailored more or less solely for gay men. She lives with HIV and when she realized she had the virus she quickly found that HIV-positive women like her had very specific needs, questions, and issues that were not fulfilled by the existing grassroots organizations and medical protocols. Thus, she decided to create Gami.

I asked her about changes she had noticed in regard to the HIV epidemic in the last two decades and she said that access to ART and the reduction in the number of daily pills—from 30 in the '90s to 3 today—has been critical to improve the lives and the adherence to treatment of people living with HIV. Ligia also said that another key transformation was the protocols to avoid mother-to-child HIV transmission, which have changed the lives of women and families all over Colombia. However, she highlighted that access to healthcare services was still problematic because of delays, poor quality, and the patient's lack of access to accurate information on how to live with HIV.

Ligia told me that working with women automatically involved working with their families, including their male partners. She knew many heterosexual men living with HIV, and she said that even though the majority of the time men were the ones who brought HIV into families, in some cases women too were responsible for bringing HIV into their families. She reported that heterosexual men did not seek information or support when they received their HIV-positive diagnosis and were often reluctant and reserved. Heterosexual men wanted to remain in anonymity at all costs, she said.

She said that *machismo* explained a lot of heterosexual men's behaviors towards HIV, especially because they don't want to be told what to do with their lives and because they believe they can handle everything on their own. She even highlighted that some men did not like their partners approaching Gami because they did not want their partners to become empowered and start requiring the use of condoms, for example. Somehow men wanted to expand their isolated HIV experience into their partners. However, she also said that living with HIV required having a lot of time to be able to do everything that is required to be healthy. She emphasized that if you are working, you need up to five or six excusals per month to deal with therapeutic and bureaucratic itineraries.

*you have to fill out forms, bring them to the office, then you have to pick up forms, go to the medical appointment, go and pick up the drugs, and come back when the formula is incomplete, go and take the blood samples for the CD4 and the viral load. And nothing is centralized, one thing is here, and the other one in another part of the city; see, it is not only time, it is money too.*

*Ligia*

Ligia also told me that many of the encounters her NGO had with heterosexual men were mainly with men looking for access to ARTs that the healthcare system did not provide due to bureaucratic issues, or because they needed help with legal writs to access healthcare services. She added that the ones who participated in activities or support groups were rare. "*Men are always busy, they are not available, and they don't have the desire, they just want everything to be done from afar, with distance,*" she said, and ended her idea rhetorically asking me if I knew a single heterosexual man who had a role of leadership in the HIV scene in Colombia.

For Ligia, heterosexual men and women, but especially men, preferred to be anonymous. She felt that heterosexual men did not want to be recognized as people living with HIV, nor to share their diagnosis with their children or family. In her words, men lived their HIV-positive diagnosis alone in silence. For Ligia this experience was painful because men were not able to be open about their anxieties nor to grasp useful information, which would improve their HIV experience.

Ligia also told me that when HIV hits both members in a couple, women often end up assuming the care of their male partners who often don't want to cope with the diagnosis, and men end up being a burden for women. But again, Ligia also emphasized that structural factors in the Colombian healthcare system prevented men from engaging in more responsible ways with their health. She saw the system as not empathetic to the sorrows and pains of men. Plus, she said, there are no reproductive health programs tailored for men, adding that the healthcare system should be more supportive of men because their absence affects families in many negative ways.

In 2013 I met with Carolina, the psychologist of the Hospital Universitario del Valle (HUV), a public institution that still resists the aggressive process of privatization of the Colombian health care system. The hospital is an epicenter for health care in the Valle del Cauca state and the Colombian southwest and is intrinsically linked to the schools of nursing, medicine, psychology, and rehabilitation of the Universidad del Valle. The hospital used to have a robust HIV program that largely provided services to the poor; however, it lost clients due to the process of privatization of the Colombian healthcare system. Today the HUV's HIV services focus on providing services to patients with AIDS, and to those who do not have health insurance coverage.

In our interview when I asked Carolina about a significant change in the HIV epidemic in Cali, she mentioned that there was an increase in HIV-positive diagnosis in youth between 14 and

18 years old and people over 60 years old. She said that these new trends in the epidemic were due to the increase in the promotion of testing among populations that were assumed to not be sexually active or at risk. Carolina highlighted that many of the men over 60 acquired the HIV virus through unprotected sex with female sex workers.

Carolina told me that HIV among the heterosexual population represents challenges because this population is not considered vulnerable, and are thus outside the epidemiological vigilance radar. She said furthermore that the lack of heterosexual individuals in the HIV political and activist scenes also made them more invisible. Regarding men, she said that it was hard to know if they were truly heterosexual or if they were in fact bisexual. She added that, in her experience this was true for approximately 20% of the men she worked with, who initially presented themselves as heterosexual and, later in the process, disclosed bi- or homosexuality. I asked her later how she thought the other 80% of self-identified heterosexual men became infected. She said that she and her team often had doubts about their heterosexuality, except for a few men for whom the heterosexual transmission was clear. I asked her about intravenous drug use and HIV infection, and she said that to date they had only had one patient report becoming infected via needles, but she believed the patient had so many risky sexual encounters that sex was the likely cause of his infection.

Here heterosexuality once more was seen by Carolina as a stable category. We know, however, that heterosexuality is flexible, for example due to economic pressure, as Padilla shows in his work with Dominican heterosexual men who engage in homosexual work with tourists (M. Padilla, 2007). Homoerotic sexual desires can of course also be driven by appeal and experimentation and can be short or long-term. The thing is that heterosexuality at its intersection with HIV is still considered under a black and white perspective. On the one hand, heterosexuality

is assumed to be an effective safety barrier against HIV, but as with any taboo, when broken it can bring about a malignant outcome, in this case, disease. On the other hand, the HIV-positive man is a bisexual hidden behind a heterosexual mask. However, by understanding heterosexuality as flexible, perhaps HIV epidemiological radars can improve their efficacy. Ideas of using the term heterosexual active men or MSW might provide options to move forward the understanding of more flexible heterosexual masculinities but usually these terminologies focus on sexual encounters and forget about the whole other dimensions of gender that exists beyond sexuality.

Carolina and other HIV specialists pointed to new populations of young gay men that were becoming infected with HIV whom often knew a lot about HIV and surprised clinicians with a stoic attitude towards the HIV diagnosis, which experts linked to a hyper familiarization of the male gay community with the HIV epidemic and a younger generation blind to the catastrophic scenes of AIDS in the '80s and '90s. In sum, for experts, the urban young gay scene saw HIV as a treatable chronic disease. In fact, many were asking for pre-exposure treatment for HIV (PrEp), still not available in Colombia at the time, through health insurance packages.

In 2018, I had the opportunity to talk to Diego Correa, a well-known HIV scholar and psychologist from Cali who has done extensive work on HIV in the city since the beginning of the HIV epidemic in the '80s. He recalled receiving initial training from Manuel Velandia, one of the most famous Colombian HIV and gay rights activists, mentioned in a previous chapter. As Velandia did in Bogota, Diego teamed up with a nurse and a lawyer and created a grassroots organization, Fundación Proyecto Vida (FPV), the first institution in Cali created to support people living with HIV/AIDS. The project lasted for 14 years and was key in the Colombian southwest, and many people talked about it while I was doing fieldwork. Diego told me FPV provided legal support, a sense of community, and information for people living with HIV. Diego recalled that

the nurse, an expert in palliative care, shared valuable techniques with patients, friends, and family members on how to deal with ailments of patients in acute AIDS conditions. FPV also imported ARTs into Cali from donations made in the US at a moment in which these drugs did not exist in the Colombian market.

Diego told me how FPV became not only a space to support HIV patients but also an organization to make Cali's gay community visible. For example, he told me they held an annual party to collect funds for FPV which they hosted in *Romanos*, a gay discotheque in which, prior to the '90s, men would get randomly arrested by the police. After FPV began doing their annual party there, the bar not only attracted the male gay community but also curious heterosexual people willing to 'explore' the gay world. Diego told me that doctors, psychologists, and public figures saw these parties as opportunities to sneak into Cali's gay underground scene. In this sense, as presented in the theoretical chapter on masculinities, the organization functioned as a nexus for pushing forward the HIV and gay rights agenda in a symbiotic move which benefited the HIV and gay movements, simultaneously framing a link between the virus and the gay community that is hard to disentangle up to the present.

Diego also recalled that they held workshops for men who, in his words, had difficulties in accepting their bi- or homosexual orientation because they saw their HIV-positive status as a punishment for their sexual orientation. These workshops, Diego said, were designed to allow men to thrive in their true or new sexual identities without assuming that their HIV-positive diagnosis was a punishment for their sexual orientation.

Diego was also part of the HIV professional team at the HUV. He told me that in 1995 he started seeing a significant influx of women into the hospital's HIV program and he recalled that 8 out of 10 of these women were stay-at-home partners and the other two were sex workers. The



team decided to ask about the route of infection of the housewives and the majority of these women reported that the sources of infection were their male partners. When they explored further, alcohol and substance abuse emerged along with extramarital sex, not only with women but with men too. Diego told me that women often believed their male partners were cheating with other women, but they many times found that their men in fact had undisclosed sex with men, which ended up being even more devastating for the women who often suspected of their men's cheating but not always with whom.

In 1995 FPV opened its doors to cisgender and trans-women and the group went through an important reshaping in which all members created a space of solidarity. Diego told me the space became a liberating one for heterosexual women, who found in it a place to openly discuss and recognize abuses and causes of unprotected sex with their male partners and in which they learned how to cope with HIV. This group received the nickname The Immortals, according to Diego, because their death rate was very low. FPV ended its activities in 2008 in a moment in which the HIV grassroots movements was losing strength and funding because HIV started to be seen as a chronic, non-mortal disease, a fact that left many HIV grassroots organizations without funding. At the same time, many iconic HIV programs held in public hospitals dissolved into many smaller ones which belonged to private insurance companies.

I asked Diego about the intersection of men, heterosexuality, and HIV. Diego talked about the fear of not being able to be a parent among newly HIV-infected people and highlighted that even though this anxiety was more common among heterosexuals, it was also a growing concern among gay men. He even mentioned that some of his gay male patients have attempted artificial and non-artificial insemination with surrogate mothers to achieve fatherhood. Among heterosexuals, he said that stable couples, even serodiscordant ones, were very often inconsistent

with the use of condoms. He said many factors were involved in that decision. He mentioned erectile dysfunction (ED) was common among men after the diagnosis, thus non-condom use served as therapy against ED. He also mentioned that couples found in the disuse of condoms a sense of trust and intimacy, a perception that is mentioned in the literature (Flood, 2003). Diego even mentioned that many women explained to him that they did not ask for protected sex with their partners because they wanted to keep them close, and not using condoms prevented them from having sex with other people. Diego also highlighted that the perception of the effects of the virus has changed dramatically, and the fact that people today often thought of it as a chronic disease made people less aware of virus. He and most clinical specialists I talked with highlighted how young gay men did not see the virus as deadly or even as a dangerous menace. He said they just saw people who have lived with the virus for over 30 years and have kept normal lives, so they felt the virus was not a menace to their lives.

At the end of our conversation, I asked Diego specifically about the role of heterosexual men in the HIV epidemic in Cali and he stated that heterosexuality is just part of the spectrum in the gamut of human sexuality. He pointed out the case of a 60-year-old heterosexual man who visited him at his office and told him that, through a casual and non-planned experience in a sauna of a hotel in Bogota, he discovered for the first time pleasure in homoerotic encounters and he was negotiating how to embrace this new aspect of his life. According to Diego, Cali is a bisexual city, and he believes that most of the transmissions of HIV among heterosexual men happen via sex with other men.

Throughout these narratives of HIV health professionals and NGO experts, it is possible to see that heterosexual men living with HIV appear in the panorama only tangentially, usually as outliers. Diego and Carolina point out the hidden bisexuality of heterosexual men, an aspect

broadly explored in the Latin American literature, especially with respect to HIV. Their narratives bring up the complexities of bisexuality among heterosexual men, especially when it is a hidden behavior, demonstrating that in fact bisexuality is an active bridge between the MSM HIV epidemic and the heterosexual HIV epidemic. Their narratives also give space for the existence of heterosexual HIV-positive men, but little is known about them because they exist in a liminal zone in which their heterosexuality is not fully recognized and in which medical expertise has little to say unless men disclose their bisexuality.

On the other hand, through their work with HIV-positive families, HIV activist Ligia and psychologist Yessid found heterosexual men active within their families but not very engaged in seeking help, information, and support, unless they were left alone with their offspring. Their narratives highlight the outsider position that men inhabit, often assuming self-destructive or bare minimum attitudes that harm them and their families. Ligia and Yessid's perspectives recognize that it is hard for men to embrace their diagnosis within HIV machinery specially designed to support mothers and children. Ligia mentions a key aspect that especially affects poor people living with HIV in Colombia: lack of time. She highlights the struggles of HIV-positive people to go to medical check-ups, be tested, and pick-up ARTs. Ligia highlighted that working-class jobs are characterized for extended and rigid time schedules which create obstacles for adherence, even more so when HIV carries a big stigma that does not allow patients to be open about it.

Ligia's point highlight an important aspect of the idea that HIV as a chronic disease is challenged by heterosexual people living with HIV in Colombia. There is agreement that chronic diseases require constant access to healthcare and treatment in order to be controllable. Without constant access to ARTs, medical check-ups, and exams, HIV becomes a menace to the lives of HIV-infected people and thus loses its character of chronic disease. Furthermore, in order to get

their lives back, people need access to time and relief from social duties to take care of their health, but to gain this time, social disclosure is a must (McGrath et al., 2014). In Colombia this social recognition is untenable for the heterosexual population, and especially men, who do not disclose their HIV-positive diagnosis for fear of being labeled as gay.

Moreover, professionals are not completely aware of the heroin epidemic and its intersection with HIV. Many professionals do not see intravenous drug use as a risky behavior for contracting HIV/AIDS. This is connected with the history of the HIV epidemic in Colombia, where transmission has historically taken place through sexual contact, mother-to-child transmission, and, in the early stages of the epidemic, through blood transfusions. Epidemiological data on injected drugs is also very scarce and hard to find in the country.

Anthropology has started to contest the widespread idea of the “end of AIDS” among biomedical, public health and popular discourses. This idea is anchored in the development of pharmacological technologies that undermine the life span of the HIV virus. However, critiques show that this idea obscures different realities among communities around the globe (Sangaramoorthy, 2018a). According to the 2020 UNAIDS fact sheet,<sup>15</sup> at the end of 2019, only 25.4 million people out of the 38 million living with HIV were receiving ART. Life expectancies of those living with HIV under ART are expected to increase by a decade, and many times people reach close to normal life expectancy (Nakagawa, May, & Phillips, 2013). The development of ARTs and its massive production and marketing fueled by international policy efforts simultaneously prompted decreases in funding and political support for HIV prevention efforts in

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<sup>15</sup> <https://www.unaids.org/en/resources/fact-sheet>

low- and middle-income countries (Kates, Wexler, & Lief, 2019), which coincides with the 2010s crisis of HIV grassroots organizations in Colombia that many HIV activists mentioned to me.

In her research with older HIV-positive women in the US South, Sangaramoorthy (Sangaramoorthy, 2018b) shows that in the context of a rich country where access to ART and care are more or less stable, aging and comorbidities, often induced by years of ART intake, blur the chronic experience of living with HIV. She says that women report a shrinking of the future due to their age and the permanent coexistence of chronic and acute diseases. I argue that something similar happens to heterosexual men living with HIV, regardless of their age. In this case, the blurring of chronicity happens because of these men's isolation from support and medical networks.

## **5.2 Testing positive for pregnancy and HIV**

Pregnancy is a common scenario in which heterosexual men and women find out their HIV diagnosis. I focus here on the narratives and perspectives of women because of the nature of pregnancy, as well as to approach how women see their male partners when HIV becomes part of blood and family ties.

I met Doris at an HIV clinic. She was referred to me through a head nurse, a member of an HIV clinic supportive of my project, who was willing to convince patients to talk with me. Since I first met Doris, she was open to talking. That day she had managed to leave her one-year-old daughter and her older son with her mother-in-law, so she was in a rush—she had to arrive in time to make lunch and give her mother-in-law enough time to go take care of two other grandsons.

Doris invited me to go with her to pick up her ARTs at the health insurance pharmacy a few blocks away from the clinic. In the pharmacy, after passing an entrance with a private guard, we entered a two-story house transformed into a clinic. We went to the 2nd floor, and Doris handed her paperwork through a small window. The pharmacist knew her and told us to wait a few minutes. We waited. After several minutes, Doris was called and informed she could only get half of the ARTs because there was a mistake in the form. Doris was furious with the nurse at the clinic; she told me that this was not the first time the same error had happened. We ran back to the clinic, got the form corrected, went back to the pharmacy, and waited more; almost two hours later, after our initial trip to the pharmacy, she got all the items in the prescription. The plan of having coffee and conducting the interview failed, yet she told me that I could visit her at her place another day to talk with ease.

I visited Doris a few days later in the house she shared with her partner, her mother-in-law, her two children, a dog, a turtle, and a parrot. Her apartment was the second in a three-story self-built house. Her oldest child was at school, and the baby was in a crib. We had coffee and pastries while we talked. Doris was anxious about the 18-month HIV test results of his daughter, which is the age in which children born to women living with HIV can get a definitive diagnosis due to transferred maternal HIV-1 antibodies, which may be detectable in the child's bloodstream until 18 months of age. Her delivery happened very fast and she did not go through a c-section, which is what the medical protocol for HIV-positive mothers giving birth establishes. However, she took ARTs for five months prior to giving birth, and the baby received one month of ARTs after being born. In 2018 her daughter was one year old and looked healthy. Here is how Doris described her baby's delivery, and the medical violence she went through.

*When they put me there, her little head came and the rest of the body did not want to get out, and the doctor said to me: push, push, but he didn't tell me 'I'm going to go up on you' or anything. And then he jumped on me and I screamed, I don't understand, and she came out and they very quickly cleaned and bathed her. And they immediately threw all those sheets in the garbage; they threw all that away! I could not see my daughter right away, but I know I saw her without blood.*

*Doris*

Doris's experience at the maternity ward speaks of medical personnel that were not prepared to deal with a delivery involving an HIV-positive mother. The violence to accelerate the process and the immediate disposal of sheets shows that after years of dealing with the HIV pandemic, the Colombian medical staff still needs more training in the matter.

Doris's partner was a truck driver from Cali. They met in her hometown located in the middle of Colombia. They fell in love when she was in high school and afterward moved to Cali. She was completely sure her partner infected her with HIV, even though he had not gotten tested. He had been her only sexual partner since they were together, and when they had their first child, she got a prenatal HIV test with a negative result. Doris told me two factors prevented him from getting tested. One was that they belonged to the *subsidiado* (the equivalent to the US Medicaid). Because they had moved from another city, the system had not updated their new residence status, leaving her husband without access to healthcare. They were waiting for the SISBEN (the Colombian welfare entity) to visit their house to give them a poverty stratification number, and Doris was anxious that they might qualify for the not-so-poor criterion, which implies high co-payments. The second factor for his reluctance to get the HIV test was his guilt; she knew he infected her, but whenever the theme emerged, he refused to continue the conversation. Doris tried

to convince him to talk to me, but after several attempts, she told me he was not interested at all. In 2019 via telephone, Doris told me she was very happy and relieved that her baby had tested negative for HIV in her 18-month test, but with a tone of resignation, she said her partner still had not gotten tested for HIV.

Doris' partner's reluctance to get tested shows the difficulties that heterosexual men have in accepting an HIV-positive diagnosis. In this case, the healthcare system bureaucracy created clear barriers that did not allow this family to have immediate access to services after moving. However, and paradoxically, in Colombia an HIV-positive diagnosis is a quick way to have access to health care because the constitution states that every citizen has the right to receive treatment for HIV/AIDS, but Doris' partner was in denial of his diagnosis. He had not gotten tested, even though Doris begged him to do it, especially for their daughter and her future. Doris told me that there was not even a chance to talk about it, and when the topic emerged he became distant and non-talkative. Most likely, Doris' partner will need to go through a health crisis to open up to discussing his diagnosis and treatment, which is a tremendous loss of time in medical terms, because the longer HIV-positive patients live without ART, the greater the chances of wearing out the immunological system. Doris was afraid of a sudden health crisis of her partner and even his death. She cared for him and his absence would deeply disrupt the economic and emotional stability of her family. She wanted to become a transit police officer because it is a well-paid job with good benefits and salary, but she did not have the time or the money to begin the process. She depended fully economically on her partner, and that worried her a lot.



### 5.3 Johana

I met Johana through an NGO, and she told me we could meet after one of her medical appointments. We met at an HIV clinic located in the Edificio de Colores (the Colorful Building), which holds all sorts of medical offices, stores, and businesses in the fashion of a shopping center. The building is located in an upper-middle-class neighborhood which is rapidly transforming into a health services area in Cali. After we met, we went to a park nearby, grabbed a coffee, and sat on a bench. Johana found out about her HIV diagnosis a few months after her second daughter was born. The baby got a nasty flu; when she took her to the hospital, she was told that her daughter had a minor virus, yet Johana suspected it was something more dangerous. However, they were sent back home with lots of drugs. Days later, the baby got worse and refused to eat anything. She rushed to the ER and the baby was hospitalized and diagnosed with pneumonia, and subsequently was tested for HIV. Her daughter was 8 months old, and Johana 20, when she learned they both lived with HIV.

As soon as she and her daughter were tested, she called her partner. The moment was tense; she told him he had to rush to the hospital. He asked her what was wrong, and she answered that their daughter had tested positive for HIV. He hung up and arrived minutes later, and she remembered looking at him with hatred because she knew he had cheated on her—she had suspected it for years.

*So I said to him: who knows what you did, and now, look how we are. I don't care about myself, I care about my girl, look how she is. They told me she was in very bad condition and that there was no hope for her life. So I said to him that I didn't want to know anything about him, that it was better for him to leave so I would not do something I shouldn't.*

*Johana*

Johana's partner panicked, felt guilty, and left her dealing with the situation on her own. However, days later he came back and told her they needed to be strong and together. He was tested and found out that he was positive for HIV. He later told her that as soon as he left the hospital, he thought of committing suicide. Their child had to struggle for her life for six months. He admitted to her that prior to knowing her, and while they were together, he had an active sexual life with multiple partners, and he recognized that he was the one who infected her and their child. He used to drive a jeep in Cali, a kind of refurbished car converted into vehicles to transport people. These vehicles are part of the landscape of Cali and connect downtown Cali with marginal and impoverished neighborhoods along with surrounding towns. He told her that as a jeep driver, he used to visit brothels and that one of them got shut down because of several HIV cases; he might have become infected there.



**Figure 8. Cali's Jeeps. Edilberto Velasquez 2018.**

After the diagnosis, their relationship changed, and their love fell apart. They tried to keep the relationship going but it did not work; later, they separated. He moved to Buenaventura, where he worked driving a jeep again; there, he stopped taking the ARTs. According to Johana, he was a caring father. Still, many times he did not send money to their children as a way to exercise control over her because she had engaged in a new romantic relationship. Johana was struggling with adherence herself; she had changed many ART schemes and doctors had told her she was taking the last available one.

Johana decided not to disclose her diagnosis to her new partner. She told me it was a difficult decision because she anticipated he would not support her. At the time, they had been living together for four years. Her daughters liked him and he was a caring stepfather, but once, one of her daughters had a homework assignment related to HIV/AIDS and asked him several questions on the topic. Her partner thought HIV was transmitted by sharing cups or food utensils, that it was an airborne disease, and that people who lived with it had skin pustules. Finally, Johana also revealed to me that things were not very good between them and that they might break up soon, so there was no positive aspect in telling him about her diagnosis.

In this case, as in many others I knew of, HIV cornered heterosexual couples into situations of despair where the possibilities to get accurate information, mental health support, and counselling were almost inexistent. Couples had to deal with HIV on their own with the resources they had, and in many cases their resources were limited to silence and fear. This added pressure to already complex situations, in which men embraced roles of abandonment and self-destruction, reinforcing cycles of what scholars have called toxic masculinities.

## 5.4 Milena

I met Milena through César, a man who was born with HIV and who appears in the previous chapter. We met in a chain restaurant inside a shopping center in Cali and we spoke over ice cream. She and César had a family composed of three children, two together and one from Milena's previous relationship. Milena grew up in a town in the Colombian coffee-growing region. When she was 12, she became pregnant. The father of the baby was 21 years old and was a thug involved in crime. When we spoke about their age difference, she recognized that an older man had brought her into an abusive relationship. Even though her parents reported the situation as a rape to the local authorities, Milena went on to live with him, and he was not prosecuted. She learned of her HIV diagnosis when she was 14 and her daughter was one year old, when and the child was going through constant bronchitis and pneumonia. A doctor from Cali, who was doing his medical internship in her hometown, suspected something else was going on and ordered the HIV test, and she and her daughter tested positive. She said the diagnosis was like a bomb; she thought it meant death, and she even stopped going to school.

*I was very young at the time I was diagnosed, so that word meant to me death [...] I stopped going to school—why would I go if I was going to die? I thought I was going to die the following month or the next year. So, for almost ten years I partied a lot, I drank, I smoked, I did not care, because I always thought I was going to be dead soon.*

*Milena*

The father of her first child learned of his diagnosis at the same time Milena and their daughter did. Still, he always denied the diagnosis and was reluctant to visit the doctor or take ARTs, and he encouraged Milena to do the same. He knew he could die anytime because of his line of work, and he thought HIV simply represented one more life threat; thus, he decided to keep

on abusing drugs and alcohol and partying while paying little attention to his health. For the almost 15 years he knew about his diagnosis, Milena thinks he took ARTs for only three months. He never got used to these; she told me he said they made him sick. When Milena was 16, another young woman, who she later realized had had a long and simultaneous relationship with her partner, died of AIDS, and Milena thinks that was the route of her infection.

Milena never got tested for HIV while pregnant. When I asked her why, she told me with some hatred that doctors in that town did not do these tests, and furthermore they assumed she was safe because she had only had one sexual partner, who was her current partner at that time. He never went with her to the medical check-ups, never got interviewed and doctors assumed there was no risk for HIV. This is very sad since by that time Colombia already had well-established protocols for HIV-testing among pregnant women. Thus, what we see here is the intersection of a weak rural healthcare system which wrongfully assumed this heteronormative family was safe, despite Milena's age, which should have raised all kinds of red flags.

Milena was a young mother immersed in an abusive relationship that involved physical and psychological violence. She was alone and without support and her partner was convinced the HIV-positive diagnosis was irrelevant, so she did not take it seriously until her daughter at the age of 9 got very sick and had to travel to Cali to seek better healthcare services. There she met a pediatric psychologist who told Milena that if she moved to Cali, she and her daughter could receive better care. The psychologist offered Milena a job at the same HIV clinic where she worked and twisted her arm into coming to Cali.

While working there, she met César, the man who was born with HIV, who appears at the end of the previous chapter, and they fell in love. They met at a Halloween party for HIV-positive people organized by the clinic, and that broke the ice. They began their relationship as hidden

lovers because Milena's partner was in Cali at the time, escaping from murky business he had been involved in, and was trying to get Milena back after their relationship ruptured. One night of jealousy and violence, Milena's partner threatened to kill her. The police were alerted and came to their house, and he went immediately to jail because on top of that, he had violated probation from another town. He died of AIDS in Cali at age 36 after spending his final years in jail. Milena said that him going to jail was the beginning of a new life for her; for the first time she felt she had control over her life, and that shift allowed her to enjoy her relationship with César openly.

Soon after though, due to a condom rupture, she became pregnant. César was happy, but she was devastated.

*César was super happy and I was sad. I already had a daughter that lived with HIV, and I was worried, but at the end we went through it and yes, I was happy too. However, it was not easy. César's grandmother, who raised him as his mother, judged us as irresponsible for having children in our condition and also when we knew they were two... I got worried because of the money, and also because I have never been consistent with the drugs [ART] and there is always fear, but I have endless faith in Jesus, and even though I never managed to have undetectable levels during my pregnancy they came out well.*

*Milena*

Milena's pregnancy became the milestone of her family with César. Together they formed a household. In independent conversations, both agreed that the fact that both lived with HIV made their relationship easier. They had to focus on the 'normal' things. However, as we know, Milena and her older daughter had difficulties adhering to ART and that created some very dramatic moments, since both almost died. Additionally, even though Milena and César worked more than 40 hours per week, they always felt they were short on money. Often Milena suggested to César

that he slow his pace at work and enjoy the family, but he felt that life was short and he wanted to leave a house for his daughters. As we know, they broke up, but for a few years they had a chance to reshape their affective lives, which were traumatic in many ways. Milena and César found in each other caring partners and had two healthy children, who they both loved deeply.

However, Milena made a reflection in our one-to-one conversation about what would have happened if César wasn't HIV-positive. Would he still be with her? Was HIV part of their love equation? This shows that HIV-status plays an important role in relationships, at least in romantic desires among the HIV-positive people I talked to. Today, revealing an HIV-positive diagnosis to a romantic partner within the heterosexual world in Colombia is hard. Many people I talked to dreamt of finding an HIV-positive partner.

### **5.5 The affective dimensions of HIV**

When HIV enters the lives of active heterosexual men who are involved in heteronormative romantic and family relationships, it often becomes a revealer of unspoken practices of their masculinity such as infidelity, (potential) bisexuality, drug and alcohol use, and sex consumption, which put men into uncomfortable situations where shame and guilt become frequent familial feelings. The undecipherable experience of HIV for heterosexual men often becomes a force that leads men to check-out, which becomes a resource to cope with the feelings and social responsibility that an HIV diagnosis brings. For example, In Johana's narrative, the father of Johana's children thought about committing suicide as soon as he knew his partner and child had HIV because of him. At that moment he ran away and disappeared for months. He did not have the emotional tools to cope with the situation, nor did he have support; he had to process the pain

and the magnitude of the situation on his own. When he came back to Johana and their child, he was tested and started treatment, but their relationship fell apart, they had to deal with their diagnosis, the health of their daughter, their family, and their romantic relationship on their own and things did not work out. Johana's partner migrated to another city and stopped taking his ARTs and taking care of his health while engaging in other romantic relationships and very likely spreading the virus.

The majority of men I talked to did not have the tools to understand how the advances in ART and medical care have transformed the lives of people living with HIV. However, I found that men's female partners, mothers, mothers in law, and sisters very often subverted these phenomena by providing love, support, care, and the information they could obtain. Women were key in transforming men's HIV experiences of sorrow and anxiety into more positive ones. I often heard from men who were able to better understand and thus change their experience of living with HIV that learning how to live with the virus had pushed them for example to have healthier relationships with drugs and alcohol, have safer sex, eat better, and exercise more. Very importantly all men who managed to domesticate their HIV diagnosis adhered to ART.

Thus, in my research study I found that HIV has the power to subvert men's behaviors that kill men, however this was possible in almost all of the cases because of the emotional labor provided by their intimate female support networks. Unfortunately, this labor often added a burden to women's lives, was not always recognized, and was performed without the support of the biopolitical apparatus. So, in this sense my research findings are an invitation to incorporate heterosexual men in the HIV biopolitical and affective networks of prevention, care, and support. I believe that in doing so the HIV biopolitical apparatus would reinvigorate itself by being able to



tackle and support a new population that is becoming infected with HIV and which is experiencing it closer to how we knew it in the 80s and the 90s.

## **6.0 Life after an HIV-positive diagnosis**

Based on my dialogues with heterosexual men and women in Cali, in this chapter I examine three aspects of life after an HIV-positive diagnosis. The first aspect is the idea of HIV as a chronic disease. The chronicity of HIV is contested by the experiences of heterosexual men and women, who are often disconnected from the resources that make HIV a chronic disease instead of an acute and deadly one. The second aspect is migration and HIV, specifically how an HIV-positive diagnosis affects men's mobility. In the two cases I present, HIV acts as a force of return and immobility undermining men's provider roles. The third aspect is family and fatherhood. I focus on how romantic love and family formation are technologies of hope to reconstruct life and give a sense of normality to HIV-positive men, even though reproductive sexuality is usually shamed among HIV-positive families. The last part of this chapter touches on sero-discordant couples who form families and get pregnant, defying biopolitical measures of reproductive control. I argue that children and love from HIV-negative women return a sense of normality that men lose when they are diagnosed with HIV and motivate adherence to treatment.

### **6.1 The privatization of HIV life expectancy: Is HIV a chronic disease in Colombia?**

Access to ARTs has been life-changing for HIV-positive people, creating longer life expectancies and changing people's ideas and practices of romance, sex, love, and family. ARTs have been key in transforming a lethal virus into a chronic disease. Studies even show that having undetectable levels of HIV reduces the risk of HIV transmission to almost zero (Anglemyer et al.,

2013; De Cock, Crowley, Lo, Granich, & Williams, 2009; Donnell et al., 2010) which is changing people's perspectives on how to navigate their sexual and reproductive lives. For example, at an event in Cali I heard of an organization in Argentina which advocated for the right to have natural births whenever the mother has undetectable levels. I often heard health professionals and people living with HIV in Cali refer to living with HIV as something similar to or even better than diabetes or cancer.

It is key to highlight that the chronicity of HIV/AIDS is achievable today thanks to at least four key bio-technological advancements: three different types of ARTs, which act on different moments of the virus reproduction cycle; viral load tests; CD4 tests; and HIV genotypifications. However, access to these is not guaranteed to everybody living with HIV/AIDS in the world today due to technological, political, and economic inequalities. Furthermore, people's experiences and ideas of longevity are of course marked by access to biotechnologies that prolong life, but perhaps even more so by the possibility to accomplish what people desire to do with their lives. These desires are more in tune with social desires and expectations (Smith-Morris, 2010), like parenthood and family formation.

Even though neoliberal policymakers and politicians brag about successful Colombian healthcare reforms, I found in my research that HIV is not a chronic disease for every HIV patient in Colombia because access to ARTs and treatment varies according to class, gender, and place of residency. As I showed earlier, people living with HIV in Colombia often face difficulties to access routine HIV tests, especially if they are heterosexual and live in the countryside. As a result, heterosexual men and women often discover their HIV-status while they are in an AIDS phase or pregnant. A prompt therapeutic response is in many cases key to allow HIV to become a chronic

illness instead of an acute and deadly one. In this sense, many of the stories about living with HIV that I heard in Cali defy the idea of HIV as a chronic disease.

ARTs are literally a lifeline for people living with HIV. Claudia, a 42-year-old woman I met in an HIV clinic in Cali, learned of her diagnosis through a prenatal HIV-test. She became infected through her partner, according to her a man without education who might have gotten infected in the brothels of his native rural Caldas, a state three hours away from Cali. While she was pregnant, she and four other HIV-positive women became infected with tuberculosis. She rapidly got very sick and received a high dosage of antibiotics which she believed led her to a miscarriage. In just a few weeks she lost more than 15 kilograms. It was only after she took ARTs that she started feeling better and gained back her lost weight.

*when I got into the HIV program I weighed 34 kilos. And in two months of treatment, I was back to 56 kilos. My recovery was pretty fast. I remember that when I began treatment I had something like 2500 copies of the virus and three months after I was undetectable, and since then I have been undetectable. Actually, in these nine years I think I have only had two colds, and that is because I got soaked in the rain.*

*Claudia*

Later in the interview, Claudia told me she had stopped taking the ARTs for a few months because she went to a psychic who told her that her HIV and miscarriage came from an act of witchcraft. She later found out that her ex-partner, the one who infected her with HIV, had lost a leg and thus thought things were settled, and therefore that her HIV was neutralized. Yet in the next blood test her HIV levels were still undetectable but her CD4s dropped sharply, and she realized again that she could not stop taking the ARTs.

Claudia's ARTs hiatus experiment is not an isolated case. Most of the people I talked to on occasion stopped taking their ARTs for many reasons, including side effects, beliefs of miraculous cures, tiredness, denial, and curiosity. In most cases people get shaken by AIDS-like experiences and realize that they cannot quit taking ARTs if they want to keep on with their lives. Claudia was quick in realizing through a routine HIV viral load and CD4 blood exam that the virus was decreasing the number of CD4s in her body and immediately resumed taking the ARTs.

However, people in Colombia are also often forced to stop taking their ARTs, and this is not because of their own ideas or desires to experiment with their bodies. HIV-positive people in Colombia have to learn how to navigate the privatized healthcare system, which is very complex. This system has many ramifications: the payment capacity of Colombians and the system's fractioned nature expose enormous cracks in which people many times fall sick or die, even more so if they are poor (Abadia & Oviedo, 2009). The lives of HIV-positive people depend on constant access to ARTs, routine tests to check the evolution of the virus, efficacy of treatment, mental health support, and support from experts in immunology, among many other services. In Colombia, these services have been centralized by numerous private health insurance companies in small clinics, usually located in main cities, designed to maximize labor expenses under a façade of specialized and tailored services. These clinics open and shut down over time, depending on the highly dynamic Colombian health market in which health insurance companies are born, shrink, expand, go into bankruptcy, merge, and dissolve. Whenever this happens, patients' lives enter a standby phase, in which the HIV process of degeneration of people's immunological systems accelerate, prompting more AIDS which reduces their lifespans.

## 6.2 From Santiago de Chile to Santiago de Cali: a forced return due to HIV

Chile has become a migration center for many South Americans seeking job opportunities. While I was doing research, many people noted that they knew somebody who had migrated to Chile or wanted to migrate there, hoping for better futures in the so-called “Latin American economic miracle.” From the men I talked to, two had travelled to Chile and both had to return to Cali because of their HIV status.

I met Hernando in one of the HIV clinics I visited in Cali. One of the health staff members introduced us and Hernando immediately agreed to participate in the project. We had a coffee in a cafeteria close to the hospital where the clinic is located and when it closed, we headed to a restaurant I knew was famous for its *arepas*. Hernando was talkative and the interview lasted for a few hours. We established a good rapport and I thought we would meet again, but that was the only time we had a chance to talk; after that day, even though we agreed we would meet again, he never answered my phone calls or text messages.

Hernando migrated to Chile in 2015. Since he arrived, he had worked in the streets of downtown Santiago selling refreshing drinks during the summer and roasted sweet peanuts in the winter. A few months later, his wife moved to Santiago too, but she did not adapt and decided to go back to Cali. One day, after being in Santiago for two years, it became impossible for him to swallow any kind of food. He thought it was due to his bad nutritional habits—he always ate street food without any schedule. He went to the doctor, and through an endoscopy he got diagnosed with a severe esophageal thrush, commonly present in immunosuppressed people. The doctor ordered an HIV test. Hernando never imagined it would come back positive; he had had one test in Colombia as part of a medical check-up before his departure, and it was negative. Hernando told me the doctor that gave him the HIV confirmatory test results in Chile told him that he should

not worry, that there were drugs to treat HIV and that the HIV treatment was similar to diabetes. He said he barely listened to what the doctor told him. He thought he was going to die soon.

Hernando was an undocumented immigrant in Chile and did not have the right to enroll in a health insurance program, so the tests and diagnosis were expenses he paid out of pocket, and he said these cost a lot of money. As soon as he learned of his diagnosis, he felt even sicker and depressed. His wife called him because she felt he was distant, and he told her what was happening, thinking that it would be the end of his relationship with her and their children. In his mind, Hernando wanted to save money in Chile to later travel to Barcelona, where he would be able to earn in euros and send more money to Colombia. But Hernando's family and wife told him to go back to Cali where he could take care of his health. Nevertheless, returning to Colombia frustrated him.

*I was telling her [his wife] that going back to Cali felt like a failure, as if I had lost two years of my life for nothing. And she told me that things were not that way, that it was important for me to recover my health because I was still young. So, I decided to come back, and indeed, the support I have received here from her and my family has been key for my health and my recovery.*

*Hernando*

Hernando's return to Colombia marked a new phase in his life. He was unemployed and living on his Chile savings. He was lucky that the bureaucracy of the healthcare system had not opted him out, and he was able to quickly enroll in an HIV program and treat a pneumocystis pneumonia he was fighting. He was hospitalized in Cali's University Hospital (HUV) in a room with other HIV-positive patients with acute illnesses. He said that experience made him realize

how precious his life was and made him engaged into a very responsible recovery. He was adherent to the ARTs and was taking care of his life as much as he could.

In Cali, Hernando also reconnected with his wife; they had split up for a while after she returned from Chile. Back then, they were having relationship issues and Hernando thinks it was in that moment that he became infected with HIV. In those days he was partying a lot and became friends with other Colombian immigrants with whom very often he drank *aguardiente*—a clear sugar cane spirit flavored with anis that Colombians have adopted as the national alcoholic beverage. In those days, in a discotheque, he met a Colombian woman who was in transit to Argentina and they had a few unprotected sexual encounters. He said he never saw her again. The other option he mentioned as a possible route of HIV transmission was a tattoo he got in Santiago. He said he ended up in a filthy tattoo parlor where he never saw the tattooist using disposable or sterile materials. The tattoo said: *Family. Where life begins and love never ends.*

Hernando embodied the message of his tattoo very well. The love from his family and wife were helping him to recover and to assume his HIV-positive diagnosis in a good way. In fact, he told me that his coming back to Cali felt like vacation after years of interrupted work in Chile. He was able to rest, eat home-cooked food, and share quality time with his family. In a way, HIV pushed Hernando away from his project abroad, which had made him an effective provider, and put him back together with his family and his wife.

At the end of our conversation, I asked him about his sexual life after his HIV-positive diagnosis and he said he was reconnecting sexually with his wife, who at the moment was HIV-negative. He told me they had an exciting and active sexual life before his diagnosis. He and his wife were not used to using condoms; he had gotten a vasectomy after their second child was born.



However, after his return to Cali they were trying to incorporate condoms in their sexual life. It was not perfect or ideal, but they were trying.

Hernando's return to Cali undermined his provider role. He felt that he was more useful for his family in Chile, and potentially Europe, than in Cali. However, he had more chances to extend his life in Cali. Chile, in the same fashion as Colombia, privatized its healthcare system in the '80s under Pinochet's dictatorship (Han, 2012) and navigating it as an undocumented immigrant is expensive and difficult, as Hernando told me. Plus, his wife and family were willing to support him in Cali. Therefore, in an attempt to live HIV chronically, he decided to move back to Cali, where he was unemployed, but as a Colombian citizen he at least had the right to healthcare.

### **6.3 Lucho**

I met Lucho in 2014 and since then, whenever I go to Cali, we meet and talk. He was the other person who was willing to take pictures of his daily life as part of a PhotoVoice project that I had planned to do with HIV-positive heterosexual men in Cali. In 2018, Lucho was 44 and had been living with HIV for 19 years. He thinks he became infected through unprotected sex with a woman with whom he had had an occasional affair. Lucho learned of his diagnosis through a skin issue common among immunosuppressed people, and as soon as the doctor saw his skin symptoms he ordered him an HIV test. As with all the other men I talked to for this project, he never imagined it was going to be positive. He became suspicious when at the clinic they told him the machine that processed the blood samples broke and they had to redo the test. He was referred to an NGO and a support group by Dr. William Lenis, an MD who was supportive of my research project.

Lucho was one of the few men I talked to who was willing to participate in support groups mainly populated by gay men and a few women. The psychologist who introduced me to Lucho told me he was a rarity and a very well-appreciated member of the support group. Lucho told me in the group he learned a lot about coping with HIV. He learned through his peers the importance of the ARTs, the possibility of resuming a romantic and a sexual life, and the role of a good diet and exercise in boosting the immunological system. Lucho also socialized with men from his support group with no issues. He sometimes even went to parties organized in gay bars in Cali, and he told me that after making clear he was not into men, the rest of the group was respectful to him.

After the diagnosis, Lucho became an avid hiker and biker and most of our conversations circulated around his bike expeditions, new hikes around Cali, a new bike he got with money his boss lent him, and so on. The majority of his PhotoVoice pictures showed him biking with friends around Cali. Many were landscapes, others were pictures of animals he ran into or monuments he saw in towns, and many were of his biking friends taking a dip in a river or having a bite somewhere. For Lucho, his bike was his life. With time, he stopped playing billiards and having a couple of beers now and then, as he used to when I met him in 2014. By 2018 he just worked and biked whenever he could.



**Figure 9. Lucho swimming after a bike ride. 2018.**

In 2014, Lucho and I climbed *Tres Cruces*, the iconic Cali mountain which Caleños love and use as one of their main recreational spaces. We hiked with a friend and lover of his who was planning on moving to Chile, seeking better job opportunities and the possibility to send remittances to her sons in Cali. That day we hiked pretty fast—both of them were in pretty good shape—and at the end we had a nice fresh-pressed orange juice. In 2018, when I met again with Lucho, he told me had visited his lady friend in Chile. He flew, for the first time in his life, from Cali to Panama City and from there to Santiago. Later, he took a bus to the mining town where his friend lived and where she had a street food business. The plan was to settle there and start a new life together. They would continue with the food business until he found a steady job as a mechanic. He told me that the preparation for the journey took months; he had to have enough ARTs for 6 months at least, and that was not easy.

Lucho arrived in this Chilean town ready to begin a new life with this woman with whom he had been cultivating a relationship for years. Informal but close, they supported each other. However, Lucho had never disclosed his HIV-positive diagnosis to her. He told me he did it on the second night after his arrival over dinner and wine. Things did not go as he expected; she panicked and got anxious. She could not understand why he hadn't told her sooner. Things got awkward. She started avoiding him, and one week later he took a three-day bus ride to Cali. Lucho told me it was very difficult for him to process all that happened on his trip and his rupture with her. But also, practically speaking, he told me that he did not see himself finding a job there as good as the one he had in Cali, and he did not know exactly how he was going to navigate the Chilean healthcare system. Lucho had always adhered to treatment, he knew well how the healthcare system worked, and the health staff supported him. Somehow, staying in Cali made sense, though of course it also bothered him to be stuck in one place because of his HIV-status.

#### **6.4 “I think that if I am with him, I am with him fully”: Sero-discordant couples**

The HIV biopolitical apparatus in Colombia does not promote family formation, unprotected sex, or parenthood among HIV-positive people. However, people defy norms and still do these things, even with partners who are not HIV-positive. Sero-discordant couples are a growing phenomenon in the world due to the chronicity of HIV and the effective barriers of HIV transmission, including ARTs. The growing literature about discordant heterosexual couples mainly explores risk of infection, pregnancy, and stigma (Beyeza-Kashesya et al., 2009; Eke & Oragwu, 2011; Rispel, Cloete, & Metcalf, 2015) and now has an emphasis on parenthood (Sastre, Sheehan, & Gonzalez, 2015). I argue that sero-discordant couples act as technologies of hope,

especially for men who live on the margins of an HIV biopolitical apparatus that does not recognize them and denies them social support and networks.

I interviewed Erika and Santiago on the terrace of a massive semi-empty shopping center in Cali. It was a fresh evening and from where we sat we could see Cali's western mountain range, where clouds filled with water collected on their journeys through the Pacific Ocean and the western Colombian rainforest meet the mountains, a clash which creates strong and beautiful thunderstorms. I met both of them in an HIV clinic located in the Edificio de Colores thanks to the introduction of the chief nurse. When we met, they were eager to talk but their schedules were tight; they had two children, worked, and studied. Thus, it took us a couple of weeks to meet again, and we did it one evening after both had finished their classes and their children were with one of their mothers.

She was 24 and he was 29, and when we talked he was HIV-positive, and she was not. In 2015, Santiago had skin sores, and when he went to the hospital, doctors suspected he was living with HIV, so he was tested. After that test he was called to get a second test, a confirmatory one, but he was not told anything about the procedure and he was panicking. He could barely sleep or rest; Erika tried to calm him down without much success, until the day he was called to receive the test results. When he got to the psychologist's office he was still hoping they were mistaken. The psychologist started by asking him if he was married and to describe his sexuality to him, among other questions, until he could not resist anymore and asked her if the appointment was to tell him he was HIV-positive. He broke down and decided to immediately call in Erika, who was in the waiting room. He said that he wanted to take the opportunity of our interview to tell her how much he appreciated her serenity when she was told he was HIV-positive, and he wanted to thank her for that important gesture. He said he was grateful to Erika because of her strength and support.

He also remembered that a doctor who was present at the office assured both of them that HIV was manageable if he was consistent with check-ups and the treatment.

Erika said that when she was finishing high school, she had mandatory community practices related to sexual and reproductive health, and HIV was a topic she learned about in the training. She said that when she received Santiago's HIV news, she remembered all she had learned and that helped her to handle things with more serenity. Erika was tested for HIV two months later; she was negative, and since then has received several more negative test results.

At the time they already had a daughter who was 4 years old, and they agreed that her existence allowed them cope with Santiago's diagnosis better—they knew they had to fight for her. When I asked Santiago how he thought he gotten infected he said he did not have a clue. He said he had never been promiscuous and that his only suspicion was an ex-girlfriend of his. However, he had never asked her anything because he was afraid of bringing up the fact that he was HIV-positive. As he said, there is too much stigma and he did not want to expose himself and his family to it.

Erika became pregnant again after Santiago was diagnosed. When I asked if the baby was planned, they joked and said, well, it was an accident but at the same time a blessing. Both told me the health staff supported them and made clear that because Santiago had undetectable levels, the risk of HIV infection for Erika and the baby was very low. Their child was born via C-section. I asked them what their condom policy was, and they openly told me that they did not use condoms. Erika said Santiago was her first and only partner, and he was the person she wanted to spend her life with. She continued:

*I think that if I am with him, I am with him fully; I know that perhaps in the eyes of science I am an irresponsible person for not using condoms, but I don't like them. And in fact, I*

*went through surgery to not become pregnant again. I enjoy having a sexual life with my husband without protection. He takes his medications, and if by god's desire I end up becoming HIV-positive, well, I will assume it because it was a risk I took.*

*Erika*

I asked them if they ever shared their position towards condom disuse with any of the health professionals they interacted with, and they told me they never mentioned it due to fear of being judged. Santiago also said that he sometimes felt awkward about not using condoms because he did not always have access to his ARTs, so he could be more infectious. He added that living with HIV required people to have money; many times, they had to buy ARTs because the health insurance had not provided Santiago's monthly pills. They had spent around 80 USD, roughly a fourth of the monthly Colombian minimum wage in 2018, to get pills for one month of treatment.

Santiago's experience is not an isolated one. HIV patients in Colombia still lack full access to ART, especially those who are in the Subsidiado and Vinculado insurance categories. Health insurance companies often delay people's ARTs for days or even months. This a direct menace to the lives of HIV-positive patients who, due to the lack of access to constant treatment, might fall into AIDS phases or create strains of HIV viruses resistant to the treatment they are denied. Non-adherence to ARTs is commonly blamed on patients, especially at the intersection of addiction and underrepresented communities (McMahon et al., 2019). However, studies in medical anthropology in Colombia have shown how barriers, delays, and denial of services and treatment in the Colombian healthcare system create unnecessary deaths, illnesses, and diseases (Abadia & Oviedo, 2009; SecSalud Bogota, UNAL, LIGASIDA, & GAMC, 2012). Furthermore, the denial and delay of healthcare services not only affects the lives of HIV-patients but also the finances of

the healthcare system because the more people reach AIDS phases, the more expensive are the emergency and in-clinic recovery costs (Kuhlmann et al., 2017).

Santiago was studying Law, and I was surprised he did not submit a legal writ to get his ARTs, which has become one of the most important mechanisms for people to access healthcare services in Colombia. In 1991, Colombia changed the constitution and stated that any citizen could approach the legal system with a demand. The figure of this legal writ received the name of *tutela*, from the word tutelary, because the writ serves to protect citizens. The concept was simple and powerful; any citizen who felt that their rights were violated could submit a tutela asking for the restitution of their rights without having a lawyer as an intermediary. Children were even allowed to present drawings as documents to protest against violations of their rights. Despite the privatization of the Colombian healthcare system, the neoliberal promise of better services based on a regulated market system never arrived in Colombia. People started using the tutela as the only available effective means to access health services and treatments, a phenomenon referred to by scholars as the judicialization of the health care system in Colombia (Bernal et al., 2013). Santiago knew well what a tutela was and its effectiveness. However, he did not feel like submitting one because he knew too many people in Cali's legal system and did not want to spread the word of his HIV-status unnecessarily. Thus, he preferred to pay out of pocket for his monthly ARTs when he did not get them. He told me that with his new health insurance, one that he got transferred to after the previous one claimed bankruptcy, the pharmacy had been consistently providing ARTs for the first three months.

I asked Santiago and Erika about their sexual life after HIV, and they both agreed that it had not changed. They said they were in love and felt they could overcome his diagnosis together. After Erika's second pregnancy they learned more about sero-discordant sex risks, but they



admitted that before that, they had kind of risked it. Often their daughters came up in the conversation as their purpose in life. I asked Santiago if he had ever thought about getting a vasectomy and he said yes; having two children had met his expectations and he also considered two to be a good number of children they could provide a better future for. To me, they were one of the most confident and stable couples living with HIV that had I met in Cali. I let them know that in the interview, and Santiago replied with these words:

*I know I live with a condition, but I know I have my wife, who I love; I have my daughters, who I love; I also have my mother, who I love, as well as my brother too. I want to live longer, and I know that the more I can keep their support the easier it is to keep on with my life; they help me feel like someone that is not different, I feel normal, I just have to take medications!*

*Santiago*

## **6.5 Arley**

I met Arley in 2018 in one of the HIV clinics in Cali located in a neighborhood full of small clinics and hospitals. I would often go to HIV clinics and, after announcing myself to the staff and letting them know I was there, spend a couple of hours in the waiting rooms in case a patient would agree to talk with me. Arley did agree to talk with me, but he told me he only had half an hour because he had to return to Buenaventura later in the afternoon. He had traveled with one of his sons and his wife early in the morning and they had to run other errands in Cali. In solidarity with the interview, his wife went to pick up Arley's ARTs in the pharmacy located a few blocks away; in the meantime, we sat with his son in a cafeteria where we had a snack while we talked.

Arley was 36 and very open and direct. He worked as a nurse in a hospital belonging to Buenaventura's diminished health network. In 2007, Arley started having constant colds and fevers, approximately one every other week, so he decided to get an HIV test. Even though he had medical training and knowledge, when he learned he was HIV-positive he fell into a three-month depression, often thinking he was facing his final days. Arley told me that praying and seeking refuge in his church helped him to overcome his depression and were key to him becoming adherent to treatment. When I asked him about how he got infected, he told me he suspected a woman who he had had occasional sex with and who people gossiped became HIV-positive. He never inquired further, but that was his guess. Arley told me that since 2008 he had been consistent with his ARTs, except for a couple of months in which his identification number was typed wrongly into the system, leaving him without treatment for 60 days.

Arley and his wife met through Facebook. She was living in another Colombian city and later moved to Buenaventura. He was open with her about his HIV-positive diagnosis; she understood and took it with ease. She had an uncle who was HIV-positive, and she had good information on how to cope with the virus. Arley's partner was very supportive and open about his diagnosis. I also asked Arley about who knew about his diagnosis and he said that many members of his family knew and that he considered it to be key for them to know because they provided empathy and support. He even was open about his diagnosis at work, and that helped him to move from the emergency area where he used to work to the sterilization area.

Arley was the father of two children; one was 4 years old and was with us in the interview, and the other was a year-and-a-half old baby who stayed in Buenaventura that day with one of his grandmothers. He had both of them after his HIV-positive diagnosis. He told me he was not planning to become a father, but in conversations with his wife, who was HIV-negative, he

changed his mind and they decided to consult the medical staff about their desire. They were supported and not judged for their decision. I asked him how he felt about becoming a father and he said:

*well, becoming a father under this condition feels like a bunch of mixed emotions. I was half nervous and half excited. I really wanted and desired to become a father, but it was the first time and of course, I wanted them to be born healthy. And thanks to god, things worked out well.*

Arley

Fatherhood gave Arley a sense of belonging and self-fulfillment, and to an extent a sense of normalcy. Becoming a parent was an important question and event among the men I talked to in Cali—the great majority wanted to be or were already parents. However, for those who were not parents yet, HIV created many questions and anxiety, which many times were unresolved. Nonetheless, I noticed that when couples were clearly established, health staff members acted in a more supportive way towards reproduction. Controlling safe sero-discordant reproduction and pregnancy is quite easy today and should be an open topic in the HIV clinics in Colombia. Men, in particular, should have access to the necessary information. Furthermore, fatherhood seems to provide powerful meaning to the lives of men, which translates to healthy outcomes. Men want to be healthy to be able to see their children grow.

*The I want least in my life now is to die. My children are small now and I want to live with them for many years, I want to see them grow. I want to see them graduate, go to the university, get married and have children. I want to have grandchildren. That is the wish I have, and I hope god concedes it to me.*

Arley told me that after having their second child, they decided not to have any more children. Thus, they were using condoms, and he was thinking about getting a vasectomy. He thought having more children was a huge economic responsibility, and for him and his wife two were enough. Arley was one of only two men during my fieldwork in Cali who told me I could share his story publicly if I wanted. He told me that as a Christian, he felt responsible to share his experience. Perhaps because of that openness, I learned so much from him in roughly thirty minutes of interviewing him. Of course, I am using a pseudonym for him.

Fatherhood and family formation become technologies of hope for people I talked with. In part, for heterosexual men living with HIV that I met in Cali, fatherhood and family formation become ways to achieve social desires, which simultaneously give their lives meaning and a social place that a large majority of men try to seek, regardless of HIV. Furthermore, I argue that family formation even functions as a defiance to death by prolonging men's hereditary lines.

## **6.6 Intimate (dis)obedience**

The chronicity of HIV in Colombia is often put in jeopardy, given the fragmentation of the Colombian healthcare system. The majority of men and women I talked to had experienced delays as long as several months with their ARTs, along with periods without medical attention. Most had often experienced the transformation, merging, or disappearance of health insurance companies that left their medical care in standby mode, sometimes for months. The few that had learned how to navigate the system relied on the knowledge and expertise of other patients or NGOs. Nevertheless, being savvy with navigating the system requires a lot of time and energy,

and people do not always have the monetary resources, the time, or the energy to do so. In order to function, the system requires high levels of self-advocacy, which not everyone is willing to embrace. Heterosexual men are further from these resources. Their low contact with other patients, their desire for low exposure to HIV matters, and their detachment from NGOs makes them less prone to self-advocacy and thus more vulnerable to experience AIDS instead of HIV. Professionals often talk about men's reluctance to adhere to treatment, but these commentaries are typically oblivious of men's position. It is hard to advocate for your rights when you do not feel entitled to them. So, in this case, men often obey the tacit rules that the system imposes and do not fight back, putting their lives in danger.

An HIV-positive diagnosis not only affects people's conceptions of time but also their relationships with space and mobility. Access to treatment for chronic conditions is a well-known issue in migration studies. For example, HIV was a travel restriction of immigration into the US until January 2010. People also engage in medical tourism as part of their therapeutic itineraries seeking health. Other people, like Hernando, become infected with HIV in their migratory journeys and, like Lucho, feel obliged to return because of their diagnosis. Others feel stuck, like Carlos, the taxi driver introduced in chapter 3, who was frustrated by not being able to migrate to Spain or Chile because of his HIV-positive diagnosis. The men presented in this chapter are obliged to return to and stay in Cali in order to have access to HIV treatment and have a better chance to extend their lives.

The matter of serodiscordant couples forms an interesting parallel with Foucault's idea of the heterotopia (Foucault & Miskowiec, 1986), suggesting that serodiscordant kinship formation is a space of resilience and resistance. Heterotopias, for Foucault, materialize in two basic forms: the crisis heterotopias designed for rites of passages, such as spaces for puberty or initiation rituals,

and the heterotopias of deviation, which are places where ‘abnormal’ individuals are placed. I propose that the serodiscordant families paradoxically occupy both heterotopic worlds. The HIV-positive body is considered a polluted one which should ideally not reproduce, thus the heteronormative family is not the ideal place for it to exist. However, as I showed in this chapter, for many heterosexual men the heteronormative family represents a utopia, a keystone that gives meaning to their lives, pushing men into adherence to treatment. Furthermore, love cemented around an HIV-discordant partnership, where the use of condoms is not the norm, raises questions about pleasure, intimacy and normalcy that defy the biopolitics of HIV. In this sense, HIV-discordant couples and families can be fruitfully viewed as heterotopias of intimate disobedience which reveals the nuances of HIV and kinship in contemporary Colombia.

## **7.0 Photographing under the influence: Visual narratives of heroin and methadone use in Cali, Colombia**

Shifts in the opioid trade market within the Americas have led to an unprecedented decade-long heroin epidemic in Colombia that is hitting youth, and especially men in urban communities. Research on the impact of the opioid epidemic typically focuses on the Global North. My research approach to the heroin epidemic in Cali, a city of the Global South, employed PhotoVoice, a methodology that invites participants whose perspectives are often excluded from artistic authorship, historical knowledge, and decision-making to capture with a camera how they perceive their reality. The aim is to generate a collective dialogue around what their photos represent and what actions are necessary to fight injustices and promote social change (Latz, 2017; Ruiz Sánchez et al., 2018; Sitter, 2017). This chapter provides a multivocal and inside gaze on the heroin epidemic based on photographs and narratives from heroin users enrolled in a methadone clinic in Cali, Colombia. Their narratives challenge ideas of addiction, support, and homelessness in a country that has traditionally exported, but now also consumes, heroin. Through PhotoVoice, I gained an intimate perspective from heroin and methadone users narrating their daily challenges with healthcare, addiction, family and romantic relationships, work, and urban life.

Cali is a city well known for its world-renowned Cali Cartel, which grew along with the Medellin Cartel. In the 1980s both cartels positioned Colombia as a key actor within the global illegal drug market and the war on drugs. Countless images have been imprinted in the minds of audiences all over the world through TV shows, movies, and press clips in which Colombia appears as a land of cocaine production, framed through clichés that often cater to colonial and

exoticized views. Both within and outside Colombia, rarely do people speak about dynamics of drug consumption within the country and how it impacts Colombians.

As noted earlier, Cali has built an image and a reputation around being a city of pleasures. Its vibrant salsa scene, which since the 1970s has connected the city with the blooming salsa industry that emerged in New York City and the Caribbean, gave it the title of the Global Capital of Salsa, which has led to some scholars to describe it as a Caribbean enclave within the Andes (Waxer, 2002). Cali is the city with the biggest Afro population in Latin America after Salvador de Bahia, and it is the most important migration knot for *campesino*, Afro-Colombian, and indigenous communities that reside along the country's Pacific coast. Despite stark racial and class divisions, the city has managed to consolidate a "tropicalized" image of itself, deeply anchored in the black and mestizo body, music, and cuisine (Wade, 2000). Furthermore, the city's open sex-work and party industries add to its image and other moniker, Heaven's Outpost.

I have three aims in this chapter. First, to contribute to the expansion and inclusion of narratives of the opioid epidemic from territories outside of the Global North that not only produce heroin but also consume it. Second, to call for the recognition that Colombia is going through an unprecedented and severe heroin epidemic that is affecting mainly poor young men and requires attention and support as a matter of public health. Third, to reflect on the use of participant-led photography as a methodological resource to uncover new elements and mundane aspects of heroin and methadone use among "hidden populations."



## 7.1 Heroin made in Colombia

Heroin is extracted from the milk that the poppy flower exudes when it is cut. In Colombia, poppies are grown in small farms that lie between 1,700 and 3,000 meters above sea level. According to the Colombian police, Cauca and Nariño are the states with the highest concentration of poppy farms in the country (Ministerio de Justicia y del Derecho - Observatorio de Drogas de Colombia, 2015). Cali is only three hours away by bus from Popayan, the capital of Cauca, and eight hours from Pasto, the capital of Nariño. Cali is intrinsically connected to the Pacific coast, especially the port of Buenaventura, where many legal and illegal Colombian goods are exported and imported. Cali's privileged geography, combined with its economic and cultural dynamics, have made it a hotspot for heroin. By 2020 in Cali, a gram of high-quality heroin cost 17 US dollars (or 50,000 COP), the equivalent to five percent of the monthly minimum wage in Colombia in 2018. These relatively low prices of high-quality heroin, distributed through traditional drug-selling channels of *basuco*, marijuana, cocaine, and other drugs have drawn vast numbers of local youth, especially men, into the habit of using smoked and injected heroin. Furthermore, word of this high-quality heroin has spread all over the country and Latin America, attracting national and global consumers into Cali's heroin landscape.

In recent years, Colombia has experienced a dramatic increase in heroin consumption, concentrated in urban areas of the country, which primarily affects youth and men specifically (Ministerio de Justicia y del Derecho - Observatorio de Drogas de Colombia, 2015). The United Nations Office on Drugs and Crime (UNDOC) calculated that in 2017, there were 35 million people around the globe with opioid use disorders who needed support and treatment services. Domestically, Colombia has exported and consumed marijuana, cocaine, and cocaine paste—locally known as *basuco*—for decades. *Basuco* is a cheap and highly addictive drug which has for

decades been a serious matter of public health all over the country, hitting the large Colombian homeless population especially hard. A decade ago, heroin was expensive and rarely seen in Colombia; today, it is a visible and palpable form of drug addiction in urban Colombia which overlaps with the *basuco* landscape.

Heroin was first produced in Colombia in the early 1990s, when cocaine traffickers saw the possibility of expansion into the US market, which then accounted for 6% of the global heroin consumer market. In 1998, 97% of pure heroin found in New York City and the US East Coast came from Colombia (UNODC, 2015). Today, most the of the heroin consumed in the Americas is produced within the continent: Mexico is the main producer, followed by Colombia and Guatemala. Colombia continues to supply part of the US East Coast, Central America, the Caribbean and South America. Mexico and Guatemala supply the US west coast, while Canada gets the majority of its heroin from the Middle East, especially Afghanistan (UNODC, 2019).

By the year 2000, Colombia had expanded its drug trafficking networks in the global market, supported by the labor of peasants who had been deeply impoverished by the strengthening of neoliberal economic policies since the 1990s. For decades, rural communities in Colombia have found risky but lucrative sources of labor in the growing of marijuana, coca, and poppy, and sometimes the production of cocaine and heroin. All this was possible with the support of guerrilla, paramilitary and other types of armed groups, who established profitable alliances with national and international drug cartels to support their armies (Ministerio de Justicia y del Derecho - Observatorio de Drogas de Colombia, 2015).

By 2013, however, two factors led to a decrease in heroin exports from Colombia to the US, leaving tons of heroin within Colombia and sparking a national market. The first was the increase of Mexican heroin in the US market to overcome the loss of income due to the legalization

of marijuana in many US states, a market that was mainly supplied by Mexico before the wave of legalization. Subsequently, by 2014, Mexico had taken over parts of the Colombian heroin market along the US East Coast, leaving the Colombian cartels with tons of heroin and no market. The second factor was the steady increase in synthetic opioids legally produced by pharmaceutical companies, which flooded the US black market. For example, the number of opioid prescriptions dispensed by retail pharmacies in the United States increased from 174 million in 2000 to 256.9 million in 2009 (UNODC, 2019). In 2018, an estimated 10.3 million people in the US aged 12 or older used opioids recreationally; 9.9 million used pain relievers and 808,000 used heroin (Substance Abuse and Mental Health Services Administration, 2019).

Cali's heroin users' personal experiences coincide with this broader picture. Their addiction to heroin, in the majority of cases, started less than a decade ago, when heroin first became more affordable and accessible in Colombia. Before that, heroin was an expensive drug intended for export; in Colombia, it was consumed primarily by upper- and middle-class users. In an interview with Juan, an HIV-positive man who appears in chapter 4, he told me when heroin arrived in Cali. He had a privileged perspective because he grew up in the barrio Sucre, where the main heroin selling spot in Cali is located, H street. According to Juan, heroin appeared in 2002. Two men and a woman started selling it with the support of two families who sold marijuana. The business was successful and the wave expanded fast. Soon, heroin consumers were seen all over the place, attracting other sellers who quickly set up selling spots along a street later to be called H Street. Juan had a small business close to H Street in which he sold juices, breakfast and lunch, and he said that his business boomed because heroin users were always very thirsty and hungry, but he also recognized the pain these people were going through.

## 7.2 A needle exchange oasis

I connected with the Methadone Clinic through *Cambie*, an avant-garde needle exchange program located a few blocks from H street in the barrio Sucre. This neighborhood is mainly composed of one or two-story houses. The first floor of two-story houses is commonly used for commercial purposes, such as auto parts and repair shops, warehouses, shoemaking shops, hardware shops, restaurants, and convenience stores. The houses are mostly built in the art deco style and the colors of the facades are often painted with soft pastel tones of blue, orange, and pink. The heroin epidemic has hit the neighborhood and city hard and the public response to deal with this issue has been almost nonexistent. *Cambie* emerged as a civil society response to the epidemic, funded mostly with international funds, and its appearance dramatically changed aspects of the heroin epidemic. The one that neighbors recall most often is that since *Cambie* came into existence, there have been no more needles in H street or the neighborhood. Heroin users find in *Cambie* a judgement-free environment where they can access free paraphernalia, useful information, anti-overdose drugs, and psychological support, if they want it. The people who funded *Cambie* led the creation of the Methadone Clinic where my research took place, and almost all the members of that clinic were recruited in *Cambie*.

I visited *Cambie* for the first time in February 2018. I met Felipe, *Cambie*'s director, at the Belalcazar MIO station, Cali's metro bus system, located in Carrera 15 at Calle 21. *Cambie* is between 19<sup>th</sup> and 20<sup>th</sup> street on the southern side of Carrera 15. The street is busy, and that day it was especially sunny and hot. The largest concentration of homeless people in the city is in this neighborhood. They are everywhere, working, walking, eating, sleeping, and oftentimes lying on the sidewalks, weak and high.

*Cambie* is two blocks away from H Street, where heroin users can buy and use heroin 24 hours a day. The house where *Cambie* is located is narrow and deep, painted in white, and has two entrances. One has a big vertical metallic sliding door, and it is open Monday through Saturday from 8am to 1pm; this is where *Cambie's* front desk is located and where clients are served. The desk is two steps away from the sidewalk and, in order to provide some privacy and anonymity, there is a curtain that also offers shield from the sun and the rain. The second door leads to *Cambie's* office spaces, a bathroom, and internal patio where clients sometimes gather.

*Cambie* provides free and clean paraphernalia for intravenous drug use, including syringes, tourniquets, distilled water, receptacles to boil heroin, and disposable wet towels. In order to get these items, clients have to show up, demonstrate that they are using drugs intravenously, and sign up. After that, they can come once a day and claim 1 syringe if they bring none, 2 if they bring 1, 4 if they bring 2, and so on. The database is anonymous and helps *Cambie* keep track of the utensils they distribute.

Most of the time, news of potent heroin being sold in H Street gets to *Cambie* via clients' word-of-mouth, which allows *Cambie's* staff to alert the community. This useful information helps prevent overdoses that are otherwise common when unexpectedly potent heroin is sold. Furthermore, *Cambie* provides Naltrexone, an easy-to-use intramuscular injected drug useful for preventing deaths from opioid overdose. *Cambie* also trains community members, including empathetic neighbors, police, and heroin users, on how to administer it.

The flow of clients at *Cambie* rarely stops. According to *Cambie's* statistics, a median of 120 people visit every day from Monday to Saturday. On Saturdays, clients get double rations to cover what they will need on Sunday; the same is the case before holidays. When clients go to *Cambie*, they all ask for water. The program office has a cold-water dispenser, a luxury in a city

that can easily reach temperatures of 32 degrees C. People usually drink at least two glasses of cold water when they arrive and often bring empty bottles for refills. Clients can also cool down there, get some shade, sit in a couple of plastic chairs that are available, and talk to the staff members. It is a place where clients can rest, and sometimes ride out the heroin high. In this vein, *Cambie* is more than just a needle-exchange program—it also offers a point of contact where family members or friends can leave clothes, money or food for their loved ones. There is a landline phone and a cell phone with WhatsApp that clients can use for free. Many of the clients live in a state of homelessness or close to it, so this set of basic and simple services, provided in a judgment-free and friendly environment, makes *Cambie* an oasis in the heart of Cali.

### **7.3 PhotoVoice methodology**

With the support of *Cambie* and the pilot methadone clinic team, I recruited eleven members who were willing to take pictures and share stories connected to them. A total of thirteen clients at the clinic, some who took pictures and others who did not, conceptualized the themes of the pictures to form the curatorial guidelines which inform this chapter. I also conducted several hours of participatory observation in *Cambie* and the methadone clinic, walked around Cali, had food and coffee with participants on many occasions, and conducted in-depth interviews with them, asking about specific aspects of their experiences with heroin and methadone. Participants had the option to use aliases to give credit to their pictures and narratives, but all of them decided to use their real names.

The PhotoVoice exercise was conducted with clients of a pilot program for a state-funded methadone clinic in Cali intended to support heroin users with their opioid dependence. The

support program had 16 spots available for clients wanting to deal with their heroin addiction. The clinic initially ran within the *Obrero Clinic*, a primary care public-city hospital located in the barrio *Obrero* in downtown Cali, just a few blocks away from H Street, Cali's heroin hub. The clinic offered psychological, psychiatric, and nursing support and was conceived as a harm-reduction clinic (Erickson, 1995; Single, 1995), meaning that sobriety of clients was not the ultimate therapeutic goal. Instead, the goal was to reduce health risks and support opioid dependence from a perspective that acknowledges that addiction to opioids might be a lifelong reality. In mid-2018, the clinic moved to the facilities of a private clinic in a middle-class neighborhood in Cali. The private clinic specialized in rehab services with the aim of becoming a methadone service provider. I collected data from the clients of this methadone rehab clinic in 2017 and 2018.

PhotoVoice is a community-based participatory research method based on community-led photography and the narratives and meanings that participants give to the photographs. The photographs and the narratives that accompany them are shared, usually in-group sessions, with the ultimate aim of achieving collective responses to the problems posed. Those discussions revealed the most valuable insights this methodology enables (Wang & Burris, 1997). PhotoVoice is based on the principle that establishing dialogues with communities is key to recognizing existing inequalities, and that elucidating and validating the knowledge that communities have are exceptional ways to imagine and create better life conditions (Freire, 2005). Thus, PhotoVoice projects are useful for producing collective meaning among marginalized groups, a goal enhanced by privileging group discussions over individual conversations with each participant or photographer (Evans-Agnew, Boutain, & Rosemberg, 2017). PhotoVoice has served to document experiences of "invisible" communities and to address topics that are hard to explain in words alone (Latz, 2017), such as the impact of natural disasters (Annang et al., 2016), minority health

inequalities (Mejia et al., 2013), addiction recovery (Miller, 2017), difficulties of parenting within minority communities (Colón-Ramos et al., 2017), the daily life of sex workers in gentrifying red light zones (Cheng, 2013), access to education for undocumented youth (Sahay, Thatcher, Núñez, & Lightfoot, 2016), romance dynamics among white European women and Afro men in the Caribbean (Meneses & Frohlick, 2019), and the daily life of Latinx immigrants in new growth communities (Ruiz Sánchez et al., 2018).

This chapter is based on a selection of photographs and narratives from the larger project, taken and shared by one woman and ten men, all of whom were enrolled in the methadone clinic. They all responded to the prompt question: How does methadone use affect your daily life? Two additional men, who chose not to take photographs, participated in organizing the pictures by theme, producing a curatorial guide for the pictures. In sum, a total of 13 people participated in the project. However, because of the formatting of this document, I have included photographs and narratives from only some of the participants. Over an 8-month period, I visited the methadone clinic and *Cambie* as well. I often had chats with staff members, hung around the facilities, helped with whatever I could, brought and shared coffee, met client's family members and friends, had meals with clients, once visited a client's house, and walked a lot with a few clients. In sum, the data contained in this chapter is informed by the PhotoVoice project and by my ethnographic work.

Participants' ages ranged from 21 to 43. They had used heroin for 4 to 16 years. Eleven participants used heroin intravenously and two smoked it. They had been enrolled in the methadone clinic for 1 to 5 months. One participant was married and three were parents. The maximum level of education was technical degrees; three participants were in a situation of homelessness and one was displaced due to violence. Eight participants belonged to the *subsidiado* regime of the Colombian healthcare system, three to the *contributivo*, and one to the *vinculado*.



Four reported being unemployed, five said they were in the informal job market, two said they were living off *rebusque* (odd jobs), one was an independent worker, and only one had a formal job. Finally, they reported using other drugs besides heroin: marijuana, tobacco, benzodiazepines, alcohol, *basuco*, cocaine, and energy beverages.

**Table 3. PhotoVoice project participant's demographics.**

<b>Gender</b>		
Male	12	92.3%
Female	1	7.7%
<b>Health Insurance</b>		
<i>Subsidiado</i>	9	69.2%
<i>Contributivo</i>	3	23.1%
<i>Vinculado</i>	1	7.7%
<b>Work</b>		
<i>Rebusque</i>	2	15.4%
Unemployed	5	38.5%
Informal job	4	30.8%
Free lancer	1	7.7%
Formal job	1	7.7%
<b>Marital Status</b>		
Single	12	92.3%
Married	1	7.7%
<b>Housing</b>		
Homeless	1	7.7%
Rental	5	38.5%
Family House	5	38.5%
Motel	1	7.7%
Shelter	1	7.7%
<b>Education</b>		
High School Complete	5	38.5%
High School Incomplete	3	23.1%
Technician	4	30.8%

Years of heroin use		
4-6	4	30.8%
7-10	4	30.8%
11-15	4	30.8%
16+	1	7.7%
Heroin intake method		
Injected	11	84.6%
Smoked	2	15.4%

Because clients had to go to the clinic for their daily methadone dose, I consulted the methadone clinic staff about the possibility of doing a PhotoVoice project with them. They liked the idea and allowed me to present the project proposal in one of the Wednesdays group sessions. By that time, the clinic had been running for four months and the initial group of 16 were in the program. They all knew each other, and most of them had a lot of free time. We met at the commons of the *Obrero Clinic*. I explained that I was interested in learning from them about their experiences with methadone consumption, and more specifically how methadone had changed their daily lives. I explained that I hoped they could answer these questions with cameras that I would give them and, most importantly, that I hoped they would be eager to share a few images and discuss them in a group session. Most of them were excited about the idea, so we agreed to meet two weeks later to start the project.

In our next meeting, I distributed disposable cameras to each of them and provided a short introduction to photographic skills and aesthetics, the technicalities of the cameras, and emphasized the importance of capturing daily life with the photographs. I highlighted the portability of the camera and the importance of being safe, that they should not put themselves at risk while taking photographs. We all took sample pictures with a training camera. In that session, we also discussed that the narrative attached to each image was important, and thus how it was

instrumental for them to come to the next session and share both their photographs and their stories. They all agreed that the clinic staff members and I could use their images in papers, presentations, and other academic or pedagogical materials or venues. Furthermore, they all wanted us to use their real names in the photographic credits.

The third meeting was at the end of May 2018. Days prior, participants handed off their disposable cameras to Mauricio, the nurse in charge of administering their daily methadone dose, who in turn handed them to me. When people arrived, I handed each one of them their packages with printed images and a CD, since they wanted to be able to have digital copies to share on the internet. Almost a month had passed since our first meeting and everyone was pleased to see and share their pictures, especially at a time when photographic film is disappearing, given the immediacy of digital photographs widely accessible from mobile phones. I had previously uploaded their pictures to my computer from the CDs and kept the film, while they kept the CDs and the prints. I asked them to choose three pictures to share. Eight of the participants shared their photographs and stories that day. Two participants had lost their cameras; one could not engage with the project and returned his camera; another carried his camera all the time but did not take pictures; and one took pictures but did not tell us anything about them. The only female participant joined the project later, so she did not share her photographs in a collective session, although she shared her pictures with me in a one-on-one session at the clinic.



**Figure 10. Camera delivery day and photographic training. Mauricio, 2018.**

The universe of images captured by the participants was diverse: it ranged from photographs of very intimate spaces and situations to panoramic images of Cali. Thus, the photographs represented a curatorial challenge that was addressed by inviting clients of the methadone clinic—some photographers, others not—to identify themes that could group the images. In that session, we organized photographs under the following six themes: (1) the program; (2) the trajectories of drug use; (3) intimate relationships with family members, pets, memories, and spaces; (4) work; (5) territories, the city, and its surroundings; and (6) making sense of life.

The PhotoVoice technique allowed me to access places, people, territories, stories, and reflections at a speed and depth hard to reach for a single ethnographer in a few months of fieldwork. Even more, the cameras travelled to places I could have never reached or photographed. Thus, I see PhotoVoice as a methodology which enables a collaborative dialogue with participants, based on their active role gathering, interpreting, and sharing data. PhotoVoice, I argue through this work, is not about objectivity—we already know the camera is not a scientifically objective

device (Sontag, 1977)—but about making sense of a social reality through artistic creations and narratives coming from the communities who are the focus of analysis. In this sense, PhotoVoice has the power to subvert the potential of a unidirectional anthropological gaze, a difficult issue to navigate, especially in visual anthropology exercises.

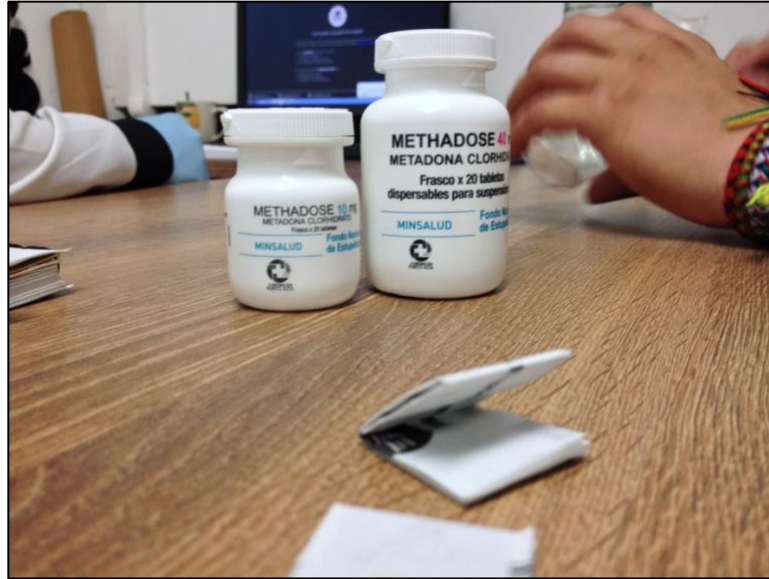
Perhaps the most famous example of visual anthropology of heroin is the iconic work of Philippe Bourgois and Jeffrey Schonberg *Righteous Dopefiend* (2009) on the intersection of homelessness and heroin in the US west coast, which started as an inquiry on the issue of injected drugs and HIV. It is without a doubt a powerful piece of ethnographic and photographic work. Schonberg's professional gaze and cameras, fastened by Bourgois' ethnographic skills and rapport with the people photographed, resulted in a high-quality product with a unified aesthetic that I would classify as state-of-the-art black and white photography material.

The PhotoVoice project I present here differs from Bourgois and Shonberg's approach in several important ways. For one, the cameras I provided to participants were color film 24-shot disposable ones, mainly because their price fit my budget, but also because I did not want to put participants' security at risk, especially in a context where people get stabbed or killed for a cell phone. For these reasons, the digital cameras that I had used in a previous PhotoVoice project in the US were discarded from this project; I discussed this with the methadone clinic staff and they agreed with this policy. Second, in *Righteous Dopefiend's* photos, the main object of attention are heroin users themselves, captured in portraits, thus capturing the situation through the individual lens of the anthropologist or photographer. Conversely, the photographs in my project were all taken by amateur photographers eager to register aspects of their daily lives, and even though the participants sometimes appear in the photographs, they are not the main focus of attention. What we see in participants' pictures are snapshots of their worlds. The materiality of the cameras

(Luvaas, 2019) and the way in which they were used, as well as the insight provided by participants in the collective analysis of their images and their curatorial process, transformed this photographic approach into a community-based one characterized by a polyphonic voice. Finally, the images, narratives, and analysis in my project circulate around methadone and treatment rather than addiction and heroin, directing attention toward access to harm reduction programs and access to legal opioids for heroin addiction.

#### **7.4 The program: The methadone clinic**

Methadone is a synthetic opioid that enters the body slowly and for longer time frames than heroin, calming brain receptors used to the opioids' stimuli and easing the withdrawal syndrome people suffer when they are addicted to opioids. In Cali, heroin users refer to this syndrome as *mono* (the monkey). Like any other depressant, methadone induces a level of relaxation and tiredness, but it does not provide a high. Thus, with an adequate dose people can operate in daily life without being high and without experiencing the *mono*. Methadone is a controlled substance in Colombia, so administering it requires a lot of paperwork and surveillance, much as with other opioids used in the treatment of pain such as tramadol, oxycodone, or morphine. Patients with chronic or acute pain, heroin addiction, or withdrawal symptoms need a lot of paperwork to get access to opioids in Colombia, and many times cannot get access to adequate opioids or doses, a paradox considering that Colombia produces huge quantities of high-quality opioids. Heroin users know methadone well and often buy it on the black market. Dealers sell it in H Street, though it is typically more expensive than a hit of heroin.



**Figure 11. Methadose 10 mg and 40 mg manufactured by Mallinckrodt. Photo by the author, 2018.**

During my fieldwork, clients went to the methadone clinic every day from Monday to Saturday to take their dose of methadone in situ, after having their blood pressure checked, and having a chat with Mauricio, the nurse. Michelle, an anthropologist and psychologist, was also there to give psychological support, mandatory for all clients, and the clinic also had a psychiatrist who made decisions about the dosage of methadone for each patient. Group sessions were sometimes held every other week, but their regularity depended on the willingness of clients to meet.

Clients of the methadone clinic were trying to stop heavy heroin use, which had disrupted their lives in many ways. For example, the majority did not have steady jobs, many had family issues, and others were still in a situation of homelessness. Like the needle exchange program, the methadone clinic represented a space to relax, chat with other people, and find shade and a cool place to rest for a bit. Very often the clinic staff offered coffee and biscuits to clients. The methadone clinic's staff were always welcoming, and it was common to see them spending time

with clients outside their offices, which illustrates the close ties built over time. For example, I often saw Sebastian, the youngest client, sitting with Mauricio and watching and sharing videos on their phones. The clinic was also a place where clients asked for support with many other things. For example, Edilberto, an energetic and always smiling man who made a living by selling books and other items in the streets of Cali, counted the clinic staff as part of his loyal customer base.



**Figure 12. Hanging with Mauricio, the nurse. José Mondragón, 2018.**

The above photo, which was part of the PhotoVoice project, depicts some of the close bonds formed in the clinic. José chose this picture in which he is with Mauricio, the clinic nurse, as well as Sebastian and Jorge, his two buddies in the clinic. He said this was the last picture left on his roll of film and he wanted to record the friendships he had built in the process of his methadone treatment. He said the photo captured a casual moment in which they were having fun. José told us that he had a special bond with Mauricio, not only because he is a nurse too, but also



because José had left that path due to his addiction to heroin. José closed by saying that Sebastian and Jorge were his closest partners in his struggle against heroin.

The picture shows the level of intimacy that was built between the staff members and the clients at the clinic. Those bonds proved to be key in the therapeutic process of every client. In the picture they are relaxed, making hand signs, leaning on the hospital bed in the same office in which they had their daily intake of methadone, which almost all disliked because of its profound bitter taste and for which clients or staff members brought soft drinks to wash out the taste. The picture shows a Coca-Cola bottle that served that purpose.



**Figure 13. The *Obrero* Clinic in Cali's downtown. Luis Alarcon, 2018.**

Luis took the above picture of the Obrero Clinic because he wanted to show how important the clinic was for him. He was not the only one who took such a picture—four other participants took an almost identical one. Luis, who was back to living with his mother and sister after years of heroin use, said that being part of the program was a “total blessing, a miracle,” because heroin

brought his life a lot of suffering and misery. When I asked how he got in the clinic, he told me that one day he was on his motorbike, passing close to *Cambie* heading to H street, and Cesar, the person in charge of handing out clean needles, shouted at him letting him know the methadone clinic was about to start that same day. He stopped, got the information, and enrolled. Luis pointed out that he was lucky—he got one of the 16 spots available in the program.

Here it is important to point out that the methadone clinic, in comparison to other detox programs available in Cali, does not punish clients for occasional heroin use. The clinic staff are aware that addiction is complex. They ask clients not to use heroin or other drugs while they are at the clinic and to report if they have consumed an opioid or any other drug in the 8 hours before their visit, since methadone is an opioid and there is a risk of producing an overdose. Also, the clinic is completely secular. This is a rarity in the panorama of heroin detox programs in Cali, since most of the help is provided by evangelical and Catholic NGOs and organizations that employ sobriety methodologies based on little or no medical evidence.

A clear example of the effectiveness of the methadone clinic came in the group session through Jimmy's pictures and stories. Jimmy was at the time a professional fumigator. He always arrived at the clinic wearing his blue uniform and a bit sweaty and thirsty from the bike ride—he biked everywhere. He started using heroin in 2005 in a moment of his life dominated by parties and got rapidly hooked on it. He stopped using heroin in 2018 when he enrolled in the methadone clinic.



**Figure 14. “The money I have saved since joining the methadone clinic.” Jimmy Medina, 2018.**

In this picture, Jimmy shows the money he saved by no longer buying heroin, a habit that cost him approximately 50 COP a day (17 USD). He said that all the money he got went to heroin. He said money simply disappeared and he could never buy anything for himself. In fact, months after he had stopped using heroin, he was happy because he was finally going to be able to buy a motorbike, which he found to be very helpful since he had to travel all over Cali with his work apparel. Even though he found biking fun and cheap, a motorbike would make his life easier.

In the next photograph, Jimmy shows the paraphernalia that clients can get at *Cambie*, the needle exchange program. The image shows a tourniquet, unpacked syringes, a heroin cooking device, a condom, a bottle of distilled water, and a lighter, the latter not provided by *Cambie*. Jimmy taught me that because of the lack of control in the processing of heroin, its hygiene cannot be assured; and since it is a product that, when injected, goes directly into the bloodstream, boiling it is highly recommended. However, many heroin users recognize that when the withdrawal symptoms are tough, they just end up getting an uncooked fix. Jimmy said this image represented

the previous kit of his daily life, but now he has the methadone kit, which he says is a much better one. In fact, when Cesar, the person responsible for giving and receiving syringes at *Cambie*, saw the picture, he said it was an interesting coincidence that the tourniquet resembled a RIP symbol (a crossed lace), one that marked an end of Jimmy's heroin use.



**Figure 15.** Intravenous drug paraphernalia provided at *Cambie*. Jimmy Medina 2018.



**Figure 16. Methadone paraphernalia. Jimmy Medina, 2018.**

Jimmy said that before, daily life revolved around the tourniquet and the heroin, but today it is the pressure gauge and the methadone. Jimmy had been at the methadone clinic for three months, but without heroin just 28 days. He explained that this was due to the adjustment of his methadone dose, which started at 20 g per day and gradually reached 100 g, which was the dose that kept him from consuming heroin by satisfying his organic desire for opioids. Jimmy, along with other clients of the methadone clinic and staff members, assumed the methadone treatment would take two years in order to overcome addiction.

Jimmy said that the changes in his life went beyond just switching from heroin to methadone. He recognized that he also had more time. He said that he was spending more time with his family, and that they were even including him in family trips and reunions. Before, he said, he just thought about heroin, and when he was at his home he was in his room all the time, isolated. In another picture, Jimmy appears in the living room of his house celebrating Mother's Day; his mom is behind him, hugging him, and both seem serene and happy. Jimmy's mind and

thoughts, he said, were free from heroin. All he used to think about was if dealers were selling, if police were around, or if the dealer had been caught. Now, he said, he could even walk close to H Street and just keep walking, without stopping.

In the middle of 2018, the methadone clinic relocated to a private clinic specializing in detox and rehab treatments in a middle-class neighborhood forty blocks away from H street. Some patients were happy with the change because the house looked nicer and they did not receive awkward looks or comments from patients at the Obrero clinic. But for many of them getting there required money to commute, which they did not have, or more time walking or biking, which affected the adherence to methadone for some of them. I ended my fieldwork when this transition was happening.

The organization where the clinic relocated was called Fundación Pilsen Wellness Center Colombia, a private clinic with an emphasis on detox programs, with offices in Mexico too. In May 2020, Fundación Pilsen Wellness Center decided to close the methadone clinic pilot program, which had 10 of the initial clients and 20 total patients, because the clinic was not profitable. In a conversation with Michelle and Felipe (the psychologist and director of Cambie, respectively), both told me they made the mistake of handing all their efforts over to a private company that was looking for profit and not the health of their clients. Apparently, the reason for closing the clinic was the cost of methadone, which was imported initially from Switzerland and later from Argentina. But the most painful part to accept is that the deeply privatized Colombian health care system asphyxiates unique initiatives because they are not profitable. Michelle and Felipe are now working in the health departments of Cali and Palmira, a neighboring city, and are now trying to move forward a policy of broader access to methadone through another public clinic in Cali. However, the daily access to methadone for many of the twenty clients that the clinic had by May

2020 was in standby, and as we now know methadone has to be taken on a daily basis in order to be effective.

### 7.5 Trajectories of drug use

Alejandro is a thin, tall, very often happy, and homeless man that makes a living guarding cars in the streets of downtown Cali. He was one of the oldest participants and the one with the longest heroin trajectory in the group. He started using it before Cali's heroin boom. In this picture, he takes us inside H Street or *La Olla*—a word that literally translates to “the pot”, which is a name commonly given in Colombia to places where drugs are sold and consumed. *La Olla* has areas specialized in selling different drugs, such as *basuco*, marijuana, and cocaine. The photograph is blurry: Alejandro took the photo quickly. He said he did not want to be erroneously seen as a spy. Despite the blur, the image shows the architecture of the Sucre neighborhood where republican architecture clashes with more modern styles, all in visible decay. By the white house on the right, groups of people are socializing and consuming drugs.





**Figure 17. H Street by Alejandro Pérez. 2018.**

Recyclers with their hand-pulled cars packed with cardboard are also present in the image (left), which represents one of the main economic activities in the Sucre neighborhood, where almost anything has value. In fact, one day I asked Daniel, a client of the methadone clinic, what a descriptive odor of H Street would be, and he mentioned that the smell of burnt rubber is common because cables are burned constantly to get the copper that is inside of them to sell it as recycling material. Cali's characteristic clear blue skies can also be seen in the image, as can the absence of shadowed places, letting the spectator feel H street's high temperature.





Figure 18. Fixing a *basuco* hit. Alejandro Pérez. 2018.

This time, Alejandro gives us a very potent image. We see here a friend with whom he used to share heroin doses. He asked his permission to take this picture in which he is fixing a *pipazo*, a *basuco* hit smoked in a pipe. Many heroin users are addicted to *basuco* as well and use it to counterbalance the drowsiness of heroin with the stimulant effect of a cocaine derivative. All the members of the PhotoVoice project recognized the wall that frames the picture; it is located on H Street and is a well-known spot. With a syringe under his cap, the character in this picture is a depiction of a common scene on H Street and its surroundings, where I often saw people carrying syringes hung on their ears.



**Figure 19. The heroin trip. Alejandro Perez, 2018.**

In this other picture taken by Alejandro, we see a raw scene. We are at H Street and see a man lying on the ground, surrendered to the effects of heroin, a common scene all over Cali's downtown. The image had a strong impact on all members; it triggered memories of similar experiences that many of them had gone through. Alejandro said that the image was blunt, and that he was just like that guy two months before enrolling in the methadone clinic. He said that thanks to the methadone, he was doing much better because he had managed to reduce his heroin. which allowed him to work much less because he had no need to find money for the next hit. He even rented a room on Sundays where he had a bed to lay down, rest, watch TV, have a shower and sleep. Before having access to methadone, all his money went toward buying heroin. Alejandro concluded his remarks by saying that on any given day between 7 am and 10 am, you could easily see eight to ten people like this guy lying in front of that same wall.

I once asked Alejandro if he could describe to me what iconic sounds identified H Street, and without a pause he said it was the sound of people shouting: *cierreeee* (meaning closure), a code-word to buy and share a hit of heroin with a fellow user. A hit of heroin on H street can cost from 6 to 7 thousand COP (2 to 2.2 USD) and many people report that they need around 30 to 50 thousand COP to meet their daily heroin addiction needs. Economies are precarious on H Street, so finding a partner to share a dose is very common. A person willing to find a dosage partner on H street shouts out loud *cierree!* and waits for another person to respond shouting the same word. The two meet and each one chips in 3 thousand COP, then they get a small zip lock bag with heroin in it and divide it. The rules go as follows: if you are my *cierre* partner and you divide the dose, I get to decide which dose to take, that way the one who is cutting the dose has to be very accurate. When the users shoot up heroin, they fill up the syringe with 5 mL of water, later add the heroin, ending up with 6 mL; afterwards, the dose is split in two—3 mL of mixed product for each. When users smoke heroin, it is harder to reach a perfect cut and disputes are more frequent.

There is also the *chute* (a hit), which is sold in the following manner: if a person buys a dose but needs a bit of extra cash for anything else, they can sell a *chute*, which consists of mixed water and heroin in a syringe. People will for example hit up 4 mL and leave 2 mL to sell, a good enough dose to calm the withdrawal symptoms of heroin addiction. The *chute* costs 2 thousand COP (60 US cents) for 2 mL and 1 thousand (30 US cents) for 1 mL. Even though 3 mL is the standard dose, bodies' tolerances of course vary. Alejandro once told me that when he had enough money, he would get two bags and dissolve these in 5 mL of water, so he would get 7 mL of a very oily dose of heroin which would not necessarily knock him out completely.

*Cierres* and *chutes* are high-risk situations for HIV and hepatitis C transmission. Sharing needles, as Alejandro clearly explains, is a common practice among heroin users in Cali, especially

when the *mono* is grasping people's minds and bodies and they do not have enough money to buy their own dose. *Cambie* has done important work in reducing these risks by providing free syringes and accurate information. However, *Cambie's* reach is limited too; for example, during the COVID-19 pandemic it is only open two days a week instead of the usual six. Furthermore, sex work, especially among female heroin users, is a common practice to get money in H Street, and a risky scenario for contracting HIV, hepatitis C, and other STIs.

Edilberto Velasquez, the peddler who sold books and other things, took the following picture of a mother playing with two children at the park in *La Alameda*, the neighborhood he works in. He said he took this picture because he wanted to evoke those moments in life when he was free of bigger issues like trying to get rid of drug addiction. His favorite place when he was a kid was a park in the neighborhood where he grew up. His grandmother would take him there to play basketball early in the morning so he would grow healthy and active, and this image evoked to him his childhood.



**Figure 20. Family at the park. Edilberto Velasquez, 2018.**

One day, as Edilberto and I were walking through *La Alameda*, heading to the market to have lunch, he told me he started using heroin when he was 25 years old, after he had quit his job as a bodyguard for the office manager of a health insurance company. At the time, he was also heartbroken, and in a party, he randomly met a woman who was smoking a joint with heroin and she shared it with him. He immediately liked it—it felt different, he asked what it was, and she said it was heroin with marijuana. For a few days after he did more research and found out that iconic artists he admired, like Ray Charles and Kurt Cobain, had consumed heroin. His curiosity about it grew; he wanted to become part of that world, he wanted to feel that world. Thus a few days later, he went with the same woman to H Street. He said she kept using heroin and quickly explained to me that she came from a wealthy family and the consequences for her were different

since she had money and support. For him, heroin translated rapidly into homelessness and emotional and physical pain.

He quickly shifted from smoking heroin with weed to smoking only heroin fumes after burning it on aluminum foil. He smoked heroin for a year. In the beginning, one bag of heroin would last him three days, but soon it lasted only one day. Eventually he needed six bags a day, which in 2013 cost four thousand COP per unit (1.33 USD). At that point, he owned a company with his father which delivered toilet paper and napkins to restaurants, schools, bars, and hotels. The business was going well and he could maintain his work and his heroin habit in a kind of balancing act until he started smoking ten bags per day. He tried to stop for a week, but his body ached and he decided not to endure it anymore. He went back to H Street and got his first injected dose of heroin. That day he woke up on a sidewalk, groggy, with the syringe still in his arm and the bag of heroin in his hand, empty.

That was the peak of his heroin use, which coincided with the death of his father, who was shot and killed. After that, he hit bottom and his family kicked him out of the house. When he became homeless, he started using *basuco* as well because it helped him to keep him awake. He said the death of his father was his breaking point because it left him without support, and he lost control of his life. His father was a key figure for him. After his death, heroin became as he said a neutralizer that numbed his feelings, fears, and pains.





**Figure 21. A cat at La Loma de la Cruz. Edilberto Velasquez, 2018.**

Edilberto loved the arts and used to have friends in Cali's arts scene, and he missed being part of it, a feeling that he connected with this picture of a cat. Cats are a visible part of Cali life; feral and domesticated cats are everywhere. In this picture, Edilberto is in La Loma de la Cruz, a park where handcrafts are sold and that has a nice view of Cali's downtown. People love to spend breezy afternoons in this park. Edilberto remembers that in that same spot, he met people involved in the arts scene of Cali—painters, actors, filmmakers, and photographers, all friends and contacts that he lost due to his addiction to heroin. He said he took the picture because his name tag is there, hard to read because it is drawn with silver paint, but also because the cat somehow reminded him that he wanted to be a writer, a promise he had made to himself in that same spot a long time ago. The cat's relaxed pose and its laziness, he said, was something he could personally enjoy again after he started visiting the clinic. He recognized that methadone gave him free time, which he valued a lot. In 2019, I talked via telephone with Michelle, and she told me that Edilberto went back to using heroin and had not returned to the clinic or to *Cambie*.

## 7.6 Intimate relationships

Relationships are, of course, an important part of life for participants. They talked about relationships in many ways, sometimes with nostalgia, other times using examples of reborn relationships or pointing to allegories to show how heroin disrupted their links with other people. They also mentioned how relationships with and nature were key in their detox process.

In *La Olla*, people build relationships of friendship, camaraderie, and love. Jorge Montenegro, a young man who was about to become a father and who made a living by selling candy on buses, took a series of pictures of his friends and acquaintances. In the images presented, men are consuming drugs and chatting. The following picture is a selfie he took with another guy. They are sitting somewhere on a street in the Sucre neighborhood. There is graffiti in the background, and his friend's face is covered by one of his hands, which is holding a joint and simultaneously offering the spectator a middle finger. While Jorge's face is uncovered, both of his hands are busy: in one hand he holds a joint close to his mouth and in the other one he holds the camera. Jorge took the picture to highlight the stereotypes built around people like him who live on society's margins. He told us that for society they were *los desechables* (the disposables)—a common term made popular by social cleansing groups in Colombia in the '90s to refer to homeless people, which enabled semantically their elimination. Jorge said he wanted to show through this picture that they were just normal people who made bad decisions, many times to escape and take refuge from a troubled world.





Figure 22. Smoking weed with a friend. Jorge Montenegro, 2018.

A friend of Jorge's took this next picture at the intersection of 18<sup>th</sup> and 13<sup>th</sup> street in the barrio Sucre. The place is called the heroin addicts' stairs. Members in the group session recognized this place and even some knew the people that appear in the picture. In the scene there are four men sitting in a row on the sidewalk, with graffiti in the background that says *fumele*—smoke it—without the f. The man on the left is smoking *basuco* and is looking to the ground; to his right is Jorge, looking at the camera and making a fist bump; the next man has a set of red headphones hanging around his neck, and he smiles at the camera while holding a cigarette in one of his hands. The last person on the right is smoking heroin and holding a syringe and was caught in the act of sitting to pose for the picture. Jorge said he wanted to show in this picture a snapshot of his life, by portraying a place in which he had hit rock bottom. Jorge tried to make a living by selling candy, but he did not get enough money this way, so he decided to sell cocaine too. In order to do so, he had to go and spend time in the Sucre. That line of work made him very susceptible to relapse into heroin, which he did. He had a cocaine addiction too, which was causing him some

issues. But in this picture we can also see that Jorge had a community in the Sucre, people he related to, people who appreciated him and wanted to appear in a picture with him.



**Figure 23. Jorge in La Olla. Jorge Montenegro, 2018.**

Luis in this next picture captured a moment of closeness with his sister at home in their kitchen early in the morning, just after his sister, who is a nurse, arrived after her night shift. Luis lived in an apartment complex with his mother, sister and a dog. He said that methadone had allowed him to reconnect with his sister and mother in ways that he had not in years of heroin use. He described how he for example used to fall asleep while eating food that his mother had served him, and how his sister avoided his presence as much as she could. He said that she used to be harsh with him and constantly expressed that she did not even like to look at his face. He felt and knew his presence created discomfort in his house, he did not feel welcomed. Fortunately for Luis and his family, methadone allowed him to feel loved by his mother and sister and to regain part of

their trust. His mother told him she and God knew he was doing things right and that reassured him in continuing with the methadone treatment.



**Figure 24. My sister. Luis Montenegro, 2018.**

Luis' case was not an exception. Almost everybody in the group shared how methadone allowed them to reconnect with their families and regain channels of communication and trust that they believed were lost. Two participants shared pictures of themselves celebrating mother's day with their families, and said it felt good to be invited again to family gatherings.

Paula, the only female participant in the PhotoVoice project and the only woman enrolled in the methadone clinic, like Jimmy, did photo essays. When we met, she was living at her sister's house with her brother-in-law, her nephew, a cat and a dog. Her sister went with her to all meetings and appointments and was constantly with her, which Paula appreciated but also disliked; she felt her sister followed her like a shadow, which created tensions between them. Paula desired more autonomy and trust, but her sister and brother-in-law preferred to be vigilant of her—they did not want her to relapse. Most of Paula's photo essays took place in the confines of her sister's home.

Paula loved her nephew and his judgment-free love. She enjoyed playing with him and she decided to incorporate many of his toys and games into her photographic essays. In this one, she put Captain America against Batman in a fight to show the difficulties of human relationships. She said that heroin brought her many interpersonal issues, and recognized that methadone was helping her resolve them, but it was not easy; there was still conflict.



**Figure 25. Members of the League of Justice fighting. Paula Rubio, 2018.**

Cats and dogs also appear all over the universe of pictures taken by participants, some as part of the landscape and others as the main focus. Luis' old dog, Princess, had died days before his birthday and he felt lonely and depressed, so he decided to get a new puppy, the one that appears in the following picture. For Luis, his puppy meant a lot; he explained how the dog allowed him to spend part of his free time in healthier ways. He explained, for example, how after he began



using methadone, to control his heroin cravings he would go out with his friends and do cocaine and sometimes snort heroin. It eased him; he felt he had something in his system, but afterwards he did not feel very good. Having a dog allowed him to avoid gathering with his friends and doing hard drugs. Instead, he would smoke a joint and chill with his dog, like we can see in the picture. The dog provided Luis therapeutic company. Paula also took portraits of a dog and a cat that lived at her sister's home, whom she loved dearly because they offered judgment-free love.



**Figure 26. Sahara behind a cloud of marijuana smoke. Luis Montenegro, 2018.**

Participants agreed that their addiction to heroin had negatively affected their emotional ties and relationships with family members and loved ones. In fact, heroin pushed many of them to live on the streets. On the other hand, heroin creates connections and liaisons with other people, many times other consumers, who become friends and acquaintances with whom they share similar experiences of marginalization and addiction. In fact, within the community of the methadone clinic, relationships of friendship and camaraderie emerged between clients and me and, as I have mentioned, between clients and staff members. Moreover, all participants of the PhotoVoice

project recognized that methadone allowed them to be sober and without *mono*, which allowed them to reconnect with their families in ways that their families missed. Methadone brought back channels of communication and trust. Finally, interspecies relationships with pets were described as therapeutic and were very much appreciated because animals gave support without judgment.

## 7.7 Work

The majority of the people involved in the PhotoVoice project worked in the informal job market, which in Colombia is called the *rebusque* (in constant search of). *El rebusque* has multiple shapes and in the case of the photographers, it emerged somewhat tangentially. People acknowledged that methadone allowed them to work less, save money, and also to look for better job positions. For example, José had studied to become a nurse assistant and found a stable job in a clinic, and with time he visited the methadone clinic less frequently; his girlfriend would pick up his weekly methadone because his work schedule did not allow him to get it. However, most of the PhotoVoice participants remained in the informal job market and struggled to make ends meet.

Alejandro, who made a living by keeping an eye on cars parked on the street, took a picture of the owner of the restaurant Pargo Rojo (Red Snapper) standing at the door of his business. The restaurant is located in Cali's downtown's San Antonio neighborhood, which is filled with cafes, hostels, bars, and restaurants, and therefore with good traffic for Alejandro's business. The owner of the restaurant liked Alejandro and she always gave him lunch, "a good one with fish soup, fish, fried plantain and everything," he said. She also stored things for him. For example, she held onto the camera he used for this project for several nights; Alejandro told us he would have lost it

otherwise “because when you live in the street you lose everything.” Alejandro grew up in that same neighborhood so people recognized him and sometimes gave him little jobs or helped him.

Alejandro did not charge a fee for his car-watching services, though some of his colleagues did; he received what people wanted to pay him. He said he made somewhere between 500 and 3,000 COP per car (15 to 90 US cents). He told us that since he had started using methadone, he worked from Monday to Saturday, sometimes both the day and night shifts, and rested on Sundays, which was new for him. Before, he had just worked all the time every day to meet his heroin needs. Alejandro took this picture of the street where the Pargo Rojo restaurant is located on a day that rained because he wanted to capture the freshness that the rain brings to his workplace. He described how asphalt traps and reflects heat in a city like Cali, and how there are days that the temperature is unbearable, so he always welcomes the rain on a hot day at work. Alejandro said he enjoyed being able to take the day off on Sunday and rent a room in a motel because it allowed him to rest and recharge his energy; he said that on Sundays he just sleeps.



**Figure 27. Carrera 9a, Cali. Alejandro Pérez, 2018.**

Edilberto shared with us two images related to his job. One came out very dark and it was difficult to see what was in it, but Edilberto explained that he put his peddler cart in front of a mural with art pieces from different parts of the world, located in one of Cali's bus station, to show how one day he wanted his writings to reach the world and to become proof of his new life. Edilberto dreamed of his poems, plays and writings becoming well known. Edilberto enjoyed selling books and miscellaneous items to people. He told us that he learned a lot about other people's lives through his conversations with them, and through what books they wanted.





**Figure 28. The Alameda market. Edilberto Velasquez, 2018.**

In this picture, taken in the Alameda market, he wanted to show the fruits that earth produces and people's effort and labor to make a living. He asked a friend of his to take the picture. He is there, standing in a white jumpsuit and offering an alphabet soup to one of his customers, who has a stand at the market. Edilberto's job allowed him to get by and to pay for a room in the Sucre neighborhood for 12,000 COP a day (3.5 USD), but since he had started using methadone he had saved more money and was thinking about moving to another neighborhood where he could get a room for 120,000 COP a month (35 USD), which would save him 240,00 COP per month (70 USD). Edilberto and I talked many times. Once, we had lunch together at La Alameda, and people liked him; often someone would stop us on our walk through the market to greet him. In our chats, he always mentioned wanting to gain more economic stability, and he took seriously every new accomplishment he made. Once he was happy because he gave a pair of new sneakers

to an old friend of his who was in real need of a pair of shoes. He said that he had the means to buy another pair of shoes and felt pretty good about it.

Most participants had lost their jobs and economic stability due to their heroin use. Two of them kept their jobs, one as a fumigator and the other as mechanic in a car garage, but only one of them had a formal contract, which means that only one person among all participants of this project had healthcare access through the *contributivo*, which ensures better quality of healthcare. The rest of the participants worked odd jobs in the informal job market and basically survived day by day. Almost all agreed that using methadone allowed them to have more time away from work because they did not have to constantly find money for the next heroin dose, and it allowed them to save money, which opened a space to think about a more stable future. Methadone on its own did not provide a route out of precarity for this group of people, but it did open a window to move forward.

## 7.8 Territories

Participants' photographs captured markets, street corners, neighborhoods, parks, buses, and streets of the city of Cali from a myriad of unique perspectives, which could have provided material for a whole human geography project. However, here I will focus on the photographers' reflections on how methadone changed their perceptions of Cali and its urban landscape and the ways they interacted with it.

Cali is a city that is public; people are in the streets all the time, people walk and use public transportation, people use sidewalks as extensions of their houses, and heroin use is also public for poor consumers, who often buy and consume it publicly. Heroin around H Street is public;



to 12,000 COP (1.8 to 4 USD), depending on the location of the restaurant. The restaurant where Sebastian's mother worked was located ten blocks away from *Cambie*, in a working-class neighborhood at the border of Cali's downtown. It served generous lunches for 6,000 COP (2 USD), and of course we were treated very well since all the workers knew Sebastian. This map shows the heroin dealing spots on H Street, including their names, qualities, and prices, and shows some stores where people can relax. Sebastian also showed me other streets which specialized in cocaine and *basuco*.

Paula took this next photograph, in which she captured an installation she made with dominos and shoes. She wrote with dominos "I Love Life" and surrounded the phrase with different pairs of shoes. She said that there are no shoes that resist the constant walking of the homeless and added that she could not remember how many pairs of shoes she had worn out while walking the streets of Cali looking for heroin and money to buy it. She wanted to have a break from that constant roaming, and she wanted to recover the time lost. She was exhausted, and methadone was giving her the chance to take a pause.



**Figure 30. I Love life. Paula Rubio, 2018.**

Sebastian, the youngest participant, took the following photograph from a metro bus station. The camera points toward the San Juan Bosco church and plaza. The station is close to where his mother works and close to H Street. He told us that when he was using heroin, he rarely took a bus because every peso counted toward his next heroin shot. Thus, for him this image marks distance with the past. He recalled that many times he had been in that same plaza or behind the church shooting heroin. He felt proud to be able to look at it with a sense of distance. Sebastian's reflection resonated with other participants, who spoke about how they felt more empowered to be part of the city, less stigmatized and with more rights to navigate the city. Also, some of them mentioned how the pause methadone provided in their lives allowed them to go back to exploring areas around Cali. Sebastian, for example, took a picture of a green area close to the city where he went with some friends to enjoy nature and smoke some weed. He said he used to go camping and



enjoyed it a lot, but he had sold all his camping gear to buy heroin; he said he wanted to go out camping again.



**Figure 31. San Bosco Plaza from the MIO station. Sebastian Londoño, 2018.**

Luis took two pictures of the residential unit where he lived with his mother and sister. The one I chose not to include here shows the commons area inside a residential complex, a common housing arrangement today in Latin American cities, characterized by fences, barbed wire, security cameras, and security guards. Luis described how the security guards that worked in the residential complex often stopped him at the gate and asked him questions and tried to prevent him from entering his own house. He usually had to sneak in while another resident was entering. He said that before using methadone, he often felt ashamed to look any of his neighbors in the face, so when he was in the residential complex he avoided eye contact or conversations with anybody—he tried to be invisible. Fortunately, he said, through methadone and the support he received at the clinic, he gained confidence to inhabit a space that he had forgotten he had the right to use and enjoy.



**Figure 32. The residential complex where I live. Luis Montenegro, 2018.**

In general, the people that participated in this project walked Cali's streets a lot, and most of them survived by working on the streets. In this sense, methadone allowed them to navigate the city in ways seemed more restful for them and to inhabit it with more dignity.

## **7.9 Making sense of life**

Making sense of life emerged as a robust theme in the PhotoVoice project. All participants were making efforts to cope with their addiction to heroin, and one strategy consisted in making sense of their lives. They all agreed that with the right daily dose of methadone occupied less space in their minds and bodies, which gave them time to think about other things, reconnect with people, rest, and think in other possible futures. People they loved emerged as the main nexuses around whom meanings of life took form. Comparing the past and the present brought on deep reflections about changes that created desire to keep controlling heroin use.



**Figure 33. My two feet. José Mondragón, 2018.**

José took this picture during a Mother's Day celebration with his family. They went outside Cali to a town called Ginebra and spent the day at a reservoir, where people can fish and have picnics. He took pictures of trees, frogs, and water, and he also captured this image of his naked feet. One foot is clean and the other one is muddy. The clean one represented him now, his change, his new attitude, his new thoughts. The dirty one represented all the bad things—his past, heroin, and the stress he had gone through with his family and his work. He said he liked the new him.

Jorge took this picture of the pregnant belly of his partner with a drawn-on smiley face. He confessed he was worried and anxious about his proximity to fatherhood. His partner consumed heroin too, but she had stopped since she found out she was pregnant. Jorge also wanted to stop and wanted to save money for his baby and his family, but the precarity of his situation made it difficult for him to build a more stable life. Jorge was always struggling to make ends meet. He sold candy in buses, as well as cocaine, but in many cases he ended up consuming more than what he earned selling it. He had difficulties going to the methadone clinic every day, so he was able



get take-home doses. Yet despite all the difficulties, he was thrilled about his baby; for him it represented a new beginning, hopefully one away from heroin. He said his baby meant for him the only true possibility to control his addiction. His baby had made his methadone use more consistent.



**Figure 34. 'My baby'. Jorge Montenegro, 2018.**

Finally, the last picture that I chose to include is this one taken by Sebastian, a portrait of his mother. He said to us that without her he would not be alive, and that the picture was a way to honor her. These were his words:

*She is the woman of my life, she is my mom. She put up with me for 20 years of her life, 20 years of shit that I have put her through, of stress, of fights. Of the 3 children she has, I am the most problematic, the one who doesn't let her sleep peacefully, the one who disappears at night, the one who uses drugs, and when I was born... this is already very personal... when I was born my father decided to leave and tell her to do whatever he wanted with her son. That was just when I was being born, so she took and raised my two brothers and me.*

*Besides, it can be said that she also raised my two nephews and with one job she supported a family. She always tried to give us her best, to pamper us as much as she could, especially to me who was very ungrateful. She did many things for me, she tried to satisfy what I asked for and I repaid her badly after all that she did. So that's why I wanted to show her here. She is my heroine, she is the best person in the world for me, she is like God to me. I do not believe that there is a being that is more loving, more kind than her.*

*Sebastian*



**Figure 35. My mother Ana. Sebastián Londoño, 2018.**

All the participants of the PhotoVoice project agreed that having access to methadone and support from the clinic allowed them to find new meanings in life by allowing them to connect and reconnect with people, animals, and ideas of life in different ways, with more time, with more serenity, and with less *mono*. In most cases, mothers were the main source of support and also the main reason to desire controlling their addiction to heroin. For participants, being able to reconnect

with them was a source of wellbeing. Meaning in life also came from fatherhood, from inter-species relationships with pets, and also from more mundane things, like having more time to rest.

### **7.10 Shooting cameras under the influence of methadone**

PhotoVoice showed a myriad of perspectives of the lives of marginalized and invisible people addicted to heroin in Cali, Colombia. The photographers, the staff members and I agreed that photographing the effects of methadone on the daily lives of clients made sense because it would help us to better understand the pilot methadone clinic from the users' own perspectives. By constructing and responding to this question collaboratively, the research exercise became an experimental contribution to the academic and aesthetic representations of marginalized people experiencing harsh structural violence (Syvertsen, 2019). In addition, the images and narratives presented dignified the lives of young people addicted to heroin in a context where their existence is denied and their deservedness for support questioned.

The PhotoVoice project also became a venue to answer the pressing questions of community members (Freire, 2005). The methadone clinic needed to know how methadone affected their clients' daily lives, and clients were willing to reflect on it. Both had data and ideas on how methadone was functioning, but participants brought a lot more richness to the analyses with their insights, their images and narratives, and their categorization of the universe of images. Participants took the most diverse aspects of their lives and put them in creative dialogue with the PhotoVoice project in an intentional way to speak out and make public their experiences and their needs as people addicted to heroin.

Furthermore, starting a dialogue about methadone in Colombia is essential since the biopolitical apparatus has chosen methadone as the first line of pharmacological treatment for opioid users, even though in the US and Europe its use has been questioned due to the high dependence and it creates, with buprenorphine being recommended instead (Ebner, Schreiber, & Zierer, 2004). Moreover, countries like Switzerland provide medicalized heroin to support addicts and other countries use opium as treatment. Colombia produces high-quality opioids and even though this project has shown the positive effects of methadone, as have others (De Maeyer et al., 2011), Colombia should consider more options in its biopolitical approach, including legal heroin and opium to treat opioid addiction. It has been proven that having the option to have recreational opioids mixed with therapeutic-only ones improves the chances of addicts to control their addiction (Bourgois, 2000).

In addition, the opioid epidemic in the Americas is complex and multi-situated. Approaching other perspectives on the effects of the opioid epidemic beyond the Global North is key to start fruitful dialogues on how to tackle this issue in more cooperative and creative ways and to further rethink the perverse and useless nature of the global war on drugs. Furthermore, I believe it is key to keep expanding this project by exploring the lived experiences of poppy growers, many of whom are impoverished *campesino* and indigenous farmers. Opium poppy growers end up in this agricultural business because of its economic benefits; however, it is considered an illegal activity so they become targets of the internationally funded war on drugs. Air-sprayed pesticides (such as Roundup, a product banned in the EU) are used as chemical weapons against poppy and coca plants, but these are not selective weapons—they pollute water, forests, air, animals (including humans), and other plants alike. Anti-narcotics police and the army are constantly patrolling poppy-growing areas, and growers can go to jail. Furthermore, poppy

growers' subsistence is based on contracts with illegal armed groups. Thus, under this logic poor poppy growers and poor heroin users, both at different ends of the opioid economic circuit, must cope with serious issues of public health and social inequity with little support. In this light, understanding the whole opioid dynamics in a country that produces, exports, and consumes heroin is a powerful scenario for applied research, and a fruitful one to open discussions on global extractivism and global health at their intersection with the opioid epidemic.

Harm reduction programs are rare and commonly misunderstood in countries like Colombia, where support for the marginalized and the poor, including addicts, has a long history based on Christian organizations and principles. The idea of providing tools like information, counseling, and clean paraphernalia to use drugs in safer ways, without demanding sobriety from recipients, seems counterintuitive in a society where abstention—from drugs, sex, and society—is a Cristian value for seeking glory and redemption. Harm reduction programs have proven to be effective around the globe (Hawk & Davis, 2012; Philbin et al., 2008; Roy, Arruda, & Bourgois, 2011) not only helping people addicted to substances to deal with their sickness and suffering but also in bringing a framework of human rights (Robertson et al., 2014; West et al., 2020)—including the right to have pleasure—into the discussion on how public policy can deal in more humane and less policing ways with addiction.

Findings indicate a potential risk for the spread of HIV and hepatitis C among people who inject drugs (PWID) in Colombia, given their widespread sharing practices, high rate of new injector initiation, and unsafe syringe cleaning practices. Colombia today has a possibly time-limited opportunity to prevent another epidemic by implementing harm reduction interventions among young, newly initiated PWID (Mateu-Gelabert et al., 2016). Colombia is experiencing an opioid epidemic that is attracting mainly poor young men to a landscape that has been ruled by

*basuco* for decades. Both the opioid and *basuco* epidemics are now intertwining in alarming ways that need attention because of the highly addictive nature of both substances, the suffering of addiction, homelessness, and because the use of intravenous drugs might bring more HIV and hepatitis C into these communities.

## 8.0 (in)Visible men navigating plagues

In an interview in 2017, Caleña HIV activist Ligia Gomez said to me, “heterosexual men live their HIV-positive diagnosis alone and in silence.” This phrase stuck with me throughout this research process and synthesizes in many ways how heterosexual men experience their HIV-positive diagnosis and how poor men experience opioid addiction in Colombia today. My research shows that these men suffer alone and in silence because of the stigma attached to HIV and heroin, and because of institutional biases. In the case of HIV, the historical trajectory of the HIV biopolitical apparatus, which emerged in response to homophobic policies and the devastating effects of the HIV epidemic on gay communities, had the side effect of excluding non-LGBTQI+ populations from its policies. In the case of opioid addiction, the war on drugs focuses on production in the Global South and consumption in the Global North, ignoring the growing opioid crisis in Colombia, which primarily affects poor men and is rapidly reshaping the HIV epidemic. Neglect of these two communities is exacerbated by the neoliberal privatization of the Colombian healthcare system, which harms all HIV and addiction patients but especially those outside the radar of the biopolitical apparatus. These factors together make what should be chronic conditions—HIV and opioid addiction—into terminal ones for these male populations. In sum, the situation today is that heroin addicts and HIV-positive heterosexual men in Colombia must face these plagues alone. Nevertheless, I found that these experiences reshape men’s gender identities and personal relationships in ways that are often positive.

In this concluding chapter, I summarize and provide final insights on my dissertation’s main findings. Using the theoretical lens of masculinities and affect, I show how men grapple with their HIV diagnosis and heroin addiction in a social and medical vacuum filled with silence,

stigma, and anxiety, but that these experiences profoundly affect their identities and personal relationships. I begin by contextualizing these issues by discussing structural issues in the HIV biopolitical apparatus, the neoliberal privatization of healthcare, and the war on drugs, which exacerbate the lack of institutional attention given to affected male populations, turning their chronic conditions deadly.

### **8.1 Structural silence in the biopolitical apparatus**

As I have demonstrated in this project, the Colombian HIV biopolitical apparatus, aligned with the global fight against AIDS intrinsically linked to the gay rights movement, has been successful in representing, including, and normalizing the male gay body. This has been of great benefit for LGTBTQI+ movements around the globe. However, the success of this movement has had the side effect of posing severe difficulties for non-gay-male persons in finding a place in the HIV treatment apparatus. This dynamic has created a hegemonic gay HIV-positive masculinity that profoundly clashes with self-identified heterosexual men who become HIV-positive in highly homophobic contexts like the one in Colombia. Today in Colombia, being heterosexual still deters attention from HIV epidemiological surveillance tools and self-identified heterosexual men do not experience HIV as a chronic disease in part due to their gender identification.

The HIV biopolitical apparatus in Colombia emerged as part of a progressive movement that mobilized radical positive change. This apparatus allowed openly gay men, for the first time in Colombia, to have access to positions of power and decision-making, and strengthened the gay male community at a moment in which AIDS was menacing their existence. However, and paradoxically, over time this biopolitical machinery and its bureaucracy became blind to new



dynamics of the HIV epidemic in Colombia. I argue that this biopolitical blindness lies in the historical trajectory of the Colombian HIV biopolitical apparatus, which emerged as a social, political, and medical response to the HIV epidemic and homophobic policies. Eventually the HIV biopolitical apparatus itself became a branch of a global gay movement, with a local agenda aligned with it.

But this is not the sole root of biased HIV policies. As I discuss in this dissertation, there has been a structural and historical transformation in Colombia contemporaneous to the HIV epidemic: the privatization of the Colombian healthcare system. The 1991 Colombian constitution stated that health was a public service and not a human right, and this caveat dramatically changed the health landscape in the country. Even though the previous public healthcare system was not perfect, it served the vast majority of the Colombian population under two main branches. The first one was designed for the poor; anybody who needed attention received medical care and was later charged according to a sliding scale fee. The second one served formal workers and charged workers and employees monthly fees and co-payments with fees according to their salaries. Both systems received money injections from the central government, states, and cities, but were often in debt, in part due to administrative issues, but mostly because they were not-for-profit institutions that were part of a welfare network.

Very importantly for the context of HIV, the Colombian public health care system was affiliated with the public university network. Students of all branches of medicine practiced in the public healthcare network and top-quality medical research emerged from these alliances in a symbiotic relationship mediated by a social contract of medical care, research, and education (Abadia-Barrero, n.d.). Hospitals were public, and patients within them created union-type organizations which served political, medical, and social needs from groups of people suffering

from one or several diseases. The first and most important grassroots HIV organizations in Colombia were born in these hospitals; meetings and support groups usually met in the commons of these hospitals, patients had access to medical resources at all medical levels and had health professionals of diverse areas as allies. In short, until the early 2000s, HIV civil organizations belonged to the national epicenters of medical care, which created synergies that allowed patients from all over the country to connect and move forward policy transformations in hand with medical specialists. It is within these contexts that alliances between HIV-positive gay men and women emerged, just when more women started to become infected with HIV and the country began to experience what is called the heterosexualization of the HIV epidemic.

The neoliberal privatization of the healthcare system in Colombia not only disintegrated public infrastructure built over centuries but also dissolved the emotional and political links Colombians had with their healthcare system. HIV patients were relocated into several HIV programs that belong to different health insurance companies. Small, specialized HIV clinics quickly emerged all over the country, usually assembled within houses located in middle-class neighborhoods that were transformed under a model of health insurance infrastructure gentrification, displacing the hospital as the epicenter of healthcare in Colombia.

Today, the Colombian health insurance market is in the top five most profitable businesses and shrinks, expands, and mutates in such a dynamic way that is hard to keep track of. Whenever health insurance companies enter modes of bankruptcy—merging, fusion, or dissolving—they commonly leave (HIV) patients without ARTs, critical medical procedures, or follow-up appointments, and with gaps in their medical needs that cause delays, sickness, and sometimes death. These dynamics, as I have stated throughout my research, are critical in shaping HIV in

Colombia as acute, rather than chronic, especially for the poor and those outside the radar of the HIV biopolitical apparatus, like heroin users and heterosexual men.

Colombia's fast-growing and expanding heroin epidemic, which is concentrated among men, has brought another actor into the country's HIV landscape: people who inject drugs. In the case of heroin users, the majority of whom are poor men, the healthcare system does not even acknowledge their existence. Colombia has lost hundreds of thousands of lives due to addiction to *basuco*, and the singular focus of Global North consumption and Global South production of the war on drugs means the only apparent national concern around the matter over the years is the increase or decrease of coca leaf hectares and the tons of cocaine confiscated before they arrive in the US, Europe, or Asia. Nobody seems to take the *basuco* epidemic as the public health emergency it is.

Heroin, as invisible as it is for the epidemiological radar, is very present in Colombia today and is changing the lives of thousands of poor young people. Even though risky behaviors when using needles to inject illegal drugs are linked to higher rates of HIV/AIDS, hepatitis C, and overdose, Colombia has no data to understand this health crisis and no public policy to support people suffering from addiction. Nor does the HIV biopolitical apparatus have data on how the HIV and opioid epidemics are overlapping. Heroin users in Colombia are left alone with no broad structural resources to deal with their addiction. Similarly, the population of HIV-positive heterosexual men is growing in Colombia, and even though they are represented in the epidemiological data, support networks seem to be blind towards their needs. Both denials are molding the shape of the current HIV epidemic into a shape that is demonstrating that the country's public policies in these matters are decades behind.

At its core, the new healthcare system deserted public research and education, breaking bridges of communication between grassroots organizations, universities, hospitals, and HIV patients. This disruption subsequently created gaps and lags in the updating of surveillance and treatment protocols. In a similar vein, the for-profit logic of the privatized healthcare system has denied the importance of medical support for addiction, which today in Colombia is treated by an array of faith-based and private organizations that rarely follow medical protocols, opting instead to follow sobriety methodologies like the ones described by Kevin O’Neill in Honduras (O’Neill, 2015) or Christina Hansen in Puerto Rico (Hansen, 2018).

## **8.2 Men walking alone**

My dissertation research project parallels a wave of medical anthropology research deeply influenced by gender studies on men and masculinities that focuses on biological and non-biological disruptive events, many of which are chronic, and that impact men’s lives, bodies, identities, and kinship in ways that challenge men’s heteronormative gender roles. I have labeled these investigative currents “anthropologies of uncomfortable masculinities” because they share interests in analyzing and questioning sexualities and gender roles through an exploration of how these “abnormalities” create uncanny emotions and interactions, as well as potential transformations. I show that the emergence of HIV-positive serostatus or opioid addiction are experiences that not only destabilize men’s lives—often forcing them to deal with the reality of their conditions with little institutional support—but also create reorganizations of individual roles and social dynamics, such as HIV-positive or serodiscordant romantic liaisons, responsible and caring single fatherhood, and the construction of a support network of “addicts” linked through

the pharmacological hope of rehab. Both epidemics insert men into deeply privatized biopolitical systems that neglect their needs and amplify their pains and anxieties. Nevertheless, men find hope for their existence within these epidemics through pharmacological treatment and reconnection with their families and loved ones.

The literature on masculinities in Latin America often speaks of *machismo* as a risk factor for death, disease, and the exercise of violence. My research project is an attempt to move beyond this archetypal representation, which has been consistently and powerfully used to denote a catch-all collective pathological force that controls not only the behavior but also the culture of Latin American working-class men. With my research I show that, besides being difficult forces for men to understand and control, HIV infection and heroin addiction can become experiences of self-reflection that often promote positive changes. The reflections with positive outcomes are typically the product of the labor of these men in conjunction with partners, family members, friends and idealistic institutions.

My work sheds light on key aspects of how men experience HIV, including how they learn of their diagnosis, typically through serious AIDS episodes; how they react to it as a sign of death, through silence and denial; how they cope with their diagnosis with little institutional support, but also through reorganization of personal social dynamics and the emotional support and labor of women in their lives; and how their experience of HIV made deadly rather than chronic due to social and institutional biases, which result in misinformation and lack of therapeutic community support. My research also shows that although self-identified heterosexual men do sometimes become infected with HIV through homosexual encounters, as the literature suggests (Montgomery, Mokotoff, Gentry, & Blair, 2003), infection among men also happens at the moment of birth, through sex with women, and through intravenous drug use. These findings move

the discussion beyond the homosexual risky encounters of self-identified heterosexual men especially when they are in an active (penetrative) role (R G Parker, 1999; Richard G. Parker, 1996) and bring new discussions to the table in which new routes of HIV infection are made visible. Furthermore, I highlight the tensions heterosexual HIV-positive men experience regarding their HIV infection, fatherhood, romance, and self-care. In this sense, I contribute a step towards conceptualizing men beyond sexual encounter categories (i.e. MSM, HAM, MSW) and as vulnerable rather than only as risk generators (Dworkin, 2015).

Through my fieldwork, I learned that denial and silence are common tools that HIV-positive heterosexual men use to cope with the weight of the unknown and fear-inducing presence of HIV in their lives, in ways that are completely at odds with the medical, therapeutic, and social advances that exist today on the HIV/AIDS front. In Colombia, heterosexual men do not like to talk about their sexual health or approach medical services when they have sexual health issues and most of the time assume reproductive health to be a women's matter. They do not expect to become infected with HIV, nor does the HIV biopolitical apparatus that produces the guidelines for HIV treatment and prevention. Many of the men I talked with had had numerous STIs, but when they approached medical care facilities seeking treatment were never offered an HIV test, which is inadmissible today in a moment in which HIV tests should simply be part of routine check-ups for sexually active people.

The embodiment of the HIV-positive diagnosis as silence can be fatal, as Wili, a gender-based violence prevention activist and former HIV activist, recalled in one interview we had in 2013. Wili told me that many times in his career he found poor men dying of AIDS alone, in terrible conditions, and with no support from family members or the medical system. Wili explained to me that part of this issue came from the stereotype of HIV being a gay disease, a

stigma which many men cannot deal with. HIV's presence disrupts heterosexual men's lives by materializing into their bodies a disease that historically has not belonged to them, one that has belonged to gay men—this is profoundly conflicting in a homophobic society like Colombia. HIV becomes not only an unknown but also an uncomfortable presence that opens questions about men's sexual trajectories, and the resources available are tailored for men who openly accept that they have sex with men.

In this sense, HIV-positive heterosexual men are lost in translation within a biopolitical apparatus that has not designed a proper language to communicate to them the facts of living with HIV and its treatment. I argue that the experience of the unknown that these men experience can be read through the lens of the studies of emotions and feelings, specifically through affect. Affects are ineffable sensations that can connect or repel, create a sense of community or division. Brian Massumi, for example, shows how a player in the field can temporally connect, emotionally, spectators who are watching the player's performance in the field and create a temporal community of affect (Massumi, 2002). Sarah Ahmed analyzes how news can create temporal communities of feelings that can lead, with time and reiteration, to the consolidation of national identities (Ahmed, 2004). In this vein, I show that HIV's specific social and historical trajectories repel some and connect others. For example, gay men who become infected with HIV today in urban Colombia know the therapeutic routes to deal with the disease and know that their sexual and romantic life can be resumed relatively easily within a community that has learned how to cope with the virus for four decades. There are even sexual communities of gay men who are open to having unprotected and consensual sexual intercourse with HIV-positive men (Balán et al., 2013; Betancourt, 2017; Elford, Bolding, Davis, Sherr, & Hart, 2007). Medical staff in Cali often told me how young gay men recently diagnosed with HIV would arrive at HIV clinics already well-

informed about the nature of HIV and ARTs and just wanting to know when and how they could get their ARTs.

By contrast, heterosexual men's silent way of coping with their diagnosis propels the accumulation of misinformation which leaves HIV-positive heterosexual men without accurate information on how to deal with HIV, ARTs, their sexuality, romance, and family formation. Many men I spoke to did not know they could become fathers and stopped taking ARTs when they drank alcohol. This silence is key in my argument that heterosexuality in this case plays against the well-being of these men because they are excluded and are not seen as deserving access to information and support networks, which have been fundamental for other groups of HIV-positive people.

I often heard from Colombian bureaucrats, HIV professionals, and people living with HIV that living with the disease is much like living with diabetes, and sometimes better than living with cancer. However, chronicity, as we now understand it, is achievable only if multiple structural and individual variables coincide (Smith-Morris, 2010). One of the most exciting findings from my dissertation research is that the intersection of heterosexual masculinities and HIV is a deterrent to experiencing HIV as a chronic disease in Colombia. Among heterosexual people, and especially men, HIV is perceived as a sign of impending death, which contradicts the growing literature accompanying the accelerated development of ART. The unexpected presence of HIV is incomprehensible to them and remains so, usually for long periods, creating discomfort, sorrow, and despair, which leads to faster processes of health deterioration. Ironically, this despair turns their misguided fear that HIV is an acute disease into a reality.

Heterosexual HIV-positive men do not have therapeutic communities to share their anguishes about living with HIV and medical spaces are not tailored to welcome them. There is no support from the HIV biomedical apparatus to help heterosexual men to categorize and



domesticate the undecipherable feeling of HIV into a set of post-hoc categorized emotions (Wetherell, 2012) which allow HIV to be experienced in healthier and more informed ways and as a chronic disease. This case study thus yields a fruitful discussion on the construction of chronic and acute diseases in specific locations and populations (Niewöhner & Lock, 2018).

In a similar way the people addicted to heroin in Cali, Colombia, who are mostly young and poor men experience their addiction without tailored support. In Colombia, the opioid epidemic embodied in young poor men is reshaping the existing *basuco*, HIV, and hepatitis C epidemics. Addiction to any type of substance in Colombia is not considered a public health issue, thus people deal with their addiction alone and without support. The opioid epidemic in the Americas is complex and multi-situated, but research on the impact of the opioid epidemic often focuses on the Global North. Studying the issue from the Global South is key to more comprehensively understand how it should be managed and to invite a critical perspective on the global war on drugs.

My research approach displayed in chapter 7 based on the heroin epidemic in Cali, a city of the Global South, employed PhotoVoice as a community-based participatory research method proved to be an effective methodology to collectively discuss how methadone affected their daily lives. And through this prompt theme the project reached a diverse and intimate perspective from heroin and methadone users narrating their daily challenges with health care, addiction, family, love relationships, work, and urban life.

Even though methadone has been criticized for being itself very addictive, especially in places in the Global North with longstanding opioid epidemics, in Colombia opioid rehab pilot programs using this pharmaceutical drug have created temporary networks of hope. Heroin users find in methadone an aide to overcome their addiction to heroin within a novel yet fragile network

of support with a harm reduction approach (Erickson, 1995). Methadone provides relief from the physical addiction created by opioids, allowing heroin consumers to have a break with their cycles. Many of the people I spoke with found in methadone a chance to reconnect with their families, recover the time lost, save money and engage in “normal” lives away from the pains of *el mono*—name given in Cali to the heroin withdrawal symptoms. However, the chances of being part of harm reduction programs with access to imported methadone are extremely low, leaving a vast population of opioid users who want access to methadone with the choice of buying it from their heroin dealers or subjugating to Christian detox clinics, mostly based on sobriety therapies.

I found that in a pleasure landscape like Cali, unprotected sex with multiple partners, the consumption of sex, and the use of drugs and alcohol are very common elements in men’s identity constructions and their ideas of indulgence. Pushed by curiosity and the desire to experiment with new sensations within a landscape of pleasures where drugs are widely available and consumed, many people end up addicted to heroin. In a similar way to HIV, opioid addiction in Colombia is experienced in silence and with shame by heroin users.

Danny’s story—he was client of the methadone clinic and one of the curators of the photographs taken and presented by other clients—encapsulates the drama experienced by heroin users in Colombia. He got hooked on heroin in his early 20s and tried to seek help, but could not get any, so he decided to enroll in the army as a way to treat his addiction. However, once he was in the army he was sent to the Cauca region to patrol areas where coca, poppy, and marijuana are grown and cocaine and heroin produced. Soon his platoon had access to cash and excellent quality heroin for allowing cargo to pass. His addiction became worse and he was expelled from the army. He ended up roaming Cali’s downtown streets as a homeless person with only the occasional support of his family, already burdened after years of his addiction to heroin.

Danny's story exemplifies the Colombian biopolitical approach to drugs and addiction, characterized by the deployment of the national army, composed of poor young men with not many other employment options, who are put at war against poor peasants who grow and produce illegal goods because these are more profitable than legal crops. The objective of the war on drugs is to control the production and export of drugs to prevent addiction in the Global North, but local addicts are completely ignored, considered to be socially disposable or *desechables*, a common derogatory term used in Colombia to refer to homeless people. This kind of structural blindness toward marginalized groups is characteristic of both the war on drugs and the HIV biopolitical apparatus.

Overall, due to the specific trajectory of the HIV epidemic, which was initially concentrated among MSM; a neoliberal transformation of the Colombian healthcare system, which destroyed a successful civil and medical response against HIV; and the war on drugs, which focuses on the production of drugs and the policing of drug users, heterosexual men and heroin users have been left in a vacuum where their needs are given no attention or care. Blame for these men's silence—and subsequent death—usually falls on individual choices and “behavioral misconduct.” Rarely acknowledged are the structural forces that keep these men invisible but active actors in reshaping these plagues.

## **Appendix A HIV-related interview guides**

### **Appendix A.1 Semi-structured interviews with HIV-positive men**

This set of interviews will allow me to explore men's roles related to partnership, love, and parenthood. And further on ask them how HIV has affected these aspects of their lives at intimate and social levels. Furthermore, I will ask in these interviews about the discomforts that the presence of HIV creates among these men's lives.

Name:

Age:

Educational level achieved:

City of residence and zip code:

- When and why did you decide to become a father?
- If you are a stepfather why did you decide to become one?
- Could you describe to me how is your nuclear family like?
- Do you live with them?
- When did you know you were HIV-positive?
- How did you know about it?

- How do you think you got infected with the virus?
- Has the HIV-diagnose changed in any way your ideas and practices of fatherhood?
- If so, how?
- Has the HIV-diagnose changed in any way your ideas of family formation?
- If so, how?
- Has the HIV-diagnose changed in any way your ideas on love and romance?
- If so, how?
- How do you cope with the virus?
- How is your access to treatment?
- How often do you go to the doctor?
- Are you taking antiretroviral treatment?
- Do you seek for help and/or information in support groups?
- If yes, why?
- If not, why?
- Is there anything else that you want to tell me and I have not asked about?

## **Appendix A.2 Semi-structured interviews with partners of HIV-positive men**

This set of interviews and the inclusion of men's female partners aim at gender-balance men's narratives and perspectives. And also has as an objective to explore the experiences and the reasons of men's absences in romantic and parenthood roles when HIV becomes present, emphasizing the repercussions of men's decisions into the private and public spheres.

Name:

Age:

Educational level achieved:

City of residence and zip code:

- When and why did you decide to become a mother?
- If you are a stepmother why did you decide to become one?
- Do you live with HIV virus?
- If so, when did you know you were HIV positive?
- How did you know about it?
- How do you cope with the virus?
- How is your access to treatment?
- How often do you go to the doctor?
- Are you taking antiretroviral treatment?
- Do you seek for help and/or information in support groups?
- If yes, why?
- If not, why?
- How would you describe the role of the father of your children?
- Is he an affectionate and loving partner?
- Is he a responsible and caring parent?
- Has HIV affected your family?
- If so, how?

- Has HIV affected your romantic life?
- If so, how?
- Do you think HIV-positive fathers assume parenthood differently than mothers?
- If so, why and how?
- Is there anything else that you want to tell me and I have not asked about?

### **Appendix A.3 Semi structured interviews with NGO and Health Staff**

In order to address medical discourses and practices that surround male HIV-positive reproduction I will conduct this set of interviews. This data will be contrasted with those collected through my fieldwork in order to identify ongoing policies, perceptions and practices of care and support directed towards HIV-positive fathers.

### **Appendix A.4 Questions targeting health staff**

- Could you describe to me who are the main clients in the HIV program?
- Could you describe more in detail the characteristics of the male clients that assist to the HIV program?

- Are there HIV-positive men who are fathers in the program?
- If so could you characterize them somehow?
- How did they get infected?
- How did they know of their HIV diagnose?
- How do they cope with the treatment?
- How do they cope with fatherhood?
- How do they cope with their sexuality and romantic life?
- Do you think HIV-positive fathers need a different approach on behalf the health care and health preventive services? If so, how?
- Is there anything else that you want to tell me and I have not asked about?

#### **Appendix A.5 Questions targeting NGO's staff**

- Could you please describe to me how is your NGO connected to HIV services?
- Do those services attract HIV-positive fathers?
- If yes, why?
- If not, why?
- How would you describe the effect of the HIV epidemic on families in Cali and the region
- How would you describe the role of HIV-positive fathers in shaping of the actual HIV epidemic in Cali and in the region?
- How do you think HIV-positive father are getting infected with the HIV virus?
- Do you think HIV-positive fathers have different needs for support in comparison to women and men who are not fathers?



- If so, what are those needs?
- Do you and the NGO you are part of feel capable of building support for those needs
- Do you see differences in how the mothers and fathers cope with the HIV diagnosis?
- If so, what do these consist of?
- Is there anything else that you want to tell me and I have not asked about?

## **Appendix B Intravenous drug users interview guide and questions for Photovoice**

### **Appendix B.1 Interview guide**

Name:

Age:

Gender:

For how long have you been using intravenous drugs?

What kinds of drugs do you inject yourself?

What other drugs do you use?

Do you have a family?

Are you a father or a mother?

Does your drug consumption habits have affected your family relationships? If so, how?

Are you a customer of the needle exchange program? If yes, why do you use it?

If you consume heroin, are you willing to stop using it? If so, have you tried using methadone?

What has been your experience with using methadone?

Do you find your intravenous drug habits harmful for your health? If so how?

### **Appendix B.2 Photovoice questions guide for heroin/methadone users**

How does the intake of methadone affect your daily life?

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