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Temporalities in Tension:

Rethinking the Sexual Health of Migrant Men Who Have Sex with Men (MSM) through the Lens of “Outness”

A dissertation submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy

UCL Centre for Multidisciplinary and Intercultural Inquiry

Doctoral Candidate Thesis Declaration Form

Part A: General Declaration

I, Arthur Davis, confirm that the work presented in this thesis is my own, original work. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

This work has not previously been presented for a degree or other qualification at this University or elsewhere.

All input or assistance in the creation of the academic work other than from the supervisory team (including AI) has been acknowledged in Part B below.

Any text or data in the thesis that has been presented for publication (including in review) elsewhere is declared in Part B below.

Part B: Declaration of Contribution from Other Sources

Data: all data were collected by me.

Code: all code was developed by me, without generative assistance.

AI: generative AI was occasionally used to familiarise myself with topics and to refine the research process.

Other: parts of this work were developed in informal conversations with colleagues, as reflected in the Acknowledgements.

Abstract

This work introduces a temporal dimension to understandings of the spatial relocations of international and intra-national migrant men who have sex with men (MSM), thereby revealing hidden dynamics of sexual risk and wellbeing. While health researchers often find migrant MSM to have poor sexual health outcomes, this purported group is far from homogeneous. MSM migrate for various reasons, from various contexts, and at various points in the life-course, the unique intersections of all these factors influencing sexual health perceptions and behaviours. Thus, an understanding of the temporal journeys of migrant MSM – from one "timeline" to another – may usefully guide attempts to better map dynamics of sexual risk and wellbeing. Through an analysis of semi-structured interviews with migrant MSM recruited from three sexual health & HIV services in London, using a modified constructivist grounded theory approach, I explore how the alignment or misalignment of temporal, coming-out journeys with spatial migrations shapes sexual trajectories. Firstly, I examine the ways in which participants navigated sexual health in their places of origin, where heteronormative institutions of socialisation often placed them on a reproductive timeline in which safer-sex practices were rarely discussed. Next, I explore the ways in which "Gay London" offered access to new spaces and temporalities that enabled many participants' gay identities to flourish, while noting that the accessibility of these spaces and temporalities was often seen to depend on socioeconomic status, for migrants and natives alike. Finally, I explore how a "critical mass of gay ways of knowing and be(com)ing" was needed to produce meaningful shifts in sexual health perceptions and behaviours, although "temporal hangovers" continued to shape patterns of engagement with sexual healthcare. I conclude that failing to remain attuned to the temporal shifts experienced by migrant (and, indeed, non-migrant) MSM risks a misidentification of their healthcare needs.

Impact Statement

This transdisciplinary research promises to deliver a range of impacts, both within and beyond academia. At the theoretical level, this work delivers impact by considering how the timing of "temporal migrations" shapes the sexual health perceptions and behaviours of migrant men who have sex with men (MSM), thereby building on key conceptual gaps in existing medical and social scientific research on "sexual migration". The theoretical insights of this work will be disseminated in multiple ways, including by publishing research findings in reputable journals, and making these outputs available for access and re-use. I intend to present partial findings of this work in a manuscript currently under review by *Gender, Place & Culture*. I have also presented partial findings at several conferences and seminar series, including *Queer Dis-Eases* at the *European University Institute*. I will continue to disseminate findings at conferences and through research networks, such as the *UCL Critical Global Health Network* and the *Thomas Coram Research Unit*.

This work also has the potential to be impactful beyond academia. I intend to present translational findings in several medical and clinical fora, such as at the *BASHH Annual Conference* and at a *UCL/CNWL Joint Academic Meeting*. Of particular interest at the level of policy and practice may be the ways in which "temporal migrations", such as coming out, contribute to "seasons" of heightened sexual health risk, especially at certain life stages and when accompanied by certain spatial movements. Engagement with clinicians and policymakers will focus on ways of flagging "temporal migrants" early, and offering them additional support. Furthermore, this research reaffirms the fundamental importance of not presuming "outness" among MSM in health research and clinical practice, instead recognising the diverse ways in which sexual identities overlay onto sexual behaviours over the life-course. By providing an empirical basis from which to better understand the unmet needs of certain migrant MSM, dissemination of these findings supports the *UCL Faculty of Population Health Sciences'* goal of using a life-course approach to maximise and equalise health outcomes, as set out in the *2022-2027 Strategic Plan*.

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Abbreviations and Acronyms

AIDS	Acquired immune deficiency syndrome (*advanced* or *late-stage HIV* in current medical parlance)
CEE	Central and Eastern Europe
Chemsex	Sexualised drug use (often in the context of private sex parties)
DHSC	UK Department of Health and Social Care
DoxyPEP	Medication to prevent certain bacterial *STIs*
GHB	Gamma hydroxybutyrate (depressant commonly associated with *chemsex*)
HAART	Highly active antiretroviral therapies (drug combinations introduced in 1996, transforming *HIV* survivability)
HIV	Human immunodeficiency virus
MSM	Men who have sex with men
NHS	UK National Health Service
PEP	Post-exposure prophylaxis (28-day course of medication to prevent *HIV*)
PrEP	Pre-exposure prophylaxis (daily or medication to prevent *HIV*)
STI	Sexually transmitted infection
UKHSA	UK Health Security Agency
WHO	World Health Organisation

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1. Introduction: Troubling Cartographies

"Queer uses of time and space develop…in opposition to the institutions of family, heterosexuality, and reproduction… If we try to think about queerness as an outcome of strange temporalities, imaginative life schedules, and eccentric economic practices, we detach queerness from sexual identity and come closer to understanding Foucault's comment…that "homosexuality threatens people as a 'way of life' rather than as a way of having sex"."

Jack Halberstam, *In a Queer Time and Place* (2005: 1)

"Some boys don't come out of the closet, they explode."

"Hazel Tyler" in *Queer as Folk, S1/E5* (Davies, 1999: 09:30)

On a grey Thursday afternoon sometime in the autumn of 2015, I found myself in *Consultation Room 7* of one of London's many sexual health clinics, chatting with a very amiable registrar, who was doing everything she could to make me feel at ease. I had gotten myself to the "big city" (Weston, 1995) approximately a year earlier, ostensibly to start university, but, more fundamentally, to gain distance from the heteronormative expectations and assumptions of my hometown. I was neither "fully out" nor was I "in the closet." I was in a moment of abrupt shift. Consequently, my first year in London had been a time of immense joy and growth on the one hand, and of great psychological and physical vulnerability on the other. Often, I found myself in risky scenarios in which safer sex became difficult or impossible to ensure, either because of a lack of knowledge, intoxication, deception, coercion, or abuse.

This was my first time undergoing a routine sexual health test in London, but it was not the first time I had discussed sexual health with a doctor here. In fact, I had been hospitalised with multiple untreated sexually transmitted infections (STIs) a year prior, not long after arriving in London. Sexual health clinics terrified me, not least because of stigmatising formative visits in my hometown that left me fearful of discussing my sexual practices honestly with medical professionals. I felt ashamed of my ostensibly denatured masculinity, so far removed from the markers and milestones of straightness that flooded the institutions of my childhood and adolescence. I did not want to admit to any lapses in prudent sexual health decision-making, instead blaming myself for taking the indulgent and unnecessary risk of seeking intimacy in the first place. Nor did I ask for readily available prophylactic treatments for fear of being viewed as a burden or a drain.

"Risk" and "risk groups" – ubiquitous in my life – were reinforced by routine sexual history questions. Gesturing towards a world map splashed with green and red in all the predictable places, the registrar proceeded to ask me about any partners from "high-prevalence countries":

Arthur: Umm… Nigeria?
Registrar: And was *that* protected?

I knew instantly why she was interested, and I recognised instantly the flawed assumptions of that interest in this case. The unnamed individual, who had moved from Nigeria to the UK many years prior, and who, apparently, represented a wholly different risk category from me, had taken a highly informed approach to sexual risk-taking during our encounter, while I, for one reason or another, had not. But, when it came to the registrar's – and many people's – understanding of sexual risk, his Nigerian origins spoke for him, while my vulnerabilities remained hidden. My migration to the "big city" – definable in hindsight as a *coming-out migration* – was not only accompanied by heightened sexual risk, but also by medical categories that did not seem to recognise that fact, partly because I originated from within the UK (albeit

rural Kent), and partly because I did not tick any obvious “high-risk” boxes, other than engaging in anal intercourse with men.

Which hidden processes were at play here, rendering the risks associated with my migration (and coming-out journey) less relevant, while emphasising the risks supposedly posed by a Nigerian man living in the UK? Why had migrant status crystallised into an ostensibly relevant category for him, but not for me? Why was his command of sexual health decision-making under greater scrutiny than mine? Why had we been coded differently? The answer is *prima facie* straightforward. But, with time, it becomes evident that the spatial risk zones by which the world is striated are not a reflection of some objectively existing truth. They are a blunt tool that does little to capture the dynamics of sexual risk that crosscut national borders. How might we usefully incorporate a temporal dimension into our understanding of the migrations of MSM? How might our understandings of sexual risk and sexual health promotion change if we supplemented our focus on migrant status with an understanding of life-course stages? Has the individual recently undergone a big life transition, such as a break-up or a coming-out? Have they reached a new milestone, such as starting university, retiring, or entering supported living? (Recent research confirms that STI rates among the elderly are on the rise, in part due to a “second youth” experienced by residents of aged care facilities able to explore new sexual avenues for the first time, often in the absence of appropriate safer sex guidance (Glaude-Hosch, 2015; Kumar et al, 2025; McDaniel, 2016; Smith et al, 2020)). In other words, how can we draw better maps, if we even need to draw maps at all? Drawing on the lived experiences of 20 gay migrants in London, in this work I will elaborate a *temporal* dimension to the migrations of MSM, which supplements the *spatial* dimension, and which has important ramifications for sexual healthcare and research.

This work will build on – and critique – a wealth of existing research on spatial migration and sexuality, and on spatial migration and sexual health. In the following chapter, I will draw on diverse literature from across a range of disciplines, using a critical interpretive synthesis approach (Dixon-Woods et al, 2006), to elucidate gaps in understanding that could not be highlighted

using a monodisciplinary literature review. While geographers, historians, and sociologists of sexuality have long highlighted that gender and sexuality could be motivators for migration (Binnie, 1997; Castells, 1983; Chauncey, 1994; D'Emilio, 1983; Escoffier, 1985; Rubin, 1993; Weston, 1995; Wilson, 1991), it is only in recent years that the relationship between sexuality and spatial migration has become a focus of health research. This research has tended to find that migrant MSM have, on average, worse sexual health outcomes than non-migrant MSM, particularly in the period immediately after their relocation (Burns et al, 2011; Evans et al, 2011; Ganczak et al, 2017; Gosselin et al, 2020; Mole et al, 2014; Schmidt et al, 2023). Understanding the needs of migrant MSM is therefore of great importance. While the introduction of pre-exposure prophylaxis (PrEP) on the NHS has made the elimination of HIV transmission risk thinkable, problems with access and perceived candidacy – as I will discuss in Chapter Seven – limit uptake, particularly among recent migrants and those earlier in their coming-out journeys.

The spatiality of MSM's migrations, however, is not the only dimension worthy of analysis. Indeed, I argue in this work that the migrations of my participants should be understood as both *spatial* and *temporal* in nature. Solely spatial accounts are blunt tools that simplify other important aspects of the "movements" of sexual minorities through the life-course. Spatial analyses, furthermore, fail to explain why sexual health perceptions and behaviours do not shift immediately after migrating, but rather lag for a year or longer (Mole et al, 2014; 2017). Thus, in the second half of Chapter Two, I will examine work that relates to the temporal dimensions of the migrations of MSM. I will consider the "worlds" inhabited by MSM through the life-course, and the ways in which these worlds are shaped by and shape queer migration. I will discuss the ways in which migrant MSM often experience "abrupt temporal shifts" away from the reproductive timeline of the "straight world" and towards "queer" ways of structuring time that reject heteronormative and homophobic assumptions, rhythms, and milestones (Halberstam, 2005). I will show that coming out, or otherwise starting to "feel gay," is a momentous life-course event that involves significant psychological

reconfiguration along temporal lines (Floyd & Bakeman, 2006; Halberstam, 2005; Lewis, 2012). Importantly, this temporal reconfiguration sometimes happens alongside spatial movements, but other times it does not (Lewis, 2012). The alignment or non-alignment of the spatial and temporal movements undergone by migrant MSM, I will argue, shapes the development of sexual identities and of sexual health perceptions and behaviours. Thus, elaborating a temporal side to the phenomenon we call "migration" is not merely a theoretical task, but also one which has important ramifications for sexual health care and research.

This thesis is predicated on the firm belief that positivist methods seeking objective, measurable truths are wholly unsuited to understanding hidden aspects of human identities, perceptions, and behaviours, insofar as they presume to define the objects of study prior even to beholding them. While I do not deny the reality of diseases, of falsifiable, repeatable methods of diagnosis, or of the wide evidence base from which treatments derive, I refute in this work the assumption that our ways of knowing the world are ever neutral or distanced (Barad, 2007; Campbell, 1998; Hansen, 2006; McKay, 2017; Wald, 2008). In trying to remove "biases" from research, positivist approaches disingenuously hide the ways in which the researcher's subjectivity inevitably shapes the research outcomes. Noting that, as a gay migrant myself, I am deeply embedded in the field of study, I make no effort to hide the ways in which my perspective shapes this research, choosing instead to bring any "biases" to the fore as a way of strengthening this work's "objectivity" (Harding, 1986).

I will draw on two distinct yet complementary post-constructivist schools of thought in this research. Firstly, I look to post-structuralist scholars, who seek to understand how the world is discursively constructed, the rules according to which objects become thinkable or knowable (Campbell, 1998; Hansen, 2006; Foucault, 1969; Wald, 2008). However, post-structuralist perspectives alone are unable to account sufficiently for the unpredictable ways in which participants – and I – exercise agency in day-to-day life. To this end, I also take inspiration from approaches more attuned to the materiality of bodies, including new materialist approaches, which

emphasise the unstable and vital nature of bodies (human and non-human) in continuously re-shaping reality (Barad, 2007, 2015; Braidotti, 2018; Mol, 2002; Preciado, 2008). Crucially, the sexual journeys of participants – and, indeed, the research interviews – were not simply events that were *known* and *re-told*; they were also *embodied* experiences. Closing the gap between being and knowing – between ontology and epistemology – is a central goal of this research.

In order to close the gap between knowing and being, I opted to conduct and analyse the research interviews for this thesis using a modified *constructivist grounded theory* lens (Charmaz, 2006; Charmaz & Belgrave, 2012), a qualitative approach often employed in healthcare research, aimed at systematically elaborating new theories from rich, complex data. This method – attuned both to the subjective meaning-making of participants and to their embodied experiences – not only *allows for* unexpected findings to emerge but rather assumes that the phenomenon of study can only take firm shape over the course of the research. Such an approach allows the analyst to deconstruct and reconstruct familiar (and inherently unstable) conceptual boundaries so that they more closely reflect the phenomena they seek to delineate. In this sense, I see this work as an exercise in "empirical philosophy", to borrow a term from medical anthropologist, Anne-Marie Mol (2002). This is work, in other words, that renders better categories thinkable and operationalisable.

Chapter Four will bridge the gap, briefly, between the theory outlined in the preceding chapters and the applications of this theory in the ensuing chapters. Acknowledging that existing conceptualisations of gay migration fall down in several ways, I will outline and justify through a series of vignettes a novel typology of queer migration, which emerged over the course of the research, and which guides the analysis that will follow. This typology includes both existing conceptualisations of queer migration and new "types" that emerged from the research and that relate to the ways in which migrant MSM move not only through space, but also between timelines. In this way, the typology may be usefully understood as a foundational "finding" that

shapes and informs the other, more detailed theoretical findings presented in the following chapters.

In Chapter Five, I will explore the ways in which the heteronormative institutions of socialisation placed my interlocutors on a presumed reproductive timeline, and how this shaped their sexual health perceptions and behaviours. I will argue that participants' temporal migrations – from presumed heterosexuality and reproductive temporality towards non-normative sexualities and new temporal configurations – often commenced well before relocating to London. These temporal shifts, which were patterned differently according to how and when individuals "came out", influenced participants' sexual health trajectories. I will argue that, in contrast with the dominant narrative that being "out" or having gay or queer networks may increase sexual health knowledge and adherence to safer sex behaviours (Hammoud et al, 2019; Schueler et al, 2019), being out in their place of origin did not appear to be a protective factor (Gios et al, 2019). In fact, the potential vulnerabilities brought about by encounters in some participants' places of origin reveal several ways in which "outness" – often assumed to be a sort of gold standard for queer fulfilment and wellbeing – may be a double-edged sword that potentially exposes people to greater sexual health risk.

In Chapter Six, I will examine the ways in which participants' sexual identities shifted after migrating to London, and how this shaped their sense of belonging in the "big city". I will show that, while shifts in sexual identity cannot be explained in terms of spatial movements alone, spatial migration continued to play a central role in some of my interlocutors' coming-out journeys. However, I will also demonstrate the limitations of unidirectional accounts of sexual migration that assume that pre-queered individuals migrate to the city in order to come out (Gorman-Murray, 2007, 2009). I will show that many participants did not move to London in order to come out, nor was their sexuality already settled before their relocation. Rather, for many, new aspects of sexuality emerged from the migration itself (Carrillo, 2004; Mole et al, 2017). I will argue that "moving out" and "coming out" were far from parallel processes for many of my interlocutors (Lewis, 2012); rather,

coming out, and being out, depended on a range of factors, including the ability to gain distance from heteronormative and reproductive assumptions and expectations, and the extent to which what I will term a *critical mass of gay ways of knowing and be(com)ing* had been reached, often in the face of significant barriers to access for certain groups and individuals.

In Chapter Seven, I will explore the ways in which participants' sexual health perceptions and behaviours shifted after moving to London. I will argue that sexual openness and inclusivity "on the ground" fostered shifts in sexual health perceptions and behaviours, such as increased frequency of sexual health testing, while positive engagement with sexual healthcare services encouraged greater adherence to safer-sex practices more appropriate to the needs of gay men. Inversely, however, I will show that certain behaviours and perceptions persisted as *temporal hangovers* from the straight world, especially among recent migrants and those earlier in their coming-out journeys. These hangovers remained rooted in the fears and misconceptions of earlier times (Dennermalm et al, 2024; Freeman, 2010), and had the capacity to reinforce stigma and discourage service use. The associated risks are heightened further by neoliberal models of care that demand high degrees of proactivity from people early in their gay journeys, while those who fall through the net of sexual health provisions may face further stigma and othering. Thus, I will show that – whilst, in the most general terms, propitious to increased sexual openness and lay sexual health knowledge – simplistic understandings of London as a locus of gay and queer flourishing are one-sided.

It is incumbent on me at this stage to define a few terms. Even though all my interlocutors identified as *gay* men, I will also refer at times to *queerness* in this work, particularly in the context of Halberstam's (2005) characterisation of "queer temporality." *Queerness* refers to transgressive ways of being and knowing that challenge traditional, heteronormative and homophobic assumptions and expectations. Of course, not all gay people identify as queer, and, while many queer people may also identify as lesbian, gay, bisexual, or transgender, one need not necessarily be any of those things to do things *queerly*. *Sexuality*, meanwhile, is employed to mean a set

of “identities, practices and performances” (Gorman-Murray, 2009: 443). I will refer to *coming out*, and *outness*, which I understand as the degree to which a person is distinguishably not cis-heterosexual at any one time. *Temporality* refers to the way in which people experience time, and themselves within it. I will make particular mention of *reproductive temporality* and *queer temporality* in this work. I follow Halberstam’s (2005) definition of *reproductive temporality* as a way of life which places those within it on a strict, gendered, linear, reproductive timeline from birth via marriage, mortgage, child-rearing *etc.*, through to death and bequest. *Queer temporality* is associated with a rejection of this linear set of milestones in favour of a sense of ongoing becoming (Edelman, 2004; Halberstam, 2005; Muñoz, 2009). Finally, I will refer frequently to research on *sexual migrants*, who – while there is no single definition – may be defined as people who migrate (geographically) for reasons directly or indirectly related to their sexuality. While some authors presume sexual migrations to be intentional and unidirectional migrations of “pre-queered” individuals (Gorman-Murray, 2007, 2009), others argue that the sexuality of migrants has not necessarily been fixed prior to their migration, but rather emerges over the course of the migratory process (Carrillo, 2004; Mole et al, 2017).

As already mentioned, due to the conceptual stretching of “sexual migration”, as the term is variously employed, I will elaborate several new “types” of migration through my analysis, some of which have already been mentioned, each with relevance to sexual health perceptions and behaviours. These new “types” include *discovery migration*, *already-out migration*, and *HIV care migration*. These were not the only novel concepts that I will elaborate through this work. I employ the novel term *abrupt temporal shift* to refer to the often-tumultuous process of switching from one “timeline” to another, with consequences for sexual health decision-making. *Abrupt temporal shifts*, I contend, can affect international and intra-national migrants alike; they can affect both younger people (moving to university, for example) and older people (moving into care homes, for example (McDaniel, 2016)); and so too can they affect people who do not move (spatially) at all. The *abrupt temporal shift* may be a useful conceptual tool in the fight not only

against HIV and HIV stigma, but also against any kind of ill-health exacerbated by seasons of elevated risk. I refer to (sexual health) perceptions and behaviours anchored in the realities of earlier times as *temporal hangovers*, a form of the phenomenon "temporal drag" described by Freeman (2010). I also frequently use the term *critical mass* in this work, arguing that, without a *critical mass of gay ways of knowing and be(com)ing*, gay flourishing and identification with gay men's sexual health norms is significantly harder to meaningfully achieve and sustain. In the absence of such a *critical mass*, I argue, sexual encounters are more likely to take place in *shadow worlds* in which identifications with gay men's sexual health needs are far from guaranteed.

The task at hand is pressing. Given the Government's ambitious goal of eliminating new HIV transmissions in the UK by 2030 (DHSC, 2023), it is vital that steps are taken at all levels to meet MSM *where they are at*, not where we imagine them to be. While increased PrEP access in the UK now makes theoretically possible the end of the sexual transmission of HIV among MSM, this goal is far from being realised, and HIV risk has not been reduced equally for all. Those born overseas accounted for 61% (1,723 of 2,810) of new HIV diagnoses in England in 2023, representing a 52% year-on-year total increase from 2022 among this group (1,133 to 1,723) (UKHSA, 2024). But geography does not hold all the answers. If we turn our attention from place of origin to life-course stage, we see that HIV risk appears to be heightened from late adolescence into early adulthood. In fact, the only age bracket to experience a decrease in HIV testing rates and an increase in the proportion of late HIV diagnoses from 2022 onwards were people aged 15 to 24 (UKHSA, 2025). This particular moment of risk coincides, as I will argue in this work, with the time during which many young people begin to navigate sex, sexuality, and coming out for the first time. Trying to address unmet PrEP needs, then, hinges in no small part on engaging people more fully during the often-tumultuous processes of starting to identify as gay, coming out, moving to "gay hubs", and any other processes associated with a shift in sexual practices.

While this work remains critical of the failure of healthcare research and policy to consider all the various forms of “movement” experienced by migrant MSM, it is worth reiterating that the account I produce in this work is itself a partial account, drawing on the scripts and frameworks available to my interlocutors and me. I do not stand, unbiased, above the field of study. Consequently, the story I tell here – whilst being *a* potentially useful account – does not constitute *the* “true” reflection of a singular external and objective reality. Rather, by challenging accounts of (sexual) migration that take its meaning as given, I aim to demonstrate the cultural and historical contingency of taken-for-granted categories, thereby shedding light on the hidden processes by which subjects come into existence and act. After all, the conceptual categories through which we make sense of migratory flows are, just like the very migrants they aim to describe, always changing.

2. Spatiality and its Discontents

"YOU MUST STOP MOVING!...

Forsake the Open Road.

Neither Mix Nor Intermarry: Let Deep Roots Grow:

If you do not MINGLE you will Cease to Progress:

Seek Not to Fathom the World and its Delicate Particle Logic:

You cannot Understand, You can only Destroy,

You do not Advance, You only Trample."

Tony Kushner, *Angels in America: Perestroika* (1993: 178)

"When you return to the environment from which you came – which you left behind – you are somehow turning back upon yourself, returning to yourself, rediscovering an earlier self that has been both preserved and denied. In circumstances like these, there rises to the surface of your consciousness…the discomfort that results from belonging to two different worlds, worlds so far separated from each other that they seem irreconcilable, and yet which coexist in everything that you are."

Didier Eribon, *Returning to Reims* (2009: 18)

Before presenting the case for conceptualising the migrations of MSM in both temporal *and* spatial terms, it is first necessary to explore in greater detail the empirical and theoretical insights that bring me to this juncture. This review of the literature will turn firstly to work exploring the links between migration and sexuality. Then, I will discuss migration and sexual health. Next, I will explore sexuality from a temporal perspective. Finally, noting the lack of literature on temporality and sexual health, I will instead turn my attention to what has been written on sexual health and "outness", a concept which often served as

a useful proxy for temporality during the research interviews. I will find that sexual migration must be understood not only through spatial frameworks of mobility, origin, and destination, but also through temporal frameworks, as a process shaped by segmented trajectories of disclosure, sexual subject formation, and life-course transitions.

In line with the principles of critical interpretive synthesis (Dixon-Woods et al, 2006), this review incorporates literature *pari passu* from a wide range of disciplines often held to be incomparable. Given that the phenomena of study are complex, and transcend existing, monodisciplinary frameworks of knowledge production, it has been necessary to appraise texts from the social sciences, humanities, medical sciences, natural sciences and beyond, as and when their appraisal is merited. For this reason, literature was not selected for inclusion according to criteria such as keywords or in line with fixed rules about “data saturation”, but rather according to its *relevance* to the phenomenon of study (Dixon-Woods et al, 2006: 38). When discussing migration and sexuality, for example, it is sociologists, geographers, anthropologists, and historians who offer the most important insights. When discussing migration and sexual health, meanwhile, insights from healthcare research become essential. And so on. Texts were retrieved from a range of sources, including PubMed, MEDLINE, PsycINFO, Scopus, Healthdirect, ScienceDirect, ProQuest, JSTOR, and EBSCOhost. For this research – unlike positivist work that starts with a clearly defined phenomenon of study and well calibrated “tools of measurement” – reviewing the literature was just as much about clarifying the research problem as it was about answering a pre-set question. The gaps identified are not so much “curiosities for further research” as they are fundamental to the task of critical reflection. Gaps, then, rather than a lack, are a signpost. In places, this literature review may open up more gaps than it closes, but these gaps are a roadmap to the missing narratives, experiences, and people that this work seeks to make visible. As I will show, gaps between quantitative attempts to map sexual attitudes and risks among migrant MSM and qualitative attempts to map the outness journeys of this group will lead us towards a better understanding of the need to recognise the varied, segmented journeys –

both spatial and temporal – taken by MSM, and how they influence sexual health perceptions and behaviours. Recognising these diverse journeys and taking life-course factors such as “coming out” (and their timing) into account is central to improving sexual healthcare for and research about migrant MSM.

2.1. Spatiality and sexuality

2.1.1. HIV through space and time

Before reviewing the literature on the sexual health of migrant MSM, it would be instructive to consider briefly the reasons for which sexual health and HIV have historically been, and continue to be, understood primarily through a spatial lens of analysis. Of course, it is unsurprising that communicable diseases, whose transmission requires the physical movement of people, are understood at least in part through a spatial lens. Without understanding where and how carriers of a disease move, our knowledge of disease transmission would be limited. Of concern in this work, however, are the ways in which the spatial lens may come to dominate our understandings of sexuality, sexual health, and movement, at the expense of other useful lenses of analysis.

The first epigraph of this chapter, taken from Tony Kushner’s magical realist examination of AIDS and sexuality in 1980s USA, *Angels in America*, offers an excellent vantage point from which to begin considering the ostensible threat posed by migrants in times of crisis. Delivered in response to the claim that the world “only spins forward”, the Angel’s feverishly nativist retort reminds us that movements of people (through space, at least) are a necessary condition for the transmission of communicable diseases. Of course, the Angel takes her decelerationist argument to the point of absurdity by synonymising “Progress” with the removal of all external or foreign risks. The Angel’s point, however, is an instructive one, because it reflects a fear of the contagious, spatially distant Other which persists in the collective imaginary, and which has re-appeared with vigour in recent years (Campbell,

1998; McKay, 2017; Povinelli, 2006; Wald, 2008). Mindful of that nationalist turn, the task of elaborating other non-spatial dimensions of sexual migration is not simply an academic one, but a political one too. By showing that spatial movement *alone* does not account for the transmission of HIV and other STIs, this work should be taken as a direct challenge to overly simplistic discourses emphasising geographic origins at the expense of other aspects of the migrant experience.

Tracing the origins of HIV has been of great interest since its emergence (McKay, 2017). Given its long incubation period, many cases of AIDS (or "Gay-Related Immune Deficiency" (GRID), as it was originally known) had already been reported across three continents before the causative virus (initially designated *LAV* by French researchers and *HTLV-III* by US researchers) was first isolated in 1983 (McKay, 2017: 7). By this time, the virus was already deeply embedded, with thousands of cases and hundreds of deaths reported in the USA alone (ibid). HIV prevalence in some communities had already surpassed 5% by the time AIDS cases were first reported (Jaffe et al, 1985). For this reason, since the earliest HIV/AIDS research, researchers have been interested not solely in treating the causative virus, but also in telling (hotly contested) stories of its emergence, in tracking the unknown infection back to a singular "point of source" (Haverkos in McKay, 2017: 104). Narratives are central to explaining disease emergence, but these narratives are never neutral (McKay, 2017; Wald, 2008).

Given that the earliest documented cases of AIDS affected men who have sex with men (MSM), intravenous drug users, and arrivals from Haiti, followed shortly thereafter by arrivals from sub-Saharan Africa, HIV was since its arrival connoted with those somehow foreign to white, Western, heterosexual society (McKay, 2017). Indeed, the association of sexual deviancy with the geographical periphery has persisted in some form for millennia (Endsjø, 2008). Thus, the emergence of AIDS in the early 1980s was the story of a silent, invisible, and tentacular infringement of boundaries – both the physical boundaries of previously AIDS-free bodies and countries, and the moral boundaries of erstwhile healthy nations (Campbell, 1998)

which had now to publicly discuss the reality of homosexuality, promiscuity, intravenous drug use, blood-letting practices *etc.* Of particular concern was – as always – the ability of this pestilence to infect "innocent" people such as haemophiliacs (ABC, 1982). Many early documentaries on HIV/AIDS explicitly separated out "that segment of society" ("promiscuous homosexual males" and, later, drug users and Haitians) from "the public-at-large" which, it was claimed with tangibly greater alarm, would start also to become vulnerable to the disease (ABC, 1982: 01:45). The "lifestyle of male homosexuals," viewers were told, "has triggered an epidemic of a rare form of cancer" (NBC, 1982: 0:05).

No case epitomises the separation of the sick, foreign, homosexual traveller from the healthy, heterosexual native more than that of Gaëtan Dugas – the unashamedly gay Québécois flight attendant, once incorrectly dubbed "the man who brought AIDS to America", who came to embody the contamination of an erstwhile healthy nation (c.f. Shilts, 1987). Whilst Dugas was neither the first confirmed nor unconfirmed AIDS case in the USA, his designation as Patient "O" – which stood for "outside of California", and which was then misread as Patient "0" by journalist Randy Shilts – led to a dominant cultural framing which seemed consistent with the importation of a new, "foreign" virus (McKay, 2017), and which then became "blackboxed" as common knowledge (Latour, 1987). Dugas's story serves as a cautionary tale against naïve understandings of "foreign" health threats. The fear of the foreign is inseparable from the blurred spatial, moral, and microbial boundaries of our ever-more interconnected, porous, globalised world (Campbell, 1998; Povinelli, 2006: 77; Wald, 2008: 260). Consequently, pandemics and epidemics are often accompanied by a strong desire to single out "us" from "them" (Haour-Knipe & Rector, 1996). Migrants, particularly those travelling from faraway or little-known lands, have frequently served as scapegoats for infections – both sexually transmitted and otherwise – through history (McKay, 2017; CARAM, 2018: 8). To this day, narratives of emergent infections register the culpability of faraway Others far more readily than a reflection of our own entanglement in the web of processes leading to the emergence of new pathogens, a reflection that may reveal the fact that the

supposedly faraway point of source is much closer to home than anticipated (Povinelli, 2006; Wald, 2008; Jain, 2020). Consequently, to what extent can we say that “foreign-born” health threats originated “out there”? How different is “out there” from “over here”? To what extent are national frontiers even capable of bounding our increasingly globalised world?

Of course, medical, academic, and lay understandings of HIV/AIDS have evolved significantly since the early 1980s. Much of the stigma, however, around gay men as fatally infectious persisted through the 1990s and beyond (Botnick, 2000b; Crewe, 2018; Dennermalm et al, 2024), with consequences at the population health level (Berg & Ross, 2014; Hatzenbuehler et al, 2013). In response to persistent HIV stigma, “good gays” came to excise “bad gays” from the gay mainstream, “bad gays” defined as those who endanger themselves and others by refusing to be “100% safe 100% of the time” (Botnick, 2000b). In this way, since the 1990s, HIV has continued to divide more than to engender solidarity. With time, homosexual sex itself came to be understood by some – particularly those more attuned to the past – as a “death wish” (Crewe, 2018; Knauer, 2000). Similarly, healthcare research has often struggled to neutralise its discussion of “dangerous” or “risky” practices associated with minority groups (McKay, 2017). These framings persist stubbornly at all levels of research – including, frankly, my own – because researchers find themselves in the same tangled sociocultural web of meanings, concepts and frameworks as laypeople (Harding, 1986; Latour, 1987; Nelkin, 1994). As Wald notes, “the common stories, the conventions of representation that infuse the images, phrases, and narratives through which we make sense of the world…inflect – and yes, infect – every aspect of the scientific and epidemiological processes from the collection and interpretation of data to the social and medical diagnoses of the problem” (2008: 14). Elaborating some of the spatial assumptions informing those narratives is central to the task of critically assessing their continued role in our understandings of HIV, sexual health, sexuality, and migration forty years on.

2.1.2. The history of the “gay hub”

Whilst I contend that the spread of HIV and STIs cannot be meaningfully understood through a spatial lens alone, it is of course necessary to recognise the well-established links between non-normative sexualities and migration to so-called “gay hubs” or “queer hubs”. Although scholars – particularly of geography, sociology, and history – have recently turned their attention to migrations of gay and queer people, sexuality was largely ignored by migration theorists for many years. Until at least the 1990s, queer people tended to be either invisible or exceptional in migration research (Manalansan, 2006). Against a backdrop of a lack of academic discussions of sexuality, much of the earliest work in this arena came from gay leftwing scholars. Works such as *The City and the Grassroots* (Castells, 1983), *American Homo* (Escoffier, 1985), and “Capitalism and Gay Identity” (D’Emilio in Snitow et al, 1983), challenged the notion of fixed, pre-social gay identity, with gay subjectivity presented for the first time as related directly to social and economic processes. This work, which was predicated on a strict rejection of liberal assimilationism, tended to embrace solidarity between non-normative sexualities in the safety of (usually urban) gay communities or hubs. D’Emilio, for example, noted the centrality of urban “affectional communities” in forging and upholding networks independent of “the bonds of blood or the license of the state” (in Snitow et al, 1983: 111).

As well as studying more recent spaces of sexual liberation, the untold histories of gay urban spaces began to be excavated in works such as *Gay New York* (Chauncey, 1994), which challenged the myth that pre-Stonewall gay life languished in a miserable, isolated closet, and *Backward Glances* (Turner, 2003), which explored the long history of cruising in London and New York City, drawing on Baudelaire’s and Benjamin’s *flâneur* as an example of how gay people have found connection within urban spaces. Weston continued the quest to outline “the historical and material processes by which “gay people” have constructed themselves” in her (1995) examination of the North American “Great Gay Migration” of the 1970s and early 1980s, “Get Thee to a Big City”. In this work, Weston argued that “the urban imaginary” was central to the identity construction and migration

patterns of queer people from rural and urban settings alike. The appearance of urban “gaybourhoods”, and their relation to the urban gay imaginary, became a topic of interest in the 1990s. For example, Kelley et al’s (1996) survey, “How Far Will You Go?”, which found that over 75% of those interviewed originated from outside London, and that London’s gay population was clustered in certain districts, such as Islington and Hackney.

From the late 1990s – in line with the broader move away from grand theories – there emerged a new wave of thinking which sought to replace general theories of gay identity and gay migration with ones that highlighted differences in people’s mobility and privilege. The shift away from understanding gay (or queer) migration as *liberatory*, and towards understanding it as *regulatory*, relied on a decentring of the mobile, white, liberal, individualistic, gay (or queer) subject. For example, Binnie’s (1997) *Invisible Europeans* asks whether everyone is in fact equally able to access the so-called “queer city”, in the absence of the correct bloodlines or marital ties. Binnie & Valentine (1999), meanwhile, move away from a simple mapping of lesbian and gay spaces towards a more critical treatment of the differences between sexual dissidents. Manalansan’s (2003) *Global Divas* challenged Western framings of gay spaces and gay identity and, pertinently for this work, challenged teleological notions of a unified “gay world” within which all gays would become assimilated and argued that the pathways to gay, or queer, modernity are multiple, complex, and dependent on a range of characteristics, including race and gender. Indeed, more work on women’s sexuality also began to emerge in this new wave of thinking. Luibhéid’s (2002) *Entry Denied*, for example, examined the ways in which sexuality and gender are regulated by exclusionary immigration regimes and policies in the USA. Indeed, the global south and east are often framed as places where queerness does not or cannot occur. What is more, as Puar (2007) argued, the exclusion of these Others is often (inaccurately) justified in terms of the need to include and protect certain queer subjects in the homeland, with “good queers” included in the nation at the expense of “bad queers” who are excluded. Consequently, Chávez (2013) argues for the need for active queer coalitions to achieve immigration rights and social justice. Of course, it should

be noted that the perspectives of gay and queer people who had not managed to successfully navigate Britain's exclusionary immigration regime were not included in the data collection for this project. The erasure of the world's least mobile from knowledge production is a continued challenge for academic research taking place within the supposedly open societies of neo-liberal modernity.

Another line of response to the extensive theorising about the "queer city" in the 1990s came from scholars seeking to challenge "metronormative" discourses according to which "the subject moves to a place of tolerance after enduring life in a place of suspicion, persecution, and secrecy" (Halberstam, 2005: 13), and which reinforced persistent and simplistic dichotomies between enlightened, metropolitan, liberal, queer-positive zones, and backward, rural, homophobic zones (Boussalem & Feliciantonio 2023; Lewis, 2012; 2014). Indeed, much of the work on gay flourishing centres urban homosexual experiences in the Global North and West (Brown, 2008) and ignores queer minoritised perspectives (Boussalem & Feliciantonio 2023). Much of the work on positive rural queer experiences centred the North American experience. Challenging mainstream understandings of life in the post-World War Two USA, for example, Howard's (1999) *Men Like That* explored the vibrant queer existences that flourished in 1950s Mississippi, contrasting this with the extreme oppression that emerged during the supposedly "free love" era of the 1960s. In *Another Country*, Herring's (2010) queer anti-urbanist project traced how rural queer people write their own narratives in the face of metronormative assumptions. In *Out in thew Country*, meanwhile, Mary Gray argued that to depict urban spaces as the principal zones of queer flourishing is to reinforce the incorrect notion that rural places necessarily operate as "the perennial, tacitly taken-for-granted closet" (2009: 4). Similarly, Kazyak interrogated the idea that rural areas "are spaces where gay and lesbian sexualities are unclaimed, stunted, or destroyed and, in contrast, urban spaces are where those identities are constructed and made visible" (2010: 1). While noting the difficulties experienced by many LGBTQI+ people from rural areas, Bell and Valentine (1995) explored the dual role of rural spaces in the gay imaginary, as

somewhere to escape both *to* and *from*. Ravier (2025), meanwhile, explores the city as a place for gay men to *flee from*, especially later in their "gay career," and especially for gay men who experience racism and oversexualisation in urban gay spaces. Other work, meanwhile, has interrogated what happens in the spaces between the centre and periphery, such as suburbs and towns "in the shadow of" gay centres (Cummings, 2024; McGlynn, 2014). Illuminating and necessary as these works are, urban places – especially London – remain the spaces of interest in this piece of work. This is because the specific dynamics of the "big city" do – as work which I will soon examine shows – produce greater sexual health risk for numerous reasons (Burns et al, 2011; Evans et al, 2011; Ganczak et al, 2017; Gosselin et al, 2020; Mole et al, 2014; Schmidt et al, 2023).

While my focus remains on the urban in this work, it is of course necessary to recognise that no urban space exists in isolation from non-urban spaces, both in terms of the role of the urban/rural dichotomy in the mainstream queer imaginary (Weston, 1995), and also in the sense that many queer people will move in and out of urban spaces frequently, for work, for pleasure, or to visit family. The way in which delineating seemingly unproblematic binaries such as rural/urban, here/there becomes challenging in our analyses of (sexual) migration is symptomatic of what Chauncey & Povinelli (1999) called the "transnational turn" in sexuality studies (and beyond). A transnational, *contra* international, understanding of sexual migration, is one that takes into account both the physical and affective non-fixity of migrants (Murphy et al, 2020). A transnational understanding of sexual migration undoes perspectives centring on "here" and "there," "then" and "now," "home" and "abroad" (Hall, 1996: 247). In a globalised world, in other words, queer migrants' lived experiences may not align with the evermore fortified international borders that constrain people's movements and define the boundaries of social research. The participants in this study straddled spatial and temporal borderlands that both sliced and spliced notions of "home" and "away". Binaries must therefore give way to a hybridity that falls outside simplistic identity categories (Boellstorff, 1999; Carrillo & Fontdevila, 2014, 2018; Cantú, 2002). "Sexual migrations," in other words,

are never *done*, but ongoing, as Aizura highlights in his (2018) assessment of trans mobility.

2.1.3. What makes a migration "gay"?

Gay and queer stories are often stories of spatial movement (Aizura, 2018; Halberstam, 2005), which is unsurprising, given that most gay and queer people are unable to learn from their surroundings how to *be* in the world, unlike their heterosexual counterparts (Halperin, 2012). Implicit to much of the existing theorisation about gay and queer migration, however, is the assumption that gay and queer migrants move *because of* their sexuality, *i.e.* to flee persecution or to come out. Indeed, "sexual migrants'" motivations for migrating tend to be viewed through a polarised lens, "either as the pursuit of economic security or as a desire to access to human rights" (Usta & Ozbilgin, 2023). The assumption that queer migration is synonymous with flight from the "perennial, tacitly taken-for-granted closet" (Gray, 2009: 4) has come to dominate both popular, and, to some extent, academic representations of queer migrations. In this way, the queer liberationist narrative may incorrectly assume sexuality to be the driving force behind the migration. However, queer people move for a variety of reasons, including reasons that are not related to sexuality, or reasons whose relatedness to sexuality – as we will see in the empirical chapters – is hard to discern. By posing the question "what makes a migration queer?", this section poses questions about the onto-epistemology of queerness and the closet. Regarding queerness, is it something we *are*, something we *do*, or something we *experience*? Regarding the closet, *what* and *where* is it? Is the process of coming out *fixed in time* or *ongoing*?

While acknowledging that gay and queer people migrate for various reasons, Gorman-Murray understands sexual migration to be motivated explicitly by sexuality, when "needs or desires of non-heterosexual identities, practices and performances" play a leading role in the decision to migrate (2009: 443). Critiquing linear definitions of sexual migration as necessarily from oppressive rural spaces to liberatory metropolitan ones, Gorman-Murray

instead understands sexual migration as an “embodied identity quest” (2007) characterised by an ongoing search for new surroundings that more closely match a person’s inner world. Noting the way in which dominant understandings of rural-to-urban queer migration normalise uni-directional narratives of displacement “while eliding the real diversity of queer relocations”, Gorman-Murray seeks to achieve greater complexity by downsizing the “explanatory scale of queer migration” from “fixed rural-urban contrasts to the actual movement of the queer body through space” (2007: 109). He singles out three different kinds of sexual migration: “coming-out migration”, where queer people move in order to re-invent themselves in a new place, “gravitational group migration”, where queer people move in order to be closer to queer environments and communities, and “relationship migration”, migrations in order to consolidate a same-sex relationship or following the breakdown of one (2009: 446). Coming out, says Gorman-Murray (2007), while underpinning many relocation decisions, takes a “variety of paths and scales”, while peripatetic migrations pose a particularly difficult challenge for one-directional rural-to-urban models. While Gorman-Murray challenges some traditional narratives of queer migration, however, the assumption that queer migration involves coming out, or living more happily or openly, remains central to his theorisation. What is more, despite using the term “queer”, Gorman-Murray does not explicitly address the differences between queerness and gayness in his work.

It is not entirely clear when a body becomes queer for Gorman-Murray. For example, his definition of queer sexual practices does not include those of heterosexual couples containing queer individuals or queer practices. Thus, as Mole highlights, Gorman-Murray “posits a one-way relationship between sexuality and migration, with sexuality prompting migration” (2021: 3). In other words, queer migrants are assumed to arrive “pre-queered”. While Gorman-Murray acknowledges that sexual migrants’ bodies may be read, regulated, and affected variously, they are nonetheless assumed to be “queer bodies” throughout the process: this fact is taken as given. Thus, people who move for other reasons, but who, through the course of their movement, discover new dimensions of their sexuality –

people who I will call “discovery migrants” – are not included within Gorman-Murray’s definition. Indeed, given that many migrants have overlapping motivations for migrating, and are unable to determine which intention(s) are “primary”, meaningfully determining intentionality appears a difficult task. Indeed, as Mole argues, sexual or gender identity can “indirectly or subconsciously” influence a decision to migrate, even where not explicitly declared (2021: 3-4). The three types of migration Gorman-Murray lists require a degree of intentionality which may not exist for some sexual migrants. Many people who come out after moving to the “big city”, for example, did not necessarily have that intention before their migration, and may not have been aware of their non-heterosexuality (Carrillo, 2004; Mole, 2021). As for “relationship migration”, it is not always clear what makes this a kind of queer migration, apart from the fact that it is queer people who are undertaking it.

Against Gorman-Murray’s account of sexual migration, which assumes the intention to embark on an “embodied identity quest”, Carrillo (2004) offers a more open definition that reflects the transformative nature of many sexual migrations: “international relocation that is motivated, directly or indirectly, by the sexuality of those who migrate” (2004: 54). Similarly to Gorman-Murray, Carrillo complicates the notion that sexual migrants are either seeking safety or freedom, and acknowledges the role of various structural constraints on migrants’ trajectories. Carrillo’s definition, however, focuses on sexuality, rather than identity, thus opening the possibility that non-normative sexual desires may lead to practical difficulties that have little to do with questions of identity. What is more, Carrillo acknowledges that the link between migration and sexuality may be an *indirect* one, refracted through a unique prism of identities and experiences. For Carrillo, any understandings of sexual migration should also take into account “the transformations in sexual identities and behaviors that they experience after migration” (ibid). It is then, as Mole argues, a definition understanding sexual migration as “a more dynamic, two-way process, whereby the experience of migration can also influence sexuality…even if the stated motivation is not sexuality-related” (2021: 3). In other words, then, it cannot be assumed that all migrants will

have a static identity over the course of their migration, as with Gorman-Murray (2009), for whom they are treated as *already* queered prior to migration. What is more, no gold standard of queerness can ever be assumed. In his later work, Carrillo (2017) challenges the simplistic liberationist notion that Mexican queer people would necessarily want to move to a more "enlightened" place like the USA. In another challenge the notion that sexual migrants arrive "pre-queered", Carrillo (2004) also notes how migrants' understandings of themselves as "gay" or "queer" only made sense in the US context, because sexual identities are often configured differently in Mexico. Lewis (2012) and Thomann (2016) similarly point out that terms such as "MSM" or "gay" do not match the lived realities of in fact highly heterogeneous populations, with potential impacts for engagement with sexual healthcare services.

These understandings take us some way towards a better framing of sexual migration, although they do retain some limitations. Let us again consider Carrillo's definition of sexual migration as "international relocation that is motivated, directly or indirectly, by the sexuality of those who migrate" (2004: 54). Firstly, and perhaps more superficially, while immigration status, culture, and language undoubtedly pattern the experiences of migrant MSM differently, sexual migrations can happen at the international and intra-national scales alike – with similar impacts on sexual health perceptions and behaviours – as I will demonstrate in the empirical chapters of this work. The second limitation is more fundamental. While Carrillo starts interesting discussions about the different motivations of "sexual migrants", he stops short of suggesting how these differences might be more usefully analytically conceptualised. Faced with the reality that sexual migrants take an array of unique and complex journeys, Carrillo opts to flatten the concept of sexual migration, rather than to propose new categories. I seek to do the opposite in this work, elaborating a new set of categories with potentially greater explanatory power. This is because there may be – as I will discuss shortly – a significant qualitative difference between the experiences and outcomes of migrants who are already out prior to their relocation, those who are ready to

come out, those who are not ready to come out, and those who do not identify as gay or queer.

Continuing some of the themes in Carrillo's work, and recognising that "identity quests" may not be equally attainable or valuable to people from all backgrounds, Lewis (2012, 2014) offers further useful challenges to universalising narratives of coming out. Lewis notes that coming out is not a linear, once-and-for-all process, but rather a process which happens over time as a series of place-based decisions. While some people may relocate in order to come out, moving away from home and coming out are understood by Lewis as two detached pathways of movement that are not always simultaneous. Due to the pervasive trope of *coming-out migration*, however, "queer migration often becomes synonymous with leaving an unsupportive or unsafe place to disclose their true, already formed queer identity in a more appropriate, inclusive place characterized by a large queer community and less restrictive sexual and cultural norms" (Lewis, 2012: 212). The reality is slightly more complicated. Norms of disclosure – and "outness" – are situated within differing cultural and social contexts.

For this reason, the notion of coming-out migration is not equally applicable to all queer migrants; many may move without coming out once-and-for-all, but rather may continue to negotiate disclosure contextually, as they may also have done before migrating. While not coming out has long been associated with "identity confusion" (Cass in Lewis, 2012), scholars have more recently recognized the "diverse, individualized pathways of disclosure and self-definition" (Lewis, 2012). The single homosexual closet has given way to an understanding of multiple non-normative sexualities and meanings of disclosure, such that coming-out journeys are not merely "unilateral 'quests' for identity formation", but "complex, dialectic interactions in which 'knowing oneself as gay' involves multiple moves, places, and (re-)negotiations" (Lewis, 2012: 227). Thus, as well as being multi-faceted and embodied, the coming-out journeys of MSM may be "segmented," such that their migrations do not coincide perfectly with a singular coming-out moment (ibid). Examples of these "segments" are relocations to 'scout' possible "queer livelihoods;" "migrating and going back into the closet;" "migrations as

coming out ‘tests’ or ‘triggers’”; and migrations to revisit former homes (ibid). Clearly, then, for Lewis, the queerness of migrations is not so much an “on/off” question, but rather something which is navigated and managed contextually.

2.2. Spatiality and sexual health

2.2.1. Writing legible narratives

Having traced the links between sexuality and migration, I will now discuss the empirical work on the sexual health of migrant MSM, or, as the research often calls them, “sexual migrants.” The definitions of “queer migration” or “sexual migration” in the literature are rarely clear, although one commonly used definition is “international relocation that is motivated, directly or indirectly, by the sexuality of those who migrate” (Carrillo, 2004). Whilst the term “migrant” refers to international migrants in much of the literature, I will also demonstrate some ways in which intra-national migrants may undergo shifts comparable to those who cross international borders. I will show that migrant MSM have consistently been found to be at heightened risk of acquiring HIV after moving to “queer hubs”, particularly in the period immediately after their migration (Burns et al, 2011; Evans et al, 2011; Ganczak et al, 2017; Gosselin et al, 2020; Mole et al, 2014; Schmidt et al, 2023). In fact, those born overseas accounted for 61% (1,723 of 2,810) of new HIV diagnoses in England in 2023, representing a 52% year-on-year total increase from 2022 (1,133 to 1,723) (UKHSA, 2024). As the task of epidemiologists and sociologists is not just to map out the spread of infections, but also to build a convincing, *diachronic* narrative explaining the spread (Wald, 2008: 129-30), it is important to dig deeper than migrant status *tout court* in explaining the factors affecting sexual risk.

Anthropologist Gilbert Herdt writes that, upon migration, “the rules of sexual behaviour change, opening new avenues for sexual encounter, but also exposing the person to enhanced risk” (1997: 3). Herdt complicates simplistic liberationist framings of queer migration by acknowledging that,

when people cross boundaries into unknown sexual cultures, it becomes harder to negotiate sexual rules and codes. Indeed, numerous scholars have highlighted the role of acculturation, that is, the ways in which sexual attitudes and behaviours change after spending longer periods of time living in a place with different social and sexual norms (Causevic et al, 2022; Newcomb et al, 1998).

Much of the existing work on the sexual health outcomes of migrant MSM centres on the experiences of Central and Eastern European (CEE) migrants in London following the expansion of the European Union (EU). Mole et al (2017) show how the attitudes of CEE migrants in London liberalise over time, particularly regarding the acceptability of homosexuality and extra-marital sex. As for MSM from CEE specifically, the longer they spend in the UK, the less likely they are to engage in higher sexual risk behaviours (Mole et al, 2014). The same can be said for MSM from Mexico in the US (Parrado & Flippen, 2010). In their examination of the timing of French immigrants' sexual débuts, Marsicano et al (2011) find that sexual risk-taking behaviours are lower for those who arrived in France before the age of 10 because they had longer to "acculturate" to the norms of the non-migrant majority.

Whilst it is certainly true that crossing boundaries into unknown sexual cultures can pose significant challenges, it is also important to consider the direction of travel that makes sexual risk particularly acute (Burns et al, 2011; Mole et al, 2014). In a challenge to understandings of queer migration as "a means of escape and self-realisation" (Binnie, 1997: 240), this work highlights the dual-edged nature of some queer migrations to particularly risk-laden destinations. As Mole et al (2014) note in their study about sexual migrants from Central and Eastern Europe (CEE) in London:

> The factors increasing sexual risk for the CEE gay men are: the removal of hostility and violence; widespread liberal attitudes; less imposed religious observance or intolerance; the relief of a 'paralysis;' greater opportunities to meet sexual partners and satisfy one's desires. Although all of these factors

> are normally deemed to be positives in life, in this context they seem to be consistent with heightened sexual health risks.
>
> (Mole et al, 2014: 95-6)

In other words, a combination of social, cultural, political and medical factors makes some (sexual) migrations riskier than others. Cities in Western Europe and North America, often seen to emblematise new sexual opportunities for gay and queer people (Binnie, 1997; Graham, 2007; Mole et al, 2014), are in actuality centres of HIV transmission, particularly in the period immediately after their migration (Burns et al, 2011; Mole et al, 2014). Given that recently acquired HIV is particularly transmissible in the first weeks and months following seroconversion (Miller et al, 2010; Selik & Linley, 2018), these intense moments of "escape and self-realisation" may become particularly dangerous in terms of HIV transmission if "higher-risk" recent migrants assortatively mix with one another.

2.2.2. Risky origins

As already stated, then, migrants' direction of travel can affect their (sexual) health trajectories. Mole et al (2014) summarise the difficulties facing CEE sexual migrants in London in terms of a mixture of: 1) the social context in the place of origin, 2) the social and health contexts in the destination, and 3) generic factors affecting the sexual health of all migrants, such as anonymity and loneliness. I will take each part of this "directional" narrative in turn, before considering some alternative lenses of analysis. The first factor in Mole et al's (2014) explanation of sexual risk is the social context in the place of origin. Awareness of and adherence to safer sexual behaviours tends to be lower in settings with a high degree of institutionalised homophobia (Amirkhanian, 2012; Attwood, 1996; Berg & Ross, 2014; Binnie, 1997; Clark et al, 2013; Gios et al, 2019; Mai, 2004: 51; Mole et al, 2014: 90; Quinn, 2006; Rivkin-Fish, 1999; Ross et al, 2013; Štulhofer & Sandfort, 2004; Waugh, 1999), such as CEE (Mole et al, 2014: 87; Quinn, 2006: 56; WHO in Evans et al, 2011: 325). In contrast with the value of individual liberty

associated with Western European societies, the “psychology of the collective” that pervaded post-communist CEE limited the possibility of positive or neutral discussions of sex and sexuality (Attwood, 1996; Binnie, 1997; Mai, 2004: 51; Mole et al, 2014: 90). Amid the economic collapse brought by the fall of the Soviet Union, panicked “dying nation” discourses steadily intensified, nourishing understandings of non-heterosexual practices as Western impositions (Rivkin-Fish, 2006). Use of sexual health services fell due to the moralisation of non-heterosexual practices (Quinn in Evans et al, 2011: 326), as well as a generally limited provision of meaningful sex education (Rivkin-Fish, 1999: 806; Štulhofer & Sandfort, 2004; Waugh, 1999: 72-3). Studies of other contexts in which sexualities are morally regulated by shared public codes similarly show lower levels of safer sex knowledge (CARAM, 2018: 7) and individualism regarding sexual decision-making (Ahmadi, 2003). It is unsurprising, then, that in a study of MSM’s health across 13 European cities, those in the North and West Europe were far more likely to be “out” than those in Europe’s South and East (Gios et al, 2019).

Due to the restrictions on discussing sex and sexuality, researchers find that social contexts in which homosexual sex is heavily moralised make individuals far more likely to judge the sexual health of partners according to performed characteristics that seem to confirm moral hygiene, rather than according to factors such as testing and sexual history (Mai, 2004; Mole et al, 2014). Mole et al (2014) highlight how sexual migrants from CEE frequently linked HIV status with unhealthy physical appearances. Mai (2004) finds that Albanian sex workers in Italy felt able to discern HIV status and risk according to the perceived femininity of sexual partners or their willingness to take a passive sexual role (a somewhat logical lay epidemiology, given that the risk of HIV acquisition is much higher through receptive than insertive intercourse among circumcised males (Patel et al, 2014)). Participants in Mai’s study felt that, while receptive sexual partners were “gay”, insertive partners assumed the separate ontological category of “men” or “straight men”. Those taking the insertive role incorrectly believed themselves to face negligible or non-existent HIV risk (2004: 284). Without the possibility of

having more informed sexual health discussions, straight Albanian sex workers in Italy understood HIV as a “moral disease” which would only impact the real “queers.” Clark et al (2013) make similar findings about sexual role-based beliefs and HIV prevention in Chile. Pineda (2020), meanwhile, finds that the sexual health knowledge – particularly regarding HIV – of Latin American sexual migrants in Madrid was often informed by numerous preconceptions connected to dominant machismo attitudes in their home environments. Furthermore, Pineda finds that internalised homophobia continues to impact on the sexual practices of many of these sexual migrants after their migration, as the following quotation highlights:

> In Colombia I had never been able to speak openly about my sexuality, neither in my family, nor with my friends, and I had to figure it all out on my own, so when I had sex I never got to ask how it was, what I was supposed to do or not, I just did it and even today, when I get to have sex with someone I still ask no questions, it is just the intercourse and that is it, I do not even ask whether we are going to use condoms or not, if the person does not say it, I just do as they please.
>
> (Pineda, 2020: 7)

For this individual, a previous life-stage in which discussions of non-heterosexuality were taboo continues to make it difficult for him to discuss safer sex with his sexual partners. This finding foreshadows the impending discussion of the temporal dimensions of sexual health, sexuality, and migration.

As well as giving rise to inaccurate lay epidemiologies, strict public moral codes in sexual migrants’ country of origin may have an indirect impact on their likelihood to observe official health advice as regards safer sex in their destination country. Carballo-Diéguez (1998), for example, finds that Latino sexual migrants in the US – while aware of the risks of HIV transmission – were less likely to follow safer sex guidance because they equated it with prohibitions imposed by the Catholic church from which they

escaped. In a similar way, internalisation of the “cultural message of disempowerment” leaves many Latino MSM feeling unable to “control [their] own destiny…and thus fail to act in a self-protective manner” (Díaz et al, 1998: 283). Thus, experiences in migrants’ countries of origin continue to influence their sexual health perceptions and behaviours long after they relocate.

While most literature focuses on the journeys of international migrants, some work examines the case of people moving within countries, particularly large countries such as the USA and China. Indeed, far from being universal, attitudes and norms around sex and sexuality are often highly heterogeneous at the country level (Mole et al, 2014: 94). Perhaps unsurprisingly, then, there is a great deal of overlap between the norms and attitudes of recent intra-national (often rural-to-urban) sexual migrants and those who traverse international borders. Similarly to studies of East-to-West European migration which found sexual risk perceptions to be guided by performed characteristics such as uncleanliness or overt femininity (Mole et al, 2014: 93; Mai, 2004: 55), so too did British MSM from rural areas frequently link HIV status with an “unhealthy” physical appearance (Gillibrand & Turner, 2013: 62), suggesting the possibility of a rural/urban divide in lay epidemiology strategies. Research has therefore highlighted the need to consider specific health interventions for rural-to-urban migrants (Tamiru et al, 2011).

Indeed, migrants who move from rural to urban places often have poorer sexual health outcomes (Bianchi et al, 2007; Chen et al, 2017; Egan et al, 2011; Ford & Kittisuksathit, 1996; Gorman-Murray, 2007; Wu et al, 2016). For example, rural migrant MSM in Guangzhou had significantly less knowledge of HIV risks than natives of the city, largely because of a lack of positive or neutral discussions of safer sex and sexuality in their homeplaces (Wu et al, 2016: 8). As a result, they were significantly more likely to engage in unprotected anal intercourse (10). Similarly, Chen et al (2017) find that migrants to Jiangsu from other parts of China were more likely to engage in condomless anal sex and had higher HIV and syphilis prevalence than residents. Similar results were found for male migrants from rural parts of

China in Shanghai (Sudhinaraset et al, 2012). Young migrants from rural parts of Thailand to large cities similarly had higher STI rates, including HIV (Ford & Kittisuksathit, 1996). As with migrants from other countries, a mixture of material and non-material factors made rural-to-urban migrants more likely to become sexually active (in the absence of safe(r) sex knowledge). Firstly, urban hubs facilitate access to LGBTQI+ venues and networks (Gillibrand & Turner, 2013; Yang et al, 2016). Furthermore, loss of friend and family networks, coupled with the anonymity afforded by city life, contribute to increased sexual risk-taking among recent migrants to urban centres (Bianchi et al, 2007; Egan et al, 2011). It is therefore clear that awareness of and adherence to safer-sex practices transcends national borders.

The existence of a range of inequalities and inequities that cross-cut international borders undermines one-dimensional risk categories. Discourses framing sexual risk as originating in "distinct and distant places" (Campbell, 1998: 88) thus stand in tension with transnational power dynamics that limit access to gay wellbeing and flourishing even within the "enlightened" metropole. In this way, framing contagion in implicitly international terms registers problematic aspects of the "outbreak narrative" (Wald, 2008), resulting in the – intentional or otherwise – reproduction of (sexual health) risk as a foreign phenomenon (Campbell, 1998). Framing migrant MSM as necessarily foreign-born also glosses over the ways in which social, cultural, economic, political and health inequities may heighten sexual risk-taking and decrease engagement with sexual health services at the subnational level. Indeed, in certain circumstances, foreign-born migrants exhibit lower HIV risk than native populations, a fact often attributed to the protective factor of traditional, conservative sexual norms (Flaskerud et al, Newcomb et al, Peragallo in Carrillo, 2004). When higher levels or HIV risk are found in the same group, however, it is attributed to – again – traditional, machismo attitudes (Flores-Ortiz, Marín & Flores in Carrillo, 2004). Insofar as heightened risk and decreased risk were *both* explained in terms of an inability or unwillingness to adopt more "Western" traits, such as self-determination, self-assertiveness, and individuality (ibid), it is clear how dominant social and cultural narratives about unenlightened, foreign Others

may continue to inflect research findings. For this reason, writes Carillo (2004), US practitioners frequently operate with the assumption that Latinx migrants have greater vulnerabilities for HIV transmission than the locals, whether or not this is actually the case.

All this is not to say international migrants do not face very specific difficulties compounding the potential upheavals of their migrations. As I will go on to explain, poorer health outcomes among foreign-born migrants are often explainable in part by difficulties understanding different healthcare infrastructures (Altman, 1999; Anderson & Doyal, 2004; Castro-Vázquez & Tarui, 2006). Furthermore, the precarity of many migrants – especially irregular migrants – often leads to an increase in higher risk transactional partnerships (CARAM, 2018; Gosselin et al, 2020). While the aim here is not to focus specifically on irregular migrants, more attention should be paid to addressing their specific healthcare needs, as well as broader structural inequities. Nonetheless, if “sexual migrants” are understood as people on both geographical and embodied journeys (Carrillo, 2004; Gorman-Murray, 2009), then it stands to reason that sexual migrants may move both internationally and intra-nationally.

2.2.3. A risky destination

The second factor in Mole et al’s (2014) “directional” narrative of the risks faced by sexual migrants is the social and health contexts in the destination. According to this part of the narrative, the prevalence of sexually transmitted infections, including HIV, in destinations favoured by sexual migrants is greater than in their home countries. Indeed, gay or queer “hubs”, such as London, are also hubs of HIV and other STIs. Indeed, for many years, London was home to the highest incidence of sexually transmitted HIV in Europe (Evans et al, 2011; Burns et al, 2011; Mole et al, 2014). In 2023, the UK recorded 1,480 cases of new sexually transmitted HIV diagnoses among MSM, the second highest in Europe and Central Asia after Spain (1,748) (ECDC, 2024). Within that, 40% (321/811) of new sexually transmitted HIV diagnoses among UK’s MSM in 2023 were among men living

in London, up from 36% (276/761) in 2022 (UKHSA, 2024). As a result, migrant MSM in London – who often come from contexts in which safer sex is hard or impossible to discuss – find themselves in a particularly risk-laden environment. These risks are heightened yet further by the increased migratory flows induced by globalisation (Burns et al, 2011; Phung et al, 2020). Changes to EU membership in 2004, for example, led to “one of the largest migratory influxes in peacetime British history” (Burns et al, 2011: 321), amplifying the public health importance of correctly framing the risks posed by this direction of movement. Furthermore, heightened access to gay venues, networks and contexts of sexualised drug use in places such as London led to an intensification of sexual networks and increased HIV transmissions (Mole et al, 2014). Correctly identifying the needs of these migrants should therefore be a central task for health policymakers (Burns et al, 2011: 318).

Further to the factors highlighted above, Mole et al (2014) mention other, more generic factors influencing the sexual health outcomes of migrant populations in general. The heightened loneliness, isolation, and loss of friend and family networks that accompanies many migrations are frequently cited as factors increasing higher-risk sexual decision-making (Bianchi et al, 2007; Dzomba et al 2019; Egan et al, 2011; Muñoz-Laboy, 2009; Lindstrom & Franco, 2005). Muñoz-Laboy (2009), for example, demonstrates that Mexican migrant workers in the USA face particularly high levels of loneliness.

Health infrastructure is another factor that has been frequently argued to have a significant impact on the health outcomes of migrant MSM. Difficulties understanding and navigating different healthcare systems is often at least in part to blame for poorer outcomes among international migrants (Altman, 1999; Anderson & Doyal, 2004; Baroudi et al, 2022; Castro-Vázquez & Tarui, 2006; Fakoya et al, 2008; Murphy et al 2020; Phung et al 2020). In their study of sexual migrants in Sweden, for example, Baroudi et al (2022) find that lack of knowledge of the healthcare system, as well as long wait times, linguistic difficulties and additional costs all contribute to worse health outcomes for sexual migrants. Murphy et al (2020) similarly find foreign-born

sexual migrants in Australia to face multiple barriers to access, including language and lack of Medicare cover. Phung et al (2020) find that language barriers and lack of knowledge of the functioning of the NHS reduced healthcare access for East European migrants in the UK. Meanwhile, Finnerty et al (2019) observe the impact of the NHS's "hostile healthcare environment" policy, including imposing charges on foreign-born residents and data-sharing with the Home Office, also contribute towards worse sexual health outcomes. Health messaging in destination countries can prove another significant barrier to equal health outcomes for sexual migrants who do not know how to navigate the healthcare system to meet their needs. Pachankis et al (2017) highlight that high levels of stigma towards immigrants, when combined with barriers to access in the healthcare system, worsen sexual health outcomes yet further.

This analysis complicates the notion that risk is located "out there." Given that London has, for many years, been the European capital of new sexually transmitted HIV infections (Burns et al, 2011; "HIV/AIDS surveillance in Europe", 2024), then one could argue that it is London, not many migrants' places of origin, that functions as a key site of heightened sexual health risk. This framing, however, does not always translate research and policy. For example, sexual history questions in clinical settings continue to ask patients about the nationalities of sexual partners, but not about the location of the sex itself. I do not wish, however, to point the finger at any person or place. As argued already, binaries of "here" and "there" fall down in the globalised world. It is for this reason that I ask in the following section: how might we radically and usefully reimagine spatial geographies of risk? How might it look to conceptualise the experience of the sexual migrant from a temporal, rather than a (solely) spatial standpoint? What might we see that may have been obscured by the alternative lens of analysis?

2.3. Temporality and sexuality

2.3.1. What's time got to do with it?

To return to Wald's (2008) description of the goal of epidemiological research as not only to map out infections, but also building a convincing narrative explaining their propagation, it would be instructive to summarise the story that is told in the research on sexual migrants that I have outlined so far, which takes us a long way towards understanding why certain migrant MSM may face heightened sexual risk. HIV risk is commonly understood, like many pathogens, through a spatial lens, with certain parts of the world being riskier than others. Given that many MSM move from places where discussions of safer sex and sexuality are less commonplace to cities where HIV risk is concentrated, migrant MSM appear to be at greater risk of acquiring HIV, especially in the period immediately after their migration (Burns et al, 2011; Evans et al, 2011; Ganczak et al, 2017; Gosselin et al, 2020; Mole et al, 2014; Schmidt et al, 2023).

However, both "migrants" and "MSM" are heterogeneous groups without a singular set of experiences or needs (Lewis, 2012; Thomann, 2016). Why do some migrant MSM face more risk than others? I propose to answer this question by introducing a temporal dimension to understandings of queer migration, a dimension that considers the timing of important life-course events, such as coming out. To this end, careful consideration of the "worlds" which migrant MSM occupied before and after migration may yield important insights as to their sexual health perceptions and behaviours. Consider, for example, two fictitious individuals. The first is from a highly homophobic environment in, say, rural England, where it was not possible to openly discuss sexuality or queer sexual health practices. He migrates to London at age 18 to start university. The second person is from a relatively queer-friendly environment in, say, Cape Town, where people openly discuss sex and sexual health. He moves to London at age 35 to start a new job. The experiences of these two individuals will be very different; their needs may also be different. And, while one is migrating much further and from a "high-prevalence area," this may not necessarily mean he is at greater risk. By

refocusing the lens of analysis from one foregrounding spatial movements to one including shifts in what might variously be called people's lived realities, timelines, temporalities, or worlds, it may be possible to articulate more suitable categories through which to analyse the patterning of sexual health outcomes among migrant MSM.

Despite the universality with which time is represented on modern clocks and calendars, the meanings of "time" are historically and culturally contingent (Assmann, 2013; Benjamin, 1942; Rao, 2020; Thompson, 1967). Indeed, time is rarely experienced with the homogeneous, empty uniformity of clocks and calendars (Assmann, 2013; Benjamin, 1942). Rather, different people experience and conceptualise time differently. For example, our socio-sexual worlds affect how we experience time (Halberstam, 2005; Edelman, 2004; Muñoz, 2009). And, as Proust (1913-1927) famously reminded us, even the subtlest of reminders may transport us "back in time". Organisations often reproduce certain temporal configurations, which may be out-of-joint with those of their staff or users (Pulk, 2022). Often, the ways of previous times take on weight in the form of institutions that may "drag" us back (Bateman, 2010; Freeman, 2010). Sometimes, collective trauma causes certain truths to get frozen in time, including understandings of sexual health and HIV (Crewe, 2018; Dennermalm et al, 2024: 389).

"Susanna," in the 1999 film adaptation of Kaysen's (1993) memoir, *Girl, Interrupted*, demonstrates what can happen when a patient's sense of time is at odds with their physician's:

> Explain what? Explain to a doctor that the laws of physics can be suspended? That what goes up may not come down? Explain that time can move backwards and forwards and now to then and back again and you can't control it?
>
> "Susanna" in James Mangold's *Girl, Interrupted* (1999)

In this case, rather than exploring the meaning of Susanna's words, the doctor dismisses them as the words of someone who either uses too many substances or needs "some rest" in a psychiatric unit. Rather than exploring Susanna's felt reality, the doctor simply deems her out of kilter with normality. Implicit in the doctor's judgement is the assumption that the only way any healthy person could conceive of time is as something linear, uniform and evenly paced. Deviations from such an understanding of time require, he believes, psychiatric intervention. This vignette from popular culture by no means reflects the typical behaviours of medical professionals in the contemporary clinic, but it does point to the historical reasons for which it may be hard to find room for concepts such as "temporality" in the rational world of medicine.

Susanna's time is deemed out of joint. But, out of joint with what exactly? As numerous scholars of time argue, the dominant, linear framing of time (past-present-future) – which first emerged in response to the need for one synchronised "railway time" shareable across vast landmasses with differing local solar times – is itself a historically and culturally contingent one, inseparable from the development of industrial capitalism (Assmann, 2013; Benjamin, 1942; Thompson, 1967). To put this another way, atomic clocks so precise that they will not lose or gain a single second during the entire lifetime of our universe (Barad, 2017: 59) do not constitute a capturing and controlling of time, but merely one representation of it. More specifically, they represent what Benjamin termed "homogeneous, empty time" (1968: 261). This time, the time of clocks and calendars which lacks any special moments to imbue it with meaning, strives for some abstract progress, such as the growth of the nation, the new reproducing the old in structurally similar moments (ibid). In opposition to this empty time are the moments of immediacy that Benjamin refers to as "messianic time" (ibid). In moments of messianic rupture, "weak messianic power" comes in to redeem the spirit of past revolutions (ibid). Memory is a key mechanism, in this framing of time, in the formation of non-linear, immediate connections between past and future. Similarly, Assmann (2013) argues that the modern time regime emerges as a result of the collapse and reconfiguration of the past-present-future model of

time. Drawing on the concepts of “collective identity” and “cultures of memory,” Assmann argues that the modern time regime is marked by several types of non-linearity, including but not limited to *temporal rupture*, *fictional beginnings*, *creative destruction*, *the invented historical*, and *accelerations.* Similar to Benjamin’s (1942) understanding on messianic time, Assmann argues that these five aspects arise during times of uncertainty and loss, in collective or individual attempts to dissect the pain of the past and construct a sort of renewal. According to Assmann, then, the past continues to inflect our futures, such that the past is never truly “past.” The purported linearity of time is, for critics of the “modern time regime,” a convention of representation designed more than anything else to reward adherence to production deadlines (Assmann, 2013; Benjamin, 1942; Mbiti, 1969).

2.3.2. Queer and reproductive temporality

While the above-mentioned scholars discuss time in more general terms, much writing on temporal otherness explicitly centres minoritised perspectives. While early sexological, psychoanalytical and anthropological understandings of queer temporal otherness relied on the depiction of “the sexual deviant or pervert – the queer…as an instance of arrested development, retardation, degeneracy, and decadence” (Rao, 2020), such framings have in recent years been subverted by gay, trans and queer scholars. In *In a Queer Time and Place*, Halberstam argues compellingly that there is such a thing as queer time, by which he means “those specific modes of temporality that emerge…once one leaves the temporal frames of bourgeois reproduction and family, longevity, risk/safety, and inheritance” (2005: 2). Queer uses of time therefore disavow inherited life-courses and re-invent horizons of possibility:

> Queer time for me is the dark nightclub, the perverse turn away from the narrative coherence of adolescence – early adulthood – marriage – reproduction – child rearing – retirement – death, the embrace of late childhood in place of early adulthood or immaturity in place of responsibility.

> It is a theory of queerness as a way of being in the world and a critique of the careful social scripts that usher even the most queer among us through major markers of individual development and into normativity.
>
> (Halberstam in Dinshaw et al, 2007: 182).

Halberstam puts time front-and-centre in his explanation not just of queer exclusion, but of other classist, ableist, racist and sexist forms of exclusion. Similarly to Halperin's (2012) notion of "homonormativity," Halberstam argues that, in Europe and North America at least, the face of the acceptable Other is the one who adheres to the rhythms of the straight (and implicitly white, male, bourgeois, able-bodied world), while those who cling to the undisciplined temporalities of immediacy – uninterested with heterosexist traditions and milestones aimed at passing on one's "legacy" – remain an aberration. For this reason, Halberstam distinguishes between those queer people who live like their heterosexual counterparts and those who choose "immature" ways of life marked by an "epistemology of youth" rather than by a "selfless" dedication to reproducing the institutions of family and nation. Halberstam also argues that the body – in this case the transgender body – becomes the site for fantasies of both futurity and anachronism (2005: 15). Halberstam also notes how centuries-old understandings of queer people as inherently immature and "ambivalent to longevity" were only reinforced by the advent of AIDS, a collective trauma which both compressed time and expanded horizons of temporal possibility (2005: 2). It is therefore important, in the wake of AIDS more than ever, to rethink the moralisations of those outside the temporal norm. In so doing, Halberstam argues, we may create space for new alliances between the many forms of Other whose rhythms cannot be disciplined. To avoid doing so may be a mortal threat if, as Bateman (2017) argued, gradual and unconscious termination of queer ways of living in countless concessions to chrononormativity (the social expectation that individuals should follow a single, standardised, linear, implicitly reproductive timeline) are capable of inducing "queer death."

The shortening or disappearance of futures is also the subject of Edelman's (2004) *No Future: Queer Theory and the Death Drive.* In this work, Edelman examines the place taken by the child in American political discourse as the symbol of futurity, a symbolism that leaves non-reproductive ways of life behind. The figure of the idealised (white, American, able-bodied) child reproduces a narrow future marked by sameness against the uncertainty of the modern world. This echoes Rohy's (2009) argument in *Anachronism and its Others* that the historical casting of homosexuals and non-whites, among others, as being in a state of "arrested development" demonstrates that the survival of the nation across (linear) time is seen to rely on (certain forms of acceptable) reproduction. (Of course, acceptable reproduction has in many places opened up in recent years to include queer parents, on certain (unequal) conditions.) Indeed, for Edelman, the placing of the (white, American, able-bodied) child outside of politics and in the realm of the natural reproductive order makes queer resistance, including a restructuring of the reproductive nation-state, unthinkable (2004: 2).

In contrast with the child as the symbol of futurity, Watney identifies its counterpart – the symbol of no future, of death – to be the rectum (1987: 126). Bersani (1987) follows Watney in his assessment of the rectum as the symbol for waste, danger, and the retraction of futures. Bersani notes that gay men, as well as intravenous drug users and other minoritised groups, had gained the same centuries-old stigma as female prostitutes "contaminated vessels, conveyancing 'female' venereal diseases to 'innocent' men" (1987: 211). Such understandings persist across various contexts, as Mai shows in his discussion of how Albanian sex workers in Italy preserved their honour and respectability, as well as gaining a misguided sense of imperviousness to sexually transmitted infections, by being "real men," i.e. by being a "top" (insertive sexual partner) (2004: 9-10). "Women and gay men", writes Bersani, "spread their legs with an unquenchable appetite for destruction" (1987: 212), their willingness to be the "object of pleasure" the nail in their metaphorical coffin:

> Tragically, AIDS has literalized that potential as the certainty of biological death, and has therefore reinforced the heterosexual association of anal sex with a self-annihilation originally and primarily identified with the fantasmatic mystery of an insatiable, unstoppable female sexuality. It may, finally, be in the gay man's rectum that he demolishes his own perhaps otherwise uncontrollable identification with a murderous judgment against him.
>
> (Bersani, 1987: 222)

Ironically, the association of gay men with death and shortened futures described by Bersani has outlived the reality of HIV as a death sentence, with understandings of sexual health and HIV prevention sometimes remaining anchored in the realities of earlier times (Crewe, 2018), such that emotional responses to HIV risk become difficult to reconcile with logical-rational claims about HIV prevention (Dennermalm et al, 2024: 389). Botnick (2000b) wrote of the continued identification of homosex as a "death wish" four years after the introduction of highly active antiretroviral therapies, while Crewe (2018) outlines in detail the fears that remained for him surrounding same-sex sexual encounters into the 2010s:

> I couldn't stop worrying. But I couldn't knock off the sex either. So, no matter how safe, no matter how minimal or risk-free, I would fret. Might I not have a nick somewhere? A scratch, here by my nail? What about the soles of my feet? Had my gums bled when I last brushed my teeth? There was the time I went to a gay sauna, reached deep into what I thought was the condom supply, only to discover it was the useds. Alcohol made it all worse. Why did I do that? Did I do that? Every time I had a cold, a sore throat, it *foretold* disaster. I would examine my tongue minutely in the mirror. Once, preparing a meal for friends, I cut my finger chopping vegetables into a stew – and poured the whole thing, still bubbling, into the bin. Negative test results were treated like *suspended sentences*.

For Crewe, queer sexual experiences were shrouded in a form of temporal lingering, each negative test result only a suspended sentence before his

inevitable death. The absurdity here, of course, is that such a death is entirely avoidable in the contemporary context. Why, then, does the unavoidability of this death sentence linger? For Freeman, this can be understood as the result of "temporal drag" (2010). Freeman argues that the chrononormative structuring of time – itself, she argues, a tool for marshalling bodies towards maximum productivity – is an incomplete representation of the way time really figures in our lives. *Time Binds* is the name of Freeman's (2010) book, and, indeed, her thesis is that the past is not simply something that has, as we would imagine it, passed away. Rather – echoing Assmann's emphasis on "memory" and "identity" – Freeman argues that the past has weight; it is embodied in behaviours and beliefs and fashions that give it a sort of living quality. It should be noted that, while one response to traumatic past realities is to remain hyper-attuned to them, silence and forgetting are a common response to HIV/AIDS trauma (Adam et al, 2008; Monteiro et al, 2018; Zea, 1999). For example, Zea (1999) explores the case of one individual who forgot his HIV status until noticing Kaposi sarcoma lesions on his skin 3 years after his initial diagnosis.

In his seminal novel, *Returning to Reims*, Eribon (2009) offers a raw account of the ways in which different identities and memories may inhere in the queer subject. Invoking Bourdieu's notion of "split habitus", Eribon describes the melancholy of returning from Paris to his working-class hometown, where he must in some senses revert to a previous, unhappy version of himself:

> When you return to the environment from which you came — which you left behind — you are somehow turning back upon yourself, returning to yourself, rediscovering an earlier self that has been both preserved and denied. Suddenly, in circumstances like these, there rises to the surface of your consciousness…the discomfort that results from belonging to two different worlds, worlds so far separated from each other that they seem irreconcilable, and yet which coexist in everything that you are.
>
> (Eribon, 2009: 18)

Reminiscent of what Herring aptly described as “the worlds I got out of, and, at the same time, I have never left behind” (2010: xi), Eribon in this work makes the case that “gay ways of life” have not simply to do with abnormal *sexuality*, but also abnormal *temporality*:

> It is just as true that those people whose existence is partially defined by these other space-times cannot live permanently within them. What characterizes queer lives or gay lives would rather be the capability — or the necessity — of moving regularly back and forth between spaces and between temporalities (from normal to abnormal and back again).
>
> (Eribon, 2009: 212-3)

When writing of “abnormal temporality”, Eribon refers to life-courses which are not only spatially nomadic, but which do not adhere to the timelines and futures set out for reproductive, heterosexual subjects, such as those set out by Halberstam (2005). Eribon was not the first to claim that gayness is better understood as a way of life than a form of sexual desire. Foucault, for example, contends that “homosexuality threatens people as a ‘way of life’ rather than as a way of having sex” (1996: 310). Weeks argues for a radical separation “between homosexuality, which was about sexual preference, and ‘gayness’, which was about a subversively political way of life” (1985: 198). In *Gay New York*, meanwhile, Chauncey (1995) demonstrates how a certain form of (mostly white, male) queer culture developed in opposition not to heterosexual sexuality *per se*, but rather to heterosexist norms and ways of life.

While the above-mentioned authors are associated with what has been termed the “negative” or “antisocial” thesis of queer temporality, there is another face of queer time scholarship, the “affirmative” or “utopian” thesis, characterised by a staunch belief that the “here and now” is a “prison house”, whereas the future represents the “way out” (Muñoz, 2009: 1). *Contra* Edelman’s thesis that queer people have no future, Muñoz writes in *Cruising*

Utopia (2009) that the future is the very domain of queerness. Queerness, for Muñoz, is "a temporal arrangement in which the past is a field of possibility in which subjects can act in the present in the service of a new futurity" (2009: 17). To focus on the current political climate as Edelman does, he claims, is excessively presentist. Instead, Muñoz argues, we must dream of futures in which all types of Others may thrive:

> There is something black about waiting. And there is something queer, Latino, and transgender about waiting. Furthermore, there is something disabled, Indigenous, Asian, poor, and so forth about waiting. Those who wait are those of us who are out of time in at least two ways. We have been cast out of straight time's rhythm, and we have made worlds in our temporal and spatial configurations. Certainly this would be the time of postcoloniality, but it is also crip time… It seems the other's time is always off. Often we are the first ones there and the last to leave. The essential point here is that our temporalities are different and outside. They are practiced failure and virtuosic.
>
> (Muñoz, 2009: 182-3)

Out of this waiting, argues Muñoz, comes a yet greater willingness to reject the here and now and build a better world. In this way, the utopian Muñoz actually echoes the antisocial Edelman's sentiment that queer temporality is that which values the "better" over the "good" (2004: 5).

2.3.3. Temporality from other perspectives

As already noted, queerness is not the only form of marginality to have precipitated significant theorisation of temporality. Samuels, for example, writes of the temporality of disability:

> Crip time is time travel. Disability and illness have the power to extract us from linear, progressive time with its normative life stages and cast us into a

> wormhole of backward and forward acceleration, jerky stops and starts, tedious intervals and abrupt endings. Some of us contend with the impairments of old age while still young; some of us are treated like children no matter how old we get.
>
> (Samuels in Ljuslinder et al, 2020: 36)

Meanwhile, in her work, *Feminist, Queer, Crip*, Kafer (2013) explicitly links together the notions of queer time and crip time. By drawing on a social model of disability that seeks to celebrate the queerness of disabled bodies while emphasising the ways in which both queer and disabled bodies are literally dis-abled by rigid social configurations, Kafer finds impressive alliances among those targeted by a "curative imaginary" (ibid: 29). "Queer kids, street kids, kids of color", writes Kafer, "all of the kids cast out of reproductive futurism, have been and continue to be framed as sick, as pathological, as contagious" (ibid: 32). What these people have in common, she argues, is a "future of no future", *per* Edelman, marked only by incapacity. Pushing beyond an intersectional analysis that parcels people up according to various intersecting and pre-existing identities, Kafer argues in *Feminist, Queer, Crip* that queerness and cripness are always already inherent to one another, opening up possibilities for empathetic alliances. This is because – historically pejoratively, but nowadays with an increasing fervent pride – disabled people may be considered to have experiences which are *queer,* and queer people may be considered *dis-abled*, in terms of the social model of disability within which people are made "unable" by societies that are inflexible to their needs. In this way, to borrow an image from Anzaldúa (1987), artificial borderlines between queerness and cripness unfurl into vibrant borderland identities. Discussing her workplace's suggestion that she use the disabled bathroom after her gender transition, for example, Doan offers an instructive example of the ways in which queer people may be dis-abled by social norms and expectations:

> At work I had to face the gendered restroom question directly. When I first transitioned, I became temporarily 'disabled' since the administration's interim solution was that I use the single access handicapped restroom on a different floor of my building.
>
> (Doan, 2010: 643)

Out of Doan's experience emerges the ways in which binary understandings of the world can forge unexpected linkages between transness, cripness, and any other kind of identity that pushes people into the 'Other' box.

Temporality, pathologisation and queerness frequently come together in works surrounding the experiences of those undergoing a gender transition. Horak (2014), for example, writes of "hormone time", an admittedly linear timeframe according to which trans subjects measure their length of time on hormone replacement therapy. Aizura, meanwhile, documents an altogether less teleological approach to transitional time in *Mobile Subjects* (2018), taking the opportunity to interrogate whether or not the trans journey necessarily requires endpoints or deadlines. Preciado, meanwhile, turns attention to the "microprosthetic" substances used to augment our inner worlds, from Prozac to poppers, and HRT to heroin. Documenting his own temporal experience of T-gel (testosterone gel), Preciado writes:

> Then, an extraordinary lucidity settles in, gradually, accompanied by an explosion of the desire to fuck, walk, go out everywhere in the city… My body is present to itself. Unlike with speed and coke, there is no immediate comedown. A few days go by, and the movement inside calms, but the feeling of strength, like a pyramid revealed by a sandstorm, remains.
>
> (Preciado, 2016: 21)

By turning the gaze inwards rather than outwards, Preciado's work provides a particularly interesting insight into the role of drugs, hormones and medicines in the shaping of one's temporal patterning.

Scholars have also turned their attention towards the relationship between time, race, and coloniality. Of course, discussions of time and race, much like those of time and sexuality or disability, have the potential to bolster harmful and oversimplified presuppositions about large groups of people, as in the case of the following comment made by the director of the *US Agency for International Development* (USAID), Andrew Natsios, in a 2001 newspaper article on the provision of antiretroviral therapies to African communities:

> They don't know what Western time is. You have to take these (AIDS) drugs a certain number of hours each day, or they don't work. Many people in Africa have never seen a clock or watch their entire lives.
>
> (Natsios in Donnelly, 2001)

It is hard to conceive of a grosser oversimplification of the lifestyles and knowledge of an entire continent, not to mention the fact that communities adhering to non-linear, cyclical understandings of time have numerous ways of adhering consistently to daily rhythms (taking pills at sunrise, for example, the time of which varies negligibly in most African countries). More successful attempts at linking time and race have come from the likes of John Mbiti (1969), who describes "Western time" from the perspective of somebody who is not native to it. "Western time", for Mbiti, which bears many similarities to Benjamin's "homogeneous, empty time", is countable, thereby enabling people to manage it, save it, and try hard not to "waste" it. By contrast, Mbiti describes "African time" as being focused on qualitative events, with time having no independent existence. This focus on events means the future is limited to a distance of around two years or so (with obvious implications for long-term economic planning), as this is the time in which foreseeable events such as the birth of a baby (nine months) or the next harvest (18 months) will take place. Unlike Natsios, who believes most Africans have "never seen a clock", Mbiti knows that this is not the case, but remarks instead that when an African sees a clock ticking, they will observe this as an event ("the clock just

ticked") rather than as the passage of an independent flow of time ("the time just changed").

Speaking to the question of how to correctly frame the temporal otherness that is, in some senses, forced upon people from certain parts of the world, Rao (2020) notes the way in which the concept of "time" has been mobilised by European scholars as a regulatory tool:

> Ever since Hegel mapped time onto space so that Africa was imagined as Europe's past and Europe as everyone else's future, time has been central to the politics of imperialism and anti-imperialism. The violence of colonial and postcolonial projects of conquest and expropriation could be justified through the claim that the temporally primitive were being 'civilised' and, later, 'developed' to the point where in a distant future, they might — if they were deserving — be entitled to think of themselves as human.

However, being "out of time", as Rao puts it, is not only a negative state of affairs, but also carries immanently within it the promise of "release":

> The experience of being relegated to what we might think of as positions 'out of time' is a deeply ambivalent one, promising both marginalisation and the prospect of release from the iron cage of hegemonic time.

From this perspective, being out-of-kilter with hegemonic time is not simply a handicap, but also, under the right circumstances, an opportunity.

If, as I argue to be the case, there are multiple temporalities, stemming from multiple, marginalised othernesses, so too, I contend, is it possible to migrate between these timelines. As already mentioned, Anzaldúa (1987), in her theorisation of borderland identities, conceives of borderlines as artificial lines in the sand separating qualitatively similar and often hybridised communities. Spilling out from these borderlines emerge the borderlands, which come to take on their own identity. Anzaldúa argues that, until

borderland identities like her own Mexican-American identity come to be recognised not as sub-identities, but as identities in themselves, with their own ways of being and knowing, there can be no justice. While Anzaldúa conceives of borderlines and borderlands in primarily spatial ways, her conceptualisations are a useful way of considering the multiplicities that cohere – peacefully or otherwise – within the divided Self, such as those identified by Eribon on his return to Reims.

Just like spatial borders, temporal borders can be crossed. Indeed, Hadžimuhamedović (2018) demonstrates, with reference to feast days in the formerly culturally and religiously diverse Bosnian border-town of Gacko, how different time-spaces may coexist or collide within people or communities. Building on Bakhtin's (1981) work on *chronotopes*, or time-spaces, Hadžimuhamedović argues that both people and landscapes may be stuck between discursive times-paces, characterised as *schizochronotopes* (2018: 58). The first time-space Hadžimuhamedović describes – the pre-war "sacroscape" – is characterised by proximity and conviviality between communities that waxes and wanes cyclically over the year, culminating in Elijah's Day, the shared harvest festival. In contrast, the post-war "ethnoscape," gridded by modern calendars, calls for the separation and enumeration of communities. Split time-spaces often lead to a sense of loss, which Hadžimuhamedović shows with reference to the lost normality of cycles, now "gridded" by calendars (2018: 153-5). In other words, the logic of quality comes to be replaced with that of quantity as the Western capitalist churns flattened markets out of interwoven, diverse fields of existence (Braidotti, 2019). Subjects occupying these time-spaces are never truly "here" or "there," but always in-between (Herring, 2010). The artificial *borderlines* between the temporalities that inhere these subjects unfurl into hybrid *borderlands*, taking on a new identity informed by the liminality between the two worlds that created them (Anzaldúa 1987).

As a final note on non-linear forms of time, I would like to be clear that to engage in a deconstruction of supposedly universal time does not, as some may suggest, run counter to the objectivity of science. Even in the "objective" world of physics, spacetime can bend, slow down, and accelerate

(Darrigol, 2005). According to Einstein's special theory of relativity, *time* is a dimension without which no object is fully configured (ibid). And, of course, moving away from classical physics, the unpredictability of time/space/matter in the quantum realm continues to chip away at Newton's Clockwork Universe. While the gulf between the "objective" world of the hard sciences and the "subjective" world of the social sciences is great, new materialist scholars in particular continue to bring these perspectives together in compelling ways, demonstrating, for example, the ways in which objects (human, animal, mineral) do not interact but rather "intra-act", emerging as distinct objects *through* the process by which they came together ("space-time-mattering"), rather than existing prior to the encounter (Barad, 2007, 2015).

2.4. Temporality and sexual health

2.4.1. Outness-as-proxy

While social researchers have produced large amounts of work on temporality and sexuality, there is currently no research focusing explicitly on temporality and sexual health. Of course, temporality is a particularly difficult concept to operationalise and deploy in positivist healthcare research, much of which relies on well-established, tried-and-tested, easily replicable theories, frameworks, and methods of data collection and analysis. By contrast, the stated goal of this thesis is to elaborate new theories, frameworks, and methods that will reveal previously unidentified dimensions of the phenomenon commonly known as "sexual migration." Due to a lack of existing research in this area, I turned to research on sexual health and "outness," which I identified as a useful proxy for temporality. Coming out – which, granted, rarely happens once and for all (Orne, 2011) – often marks a shift away from the markers and milestones of reproductive temporality and towards those of queer temporality. Indeed, as Puar et al note, coming out is in some ways "tantamount to spatial displacement" (2003: 286). During the research interviews for this project, "coming out" and "outness" were usually much more legible and relatable terms by which participants made sense of

temporal shifts in their lives, such as shifts in their imagined futures or their day-to-day routines.

2.4.2. Outness and sexual health

Sexual health research focusing on migrant MSM's direction of travel is telling, but it paints only a partial picture of the patternings of sexual health perceptions and behaviours. Positing sexual risk as something originating from distinct and distant places stands in tension with the chequered reality of sexual decision-making that cross-cuts borders. Many migrants do not face particularly heightened sexual risk, whilst many non-migrants do. What explains this? What is more, much of the existing research assumes migrants' sexuality to be static, but in fact it shifts over time (Carrillo 2004). What is to be said for those who do not migrate for reasons related to their sexuality, but who come out after their migration? Research on "outness" and sexual health offers some answers in these regards (Annequin et al 2017; Hu et al 2019; Ogaz et al 2019; Rodger et al 2020; White & Stephenson 2014; Witzel et al 2016).

While there is no mutually agreed definition of "outness," I understand it as the degree to which a person is distinguishably not cis-heterosexual at any one time. One can never be fully "out," because individuals use diverse toolkits to modulate their "coming out" to different individuals (Orne, 2011: 699). What is more, many non-heterosexual individuals from marginalised backgrounds face significant barriers in appropriating the markers of a culturally and historically contingent gold standard of "outness" (Lewis, 2012; 2014). Certain masculinities – especially "closed" masculinities (Elliott, 2020) – may be defined in terms of adherence to heterosexist gender norms. "Acting straight," meanwhile, is a primary way in which many anti-effeminate gay men uphold their masculinities (Sanchez & Vilain, 2012), while MSM "in the closet" may be more likely to be behaviourally bisexual (Gios et al, 2019). Of course, it should be noted that masculinities are multiple, relational, and negotiable (Waling, 2019). Caring masculinities, for example, may involve some degree of "effeminacy" (Elliott, 2016). However, despite the increased

mainstream acceptance of homosexuality reflected in the recent "homonormative" turn, heterosexuality remains a central feature of many masculinities, including hegemonic masculinity. Working with the meanings that inform these masculinities may be key to creating transformative sexual health interventions (Zeglin, 2015).

Being "out" to more people appears to be linked with increased engagement with sexual health services and fewer risk-taking behaviours (Quinn, 2006: 14; White & Stephenson, 2013; Xu & Xu, 2022), as well as fewer syndemic conditions (Pitpitan et al, 2016). White & Stephenson (2013) find that US men "who did not know their status or had never been tested had lower odds of being 'out' to any groups, relative to those who knew their status to be negative". Outness also appears to affect PrEP candidacy among eligible individuals, with candidacy understood as the way eligibility for medical attention and intervention is negotiated (Dixon-Woods et al, 2006). Indeed, gay and bisexual MSM appear to be far readier to identify PrEP need than heterosexual individuals ("HIV testing", 2024), which is unsurprising given the high number of conversations about sex and sexual health that take place in gay and queer spaces and contexts. Hu et al (2019) find more out gay and bisexual male university students in China to be less likely to engage in high-risk sexual behaviours. In France, lower PrEP use was also associated with, among other things, those who were less out (Annequin et al, 2017). Smolenski et al (2011) argue that not-out MSM may engage in sexualised drug use to reduce feelings of shame and distress, which leads to greater sexual risk-taking (Ross et al, 2011) and higher chances of contracting HIV (Koblin et al, 2006). Indeed, research continues to find that homonegative legal, social, and political climates increase HIV risk behaviours among MSM (Ross et al, 2013). Medical stigma, including homophobic and transphobic attitudes, reduces the likelihood of MSM to be out, worsening health outcomes and experiences (Ayhan et al, 2019; Balfe & Brugha, 2009, 2010; Li et al, 2015; Mawson et al, 2025; Mbeda et al, 2020; Whitehead et al, 2016). Contexts of criminalisation have also been found to reduce sexual health service use (Müller et al, 2018). Qualitative research has also found internalised homophobia to be a key barrier to health-seeking

behaviours, including honest disclosure of sexual histories, among behaviourally bisexual individuals (Zea, 1999, 2000). Given that more minoritised individuals within the queer community, such as bisexual or non-binary individuals, are less likely to be out to more people, MSM who do not identify as gay appear to face particularly heightened sexual health risks (Reynolds et al, 2025).

Against this, some scholars offer a more chequered picture of the relationship between outness and sexual risk. In an analysis of 13 European cities, outness was found to not necessarily be a protective factor when it came to the health outcomes of MSM (Gios et al, 2019). It was true that MSM who were out were more likely than those who were not out to report HIV testing and being reached by HIV prevention programs, suggesting that “a non-LGBT friendly social arena might heavily hamper the disclosure of one’s sexual orientation and in doing so lead to a decreased access to testing services” (Gios et al, 2019). However, they were also more likely to use party drugs, which made safer-sex practices harder to navigate. While outness is generally linked to positive sexual health outcomes, Gios et al (2019) highlight “a multifaceted characterization of both MSM in the closet and out of the closet”.

It appears, then, that fuller engagement with sexual health services and advice relates to the extent to which individuals feel part of the “world” in which such considerations have salience. Rather than simply moving to more “liberal” spaces, queer migrants must constantly navigate sometimes incompatible social worlds, both “here” and “there,” at “home” and “away.” Obviously, engaging more with people who have spent longer openly engaging in same-sex relations is likely to increase individuals’ knowledge of safer-sex practices, and their engagement with sexual health services. PrEP use in Chicago was associated with participants knowing two or more other PrEP-users (Schueler et al, 2019). Similarly, MSM in Australia who had lower social engagement with gay men were less likely to use PrEP (Hammoud et al, 2019). For many individuals, however, such social engagement is fraught with actual or perceived risk. In the absence of such engagement, however, individuals are far more likely to make judgements about their own sexual

health or that of others according to performed characteristics that confirm moral hygiene, such as perceived masculinity or straightness (Clark et al, 2013; Mai, 2004) or healthy physical appearance (Mole et al, 2014), even if they possess information about other factors such as testing and sexual history (Pineda, 2020). In other words, access to sexual healthcare advice and testing alone does not ensure engagement with it, especially when contending with the strong psychological effects of internalised homophobia. This work highlights some broad patterns driving worse sexual health outcomes for not out or newly out individuals but does little to address the ways in which healthcare institutions may fail to reach the people they are commissioned to serve. For this, it may be more productive to focus on the temporal frames of healthcare institutions and the temporal frames by which not out or newly out individuals frame their lives.

Where the lens of "outness" helps explain why some migrants take a less proactive approach to their sexual health at certain times, it sheds little light on the different "worlds" inhabited by migrant MSM, particularly worlds in which expressing gender and sexual diversity may be shameful or fraught with danger. Thus, the lens of "outness" may put the onus on already marginalised individuals to be out to more people, temporality may be a way of lifting the weight imposed by such a responsibilisation. While scholarship on queer and reproductive temporality is rarely applied to healthcare research, I propose that it may be highly relevant to understanding how migrant MSM engage with sexual health services. The lens of temporality may also help to shift the focus away from the individual's relative "outness" and towards abrupt oscillations between the "worlds" inhabited by migrant MSM.

2.4.3. Seasons of risk

Earlier, I discussed the significance of the historical and cultural contingency of *time*, but I have not yet touched on what may be revealed by examining the term's other meanings. Our notion of *time* is consistently reproduced by clocks and calendars and, more broadly, by ontological and

epistemological conventions that make those clocks and calendars *true*. *Time*, as it is understood by a contemporary English speaker, refers either to the *linear, one-dimensional* progression of existence from past, through present, to future, or to a certain *point* in time, for example, three o'clock. In Ancient Greece, however, *time*, roughly translated, had multiple senses, some more "measurable" than others. *Chronos* refers to linear, one-dimensional time in the contemporary, Western sense. *Aion*, meanwhile, refers to cyclical temporal processes, such as the turning of the seasons, or night and day (Braidotti, 2019). *Kairos*, meanwhile, refers to an ideal or critical moment, similar to when "the time is right" for something (ibid). Drawing inspiration from this latter face of classical *time*, *kairos*, I wish to elaborate here an understanding of the ways in which certain critical moments – key transition periods in the life-course – may produce seasons of heightened risk, and how these might influence sexual health research on and care for migrant MSM.

As Cassels et al argue in their analysis of time and migration in HIV prevention and care, "mobility occurs in a space-time continuum", such that timing is just as important as origin and destination in understanding the needs of mobile sub-Saharan populations with seasonal and circular migration patterns (2018: 98). Firstly, high-risk sexual behaviours vary over time and – assuming a "dose-response relationship" to HIV prevention programmes – will likely be lower after the first bout of migration as "acculturation" occurs (ibid). Secondly, treatments and prevention strategies may not reach circular migrants due to missed opportunities for contact and linkage to care pathways, and to the *timing* of rollouts of various treatment and prevention services, as demonstrated by findings from studies of HIV incidence in Ugandan recent migrant communities (ibid). Thirdly, and with clear links to the case of coming-out migrants, for example, the point in the life-course at which individuals migrate will influence their sexual behaviours and attitudes (ibid). Fourthly, migrants' situation within chronological time produces a "cohort effect", whereby the "constraints and opportunities" in treatment and prevention differ from those placed on individuals moving a decade earlier or later (99). Clearly, people's health needs and experiences

hinge in no small part on the specific point in the life-course at which they find themselves.

Balfe & Brugha (2009, 2010) concur, in their research on young people's use of STI testing in Ireland, that timing is everything. While this research did not focus on the experiences of young queer people specifically, the authors rightly associated adolescence with various transitional moments that may echo "coming out" in some senses. Indeed, STI testing among young people was, they found, associated with reaching one of four transitional moments, namely: "young adults leaving relationships, those entering relationships where condoms will not be used, those who have had unprotected sex, and those with STI-related symptoms" (2009). Given the time-sensitive nature of decisions to seek STI testing, the existence and normalisation of long delays for appointments was particularly problematic (ibid).

As I have argued, coming out, or otherwise starting to "feel gay" or engage in gay practices, is a momentous life-course event which involves significant psychological reconfiguration along temporal lines, and which can affect wellbeing (Floyd & Bakeman, 2006; Halberstam, 2005; Lewis, 2014). Coming out is not the only life-course event that gay people experience, however. Other examples of entering a new phase of life include starting university, retiring, or entering supported living. (Indeed, STI clusters can form in retirement communities, where residents are often able to explore new sexual avenues for the first time (CDC, 2017).) How might our understandings of sexual risk and sexual health promotion change if we supplemented our focus on migrant status with an understanding of life-course stages? Has the individual recently undergone a big life transition, such as a break-up or a coming-out? This reasoning has already been applied to PrEP use strategies within health scholarship on so-called "seasons of risk," including work specifically on "seasons of PrEP" and "vacation PrEP" in the context of male users (Baeten et al, 2013; Elsesser et al, 2015), female users (Corneli et al, 2022), and those experiencing intimate partner violence (Namey et al, 2016; Willie et al, 2021). The notion of "seasons of risk" arose initially in the early 2010s out of concerns about the

affordability of daily PrEP (when the drug cost was much higher), while mention of the term subsided into the 2020s as concerns about the (now lower) cost of daily PrEP abated. *Seasons of risk* is a powerful conceptual tool through which to understand the variability of (sexual) risk and wellbeing over the life-course. It takes us deeper than simplistic, linear notions of "outness," focussing our attention instead on the "worlds" inhabited by migrant MSM at various moments, and their transitions between them. For example, migrant MSM face significantly higher sexual health risks in the year after arriving in London than they do 2-4 years after arrival (Mole et al, 2014). Thus, *recent* migrant MSM may have a greater care need.

Returning to the notion of *kairos* – a critical moment – it could be said that, for some, the period immediately after migration may be a moment of *kairological risk*, a bursting forth of new opportunities in the absence of protective sexual health perceptions and behaviours. Further compounding the risk to new arrivals and their sexual partners is the fact that – as I already alluded to in the last section – HIV transmissibility varies over time. Moments of increased sexual activity and risk-taking in the period immediately after relocation may pose even greater public health risks if they coincide with HIV seroconversion, given that HIV is especially infectious during the acute infection phase, in the first weeks and months following exposure (Miller et al, 2010; Selik & Linley, 2018). In other words, recently infected individuals have a much greater chance of transmitting HIV than those with chronic (but not late-stage) infections, most of whom would be receiving treatment anyway. While a more detailed discussion of this hypothesis lies beyond the scope of this research, it may signal fruitful lines of further inquiry in the realm of statistical epidemiology.

2.5. Conclusions: temporality and world-making

In the preceding analysis, I explained the reasons for which migrant MSM are a group of particular interest in sexual health research. I showed that migrant MSM often experience significant sexual health risks in the period following their migration, particularly in the period immediately after

migrating (Burns et al, 2011; Evans et al, 2011; Ganczak et al, 2017; Gosselin et al, 2020; Mole et al, 2014; Schmidt et al, 2023). This, I have shown, is because inclusive safer sex knowledge and behaviours are generally less well established in settings with higher levels of institutionalised homophobia and rigid gender norms (Amirkhanian, 2012; Attwood, 1996; Binnie, 1997; Clark et al, 2013; Gios et al, 2019; Mai, 2004: 51; Mole et al, 2014: 90; Quinn, 2006; Rivkin-Fish, 1999; Ross et al, 2013; Štulhofer & Sandfort, 2004; Waugh, 1999). The high prevalence of HIV and other STIs in queer hubs such as London places those without adequate safer sex knowledge at even greater risk (Evans et al, 2011; Burns et al, 2011; Mole et al, 2014). Other factors affecting migrants, such as isolation, anonymity, and access to more venues and potential partners, may also heighten risk-taking behaviours (Bianchi et al, 2007; Dzomba et al 2019; Egan et al, 2011; Lindstrom & Franco, 2005; Mole et al, 2014; Muñoz-Laboy, 2009). These processes, I have shown, may affect internal migrants just as they affect international ones, especially when migrants are moving from rural to urban environments (Bianchi et al, 2007; Chen et al, 2017; Egan et al, 2011; Ford & Kittisuksathit, 1996; Gorman-Murray, 2007; Wu et al, 2016).

However, as I have also argued, migrant status *tout court* is not sufficient to fully explain the dynamics of sexual risk affecting migrant MSM. Why do some migrant MSM face higher sexual risk than others following their migration? Why do some migrant MSM engage less with sexual healthcare services? Given that the queer migrations are often deeply enmeshed with migrants' understandings of their own sexuality (Carrillo, 2004; Gorman-Murray, 2009; Lewis, 2012), I have sought to conceptualise migrations in both spatial *and* temporal terms, suggesting that some sexual migrations may be associated not just with spatial relocation, but also a "timeline shift." Following or alongside their relocation, for example, migrant MSM may undergo an abrupt shift in their sexuality or gender identity (such as "coming out" or transitioning). I ask in this work to what extent these "abrupt temporal shifts" aligned with spatial relocations, and how this variably impacted participants' sexual health perceptions and behaviours. While both Gorman-Murray (2009) and Carrillo (2004) steer admirably away from defining

migrants in terms of specific spatial dynamics (specific origins and destinations are rarely mentioned), and while Carrillo correctly recognises the importance of the post-migration period, their definitions of sexual migration may be made more meaningful at the level of sexual healthcare research and practice by recognising the role of temporality and temporal shifts.

Given the lack of research on temporality and sexual health, *outness* may, I have argued, be considered a useful proxy. Outness was linked with sexual risk among migrant MSM insofar as being less "out" may make people less likely to engage with sexual health services and risk-taking behaviours (Annequin et al 2017; Hu et al 2019; Quinn 2006, 14; White & Stephenson 2013). Given the general inaccessibility of temporality as a concept, *outness* often also came to serve as a proxy for temporality during data collection and analysis, as I will explain in more detail in the following chapters. For example, all participants will be identified with some key demographic information, including their outness at the time of migrating, captured in the form of one of several "types" that I will elaborate in the following chapter. While these types are by no means perfect, comprehensive distillations of my participants' identities and experiences, they help us to understand the temporalities or "worlds" that they navigate, and how these may shape their sexual health perceptions and behaviours.

3. Methods, Movements, Messes

"Who gets to name? How do they see the world? What preexisting frameworks, narratives, and experience do they draw on? How do they tell their stories? To whom? "Knowledge"…is an uneasy, unstable, and time-bound truce in an ongoing and unending struggle for understanding."

Richard McKay, *Patient Zero and the Making of the AIDS Epidemic* (2017: 6)

"Practices of knowing and being are not isolable; they are mutually implicated. We don't obtain knowledge by standing outside the world; we know because we are of the world. We are part of the world in its differential becoming."

Karen Barad, *Meeting the Universe Halfway* (2007: 105)

In this work, I seek to frame the sexual health experiences and outcomes of migrant MSM in new ways that take into account both their spatial and their temporal movements, asking the question: how might we usefully incorporate a temporal dimension into our understanding of the migrations of MSM? That is to ask, how might our understandings of sexual risk and sexual health promotion change if we supplemented our focus on migrant status with an understanding of life-course stages? How can we draw better maps, if we even need to draw maps at all? As I demonstrated in the previous chapter, research on sexuality and migration, from a variety of disciplines, abounds. Rather than focusing on one perspective in isolation from others, I opted – in line with a "critical interpretive synthesis" approach (Dixon-Woods et al, 2006) – to take a pluralist approach to reviewing literature, which enables a more holistic elaboration of the research problem that takes into account the non-fixity of analytical categories that have come to be naturalised. I showed that

social researchers, for their part, seek to understand migrants' motivations, pathways and trajectories, with a particular emphasis on the meanings attached to migrations across various socio-cultural contexts (Binnie, 1997; Carrillo, 2004; Gorman-Murray, 2009; Lewis, 2012; Puar, 2007). Health researchers, meanwhile, seek to trace out migrants' patterns of engagement with healthcare services, with emphases on health outcomes and experiences (Burns et al, 2011; Evans et al, 2011; Ganczak et al, 2017; Gosselin et al, 2020; Mole et al, 2014; Schmidt et al, 2023).

Just as appraising a plurality of literatures facilitates the richest possible understanding of this research problem, so too, I contend, does a combination of methodological insights facilitate the elaboration of the most appropriate methods. While my approach may be characterised in the broadest terms as a rejection of positivism, I draw on a range of broadly post-constructivist methodological insights. In the first part of the chapter, I will discuss my epistemological and ontological approach, drawing heavily on *post-structuralist* and *new materialist* insights. While new materialist and post-structuralist approaches are sometimes juxtaposed against one another, I view the insights of both as salutary to the task of bridging gaps between scientific knowledge production on the one hand and embodied experiences on the other. Next, I will outline my research design, a slightly modified "constructivist grounded theory" approach (Charmaz, 2006), aimed at building novel theoretical insights directly from rich, complex data. This approach is "grounded" in original empirical data but does not take a positivist understanding of this data as objectively "true," rather acknowledging the integral role of the research context and the researcher's subjectivity in shaping the research findings. I will outline the demographics of my participants. Next, I will discuss how I collected my research data using in-depth, semi-structured interviews. I will then explain how I analysed the interview data through an iterative, inductive, multi-stage coding process. Finally, I will discuss the ethical considerations associated with this complex and sensitive research topic, as well as addressing in greater detail how my positionality as a researcher shaped the research process and outcomes.

This research, I will argue, is strengthened not by eliminating "bias" from it, but by remaining aware of it and presenting it transparently (Harding, 1986).

3.1. Ontological and epistemological assumptions

Before expounding my research design in greater detail, it is necessary to outline my epistemological and ontological assumptions, that is, my assumptions about *where knowledge comes from* and *what it is made of*. Central to this work is a broadly post-constructivist understanding of the social world, according to which objective reality is not – as positivists would have it – given, but rather unstable and in continuous reconstruction (Campbell, 1998; Foucault, 1973; Hansen, 2006; McKay, 2017; Wald, 2008). To make such a claim is not to deny the "reality" of diseases, of falsifiable, repeatable methods of diagnosis, or of the wide evidence base from which treatments derive. Rather, to make this claim is to refute the positivist assumption that our ways of knowing the world around us are ever neutral (Hansen, 2006; Lisle, 2006; McKay, 2017; Wald, 2008). For example, whilst a positivist may claim that the findings of quantitative research on the health outcomes of migrant MSM are a "true" reflection of reality, we might instead ask how the researcher's categories of analysis came into being, and the extent to which they are inflected by "the common stories…that infuse the images, phrases, and narratives through which we make sense of the world" (Wald, 2008: 14). To pose such questions is not to navel-gaze; rather, it is to highlight the slippery and inherently political nature of the categories through which the world is interpreted. Knowledge categories, for post-constructivists, are not a "neutral, natural label or a depiction of how things "actually" are in the world," but rather an "uneasy, unstable, and time-bound truce in an…unending struggle for understanding" (McKay, 2017: 6).

Post-constructivism is a broad metatheoretical label encompassing a range of overlapping but distinct approaches. (The "post-" tends to denote approaches that recognise that truth is complex, contingent, and diffused among a range of actors and structures.) *Post-structuralist* scholarship – which highlights the ways in which discourse shapes the contours of reality –

has been of particular importance in this work. *Post-structuralists* characterise discourses – patterns of meaning-making that shape truth – as "practices that systematically form the objects of which they speak" (Foucault, 1972: 49). In other words, discourse is the vehicle by which subjects come into being and act legibly (Laclau & Mouffe, 1985), with subject both re-making and being re-made by the discursive structures around them (Lisle, 2006: 76). For this reason, *post-structuralists* find the world to be "inconceivable outside of language and our traditions of interpretation" (Campbell, 1998: 6). Language, rather than being "a medium for the registration of data", in fact shapes reality (Hansen, 2006: 18).

Such an understanding is of clear relevance to better framing the contours – and needs – of demographic groups which have only recently appeared (under their current name) – migrant MSM or "sexual migrants" – in scientific discourse, especially given the multiple stigmas and precarities faced by many that fall under this banner. Given that categories like "sexual migrant" do not exist objectively "in some extra-discursive realm" (Hansen, 2006: 23), it is only by examining the discourses through which non-heterosexual migrants make sense of their migrations that their migrations can be meaningfully, qualitatively understood. However, because they focus less on the role of individuals than on patterns of meaning-making taken at the disembodied level of discourse, post-structuralist perspectives alone are unable to account sufficiently for the unpredictable ways in which individuals exercise agency in their day-to-day lives, nor for the contexts that limited the discursive and material options available to them. What is more, while the catalogues of random, chance encounters that shaped the sexual journeys of the participants in this study may have been narrated discursively, the ways in which these encounters came about were not wholly explainable or predictable as "discursive" events.

To this end, I have also taken inspiration from scholars emphasising the importance of materiality, including but not limited to *new materialist* scholars (Barad, 2007, 2015; Braidotti, 2018; Frost, 2011; Latour, 2003; MacLure, 2013; Mol, 2002; Preciado, 2008), who emphasise the vital nature of bodies (human and non-human) in shaping reality. New materialists follow

post-structuralists in their rejection of epistemic binaries, and in their affirmation that categories are simultaneously "foundation and product" (Hansen, 2006: 21). However, new materialists hold in question what these foundations and products really *are*. As Latour argues (2003), objects are better understood as *actants*, not passive bystanders in knowledge production, but active participants in shaping our realities. Barad (2007, 2015), meanwhile, highlights that the world cannot be delineated accurately into static, pre-existing things that interact with one another: rather, bodily contours are shaped and reshaped in their migration through space and time, a migration that produces not interactions between clearly defined things, but rather "intra-actions", actions within the *phenomenon*, an *encounter* produced by a multitude of human and non-human actors. "We don't obtain knowledge by standing outside the world," argues Barad, but rather because we are part of the world (2007: 105). Just as electrons behave differently when observed, Barad argues, objects of social scientific study are co-constituted uniquely through observation: "practices of knowing and being are not isolable; they are mutually implicated" (ibid). In other words, the researcher's position in relation to the phenomenon (their distance from it (emotional, physical), the angle from which they measure it etc.) does not simply change the *perspective* of the researcher and researched, but in fact changes the very composition of the two things.

For this reason, I follow Barad in understanding the separation of epistemology and ontology as a hangover of a metaphysics that falsely "assumes an inherent difference between human and nonhuman, subject and object, mind and body, matter and discourse" (2007: 105). The sexual journeys of participants – and, indeed, the research interviews – were not simply events that were *experienced,* then *known* and *re-told*; they were also *embodied* experiences. Closing the gap between *being* and *knowing* must remain a central challenge of research about people's sexual lives. Of course, this cannot be done once and for all: the contours of being and knowing shift according to the measurement apparatus, the context and the knower (Latour, 2003; Barad, 2007, 2015). The question, therefore, is not: "Is categorisation *true*?", but rather "Is this categorisation *useful*?". For example,

the production of a useful definition of “sexual migrant” in, say, a *social* or *cultural* context, will entail entirely different questions and “measurements” than the production of a useful definition in a *medical* context. When the context shifts, we measure differently, and when we measure differently, we find differently – even in the “hard” sciences (Barad, 2007).

While new materialism is sometimes juxtaposed against post-structuralism, I draw on the complementary insights of both camps. In this way, my work is *onto-epistemologically* migratory, bringing together complementary insights revealed by the unique journey that produced it. By cutting across these different approaches, rather than standing in line with one, this work remains cognisant of the ways in which a range of human and non-human actors – migrants and clinicians, clinics and sex clubs, microbes and memories, infections and ideas – come together in ways that pose unexpected challenges both for many traditional tools of measurement and analysis that front-load the research with rigidly pre-defined actors, objects, and categories. To recognise that complexity is rarely reducible to neat and simple lines of analysis is to acknowledge that theoretical approaches can be combined and exchanged, that, as new materialists highlight, the logic of “either/or” may be replaced with “both/and” (Braidotti, 2017). By recognising the hard-to-measure complexities that emerge from the field, I aim to go some way towards revealing hitherto unrecognised and “missing” people (c.f. Braidotti, 2018: 11). Whilst this work will stay attuned to established identity categories – both in isolation and applied intersectionally – the emphasis will be on the ways in which experiences and narratives clustered to reveal intriguing, un-theorised or under-theorised, patterns of migration, with potential consequences for sexual health and wellbeing. Thus, the narratives of migration that emerge in this work are intended to destabilise established identities just as much as to recognise them (Puar, 2012: 63).

3.2. Research design

As already noted, the contours of this research emerged through the research process itself. Indeed, the design of this research did not just *allow*

for unexpected findings to emerge, it was predicated on the assumption that the phenomenon of study can only take firm shape over the course of the research. This started formally with the literature review, although as a knower embedded in the world around me, the frameworks and ideas on which I draw long pre-date the formal research process. Using a critical interpretive synthesis lens to theoretically sample a range of relevant literature (Dixon-Woods et al, 2006), the research problem became clearer. What became particularly clear was the gap between quantitative attempts to map sexual attitudes and risks among migrant MSM and qualitative attempts to map their outness journeys. Noting that migrant MSM were a large and diverse group, it appeared as though breaking this group into smaller sub-groups may offer greater explanatory power regarding the reasons for which some migrant MSM face higher HIV risk after migration than others. While qualitative approaches to sexuality and migration seemed to return frequently to the question of "outness" and "coming out," this was rarely, if ever, mentioned in quantitative healthcare research on MSM. Thus, migration seemed to be happening not only along a spatial axis, but also along a temporal axis relating to the life-course. Rather than seeking to test existing categories (MSM/migrant) using existing measurement tools, this work seeks to elaborate new theories and categories. The novel concept of *temporal migration* that I propose challenges traditional understandings of migration as inherently spatial, with potentially useful results for sexual health care and research on the needs and experiences of migrant MSM.

In line with the onto-epistemological approach outlined above, I employed an adapted version of the constructivist grounded theory approach to data collection and analysis in this work, an approach which allowed for novel theories to be generated from rich and complex data (Charmaz, 2006; Charmaz & Belgrave, 2012). I also incorporated some methodological aspects of framework analysis into my approach, which enabled me to map out themes more clearly and dynamically (Gale et al, 2013). Constructivist grounded theory is the latest permutation in a line of grounded theory approaches, frequently used by qualitative researchers seeking to understand how people move through medical spaces. These so-called

"middle-range approaches", which offer abstracted yet locally relevant renderings of social phenomena, and the links between them, challenge the logic of grand, sweeping theories, popularised by mid-century sociologists, that ignored the importance of meaning-making processes (Charmaz, 2006: 7-8; Glaser & Strauss, 1967). Data are separated, sorted, and synthesised in a series of iterative stages, with layers of abstraction being built directly from the data (Charmaz, 2006: 3-4). Constructivist grounded theorists understand individuals to be "active agents in their lives and in their worlds" and not "passive recipients of larger social forces" (Charmaz, 2006: 7). They are therefore interested to know, in their own words, *what is happening* (over time) in the lives of research participants (Charmaz & Belgrave, 2012: 351). In line with new materialists, grounded theorists understand meaning to emerge through *processes* or *actions*, rather than *structures* (ibid). Recognising the contingency and instability of ostensibly stable and objective knowledge categories, constructivist grounded theory is a largely appropriate tool with which to re-assemble better, more useful – but still subjective and context-dependent – understandings of the life-course.

I opted to conduct in-depth, semi-structured interviews, each of up to two hours in length, with 20 men who have sex with men who migrated to London in the last 20 years. The recruitment target was set at 20 participants in consideration of several factors. On the one hand, too high a target risked failing to recruit enough participants in time, as participant interest in qualitative NHS studies is typically much lower than more straightforward quantitative ones. On the other hand, under-recruiting risked failing to achieve relative data saturation. As a result, 20 was felt to be a reasonable recruitment target, with the length of each interview ranging from approximately one to two hours. This approach allowed me to prioritise depth over breadth, insofar as long, relaxed interviews allowed for a more in-depth understanding of participants' life stories. The cut-off of 20 years since migration was set in order to ensure the findings of this work were historically sensitive. 20 years was felt to be a relevant limit for two reasons. Firstly, it corresponded with a moment of significant shift in gay and queer migration patterns in Europe, with the number of MSM migrating to the UK rising

sharply following the accession of eight new CEE countries to the EU in 2004 (Burns et al, 2011; Evans et al, 2011; Mole et al, 2014). Secondly, this limit corresponded with a slightly broader period of change in HIV treatment outcomes. Whilst highly active antiretroviral therapies (HAART) had been introduced in the UK as early as 1996, the improvements afforded by these treatments did not take instant effect, with the number of people accessing HAART and achieving long-term viral suppression growing substantially through the mid-noughties (Porter et al, 2003).

Participants were to be recruited through sexual health & HIV services in three London *NHS* trusts, namely, *Central and Northwest London NHS Foundation Trust*, *Royal Free London NHS Foundation Trust*, and *Barts Health NHS Trust*. The respective research sites were to be *Mortimer Market Centre* in Fitzrovia, *Ian Charleson Day Centre* in Hampstead, and *Ambrose King Centre* in Whitechapel. The purpose of the research interviews was to elucidate the ways in which their sexual health perceptions and behaviours could be understood not just in terms of geographical shifts, but also in terms of embodied shifts around sexuality and outness, and how the different shifts were timed in relation to one another. A number of documents, including participant information sheets, consent forms, and the topic guide, were reviewed by a PPI (patient and public involvement) group, who suggested adding extra support resources to the patient information sheet and making some phraseological changes to the information sheet and consent form.

I will outline the participant demographics in more detail shortly. For now, however, a note on inclusion criteria: most studies on the health experiences and outcomes of queer migrants focus on migrants from a certain region or country, which, while facilitating the production of more specific knowledge about migrants from a certain place, may unintentionally reproduce exceptionalist or othering attitudes towards certain national or regional groups. In this work, I examined the experiences of participants from a range of places, choosing instead to understand their decision to move to London as a qualitatively similar aspect of their experiences which united them. It should be noted, however, that not all participants were willing or

able to access “Gay London” in the same ways (Binnie, 1997; Lewis, 2012; Luibhéid, 2002; Manalansan, 2003).

The chosen study design gave me access to many diverse users of sexual health & HIV services in London. While difficulties obtaining buy-in from service providers and ethics committees for ethnographic methods meant I did not conduct a formal ethnography in these spaces, the ability to conduct semi-structured interviews on sexual health & HIV turf gave them an ethnographic edge. Furthermore, by working in person in sexual health & HIV clinics during the fieldwork, I did a great deal of ambient learning about the world of sexual health & HIV. Exposure to this new world gave rise to some “accidental ethnography”, that is, ethnographic observations of day-to-day life in clinical and clinical research contexts, encountered in accidental and unplanned ways (Levitan et al, 2017). Such “incidental findings” shaped my research in multitudinous ways. To give just one example, it was during a water-cooler discussion with my colleague, Erica, that I became familiar with the literature on “seasons of risk”, a highly fruitful area of research of which I was previously unaware.

However, there were also several limitations from the design of this project. As the recruiting locations were both in central London, participants tended to be of higher socioeconomic status. Similarly, participants needed to take time out of their day to participate, potentially excluding those in more precarious situations. Furthermore, non-English speakers were excluded from the study following the assessment of the *NHS* research ethics committee, meaning that the perspectives of non-English speakers were not gathered. There was also a heavy skew in terms of sexuality: while the study was open broadly to men who engage in non-heterosexual sex, only gay men participated. Furthermore, participants were all cis-gay men who were currently accessing care through an *NHS* sexual health or HIV service, meaning – importantly – that the perspectives of those who were not currently accessing these services or of those who identified as trans were not included. However, nearly all participants had historical experience of non-engagement with sexual health services, on which many of them were able to draw during our interviews. Finally, it should be noted that, whilst

straight people, particularly straight women, were not involved in this research, many of the processes that I will describe in the coming pages may well affect heterosexuals moving away from sexually restrictive contexts. It is my sincere wish that future work explores the ways in which temporal migration affects other groups, such as straight women, particularly in the context of the pervasive notion of the "biological clock".

3.2.1. Participant demographics

All participants in this study were aged 18 and over, spoke English confidently enough to conduct an interview, and were able to give informed and enthusiastic consent to participate. Participants were either service users or clinic staff who also met the inclusion criteria. To ensure that a variety of perspectives were represented, I had initially intended for recruitment to take place on a purposive basis, according to participants' outness at time of migrating. It soon became clear, however, that the complexities of people's outness journeys were too difficult to assess meaningfully prior to interview. *Figure 1* is a list of all study participants, alongside some key information about their migrations. As already noted, all participants identified as gay men:

Country of origin	**Settlement type**	**Year of migration**	**Age at migration**	**Reasons for migrating**	**HIV status**
Argentina	Capital city	2011	28	Joining partner, liked Europe	Negative
Bulgaria	City	2010	20	Undergraduate studies, joining friends	Positive (after migrating)

Colombia	Large city	2025	35	Joining family, scoping study opportunities	Positive (before migrating)
England	Village	2005	21	Career progression, liked big cities	Positive (after migrating)
England	Village	2008	21	Postgraduate studies	Negative
Germany	City	2022	27	Starting a new job, seeking change	Negative
Germany	Small town	2019	23	Postgraduate studies	Negative
Greece	Village	2019	18	Undergraduate studies, liked London	Positive (after migrating)
Greece	Village	2016	24	New job, “to actually *be* gay”	Negative
Italy	Capital city	2013	31	Joining a straight friend	Positive (before migrating)
Poland	City	2005	19	Joining family, “running away”, undergraduate studies	Positive (after migrating)
Poland	Large town	2013	21	Undergraduate studies, career progression	Positive (before migrating)
Poland	Village	2010	19	Joining family, “getting away”, liked London	Negative
Portugal	Capital city	2020	30	Career progression	Negative

Romania	City	2017	25	Seeking change, joining sibling	Positive (before migrating)
Spain	Small town	2005	17	Undergraduate studies	Negative
UAE	Large city	2012	17	Undergraduate studies	Positive (after migrating)
Uganda	Capital city	2024	23	Seeking asylum	Positive (before migrating)
USA	Large town	2016	39	Starting a new job	Positive (before migrating)
Wales	Small town	2012	18	Undergraduate studies	Negative

Figure 1: List of study participants

3.2.2. Data collection

In line with the principles of constructivist grounded theory (Charmaz, 2006; Charmaz & Belgrave, 2012), data collection and data analysis overlapped significantly. In the interest of clarity, however, I will present them separately. As already stated, 20 in-depth, semi-structured interviews of up to two hours in length were conducted with MSM who migrated to London in the last 20 years, and who were recruited via routine sexual health & HIV services. Participants were recruited by research nurses and research assistants based in the participating trusts, who informed potential participants about the research, and shared their contact details with me if they were interested. I then contacted potential participants, usually by phone, to arrange a convenient time and location for interview. As this study was funded by *Wellcome*, participating clinics had associated study costs reimbursed through the *NIHR Clinical Research Network*.

During the interviews, participants were asked a series of questions about their life-course, sexuality, outness over time, their migration to London, and their engagement with sexual health services before and after migrating. Interviews began with more general and less sensitive questions, which helped to establish rapport. Questions were often open-ended, allowing for participants to say whatever they felt was necessary (Charmaz & Belgrave, 2012: 351). Only once basic rapport was established did I move on to more sensitive questions, the handling of which I will discuss in the section about ethical considerations. All participants received, by email, a £20 *Amazon* or *Tesco* gift voucher as a token of gratitude.

As well as recording the interview on an encrypted, password-protected voice recorder, I took some paper notes, which I destroyed after securely storing a digital copy. All recordings were given a unique study number and stored securely. Interviews were securely transferred to and transcribed *verbatim* by a third-party transcription service, *UK Transcription*. Once returned, I checked the transcripts for completeness and accuracy, before de-identifying and pseudonymising them. Transcripts were assigned a unique study code and stored securely, alongside contact details and some basic demographic information, in the *UCL Data Safe Haven*. *UCL* was the data controller for this study. In keeping with *UCL*'s data management policy, data will be archived on the *UCL Data Safe Haven* for 20 years following completion of the research.

3.2.3. Data analysis

As already noted, there was significant overlap between the processes of data collection and data analysis in this work, with emergent theoretical insights being developed and refined iteratively. These insights were also compared with established literature on queer migration and sexual health to ensure theoretical sensitivity. By extending fieldwork over a ten-month period, I was able to start analysing data as I went, thereby enabling me to improve my data collection processes in parallel, by honing the lines of questioning, or by reflecting critically and at length on my own assumptions. In this way,

interviews were not just a data collection tool, but also a way of mapping out the field of study and narrowing down pistes of analysis. As already noted, the possibility of theoretical (purposive) sampling was limited by difficulties gauging the relative "outness" of participants prior to interview.

In line with the principles of constructivist grounded theory (Charmaz, 2006; Charmaz & Belgrave, 2012), data were categorised iteratively and inductively, building higher levels of abstraction from the data with each step. (Examples of the coding process are included as *Figure 2* and *Figure 3* below.) Raw data from the interview transcripts were initially broken down into small meaningful chunks that captured key actions, processes, or feelings that allowed me to start refining analytical categories. Using a word processor, data were systematically inputted into a matrix – similar to the kind used in some framework analyses (Gale et al, 2013) – which contained a large range of *open codes*, such as "learning about gay sexual practices", "learning from older men", "learning about condoms", and so on. As seen in *Figure 2*, it was possible for the same chunk of raw data to be openly coded in multiple ways. It should be noted that every effort was made to avoid making imprudent analytical jumps before all the data were gathered and coded (Charmaz, 2006: 47-8, 60).

Following the initial *open coding* stage, I proceeded to *axial coding*, wherein categories were refined further, with *open codes* being organised into more meaningful categories, leading to an overall reduction in themes (Charmaz, 2006: 60). For example, as seen in *Figure 2*, the codes "learning about gay sexual practices", "learning from older men", and "learning about condoms" were superseded by the axial code "gay intergenerational mentorship".

Following the theoretical refinement offered by the *axial coding* process, I proceeded to the *selective coding* stage, in which data were sorted into the key theoretical categories around which this research is shaped. For example, the *axial code*, "gay intergenerational mentorship" was an example of the more abstract concept of "temporal shift" (see *Figure 2*). Given that knowledge production is, naturally, a messy process (Latour, 1987), coding

was not always a straightforward process whereby more categories were reduced to fewer: at times, a singular piece of raw data or lower-order code gave way to multiple selective codes. For example, as demonstrated in *Figure 3*, the excerpt from the Polish participant which was axially coded as "entering the gay world" was selectively coded as an example of the role of both "temporal shift" and of "spatial shift" in the participants' sexual health perceptions and behaviours.

Given that the mental process of sorting through audio and written data extended beyond the immediate context of the interview room or work desk, many key insights emerged when it was not possible to work in a detailed and rigorous way with the data, for example, when I was sat on the bus or lying in bed at night. *Memoing* played a vital role in capturing key insights and retaining them for later analysis (Charmaz, 2006: 72, 115). Memos informed initial drafts, which, along with interview transcripts, were shared with research supervisors for discussion. During this process, further key themes were elucidated. Drawing on Clarke's (2005) approach to applying *post-structuralist* thinking to practical research, I also frequently used situational maps to trace out the relations between human and non-human actors in the research process.

Raw data	Open codes	Axial codes	Selective codes
"I would talk with older guys… I didn't know anything…until I met one guy [who] showed me how to douche and stuff." (Uganda, capital city, queer asylum)	Learning about gay sexual practices	Gay intergenerational mentorship	Temporal shift
	Learning from older men		
"I had a conversation with an older man in a…cruising park… He was like, "You need to use a condom." (Italy, capital city, already-out)	Learning about condoms		

Figure 2: Reduction of open and axial codes

<table>
<tr><th>Raw data</th><th>Open codes</th><th>Axial codes</th><th>Selective codes</th></tr>
<tr><td>“I started clubbing when I was 16… I remember they give you a lot of condoms in the toilets…and people talking about this.”

(Italy, capital city, already-out)</td><td rowspan="2">Going to gay venues

Learning about condoms</td><td rowspan="2">Entering the “gay world”</td><td>Temporal shift</td></tr>
<tr><td>“I started to think more about sexual health [in London]… In the clubs, there were posters… I think they gave away condoms and lube for free.”

(Poland, city, already-out)</td><td>Spatial shift</td></tr>
</table>

Figure 3: Expansion of open and axial codes

3.3. Ethical considerations

As fieldwork was to be conducted at *NHS* sites, study approval was sought through the *NHS Integrated Research Application System (IRAS)*. The *UCL Joint Research Office (JRO)* acted as the sponsor for this study (sponsor reference: 158972). The study was reviewed by the *Greater Manchester West Research Ethics Committee* in September 2023 (REC reference: 23/NW/0250). Ethical approval was obtained from the *NHS Health*

Research Authority on 5 October 2023 (EDGE reference: 314102). Of course, these approvals were merely a starting point for ensuring good ethical practices; ethical decision-making also had to happen “repeatedly throughout the research and in response to specific circumstances” (ASA, 2011).

The interviews, which were designed to protect privacy and minimise embarrassment, were conducted in person, in safe, quiet, private locations – usually a clinic room – between December 2023 and October 2024. Informed consent was obtained prior to interview, and signed forms were securely stored on the *UCL Data Safe Haven*. I employed several strategies to support participants, including non-judgmentally acknowledging their feelings and minimising “non-verbal leakage”, especially at potentially sensitive moments, by maintaining neutral or positive facial expressions. Participants were reminded that they did not have to answer any question they did not feel comfortable answering, that they could withdraw from the study at any time and their data could be deleted, and that they could take breaks during the interview, or reschedule it, if needed. All participants were reminded after interview of organisations that could provide further advice and support around particularly sensitive topics that sometimes arose. Interviews were held no later than mid-afternoon to leave time to liaise with clinical teams if participants found themselves in need of additional support. Participants were made aware that anonymised direct quotations from interviews may be used in publications. Where there was a higher risk of identifiability, some aspects of the quotation were changed, without altering the quotation’s meaning. Participants were informed that their confidentiality may have to be breached in the event of disclosures relating to serious harm or abuse to themselves or others. Participants were also made aware of whom to contact if something went wrong for them.

Navigating disclosures was one challenge which emerged unexpectedly during the research process, and which necessitated active and ongoing ethical decision-making. On several occasions, for example, study participants disclosed experiences of child abuse or grooming, but this was either a trauma which they had resolved already, or something which

they continued to narrate in positive, even empowering terms. These participants invariably declined offers of extra support around these disclosures, and it would have been inappropriate to escalate any concerns, a fact of which my clinical colleagues reminded me. Nonetheless, I had sometimes wished that I had been able to follow up on participants' disclosures. As a social researcher parachuting in and out of my participants' lives, I was unable to build a relationship over repeat visits as clinicians often could.

While these instances did not constitute a significant risk of psychological harm to study participants, I sometimes found disclosures personally challenging or distressing. To mitigate this, I remained in frequent contact with my supervisors, who were able to offer support. I also used weekly psychodynamic therapy sessions as an opportunity to discuss feelings that emerged during distressing interviews. Interview locations were always considered with both my safety and the participant's safety in mind. I followed *UCL*'s Lone Worker Policy, making sure to always remain contactable.

To mitigate the unlikely scenario of a data breach, all identifiable data were stored securely on the *UCL Data Safe Haven*, where they will remain for 20 years. All data were pseudonymised, stored securely on the UCL Data Safe Haven, and analysed on UCL devices. All emails with NHS staff and participants were deleted after the necessary details were transmitted. Interview data were only available to me. I made sure to stay up-to-date with all necessary data protection, information governance, and good clinical practice training. The study was compliant with the requirements of *General Data Protection Regulation* (2016/679) and the *Data Protection Act* (2018). I complied throughout with the requirements of the *General Data Protection Regulation* (2016/679) with regards to the collection, storage, processing and disclosure of personal information, upholding the core principles of the *Act*. All data were stored in accordance with the *Caldicott Principles*.

3.3.1. Positionality statement

Integral to being an ethical producer of knowledge is the need to reflect actively and continuously on the ways in which one's positionality shapes the research. (For this reason, my questions and interjections are – where relevant – retained in excerpts of transcripts presented in the empirical chapters.) In line with standpoint theory, notably Harding's (1986) notion of "strong objectivity", I contend that personal bias – when properly addressed in the research process – is not only unavoidable, but in fact strengthens the "objectivity" of research. Indeed, I began this thesis with my tales of *Consultation Room 7* not only to vividly situate the research problem, but also to be upfront about my own, situated relationship with the topics of sexuality, migration and coming-out journeys.

Unlike traditional, positivist grounded theory approaches, constructivist grounded theorists remain upfront about the ways in which research is shaped by the social, cultural, geographical and (onto-)epistemological location(s) of the researcher (Charmaz, 2006; Charmaz & Belgrave, 2012). The researcher's perspective is, in this sense, a productive, driving force which cannot be eliminated from the research, but which, instead, should be made as clear as possible. As noted in the introduction, the account I produce in this work is not intended to be understood as a *true* reflection of an objectively existing reality, but rather a *useful* interpretation from the (transparent) perspective of a researcher who is, I hope, well positioned to offer helpful insights. For this reason, the results of this work should not be presumed to be generalisable in all contexts or under all conditions. Our knowledge categories are – just like us – situated, and in constant flux (Schwartz-Shea & Yanow, 2012). As a situated researcher, uniquely entangled in the world around me, so too will my findings be very much *of* that world.

I reflected actively on my positionality throughout the research process through regular memoing, sketching, and ongoing discussions. As well as keeping my positionality in mind while coding the interview data, the iterative process of data coding also elucidated further consequences of my positionality that I had not considered. For example, during open coding, I

realised that my experience growing up in a (relatively) gay-friendly social, cultural, legal and political context was reflected in assumptions about participants' reasons for not coming out. As a result, it became clear that I needed to ask more targeted questions in order to bring out more clearly the difference between participants' *outness* and their *awareness* of having non-heterosexual desires, as being visibly out was not possible or desirable in all contexts. In this sense, the data coding process helped to reveal new aspects of my positionality, thereby challenging assumptions about outness and intentionality that I had unconsciously brought into the research. Meanwhile, the interviews themselves gave me an opportunity to reflect on the challenges arising from my positionality as an academic and social researcher. For example, after I – at times – used jargonistic language during interviews that the participants did not understand, I realised the importance of putting some of my questions – particularly the ones relating to temporality – in more accessible language. In moments such as these, there arose in my mind an acute awareness that – just as had been the case in *Consultation Room 7* – I was an "expert" using language that did not make sense to the "layperson" who was facing me. Thus, the risk of reinforcing some of the patterns of knowledge production that I had intended to shatter hung constantly over this research.

4. Grounding the Analysis: A New Typology

> *"On a temporary stage erected in San Francisco's Castro district, Meg Christian leaned toward the microphone… I stopped to listen. Following a spirited rendition of "Ode to a Gym Teacher," a comedic ballad about a young girl's crush on her physical education instructor, the singer paused to comment on the difficulties of "growing up gay" in a rural area. Her advice to onlookers who had friends or relatives still struggling to "come out" in the countryside: Tell them to take the next bus or train to a big city. Whistles, cheers, and nodding heads greeted this clarion call."*
>
> Kath Weston, "Get Thee to a Big City" (1995: 253)

> *"For men who had moved at younger ages, relocating was bound up with plans to explore their sexual identity or disclose it to others… For them, "the big city" had provided evidence of potential social and romantic contacts…and institutions that might facilitate coming out or meeting others… For men in midlife, moving — or the decision to not move — was more related to desires for secure economic livelihoods and meaningful community identities. Over time, however, these divisions have perhaps become less stark… The narratives suggest a landscape of potential destinations for gay men altered radically from the homeland–hinterland binary suggested by Weston (1995)"*
>
> Nathaniel Lewis, "Moving "Out", Moving On" (2014: 231-2)

Before proceeding to my empirical chapters proper, it is first necessary to outline a novel typology of queer migration, which emerged over the course of iterative data collection and analysis, and which guides the analysis that will follow. In this small chapter, I briefly explain and justify this typology, which includes both existing conceptualisations of queer migration, and new "types" that emerged from the research. These "types", I argue, speak to

"temporality" insofar as coming out and being "culturally gay" (Halperin, 2012) are life-course events that involve significant psychological reconfiguration along temporal lines (Floyd & Bakeman, 2006; Halberstam, 2005; Lewis, 2012). I will offer brief vignettes of each migration "type", as well as demonstrating how these "types" may shape the particular needs and vulnerabilities of migrant MSM. In this way, the typology I present here may be understood as a foundational "finding" that shapes and informs the other, more detailed theoretical findings that I will present in the following chapters.

As already noted, the paradigm of *coming-out migration* – typified by Weston's (1995) retelling of the pathways taken by many queer migrants in the second half of the 20th century – occupies an outsized share of existing theorisation about migrant MSM, as well as heavily informing my *own* lived experiences of sexuality and migration. However, as a reflexive, inherently *situated*, grounded theory researcher, it was necessary for me to imagine beyond this paradigm, as Lewis (2014) does in the counter-epigraph to this chapter. Indeed, over the course of the research interviews, it appeared as though many participants of this study were unsuited to the *coming-out migrant* classification. For example, some participants were already well out at the time of migrating, while others were not out to anyone and had no intention of coming out. Other "types" emerged, too, tied to qualitative aspects of participants' lived experiences. To take one example, HIV care emerged as something that was not just incidental, but rather central, to some migrants' trajectories, necessitating the elaboration of the new migration "type", *HIV care migration*.

It should be noted that the classifications I outline here are only intended to be understood as *ideal types* that may usefully guide analysis. It is hoped that this typology allows for the recognition of the ways in which people from different contexts may share important, unifying temporal experiences, while those from ostensibly similar contexts may not. However, the inherent gap between a typology – or any abstraction afforded by scholarly analysis – and the complexity of lived experiences is self-evident, and it must be acknowledged. Furthermore, the following "types" are neither

exhaustive nor mutually exclusive; there is often overlap or blurring between them. Some types refer more abstractly to the relationship of outness to an individual's migration (for example, *coming-out migration*, *discovery migration*), while others refer more specifically to certain circumstances surrounding the migration (for example, *HIV care migration*, *relationship migration*). These ideal types are not intended to rigidly drive the ensuing analysis, but rather to show how specific (often hidden) constellations of lived experiences may play a significant role in shaping the healthcare needs and experiences of migrant MSM.

4.1. Existing migration "types"

As noted previously, certain "types" of queer migration arise frequently in the literature, with each "type" speaking to a specific set of reasons or circumstances that explain the migration of MSM, usually in terms related to their sexuality. These migration "types" appeared to be linked – as I will discuss in the following chapters – with certain sexual health perceptions and behaviours.

4.1.1. Coming-out migration

The queer migration pathway most frequently described in literature related to so-called "sexual migration" was *coming-out migration*, that is, migration associated with coming out or living more openly as an out gay or queer person (Gorman-Murray, 2007, 2009). The following participant, who moved from a Polish village at the age of 19, explained how his reasons for migrating to London differed from those of his siblings:

> My brother and my sister were here [London] for about two years, three years, before I moved… It was all about money for them. There were opportunities here, and far better money.

> *I* was after freedom. More of this- Part of- To be far away from parents, for example, so I would have *my* life.

Some *coming-out migrants* may have navigated some aspects of sex, sexuality and coming-out before migrating. For these individuals, however, moving to London was associated with leading a "gayer" way of life (Halperin, 2012), as described by the following participant who migrated from a Greek village at the age of 24:

> I had to come to London if I want to do things. London really was the place to come for actually *being* a gay. (Laughter)

While certain social, cultural or political considerations made coming-out appear less viable prior to migration, *coming-out migrants* already understood themselves to be non-heterosexual, with migrations often quickly precipitating comings-out. Take for example the following vignette from a participant who moved from a large city in the UAE at the age of 17:

> I mean, as a child, I just knew I liked men. When you're 14 years, "Oh, maybe bisexual," and then really- but after year- once I was 17 years old, again, that's it. I can be- "Oh, I'm gay." Yeah.
>
> I mean, I moved [for university] and that day immediately I had a group of friends. And there's one guy in there who was gay and he was out. I think the first weekend, I just told him I was gay. Then that was my first sexual experience. After that, then I got Grindr, and then from then on it was- yeah.

For coming-out migrants, migration offered a means to come out or to live more openly gay ways of life. The spatial migrations of *coming-out migrants* are therefore accompanied by a timeline shift away from reproductive and heteronormative ways of knowing and being. Because of these simultaneous,

and often abrupt, temporal and spatial shifts, this group – I will argue – may experience heightened sexual and mental health vulnerabilities in the period immediately after their relocation, which may go unnoticed where *coming-out migrants* are from otherwise low-prevalence or low-risk HIV areas. During this period, many *coming-out migrants* navigate new sexual practices, including chemsex, often for the first time, and in the absence of more inclusive and up-to-date sexual health perceptions and behaviours. Correctly identifying the needs of this group therefore remains critically important.

4.1.2. Queer asylum

Queer asylum, referring to the process of seeking refuge due to persecution, violence, or discrimination based on sexual orientation, gender identity, or sex, is another well-established framing of queer migration (Danisi et al, 2021; Mole, 2021). In some regards, queer asylum-seekers can be understood as *coming-out migrants* or *already-out migrants*. However, the unique social and legal circumstances surrounding the asylum process mean that this queer migration pathway may usefully be considered separately. The persecution experienced in their place of origin may be a source of trauma for queer asylum-seekers. The following participant, who left the Ugandan capital at the age of 23, described the treatment to which he was subjected before migrating:

> It's so dramatic in Uganda, like when they arrest you… It was dark, I saw police trucks entering the gate, these big police trucks, and gathering everywhere, and I was hiding under a bed for some reason. (Laughter) Pulled out. Hit. They didn't mind beating us because we're gay, we deserve it, they hit everyone. Threw us outside, and made us kneel down with our hands behind our backs, as they were slapping us and asking us what we were doing. Everyone couldn't say shit. Everyone was just quiet. And then they pushed us on the trucks.

The queer asylum-seeker with whom I spoke confirmed that racism and other forms of marginalisation in the UK heavily shaped his experience:

> People are very judgmental… I know people have a lot to say about it [asylum hotels]. I don't want to be judged by that.

It is important to note, however, that queer asylum-seekers are not defined by traumatic experiences, as noted once more by this participant:

> Everyone thinks, “They have left their country because they have nothing, they have come here for…” I have left a very good life back home, because of who I am, because I don't want to be arrested. In a heartbeat, I would love to go back home. If I could find a way to be straight, I would go back.

Queer asylum was nonetheless a means by which this individual could live safely as an out gay man. His spatial migrations facilitated a timeline shift away from those set out for him in the context of rigidly homophobic ways of knowing and being. Though I was only able to speak with one queer asylum-seeker, this group may similarly experience heightened sexual and mental health vulnerabilities in the period immediately after their relocation, during which time they may navigate new sexual practices for the first time, and in the absence of more inclusive and up-to-date sexual health perceptions and behaviours. What is more, their vulnerabilities may be compounded by their uncertain immigration status, ongoing financial precarity – especially during the first year, when asylum-seekers are forbidden from working – and a febrile, anti-refugee social and political climate.

4.1.3. Gravitational migration

Another queer migration pathway is *gravitational migration*, a sort of coming-out or being-out migration associated with moving towards gay

networks or “gaybourhoods” (Gorman-Murray, 2009; Kelley et al, 1996). *Gravitational migrations* were often associated with access to the status symbols of “gay modernity”, such as living in Soho or working for certain companies or brands, as in the case of the following participant who left his Polish city at the age of 19:

> Oh, but prior to that, I came for the summer, in 2004, and stayed in my uncle’s flat, on Seven Dials, and he moved out to his boyfriend’s, so I had the whole flat to myself, and I worked in Soho.
>
> Can you imagine? Living on top of Seven Dials and working in Soho. Yes, that was very interesting… Just turned 18…
>
> I worked in… There used to be a place called Shaun and Joe. So, there was all that flashy plush velvety stuff. So, even we had, like, made-to-measure clothes from Nico Didonna in Soho.
>
> I, at that time, hooked up with the head of- you know Buzz Magazine, through there. He was like the head of marketing, or something.

The following participant from a Greek village, who moved several times in his 20s, explained his move from Aylesbury to London in terms of access to, in his case, hook-ups:

Interviewer:	So, London really was the place to come for…
Participant:	For actually being a gay. (Laughter) … It was two and a half years [in Aylesbury]. But there, there is absolutely nothing to do… I had to come to London if I want to do things.

However, moving to London did not always facilitate access to gay networks or a sense of community in the ways imagined, as the above participant went on to add:

> In the beginning it was nice. But, actually, not a long time after I understood that here there is not so much variety… I have to say that people look exactly for the same thing constantly. No matter what kind of app I'm turning or wherever I go outside, I felt like I'm encountering the same version of people with different faces. So, either they will want to talk about Rupaul or they will want me to talk about drugs or…
>
> When I was younger, what I was dreaming was having a boyfriend… I feel like London has traumatised my young dream.

Gravitational migration appeared to be a sub-type of coming-out or already-out migration, insofar as it facilitated access to communities or networks that enabled participants to live more fully on a "gay timeline". Again, spatial migration here facilitates a timeline shift away from heteronormative and reproductive ways of knowing and being, and towards queer networks and knowledges. Thus, *gravitational migration* appears to be associated with many of the same sexual and mental health vulnerabilities already noted.

4.1.4. Relationship migration

Another queer migration pathway noted by Gorman-Murray (2009) is relationship migration, that is, relocations related to family ties, with the goal of either reunifying or forming a family. (Notwithstanding the latest troubling proposed changes to British immigration policy, "family" is understood here to encompass spouses and partners.) Relationship migrations were often segmented and involved making sacrifices, as explained by the following participant, who moved from the Argentinian capital at the age of 28:

> I met an Italian guy, which is my best friend, we fell in love. He was there for 6 months, so he decided after 6 months to live in London, whether we continued or broke up.

> I moved to Madrid, because, at that time, I didn't speak a word of English. It was really hard there, because of the crisis, so I tried to finish my study, but then it wasn't for me, because it was very bad.
>
> And I had to emigrate to the UK, but he was Arabian, so we see each other once a month or twice a month. And, it was the hardest time of my life, because I started working in a coffee shop, in Pret, without English. It was super hard.
>
> It was good. I mean, I grew up a lot. Then, I broke up with my ex. We broke up, but we're still friends. So, I've been here a couple of months, then I moved to another house. But, also, because I was working on fitness, I had to remake all my qualifications for Europe.

Insofar as *relationship migration* usually affects people who are already out, it has much in common with what I will term *already-out migration*, and its associated vulnerabilities, which I will discuss shortly. Whilst increasing legal recognition of same-sex relationships globally may have eased many of the difficulties associated with this type of migration, the mobility of queer people in polyamorous relationships remains largely restricted.

4.2. Novel migration "types"

As I have already noted, during the research interviews, several migration pathways emerged which could not be adequately captured by existing conceptualisations of queer migration. It was not necessarily the case that these pathways had not been considered before. To the best of my knowledge, however, these migration pathways have not been systematically schematised before now. By placing these novel "types" within a broader schema of the migrations of MSM, new understandings emerge, not only about the nature of so-called "sexual migration", but also – as I will show in the following chapters – about sexual health decision-making.

4.2.1. Discovery migration

Discovery migration refers to migration taken by people who are not out and have no intention to come out, possibly with no awareness of their non-heterosexual desires. While Carrillo (2004) understands migration as a cause of shifts in sexual identities or practices, and while Lewis (2012) notes the often-segmented nature of coming out, this "type" has not been systematically schematised. Indeed, while many participants in this study were aware of their non-heterosexual desires prior to migrating, some of my interlocutors explained that it was only after relocating that such feelings were first acted upon, as in the case of the following participant, who moved from a small Welsh town at the age of 18:

> Interviewer: At what age did you come out – ish?
>
> Participant: Twenty-two, twenty-three.
>
> Interviewer: Who did you come out to first?
>
> Participant: Who did I come out to first? Probably my first boyfriend. (Laughter) … I was straight at the time. And he took me to like- where did he take me to? He took me to one of the clubs in London, and then I kissed him. And then, he stayed over mine…

Some *discovery migrants* came from environments in which sex was rarely discussed:

> In terms of how I grew up and things, it was more repressed, I would probably say. My family were very traditional – quite old-world-y, I'd say – so new, modern concepts of sexuality and stuff like that, were probably… It wasn't spoken about. You don't talk about yourself, in that sort of sense. You don't talk about relationships. You don't talk about sex. You don't talk about girlfriends, boyfriends, whatever… I didn't know any different.

> At school, being a Catholic school, it wasn't talked about… So, I didn't realise [I was gay]. It was a very country life, and as I say, there wasn't much to do for a person.

While *discovery migrants* often had to navigate new sexual practices and contexts after migrating for the first time, much like *coming-out migrants*, this group's main vulnerabilities appeared more associated with accepting themselves as gay men on a "gay timeline". Interestingly, as I will argue later, this group's lack of sexual activity from a young age did not always appear to translate into a lack of sexual health knowledge, indicating that this group often remained attuned to the sexual health needs of gay men prior to identifying as gay men themselves. This intriguing pattern merits further study.

4.2.2. Already-out migration

While it is evident that many MSM who migrate are already well out at the time of migrating, for example, Gorman-Murray (2009) recognises that *gravitational migration* or *relationship migration* is usually undergone by people who are already out, this fact is rarely noted in much of the literature, in which sexuality and migration are assumed to be directly related. Thus, I suggest that *already-out migration* may usefully be understood as a "type" of queer migration which encompasses other "types", such as *gravitational migration* and *relationship migration*. Already-out migrants often attributed their relocations to career progression, as in the case of the following participant, originally from a large town in the USA, who moved several times throughout his teens, 20s, and 30s:

> There were these moves that were basically career-driven, including the one to London.

That did not mean to say, however, that sexuality did not enter at all into the migration decisions of *already-out migrants* such as this participant:

> There was nothing to do in Pittsburgh anyway, there were two bars and they were tragic. Why would I spend time in there? And it was full of either old people or students, neither of which I was interested in.

As I will argue in the coming chapters, while one might assume that navigating sex and sexuality in a new place may be easier for those who were already out in their places of origin, *already-out migrants* faced a number of mental and sexual health vulnerabilities related to, often traumatic, experiences navigating sex and sexuality in more restrictive contexts and in the absence of appropriate safer sex knowledge. Indeed, within the sample of participants, *already-out migrants* were the most likely to have acquired HIV before migrating. Furthermore, as I will show in the coming chapters, even those who were already out in their places of origin sometimes experienced abrupt temporal shifts after migrating to contexts in which there was what I will term a *critical mass of gay ways of knowing and be(com)ing*.

4.2.3. HIV care migration

The desire or ability to access adequate, comprehensive, and inclusive HIV care emerged as another key aspect driving the migrations of some participants. While “health-seeking migration” appears in the literature (Hunter & Simon, 2017), including in relation to HIV (USAID, 2019), *HIV care migration* has not recently been explicitly typified as a queer migration pathway, although earlier work has sought to explore the links between AIDS diagnoses and migration (Ellis & Muschkin, 1996). Other more recent work has examined the relationship between migration and the perceived need to escape the “second closet” of HIV status (DiFeliciantonio, 2020). The following participant, who moved from a large Colombian city at the age of

35, explained how his decision to move to the UK related to the ability to access adequate care:

> In Colombia, it's just that there is a health crisis right now… I tried to change it [HIV drug cocktail] back in Colombia, but my doctor was very reluctant about it. It just comes to the money because, of course, certain medications are cheaper…
>
> My experience [in London] has been very positive. It's just four months here and I have found a great deal of support here. They have been very open. They have provided me with medication… They suggested I changed my medication because I was taking a different cocktail, which actually did have some side effects to it.
>
> I'm actually guessing how I'm going to continue taking my medication when I come back to Colombia because it's going to be a fight, I'm sure.

Some participants found that their HIV status limited their choice of migration destinations, as with the following US participant who moved to London at the age of 39:

> I was living in DC; in 2010 I became HIV-positive. So, part of the consideration for that move [to London] was, am I allowed to emigrate, as a HIV-positive person? The UK was very up-front that it was fine. Most countries support it now, but when I was younger, it was definitely a thing where, "Oh my God, I can never go anywhere again."
>
> That was definitely a factor in the decision, or how I evaluated it. Yeah, it's not something you can suspend care or take it on privately or something like that, it's complicated enough. There needs to be institutional support for migrants. Yeah, so that was something I looked into before making these decisions.

HIV care migrants were sometimes, but not always, already out at the time of migrating, and they sometimes faced similar difficulties to *already-out migrants*. Naturally, *HIV care migrants* appeared to encounter some mental health vulnerabilities insofar as their ability to continue accessing adequate and comprehensive care was not always assured, leaving them navigating uncertainty in relation to their long-term health outcomes.

4.3. Applying the typology

Figure 4 is a summary of the queer migration pathways which were identified during the research process, and which helped guide the ensuing data analysis. Novel "types" have been italicised:

Migration type	**Characteristics**	**Source or related literature**
Coming-out migration	Migrating to come out or live openly without stigma	Gorman-Murray (2007, 2009)
Gravitational migration	Moving to be near gay networks or "gaybourhoods"	Gorman-Murray (2009) Kelley et al (1996)
Relationship migration	Moving with or joining a partner	Gorman-Murray (2009)
Queer asylum	Seeking legal protection due to persecution	Mole (2021), Danisi et al (2021)
Already-out migration	*Already out to most people at the time of migrating*	*Gorman-Murray (2009) discusses already-out people in the context of gravitational/relationship migration*
Discovery migration	*Not out, with no intention to come out; possibly no non-heterosexual desires*	*Carrillo (2004) frames migration in terms of a sexual shift; Lewis (2012) notes the often-segmented nature of coming out*

HIV care migration	*Seeking access to adequate and comprehensive HIV care*	*Hunter & Simon (2017) and USAID (2019) discuss "health-seeking migration". Ellis & Muschkin (1996) and DiFeliciantonio (2020) explore links between migration and HIV/AIDS.*

Figure 4: Typology of queer migration

While not allowing my analysis to be driven rigidly by this typology, considering the "type" of migration undertaken by participants in this study provided fruitful insights regarding differences in their experiences and outcomes. By breaking down "migrant MSM" into more specific pathways, the above categories enabled me to demonstrate the ways in which existing understandings of queer migration may be deepened by an acknowledgement of migrants' outness over time and space. *Figure 5* contains the list of study participants, this time including the migration "type" undertaken in each case. In this way, simplistic queer migration narratives may be complicated by an understanding of the variety of queer migration pathways that cut across other dimensions, such as place of origin and age:

Country of origin	**Settlement type**	**Year of migration**	**Age at migration**	**Reasons for migrating**	**Migration type(s)**	**HIV status**
USA	Large town	2016	39	Starting a new job	Already-out, HIV care	Positive (before migrating)
Italy	Capital city	2013	31	Joining a straight friend	Already-out	Positive (before migrating)
England	Village	2005	21	Career progression, liked big cities	Already-out	Positive (after migrating)

Germany	City	2022	27	Starting a new job, seeking change	Already-out	Negative
Portugal	Capital city	2020	30	Career progression	Already-out	Negative
Poland	City	2005	19	Joining family, “running away”, undergraduate studies	Already-out, gravitational	Positive (after migrating)
Colombia	Large city	2025	35	Joining family, scoping study opportunities	Already-out, HIV care	Positive (before migrating)
Argentina	Capital city	2011	28	Joining partner, liked Europe	Already-out, relationship	Negative
Poland	Large town	2013	21	Undergraduate studies, career progression	Coming-out	Positive (before migrating)
Romania	City	2017	25	Seeking change, joining sibling	Coming-out	Positive (before migrating)
Greece	Village	2019	18	Undergraduate studies, liked London	Coming-out	Positive (after migrating)
UAE	Large city	2012	17	Undergraduate studies	Coming-out	Positive (after migrating)
Bulgaria	City	2010	20	Undergraduate studies, joining friends	Coming-out	Positive (after migrating)
Poland	Village	2010	19	Joining family, “getting away”, liked London	Coming-out	Negative

Greece	Village	2016	24	New job, “to actually *be* gay”	Coming-out, gravitational	Negative
England	Village	2008	21	Postgraduate studies	Discovery	Negative
Germany	Small town	2019	23	Postgraduate studies	Discovery	Negative
Spain	Small town	2005	17	Undergraduate studies	Discovery	Negative
Wales	Small town	2012	18	Undergraduate studies	Discovery	Negative
Uganda	Capital city	2024	23	Seeking asylum	Queer asylum	Positive (before migrating)

Figure 5: List of study participants including migration “type”

In the following three chapters, I will draw on the lived experiences of my interlocutors in order to bring to the fore the ways in which existing understandings of gay and queer migration, understood as movement *across space*, may be deepened by an acknowledgement of migrants’ movement from reproductive to queer timelines (and back again). Given that, for many, “coming out” signals a desire to disidentify from heterosexuality, and the values and milestones associated with it, outness became a particularly useful tool through which my interlocutors and I made mutual sense of the temporalities they inhabited over time. While remaining aware of the limitations of “hetero/homo” ontologies of sexuality and “in/out” norms of disclosure, especially in restrictive social contexts (Carrillo, 2004; Lewis, 2012), I will remain particularly attuned in the following chapters to the ways in which the coming-out journeys of my interlocutors inflected their sexual health perceptions and behaviours, referring back to the migration types outlined in the previous chapter. For this reason, all interview quotations will be accompanied by some demographic details, including **country of origin**, **home settlement type** (village, town, *etc*.), **year of migration**, **age at the**

time of migration (*not* at the time of interview), and **migration type** (*already-out*, *coming-out*, *discovery*, *queer asylum*, *etc*.), for example:

> Romania, city, 2017 (25), coming-out

With all that in mind, let us now proceed to my analysis of the research interviews.

5. Navigating Sexual Health in Contexts of Institutional Reproductivity

"People back home would say like, "Every gay person is HIV-infected," and stuff like that… I can understand the straights, how they're thinking, because I was thinking like them before."

Polish participant, large town, 2013 (21), coming-out

"My first conversation about condoms? I remember I had a conversation with an older man in a park, like a cruising park. This man was talking about a lot of things like, "Don't be scared, you're not alone." But I knew already. And he was like, "You need to use a condom"… That was new."

Italian participant, capital city, 2013 (31), already-out

In the preceding chapters, I made a case for understanding the sexual health needs of MSM in terms of both spatial and "temporal" migrations, taking into account factors associated with "switching timelines", such as "coming out". Migrant MSM, I have shown, often experience significant sexual health risks in the period following their migration to the UK, particularly in the period immediately after migrating (Burns et al, 2011; Evans et al, 2011; Ganczak et al, 2017; Gosselin et al, 2020; Mole et al, 2014; Schmidt et al, 2023). Contributing significantly to worse sexual health outcomes among this group is the fact that many MSM migrate from contexts where inclusive and appropriate safer sex knowledge and behaviours are generally less well established and where there are higher levels of institutionalised homophobia and more rigid gender norms (Amirkhanian, 2012; Attwood, 1996; Binnie, 1997; Clark et al, 2013; Gios et al, 2019; Mai, 2004: 51; Mole et al, 2014: 90; Quinn, 2006; Rivkin-Fish, 1999; Ross et al, 2013; Štulhofer & Sandfort, 2004; Waugh, 1999). It is important, however, to supplement this spatial lens of

analysis with a temporal one, that is, an understanding of the timelines on which individuals find themselves. Following Halberstam (2005), I contend that the "straight world" centres on reproduction and "family values", placing those within it on a strict, gendered timeline from birth via marriage, mortgage, child-rearing, retirement *etc.*, through to death.

Given that many participants' temporal migrations – away from the timeline presumed by heterosexist institutions – commenced before they arrived in London, the focus in this first empirical chapter will be on the ways in which participants' sexual health trajectories were already being shaped and re-shaped in their places of origin. One of the experiences shared by all participants was the need to navigate safer sex and sexuality in contexts of institutional heteronormativity, that is, in environments in which institutions assume heterosexuality as standard. While there was some variation in the degree to which participants experienced institutional heteronormativity during their lives, participants frequently described the need to get away from the "straight world" epitomised by "family values" and "reproduction", which placed them on a strict reproductive timeline (Halberstam, 2005). Even where relocation was not undertaken with the specific goal of fleeing these worlds, many participants described them in mostly negative terms. It should be noted – as I will highlight in the following chapters – that London did not always present an escape from "reproductive" temporality, particularly in London's "straight world" and in lower socio-economic contexts. In this chapter, however, I will examine primarily the ways in which participants' formative experiences prior to migrating shaped their sexual health perceptions and behaviours, paying particular attention to the role of the social and sexual "worlds" they inhabited. I will show that navigating sex and sexuality in heteronormative or homophobic environments, and in the absence of adequate safer sex knowledge, engenders significant health vulnerabilities (Gios et al, 2019) with implications for life both before and after relocating.

The following chapter will proceed as follows. Firstly, I will outline how heteronormative institutions of socialisation shaped sexual health perceptions

and behaviours during participants' formative years and to this day. I will explore the ways in which heteronormative and highly moralised sexual health discussions, which presumed participants to be on a reproductive timeline, left those who came out or became sexually active at a younger age ill-informed. I will examine the resultant patterning of sexual health perceptions and behaviours among participants, considering how internalised shame and stigma induced by heteronormative institutions of socialisation may promote outdated sexual health beliefs that reduce adherence to and the perceived salience of safer sex strategies. Finally, I will examine how some participants moved between the "straight world" and the "gay world" in their places of origin, highlighting the ways in which outness and (in)visibility were negotiated in often restrictive settings. Here, I will explore the role of gay venues, social circles, and intergenerational mentorship in transmitting safer sex knowledge and behaviours, while also examining potential vulnerabilities arising from these forms of learning, which often took place "in the shadows" (Odets, 2019) of mainstream society, whose fears and stigmas continued to permeate the formative sexual encounters of many of my interlocutors. In this way, I will show that occasional encounters with "the gay world" in their places of origin by no means guaranteed awareness of or adherence to more informed and inclusive sexual health perceptions and behaviours, as a *critical mass of gay ways of knowing and be(com)ing* had not been reached. Thus, I will reveal, through the following analysis, the ways in which "outness" – often understood to increase fulfilment and wellbeing (Annequin et al, 2017; Hammoud et al, 2019; Hu et al, 2019; Schueler et al, 2019; White & Stephenson, 2013) – may be a double-edged sword that exposes people to greater sexual health risk (Gios et al, 2019).

5.1. Getting it straight: sex education in heteronormative contexts

Common to the lives of all participants in this study was instruction around (safer) sex that assumed heterosexuality as standard. On the rare

occasions that homosexuality was discussed, it was always as an “extra”, rather than as a potentially fundamental part of young people’s lives. Schools were one of the most frequently reported places of learning about sex and sexuality during participants’ formative years. Most participants’ accounts of sex education at school were highly negative, regardless of age or place of origin, which supports the notion that norms around discussions of sex and safer sex even in the “enlightened West” are heterogeneous at the sub-national level (Gillibrand & Turner, 2013; Mole et al, 2014). Educational content almost always centred on heteronormative assumptions that placed participants on a reproductive timeline in the context of which discussions about non-normative sexual practices were foreclosed (Edelman, 2004; Halberstam, 2005). Further to the educational context, I will also discuss in this section the role of healthcare institutions, participants’ families, and the digital media in reproducing heteronormative knowledge that placed people on a reproductive timeline, thereby exacerbating difficulties envisioning and accessing appropriate healthcare both before and after migrating.

5.1.1. Hetero-sex education

Schools were frequently described as oppressive institutions (Adelman & Woods, 2006) which presumed straightness, and in which it was not safe to come out or be “visibly gay”. I should note here, in transparent recognition of the ways in which my positionality inevitably shapes this research, that participants’ characterisations of schools as oppressive institutions resonated strongly with my own experience of (single-sex state grammar) school as a place in which toxic masculinity not only flourished but was tacitly encouraged. I was therefore particularly attuned to this characterisation whenever it arose in the interviews, although I endeavoured to avoid foreclosing other characterisations.

Some participants reported receiving little to no meaningful sex education at school, such as the following participant, who seroconverted not long after leaving home:

> I mean, we didn't have a sexual health class, it was only in biology you learn about infections and HIV and how it works. That's it. We never had any course on using protection, or what's chlamydia or gonorrhoea or anything.
>
> (UAE, large city, 2012 (17), coming-out)

Most participants, however, recalled receiving some form of sex and relationship education. Nonetheless, this invariably pertained mostly or exclusively to heterosexual sex, a sad fact which is echoed even in recent findings from the UK (DfE, 2021), Sweden (Dennermalm et al, 2024), and a systematic review of 24 studies globally (O'Farrell, 2021). Consequently, not one participant felt that they had received a comprehensive education on sex and relationships. Curricula were usually described to focus almost exclusively on pregnancy and contraception (DePalma & Atkinson, 2010; Heffner, 2017), meaning that sex education happened within a temporally reproductive context in which participants were assumed to follow certain, straight, reproductive trajectories into adulthood. Discussions about pregnancy were framed more in terms of moral notions such as "saving oneself" for the right time than in terms of empirical knowledge and targeted strategies:

> Yeah, they would talk about stuff like, "Don't sleep with girls," or, like, "You want to save your life. You want to build a life," or something like that in high school, but not so deep into it. We didn't know much about STDs.
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

Other participants, despite receiving more specific instruction, for example around condom use, only received this instruction in relation to preventing pregnancy. The following two participants seroconverted later in life:

> In my time I think we had only once in middle school contraception something… It was short. About 20/30 minutes. And I think they gave us some condoms. And we all started to play with the condoms and to inflate them. We were around 14/15… We studied biology, anatomy, but not that much about sexual diseases… We studied about reproduction.
>
> (Romania, city, 2017 (25), coming-out)

> Sex education is quite a strong word. The level of sex education in the country is just the bare minimum. And it's so old-school, so outdated. It happened only once, basically…maybe 6th or 7th grade, and they would make us watch this video of a man and a woman in a bathtub, with foam around their bits… And obviously, nobody would mention anything about homosexual relationships… It would be a huge scandal if that happens.
>
> (Bulgaria, city, 2010 (20), coming-out)

Despite some mention of HIV in such contexts, nobody considered it a "real threat", as heterosexual life-courses in which HIV was considered less of a threat were institutionally presumed:

> Participant: They would mention HIV, but I don't really remember much about it.
>
> Interviewer: And what was the advice?
>
> Participant: Condoms. But obviously, nobody would ever consider it as a real threat.
>
> (Bulgaria, city, 2010 (20), coming-out)

Unsurprisingly, this participant felt that the erasure of gay people from Bulgarian sex education curricula resulted in preventable HIV transmissions and left young gay men feeling unprepared for an HIV diagnosis:

> I felt so unprepared, and so uneducated after I got HIV… I feel like, had we had more education on that…– specifically, for gay people, because we might be more at risk – that could prevent some cases.
>
> (Bulgaria, city, 2010 (20), coming-out)

Within the context described, young MSM who were sexually active and who were not willing or able to conduct their own research about their sexual health needs appeared to be particularly vulnerable to HIV and STIs.

Participants frequently noted other ways in which gendered assumptions impacted the sex education they received. Firstly, gendered and heteronormative assumptions about men's sexual health needs foreclosed the possibility of discussing sexual health needs that did not affect most men. This, the following participant explains, may cause young people to find the sexual health advice they receive inapplicable to them:

> Participant: We had separate sessions…for boys and girls. And you know, there wasn't any sort of time where we would speak about gay people, or transgender… They would be showing us how to pro- Well, not protect. Yeah, how to protect ourselves. And then, they would talk about, like, pills to the girls.
>
> Interviewer: If they were only talking about men and women, did you think that any of this stuff applied to you?
>
> Participant: Not really, no, and it wouldn't, because there was no information about the sex life that I would be exposed to.

(Poland, large town, 2013 (21), coming-out)

Secondly, educators' discomfort discussing the sexual needs not just of MSM, but also of men in general, had consequences for men's sexual health more broadly:

> Our teacher, she wasn't great… And she was a bit of an elderly lady as well… I don't think she would be massively comfortable talking about it, you see? I mean, [with the girls] she was super amazing… All the girls, and the menstruating, all that was very common to her.
>
> (Poland, large town, 2013 (21), coming-out)

Participants from more religious settings frequently noted the extent to which religious institutions restricted their access to liberal instruction around sex and sexuality in which non-reproductive futures were imaginable. This had implications for their sexual behaviours before and after migrating. One participant, who seroconverted before migrating, recalled the ways in which religious ideas precluded the discussion of gay safe sex at school:

> They were very constrictive. They were very picky about speaking even about contraceptive methods for women, so of course they weren't going to speak about gay safe sex. They were judgmental about so many things.
>
> (Colombia, large city, 2025 (35), already-out, HIV care)

This participant went on to explain that the prohibitive nature of his schooling made him less likely to openly discuss sexual health with authority figures such as doctors, giving credence to Carballo-Diéguez's (1998) finding that Latino sexual migrants in the USA – while aware of the risks of HIV

transmission – were less likely to follow safer sex guidance because they equated it with prohibitions imposed by the Catholic church from which they "escaped".

The influence of the Catholic Church on schooling was likewise felt by participants from the UK, showing how religious moralisations of sex can transcend national borders. Discussing the ways in which religious educational institutions shaped his sex education, the following participant explained how such moralisations also impacted his ability to seek out sexual health services when appropriate:

> Being a Catholic school, it wasn't talked about. It was brought up as, "It's a sin; it's an issue; it's a bad thing." I knew nothing about it, because to be fair, I knew nothing, at that point, about healthcare, realistically. I knew nothing about sexual health or sexual health services. I didn't even know they existed… They don't promote condom needs.
>
> (England, village, 2008 (21), discovery)

As well as failing to transmit the necessary safer sex knowledge, the absence of inclusive safer sex discussions left this participant feeling unprepared to access healthcare services which may have empowered him to take greater control over his sexual health.

Clearly, institutional heteronormativity was not limited to the Global South and East. Even the younger participants from the Global North and West reported a deeply ingrained institutional focus on reproduction:

> So, sex education, at school, they showed us one video in biology… To somebody who is…coming into puberty…all of a sudden, there are urges, and they're not explained, and you've just a video saying, "Yes, you have a

> penis. They have a vagina. This is normal. One goes into that, and then a baby." That was it.
>
> (England, village, 2008 (21), discovery)

British participants frequently alluded to the impact of *Section 28*, which prohibited the promotion of homosexuality in schools and local authorities from 1988 until 2000 in Scotland and until 2003 in England and Wales. (Kent County Council retained a slightly amended version of the law until it was quashed by the *Equality Act* in 2010: one of the less proud boasts of my county of origin.) Despite the length of time that had passed since the repeal of *Section 28*, participants reported that educators remained fearful of discussing homosexuality well into the 2010s. Speaking of his post-2003 schooling, the following participant stated:

> It's like a "deer in the headlights" moment. You're just not- you just wouldn't dare [to ask questions about gay sex]. I mean, some person may make a joke, or whatever, but nothing- no serious questions asked… I wonder if they'd be able to answer it, to be fair.
>
> (Wales, small town, 2012 (18), discovery)

Here, the participant echoes other participants' fears that, even if it had been possible to ask questions about homosexual sex, sex educators – on timelines in which HIV was not important – would not have known how to respond appropriately.

In contexts where sex education curricula were reportedly relatively well developed, they were still designed with heterosexual sex in mind, as one German participant recalled:

> In second grade…they showed people, basically, how sex works and stuff… They explained how it works and how you should stay safe. They explained to us what sexual abuse is.
>
> In like, seventh, eighth grade…they had sexual health professionals come to our schools, and they showed us how to put condoms over dildos…
>
> This was all, like, straight… They didn't really talk about gay stuff… I think most states now, they have LGBT-inclusive education. But when I went, they didn't have that.
>
> (Germany, small town, 2019 (23), discovery)

Interestingly, while gay men's sexual health issues were rarely explored in this participant's sex education curriculum, he reported greater awareness of HIV than other sexually transmitted infections, which is consistent with Samkange-Zeeb et al's (2013) findings on STI awareness among German adolescents, thanks in part to stronger nationwide campaigns about HIV/AIDS than other STIs. Consequently, the participant was not aware of oral infections until a sexual partner made him aware:

> I don't really remember if they talked about bacterial things… Like, they talked about HIV…
>
> I knew HIV, of course, because it's not curable, right? I didn't really know about oral- (Laughter) It's so stupid but I didn't know about oral infections until about 25… And that was basically a sexual partner telling me. Like, you can have an STI in your mouth and your throat… Not just, like, ass and genitals.
>
> (Germany, small town, 2019 (23), discovery)

Whilst this participant's schooling improved his understanding of HIV – a vast improvement on the experiences of other participants – there remained

significant gaps in understanding around bacterial infections, which came to be filled by sexual partners.

Older participants reported more explicitly homophobic attitudes during their formal sex education. The following participant from the USA, who seroconverted after migrating several times, explained how sex education delivered by his football coach in the 1990s continued to reproduce out-of-date understandings of HIV:

> They put sex ed in “Health”. And it was the assistant football coach who taught it. And this would have been in ’95 or something like that. He said something like, “Oh, we’ve got to talk about AIDS today, what is that? Is it cancer or something? Well, here’s a video.” And it was this video from 1984. It was like, “If you are caring for an AIDS patient and they are sick, the vomitus will not carry the disease, you can clean it up”.
>
> (USA, large town, 2016 (39), already-out, HIV care)

The betrayal felt by this participant around the fear-based and religiously infused sex education he received in school dovetailed with his profound mistrust of “institutions in general” to this day, especially healthcare institutions. It became clear during his discussion of Covid the extent to which this participant’s appraisal of health messaging remains inflected by his formative sex education experiences:

> I was like, “You are exactly the evangelicals who were telling us to repent for our sinful ways – the gays will all die of AIDS – and things like that, in the ‘80s. You're indistinguishable from them, just this relentless moralising cast to all of this advice…” I had a couple of years of therapy [after Covid] because I was just so distrustful of institutions in general.
>
> (USA, large town, 2016 (39), already-out, HIV care)

The way in which this participant's attitude towards public health messaging was inflected by heavily moralised health messaging during his formative years is once again reminiscent of Carballo-Diéguez's (1998) description of the ways in which Latino sexual migrants in the USA – while aware of the risks of HIV transmission – were less likely to follow safer sex guidance because they equated it with prohibitions imposed by the Catholic Church from which they had escaped.

5.1.2. Ghosts of healthcare past

Participants from sexually restrictive contexts often described experiencing shame, stigma, and fear in medical settings, which centred on the assumption that sex served the sole or primary purpose of procreation. Consistent with the literature, it appeared that high levels of medical shame and stigma in participants' places of origin made them less likely to engage with sexual health services (Ayhan et al, 2019; Balfe & Brugha, 2009; Mbeda et al, 2020; Whitehead et al, 2016), or even to understand themselves as candidates for them (Mawson et al, 2025). Participants who navigated sexual healthcare as *out* gay men in stigmatising environments appeared more likely to retain hesitancies accessing sexual healthcare after migrating. Meanwhile, in contexts where "promoting homosexuality" remains restricted or criminalised, young MSM may face the double-bind of being unable to access, on the one hand, heteronormative sexual health services, and, on the other hand, LGBTQI+ organisations, fearful of being portrayed as "promoters" of homosexuality (Müller et al, 2018). The following participant, who needed to hide his sexuality after being diagnosed with HIV in Uganda – where homosexuality is criminalised – was particularly hesitant to access sexual health services:

> He began asking me questions like, “Do you have anal sex?” Shit like that. Then I eventually asked him, “Am I HIV positive? What’s happening?” and he was like, “Yeah, you're positive. But then it seems, the way you’ve contracted this thing, you must be doing illegal…” they do this thing in Uganda called…an anal test…
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

The violence of homophobic medical treatment was worsened by the unpredictability of when arbitrary homophobic rules might be applied, causing people to be fearful to access the few remaining sexual health services:

> I really thought I could trust [the HIV clinic] openly, because the doctor was really nice to me, until, for some reason, it came out of my mouth that I'm gay. (Laughter) Oh, my days. She made me feel so uncomfortable. Yeah, then the questions she would ask, and then that stuff of, “Oh, you have to start going to church, blah, blah, blah.” And then…someone else in the clinic, she was about to tell my stepmum now, about my sexuality.
>
> Actually, last year, it got…so bad. I couldn’t even go to the clinic. Because now everybody was suspecting I was gay, and they had an obligation to report gay people. (Laughter) So I couldn’t even go to get medication…
>
> People are now very scared because many sexual clinics were closed because of this law that says they are promoting homosexuality in the country. A few sexual clinics are still open, but it's difficult.
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

It is evident that such traumatic experiences may make individuals likely to conceal certain aspects of their lives when accessing medical treatment.

In other cases, participants reported that, because their presumed heterosexuality placed them on a reproductive timeline, opportunities were

missed to discuss non-reproductive sexual health practices during formative clinical encounters. The following participant – who went on to acquire HIV after moving to London – explained how a private doctor in Poland failed to engage in any safer sex discussions when treating him for a bacterial STI at age 15, noting that she didn't "even ask if I'm gay or straight":

> Participant: I don't think she [the doctor] even asked if I'm gay or straight. She kind of just- just you get the prescription, and that's it.
>
> Interviewer: So, there was no discussion about safer sex?
>
> Participant: No, no.
>
> (Poland, city, 2005 (19), already-out, gravitational)

The participant explained that his older sister had helped him to find a private doctor because of concerns that his regular family doctor would out him to his parents, with "fuss-free" private treatment assuring that he would not be "outed". This demonstrates one way in which participants ensured that their sexual behaviours went undetected in a heteronormative society in which privacy was hard to maintain (Attwood, 1996; Binnie, 1997; Mai, 2004: 51; Mole et al, 2014: 90).

Public health campaigns about HIV/AIDS – particularly from the 1980s and 1990s – were a memorable source of sexual health information for participants from Western Europe and North America. No participants were sexually active before 1996 (when HAART began to transform HIV into a manageable condition); the eldest participant was born in 1977. Consequently, participants often recalled seeing the "hard-hitting", fear-based public health campaigns of the 1980s and 1990s as children and adolescents. Participants – who spoke in overwhelmingly negative terms about these campaigns – frequently noted that they did not result in behaviour changes (Earl & Albarracín, 2007; Nyhan et al, 2014), because they lacked practical

advice that spoke to them. In other words, they did not meaningfully or effectively suggest new attitudes or behaviours as ways of alleviating future fear (Albarracín et al, 2005; Soames Job, 1988). Of course, the absence of context from early awareness-raising campaigns is likely to have made them even less legible to children, such as the following two participants born in the 1980s, the first of whom seroconverted after relocating:

> I just remember the AIDS adverts, which were quite traumatic, especially for a five-year-old.
>
> (England, village, 2005 (21), already-out)

> I remember the adverts from the 1980s. I was a very young child, and I saw those very hard-hitting adverts… All I remember is the advert where they had [gestures a falling gravestone]. I always remembered that. That was quite profound, because I didn't understand it. I had no idea what it was… I didn't know anything about it. I didn't know that touching someone, or this, that and the other, was…I didn't know…
>
> (England, village, 2008 (21), discovery)

One younger participant acknowledged that, even though HIV/AIDS was "never talked about" when he was growing up, "everyone my parent's age remembers the gravestone adverts". This suggests either that people were shocked into silence or that the adverts lacked substance that felt relevant or appropriate to share with children:

> I don't know if you've seen *It's a Sin*, but it was very like the Welsh guy from there. Nobody really talked about it. I mean, everyone remembers. I mean, I don't remember, but everyone my parent's age remembers the gravestone adverts, and things like that. But no, it was never talked about.

(Wales, small town, 2012 (18), discovery)

Similarly, the following participant born in the 1980s, who went on to acquire HIV, explained how he continued to use condoms permissively despite being "shocked into" HIV awareness by public information films:

> Interviewer: So, before you moved did you use condoms when you had sex with people typically?
>
> Participant: Rarely. Rarely…
>
> Interviewer: You had no fears around sexual health?
>
> Participant: No. And I think it's not that it was a lack of education. In the '80s I was shocked into all of it. I don't know why I had been so willing to have unprotected sex for such a long time.

(England, village, 2005 (21), already-out)

Aside from ethical questions around the appropriateness of fear-based health promotion campaigns (Chapman, 2018), these testimonies certainly bring into question the efficacy of such campaigns in the hands of audiences for whom they are unsuited. For those who grew up in the absence of neutral or positive discussions about sex and sexuality, fear-based health promotion campaigns – with few take-away messages other than "AIDS=death" – came to shape many participants' earliest understanding of (gay) sex.

As previously noted, the perceived complicity of implicitly heteronormative healthcare institutions with conservative political agendas in participants' places of origin altered their perceptions of and engagement with sexual health services and advice both before and after relocating. The following participant outlined his belief that public health institutions (in London and elsewhere) were underpinned by a profound discomfort (or

disgust) towards practices deemed unnecessarily high-risk by people with differing values and risk tolerances:

> Participant: After the fact, you do realise again this is public health's profound disg- discomfort-
>
> Interviewer: Disgust?
>
> Participant: Disgust. With… people with different priorities… I think we're very uncomfortable with the idea that people… The big thing with public health is that they have demonstrated that they don't have a good respect that different people have different tolerances for risk, and different values, and things like that. They've made that very clear.
>
> People come to different conclusions about these things and…these people are incapable of evaluating people in a way that gels with me.
>
> (USA, large town, 2016 (39), already-out, HIV care)

While this participant felt that public health messaging continued not to have his "best interests" at heart, he also explained that healthcare professionals in London were usually less judgmental than anticipated. Nonetheless, the anticipation persists, underscoring how emotionally charged formative healthcare experiences can be:

> The most uncomfortable aspect of dealing with sexual health, is my assumption that people are just going to be judgmental… But it's actually not the experience I have, I think, really, ever, when I go to seek it out on a one-to-one. You know, I actually seek- Not *public* health, but *real* health, in these kinds of clinics.

> I'm always still surprised that sexual health, one-on-one, when I go and have a test or whatever, is always less awful than I assume it's going to be, on the basis of those formative experiences and the experiences of how public health people are… There's this huge gap for me still in my head, between, "Gosh, they're going to be judgmental."
>
> (USA, large town, 2016 (39), already-out, HIV care)

The above excerpt demonstrates that, under the right conditions, lost trust between healthcare institutions and individuals with negative healthcare experiences may be redeemable through good, non-judgmental practice that reflects the needs of sexually non-reproductive individuals. While public health campaigns often failed to speak to participants in language that made sense to them, clinicians more frequently managed to build back trust.

5.1.3. The role of family

Participants' sexual health perceptions and behaviours were often shaped by their families and social circles. Knowledge acquired here, however, usually offered little by way of practical guidance, such that many participants believed their families had left them with incomplete, heteronormative understandings of sexual health that placed greater value on child-rearing and the continuation of the family line. Where family members found sexual health and HIV to be particularly taboo, participants reported that engagement with these topics often took the form of hints and coded messages:

> My mum would hint to be careful when it comes to like- when I would go somewhere, or travelling to the UK, before I moved here, she would be like, "You know, HIV, and stuff." She would mention that, but she wouldn't go into details. She would just say that. I remember her saying, "You know what happens," talking about HIV, "you know what happens." She wouldn't tell me

> what happens, she would just say, “Oh, you know what happens.” Expecting me to already know everything.
>
> (Bulgaria, city, 2010 (20), coming-out)

When I quizzed him further on why his mother chose only to *hint* about HIV, he re-iterated the commonly held belief that “it would never happen to him”, especially because HIV was viewed as a Western infection and a gay infection, neither of which were presumed to apply to presumed-straight members of the family unit:

> I mean, again, I feel like a lot of people don’t think it’s something that will happen to their children, or to themselves. I mean, I never thought it could happen to me… Inevitably…I would go and probably have some experiences. So, she would assume that I would just find out from somewhere else. I would get my information from somewhere else. I felt like they didn’t really feel it was their responsibility to educate their children…
>
> I don’t think there is enough education for young people, especially for people travelling, or about to go abroad, or something like that.
>
> (Bulgaria, city, 2010 (20), coming-out)

This excerpt demonstrates how mobility and coming out were often closely related concepts, with the understanding – shared by the participant and his mother – that many young gay Bulgarians would naturally move away from Bulgaria towards Western Europe, where gender and sexual diversity are seen to be less widely stigmatised.

Another participant with HIV similarly explained how his mother – who herself carried trauma related to experiences of HIV/AIDS – had chosen to code her fears about HIV in cryptic ways:

> When my mother found out [about my sexuality], she just was very dramatic about it. I was around 20 years old… She found out, she confronted me and then all she said was – she was in tears – "you should really take care of yourself."
>
> She actually meant about AIDS. She didn't say that, but now, when I grew up, when I was 25-ish, I started recalling these memories about a friend…who came from a part of the country where my mummy came from, and he was staying in the house. I do believe that he was queer, and I do believe that he had AIDS. So, of course, later, that left a scar on my mum and maybe that's why she couldn't actually talk about it very openly.
>
> (Colombia, large city, 2025 (35), already-out, HIV care)

For this participant, his mother's silence on HIV/AIDS was explainable in terms of the scar left by her own experiences of AIDS, once more echoing findings that silence and forgetting are a common response to HIV/AIDS traumas (Adam et al, 2008; Monteiro et al, 2018; Zea, 1999).

Participants from highly religious families, meanwhile, often reported the total erasure of sex-related topics at home:

> My family were very religious – quite old-world-y, I'd say – so new, modern concepts of sexuality and stuff like that, were probably… It wasn't spoken about… You don't talk about relationships. You don't talk about sex. You don't talk about girlfriends, boyfriends, whatever… So, I didn't know any different.
>
> (England, village, 2008 (21), discovery)

Other times, having a religious family did not preclude discussions of sex and sexual health, but it meant that these matters were not neutrally discussed. The following participant explained that his father's claims that HIV was

God's punishment to gay people informed his sexual health perceptions and behaviours:

> I remember my father was telling me that HIV's a curse…from God that is sent to homos. I'm not sure how did I internally respond to that, because he was telling that to a person who didn't have any prior healthcare knowledge… I think my father has influenced me a lot, and that influence has also played a role religious-wise as well. I'm still religious.
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

The idea of HIV as divine punishment has been found to circulate widely in Uganda (Otolok-Tanga et al, 2007), as well as in other sub-Saharan African contexts, including Tanzania (Roura et al, 2010), Nigeria (Olaore & Olaore, 2014), and South Africa (Pantelic et al, 2016). As well as being psychologically damaging, faith-based understandings of HIV as divine retribution may also make young MSM less likely to access testing and treatments that are based on scientific evidence.

5.1.4. Digital media

Participants described mediatic depictions of safer sex and HIV in mixed terms. On the one hand, some participants – as I have discussed already – associated mediatic depictions primarily with fear-based public health campaigns which, by their own estimation, did more harm than good. For others, however, TV and films were one of the only sources of inclusive safer sex knowledge available, with some participants even describing filmic representations of HIV as a lifeline. While these depictions were not necessarily accurate or up-to-date, TV and film nonetheless continued to be a key source of learning about gay sex and sexual health in highly restrictive contexts. One Ugandan participant, for example, described how *Pose* prompted him to recognise symptoms he had previously ignored and to seek

testing in Uganda, where discussions of safer sex and HIV were otherwise seriously impeded:

> Interviewer: How did you discover that [you had HIV]?
>
> Participant: I guess I was just finishing watching *Pose*, and that's when I saw about [the history of AIDS]… I was alone, and I was watching *Pose*. *Pose* was so sad. And I was drinking so much at the time. I would get drunk alone in the house… I was watching that, I was drunk. Then I felt a bump on the back of my head, and I thought, "I could have this thing," you know?
>
> Interviewer: Was the bump actually related?
>
> Participant: I think so, yeah. And it must have been because I saw it on *Pose*… One of them said that could be a sign…the thyroid swelling… So, the next day I went to the nearby clinic.
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

This excerpt appears to support the idea that popular mediatic representations could be an imperfect source of information in settings where the neutral or positive discussion of safer sex and HIV is extremely limited. While popular media representations did not prevent HIV acquisition in this case, they may have prevented a late diagnosis.

In other cases, participants reported seeing mediatic depictions soon enough to have a potentially preventative effect. The following participant from Portugal attributes his earliest awareness of condoms and HIV to watching Brazilian telenovelas:

> In Portugal, Brazilian soap operas are really big, always has, I must have been eight or nine, there was this show, it was really funny because they kept talking about condoms… And the word they used for condom, it's not

> the word that you use in mainland Portugal, the one they use in Brazil which literally translates to “small shirt”. And I’m like, “What the hell is that…?” Then, I guess that led to a conversation, but I can’t remember how…that, oh, this is used to prevent HIV. It clearly is something that people die of for having sex without it.
>
> (Portugal, capital city, 2020 (30), already-out)

For this participant, exposure to the idea of a condom at a young age laid the groundwork for ensuring safer sex behaviours later in life. Interestingly, for discovery migrants such as this, lack of (awareness of) homosexual desires did not translate into fewer sexual health-seeking behaviours; in fact, the opposite appeared to be true. The links between “outness” and perceived HIV vulnerability and morbidity are unclear and merits further investigation.

Some mediatic depictions were considered less helpful, with the depiction of homosexuality and HIV in TV shows sometimes reported to perpetuate misleading stereotypes, with damaging effects on impressionable viewers (Johnson, 2013). Depictions of HIV patients – both real and fictitious – on their deathbeds left many participants (and me) with strong residual associations between HIV and a “terrifying” death:

> My only knowledge of HIV was from movies and TV shows that happened in the crisis. And all those really tragic stories… So, you have the pictures of people on their deathbed, you know, that's what you have of HIV.
>
> (UAE, large city, 2012 (17), coming-out)

Where perceptions are derived from historical films, there is a risk that they may do more harm than good. For example, out-of-date or stigmatising understandings of HIV risk and prognosis may prevent impressionable viewers from testing regularly or observing safer-sex practices (Johnson,

2013). Indeed, even though mass media representations occasionally acquainted young MSM with more conceptual tools through which to make sense of gay men's sexual health, they could by no means be described as a reliable source of sexual health knowledge.

Some participants turned online in the absence of other means of accessing sex education geared towards the needs of people on non-reproductive timelines, in line with the findings of O'Farrell et al (2021). For some, online research was prompted by experiences that they knew *on some level* could be unsafe. Indeed, participants sometimes described experiences – especially "first times" – in terms of an asymmetry between their safer sex knowledge and their ability to put it into practice. It was often not until after the encounter that they sought to fill the knowledge gap left by the institutions of "the straight world". The following two participants had some knowledge of the HIV window period and of prodromal HIV, respectively, but they had not yet been able to develop more proactive safer sex strategies:

> I had unprotected before using a condom. Like, unprotected anal for two minutes, or whatever. Then, I was already concerned, and I knew about the time window and stuff… I Googled "take HIV test, how long do you need to wait?", stuff like that. "How long do you need to wait after sex until it shows?"
>
> (Germany, city, 2022 (27), already-out)

> I had unprotected anal sex with someone, and I started having some flu-like symptoms afterwards… So, I started getting very worried about that because I started reading online…that there is like this HIV previral syndrome [sic]. I was getting super worried.
>
> (Greece, village, 2016 (24), coming-out, gravitational)

While researching online evidently requires a certain amount of self-motivation, *discovery migrants* appeared just as likely, if not more likely than those who were *already out*, to exhibit awareness of the risks associated with condomless anal sex from a young age – at times, to the point of health anxiety. In this way, neither being "out" to more people nor awareness of same-sex desires appeared to increase the perceived salience of safer sex knowledge.

Participants from settings where discussions of safer sex and sexuality were less normalised tended to describe more reactive patterns of online sexual health research. Given that sex education designed for straight people did not prepare them for sex in the "gay world", some participants only conducted their first sexual health research following an HIV diagnosis:

> I learnt when I got infected [aged 22]… I didn't have a lot of sexual education in high school or university. And I didn't really know what this is about. After [my HIV diagnosis] I was doing research. I was looking for answers on the internet, different websites. I was trying to find something legit, you know? Something trustful. And, yeah, when I moved here, I learnt more.
>
> (Romania, city, 2017 (25), coming-out)

> I went on Google that day and learnt a lot that very day. I watched a lot of YouTube videos and a lot of Google.
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

It should be noted that some participants reported that they had encountered HIV misinformation online, during both reactive and proactive research. There is a risk that the increasing prevalence of HIV misinformation may make people less likely to access sexual health services (Garrett & Young, 2022).

5.2. Frozen in time: fragmented knowledge, improvised strategies

Having discussed the heteronormative nature of the key sources of learning about sexual health in the lives of my interlocutors, I will now examine some of the sexual health perceptions and behaviours into which these limited learnings translated. I will discuss some commonly held perceptions of HIV – including outdated understandings of HIV as a "gay disease", as a "death sentence", and as an inevitability – exploring how these understandings reflect heteronormative moralisations of homosexuality as a "waste" or "the end of the line" (Bersani, 1987; Edelman, 2004; Halberstam, 2005; Rohy, 2009; Watney, 1987). Reflecting the realities of earlier times, these understandings are a sort of temporal "hangover", lagging, or "dragging" in people's imaginations (Freeman, 2010). As a result, stigma abounded in the lives of participants – particularly those who were already out or navigating the scene – leading them to feel that HIV acquisition was unavoidable or deserved, and thus to fail to take protective measures (Díaz et al, 2003). In the absence of positive or neutral discussions about gay men's sexual health needs, some participants reported relying on ineffective precedent-based and trust-based safer sex strategies. Condom use was frequently reported to be difficult to navigate, and decisions were often found to fall to "tops" (insertive sexual partners), mirroring heteronormative gendered assumptions about sexual decision-making (Mai, 2004). Participants often reported engaging in sexual health testing only when symptomatic, perhaps mirroring the testing norms of the "straight world".

5.2.1. HIV as the "gay disease"

The association of HIV with homosexuality was one of the most frequently reported perceptions among participants, echoing findings that gay men are at particularly high risk of HIV stigma (Botnick, 2000a, 2000b,

2000c; McKay, 2017; Dennermalm et al, 2024), and that HIV stigma is frequently internalised by gay people (Berg & Ross, 2014). Experience navigating the “scene” in their place of origin did not appear to undo ideas of HIV as the “gay disease”. The association of HIV with homosexuality appeared to particularly affect participants from more restrictive sexual contexts, as in the case of the following participant from Uganda, where homosexuality is criminalised. The participant explained that the effect of the widespread moralisation of homosexuality as unnatural was a generalised association of homosexuality with HIV, even though heterosexuals are also widely affected:

> In Uganda, it’s mainly known as a gay disease, you know, like, it’s a disease for homosexuals… That's not true. I mean, most people who have it are not homosexuals in Uganda, so, yeah.
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

Such associations with HIV did not persist only in places where homosexuality was criminalised, however. Participants from other sexually restrictive contexts reported similar understandings of HIV:

> I think it’s a quite common- it *was* at least a quite common thing. HIV equals gay.
>
> (Greece, village, 2016 (24), coming-out, gravitational)

> I knew that it was an incurable disease. I knew that it was transmitted by blood or other kinds of fluids. I knew that it wouldn’t be transmitted by saliva, for example. I knew it was a queer thing.
>
> (Colombia, large city, 2025 (35), already-out, HIV care)

> People back home would say like, “Every gay person is HIV-infected,” and stuff like that… I can understand the straights, how they’re thinking, because I was thinking like them before. I was thinking women, straight guys, they don’t have HIV. Gays, we have HIV. I didn’t realise anyone could have it.
>
> (Poland, large town, 2013 (21), coming-out)

For participants growing up in heteronormative societies, the link between HIV and homosexuality was often cemented at a young age (Dennermalm et al, 2024). The latter participant, interestingly, points explicitly to “the straights” as key reproducers of this association. As I will demonstrate later, participants who were aware of non-heterosexual desires from a younger age (*already-out migrants* and *coming-out migrants*) were often thrusted into the “gay world” without sufficient safer sex knowledge, meaning that the transmission of safer sex norms depended on the direct or latent mentorship of more knowledgeable sexual partners and friends. For example, while advertisements left one already-out participant – born in the early 1980s – “obsessing” over his partners’ serostatus, such obsession was of limited use, as he went on to acquire HIV anyway:

> Participant: I remember once, I had sex with a man… He used a condom, and I was so obsessed, I said, “Oh, maybe the condom ripped off.” When I went home, I couldn't sleep. I came back with my car to the place looking for the condom to check if it was still there, not ripped off. So, I was obsessed.
>
> Interviewer: What were you obsessed about?
>
> Participant: HIV.
>
> Interviewer: Why? Where had that come from?

> Participant: There were a lot of advertisements, even on the TV. They were very scary advertisements.
>
> (Italy, capital city, 2013 (31), already-out)

While almost all participants acknowledged commonly held associations between HIV and homosexuality, these associations were felt to frequently go unspoken, not just among heterosexual people, but also among MSM. For some, the discussion of HIV was somehow conspicuous by its absence, especially during their childhood years, echoing findings that silence and forgetting are a common response in the face of HIV/AIDS stigma, both in and out of queer communities (Adam et al, 2008; Monteiro et al, 2018; Zea, 1999). Because of the collective denial, there was, to some extent, a tacit agreement that systematic STI prevention strategies were either unnecessary or impossible:

> Men in Greece, Corfu at least, weren't talking about that…they don't know what the chlamydia bacterium is, they don't know what gonorrhoea is. They know what HIV is, but everyone thinks, "Oh, it's fine, no-one gets it", or something like that…
>
> It's as if no-one was talking about it, so was forgetting about it.
>
> (Greece, village, 2019 (18), coming-out)

This does not mean to say there was no awareness of HIV in such contexts. Hyper-awareness and forgetting are often two sides of the same coin; the extreme stress caused by HIV stigma may lead individuals to forget selectively (Zea, 1999).

As well as being seen as a "gay disease", participants from Central and Eastern Europe frequently associated HIV with intravenous drug use (c.f. Mole et al, 2014). It is perhaps unsurprising that Eastern European

participants associated HIV with intravenous drug use, given that this remains a leading cause of new HIV diagnoses in Eastern Europe and Central Asia (LaMonaca et al 2019; Ward et al 2022):

> There would be two ways that you can get HIV: You're either gay or you are one of those that have used drugs and something, God knows, stays on the streets and stuff.
>
> (Poland, large town, 2013 (21), coming-out)

> Obviously because from Poland- in Poland, they tend to be- in the '80s there was this awful heroin pandemic, and so that was kind of- so you always kind of just knew [about HIV risk].
>
> (Poland, city, 2005 (19), already-out, gravitational)

While such perceptions reinforced negative perceptions of HIV, the two populations were always discussed by participants in entirely separate terms.

5.2.2. HIV as "death sentence"

Another recalcitrant perception among participants from sexually illiberal contexts was the continued association of HIV with untimely death (Dennermalm et al, 2024; Monteiro et al, 2018). As well as understanding HIV as a gay disease, many participants – younger and older alike – reported perceiving HIV to be a "death sentence". This was perhaps unsurprising, given the common associations of gayness with death which came to be gruesomely literalised by AIDS (Bersani, 1987; Crewe, 2018; Edelman, 2004; Halberstam, 2005; McKay, 2017; Rohy, 2009; Watney, 1987). The perception that HIV was a death sentence was usually cemented at a young age (although the validity of this perception was geographically and historically

variable), and it informed the ways in which participants navigated sexual health spaces, both before and after relocating:

> I didn't have the image of people living with HIV and [it being] manageable… I thought HIV was a death sentence.
>
> (Greece, village, 2016 (24), coming-out, gravitational)

> I just knew, "It's a virus, and you will have it for all your life. There's not like a treatment. It's just something that will keep it under control. But still you're going to die soon." (Laughter)
>
> (Romania, city, 2017 (25), coming-out)

The stresses caused by HIV/AIDS stigma appeared most acutely in participants' accounts of HIV diagnoses. While discussing his HIV diagnosis experience in Poland, one participant touched on his incredulity towards the clinician's reassurances that HIV was a non-fatal condition:

> A nurse…broke the news with me, said that I have HIV, and all I did, I started to cry, because I didn't know what to do. I thought, "I'm going to die tomorrow." I guess it's all this hitting you at once. You've got loads of questions, very little answers. I remember hugging this nurse. She said to me, "Oh, don't worry, you're going to be living for another 50 years." And I was like, "How do you know that?"
>
> (Poland, large town, 2013 (21), coming-out)

Deep-seated understandings of HIV as a death sentence arose even for participants who possessed a reasonable amount of HIV knowledge,

demonstrating how HIV stigma anchored participants emotionally to the realities of earlier times (Dennermalm et al, 2024: 389):

> I did know a fair amount about HIV. However, when they did talk about my diagnosis on the phone, it's as if I forgot everything. I was like, "Yeah, I'm definitely dying, that's it, dying." Obviously like, at the time, the shock, you forget everything but generally I would say I knew the means of transmission.
>
> (Greece, village, 2019 (18), coming-out)

Whilst the notion of HIV as a death sentence prevailed, understandings of HIV were rarely straightforward or singular, with participants often reporting difficulty reconciling emotional responses to HIV with logical-rational claims (Dennermalm et al, 2024). Some knowledge of highly effective antiretroviral treatments often coexisted with persistent fantasies of untimely death, particularly before participants had access to consistent, judgement-free engagement with sexual health services, which in many of their places of origin was difficult or impossible. Observe, for example, the variation between what was *said* and what was *felt* when the following participant disclosed his HIV status to his aunt:

> I told her, "I'm on the medication." And I think I was already undetectable. She didn't have much knowledge about it also. And I was trying to explain to her what the doctor was explaining to me. Like, "It's like this. They said I'm not going to die."
>
> But still in my mind was this idea that, "I might go to sleep and die. I'm not going to wake up tomorrow." (Laughter) Yeah.
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

For the following participant, too, lingering notions of HIV as a death sentence coexisted with up-to-date knowledge of contemporary treatment options:

> Participant: It really isn't a big deal today… There is that medication now. You do go undetectable. I can't pass it on. It's not going to affect me…
>
> When I went and got myself tested and I received the news it was just- I think after a bit of reflection as well. "You've done this to yourself. I mean how many times can you roll the dice of death before it happens?"
>
> Interviewer: The dice of death?
>
> Participant: Well, that's what I was always saying. Even though it's not a death sentence.
>
> (England, village, 2005 (21), already-out)

The recalcitrance of deathly imagery in participants' discussions of HIV often appeared to reinforce deeper-seated feelings of worthlessness, or of being the "end of the line" (Bersani, 1987; Edelman, 2004; Halberstam, 2005; Rohy, 2009; Watney, 1987).

Among participants, scientific understandings of HIV as an infectious agent with both specific modes of transmission and highly effective therapies often coincided with a deeply embedded fear that the threat of HIV was always lurking in the background:

> Growing up it sort of became ingrained that HIV will always be a risk in our lives. But there was nothing else, I mean there was the condom, there was nothing else. Celibacy, I guess. There was nothing else to mitigate that. So, I sort of got used to that feeling that there will always be a chance…

(Spain, small town, 2005 (17), discovery)

For many participants, these background fears about HIV produced a profound sense of powerlessness, and a perceived inability to protect themselves against HIV in the long-term. The perceived inevitability of HIV infection reflects the observation that a generalised sense of powerlessness meant that many gay and bisexual Latino migrants in the US felt unable "to determine their own fate…and thus fail to act in a self-protective manner" (Díaz et al, 2003: 283). One English participant, who seroconverted after migrating, described this perceived inevitability:

Participant: In my late 30s I contracted it. It's my own fault and to be expected. That's why I wasn't really shocked, *per se*, when I was first told… I think it was just an expectation. I've always been expecting it at some point.

Interviewer: You've always been expecting that you were going to get HIV?

Participant: Yeah. Don't know why.

(England, village, 2005 (21), already-out)

Despite having described a certain sense of powerlessness around HIV acquisition, this participant was very reticent to acknowledge the reality of this feeling, which was indicative of a certain degree of self-judgement for his behaviours:

Interviewer: And that just didn't feel like something that could be stopped?

Participant: It definitely *could* have been stopped.

Interviewer: Did it *feel* like something that could have been stopped?

Participant: It definitely was something I could have stopped, but we all make a stupid mistake in our life at some point… You ask those questions [about partners' HIV status], and then you take their answer on a trust level. I'm still trying to explore in myself as to why I was never taking precautions.

(England, village, 2005 (21), already-out)

Echoing the language of the heteronormative contexts in which he grew up, this participant framed HIV infection as an inevitable punishment for his own perceived "stupidity" (Dennermalm et al, 2024).

5.2.3. Lay epidemiologies

As already noted, participants' responses to HIV threat ranged from perceived inevitability to total denial, sometimes oscillating between the two. Indeed, these responses can be two sides of the same coin, with the extreme stress caused by HIV stigma, for example, causing individuals to forget selectively (Zea, 1999). In the absence of positive or neutral discussions in heteronormative environments geared towards reproductive timelines, participants reported relying on precedent-based and trust-based lay epidemiologies, instead of testing frequently and negotiating condom use assertively (Amirkhanian, 2012; Attwood, 1996; Binnie, 1997; Clark et al, 2013; Gios et al, 2019; Mai, 2004: 51; Mole et al, 2014: 90; Quinn, 2006; Rivkin-Fish, 1999; Ross et al, 2013; Štulhofer & Sandfort, 2004; Waugh, 1999). In the absence of clear guidance on HIV risk, some participants did not use condoms due to a long-established, erstwhile unproblematic precedent of non-condom use. One participant expressed his shock upon

being diagnosed in Italy, even though he had rarely used condoms from a young age:

> And when I was diagnosed with HIV, I was in shock. I was 29. I was really in shock… Since I was 11 to 16, I didn't use a condom, or 14 or 15, and I had a lot of sex… Even the doctor, when I explained my stories, “Oh, it's a miracle you don't already have HIV”.
>
> (Italy, capital city, 2013 (31), already-out)

Some participants believed that – even though HIV circulates freely – *they* would not be affected by it, especially if a long time had passed since they became sexually active. Within the context of the infrequent discussion of HIV and sexual health in their places of origin, participants who had been sexually active for a long time often reported relying on precedent-based HIV prevention strategies (“it’s never happened to me before, so it won’t now”):

> Interviewer: Who would it happen to, if not you?
>
> Participant: Exactly, I know. It was just something that I wasn’t- I didn’t know anyone who would be positive. It would be very much something that I know from, like, stories that you heard about…
>
> (Bulgaria, city, 2010 (20), coming-out)

> But even still I was just one of those people that just thought, “It’s never going to happen to me.” And it didn’t for a very, very, very long time. And, because that was always the case, “It’s never going to happen to me.”
>
> (England, village, 2005 (21), already-out)

Given that those individuals who were *already out* or *coming out* at a younger age were often sexually active in their places of origin, it was unsurprising that many such participants exhibited inconsistent testing behaviours prior to relocating.

Non-condom use was sometimes related to trust and trustworthiness. One participant explained that being from a smaller settlement like a village may make people more likely to rely on ineffective precedent-based and trust-based strategies:

> Even though I had knowledge about sexual life, the protection and what you need to do to prevent certain situations, I also had a lot of trust in people… I was very naïve, very naïve… I knew about it, but it's something that would never, ever happen to me, I guess. That was my approach to it, you know…
>
> Being in the smaller area the likelihood of HIV spreading is not going to be as high, let's say, as in the city. You've got more gay people in London. You've got more gay people in London with HIV. And therefore, the chances increase.
>
> (England, village, 2005 (21), already-out)

Participants from smaller settlements often alluded to the decreased accountability that comes with the anonymity of city life. The risks associated with employing precedent-based and trust-based safer sex strategies only increase upon arrival in queer hubs, where HIV and other STIs circulate widely (Burns et al, 2011; Evans et al, 2011; Ganczak et al, 2017; Gosselin et al, 2020; Mole et al, 2014; Schmidt et al, 2023).

Participants often reported infrequent interactions with STI screening in their places of origin. Given that adherence to safer sexual behaviours is lower in heteronormative environments (Amirkhanian, 2012; Attwood, 1996; Binnie, 1997; Clark et al, 2013; Gios et al, 2019; Mai, 2004: 51; Mole et al, 2014: 90; Quinn, 2006; Rivkin-Fish, 1999; Ross et al, 2013; Štulhofer &

Sandfort, 2004; Waugh, 1999), it was unsurprising that many participants reported that the need for regular testing was often ignored in places where monogamous heterosexual relationships were the assumed norm. Thus, prior to migrating, many participants tested solely or primarily when symptomatic:

> I only went when I had symptoms of something.
>
> (Poland, city, 2005 (19), already-out, gravitational)

> Participant: I didn't [test frequently in Italy]. It's just if I had something. I was sure that I was doing things properly. I didn't have symptoms for a long time.
>
> Interviewer: So then, why did you go and have a test when you were 29?
>
> Participant: I had some symptoms, and I researched it on Google. There was something about my throat.
>
> Interviewer: So, your lymph nodes were swollen?
>
> Participant: Yeah, and I was thinking, “I think I have HIV.” This is why I went, for HIV, and I was so nervous about the outcome, and I was right.
>
> (Italy, capital city, 2013 (31), already-out)

The patterns of engagement with sexual health services described by many of my interlocutors – particularly those navigating sex and the “scene” from a younger age – suggest that young MSM in more restrictive sexual contexts may face significant challenges in accessing the appropriate services when they need them.

5.2.4. Difficulties negotiating condom use

As I have shown, many participants believed from a young age that HIV would inevitably affect them, but they often lacked clarity about the steps they could take to avoid acquiring HIV, especially in places where collective moral codes impeded positive or neutral discussions of sexuality and safer sex (Amirkhanian, 2012; Attwood, 1996; Binnie, 1997; Clark et al, 2013; Gios et al, 2019; Mai, 2004: 51; Mole et al, 2014: 90; Quinn, 2006; Rivkin-Fish, 1999; Ross et al, 2013; Štulhofer & Sandfort, 2004; Waugh, 1999). Given that condom use is harder to negotiate in settings with a high level of social stigma, misogyny and homophobia (Clark et al, 2013; Mai, 2004; Pineda, 2020; Zea, 2000), it was unsurprising that those who had been sexually active in restrictive contexts appeared to face more difficulties negotiating condom use assertively both before and after migrating:

> I remember at that time that I should have used a condom, but I was scared about asking it or kind of scared of negotiating. On the first time I think he used a condom. But that time, I remember I didn't know how to ask about it.
>
> (Greece, village, 2016 (24), coming-out, gravitational)

While participants often understood at least some of the health risks associated with condomless sex with other men, they also often felt they lacked the agency to insist on certain behaviours, such as assertively negotiating condom use.

Decisions about condom use were frequently seen to rightly belong to "tops", echoing Pineda's (2020) findings that decisions about condom use were tied to sexual role among migrant MSM in Madrid. Mirroring heteronormative gendered assumptions about sexual decision-making, condom use appeared to be handed to tops more frequently in contexts where it had not been possible for participants to have positive or neutral conversations about sexuality and safer sex:

> If I topped, I would use a condom… When I bottomed, I would try to ask. I would be like, “I'm not going to,” but men have a way of- And that’s how it happened. That boyfriend I told you from 2020… I'm sure I got HIV from him.
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

Despite preferring to use condoms, this participant reported that condom use was harder to insist on when “bottoming”. Having acquired HIV from somebody who pressured him not to use a condom, the participant described his difficulty now protecting himself against other STIs in the same context:

> If someone pressures me like that, I would still…even up to now… And, like, I always keep saying, “Can we just use a fucking condom?” and then someone says no or, “I've done this, I've checked myself.”
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

In a similar way to that described by Pineda (2020), internalised heteronormative and machismo attitudes caused this participant to relinquish control over his sexual health and sexual pleasure when being penetrated. Indeed, silence and stigma around sexuality appeared to impact frequently on many participants’ ability to negotiate more fulfilling and safer sex both before and after migrating to London. Notably, while participants frequently reported that condom use was difficult to negotiate, they also often blamed themselves for perceived failures in decision-making.

While many participants expressed difficulties negotiating condom use in their place of origin and in the period immediately after their migration to London, some participants reported observing the “condom code” from a young age, that is, the consistent and widespread use of condoms as the primary strategy for preventing HIV transmission, often also entailing a moral

imperative to be “100% safe 100% of the time” (Botnick, 2000b; Knauer, 2000). Echoing findings that being out may not always be a protective factor when it comes to sexual health (Gios et al, 2019), *discovery migrants* often appeared to report the strictest adherence to the condom code – as well as other STI prevention strategies. The reasons for this are not entirely clear. This group had usually become aware of the risks of unprotected sex at a young age through socio-cultural, educational, and medical institutions, and self-driven research:

> I would assume that there would be no sex without a condom. It wasn’t even a question at that point to me… One guy that I ended up being in a relationship with for a couple of years, maybe the first or second time we hooked up he didn’t have a condom. I’m like, “What the hell do you think you’re doing?” Like, “It’s fine, we’ve known each other for a while.” I’m like, “No, it’s not. If you want, we’re going to get tested together, and then after that we’ll make a discussion after discussing it…”
>
> I can't tell you exactly when and how the trajectory was formed. But I think it was always having to do with self-education.
>
> (Spain, small town, 2005 (17), discovery)

Once again, for those early in their coming-out journey, such as *discovery migrants*, it sometimes seemed as though the perceived danger of coming out had become entangled with the perceived danger of HIV. As already noted, the links between outness and perceived HIV vulnerability and morbidity merit further investigation.

5.3. Out, there: complicating simplistic geographies of backwardness

As I demonstrated earlier in this chapter, some participants conducted their own, self-driven research into sexual health and safer sex in the absence of more reliable forms of guidance from their heteronormative institutions of socialisation. As well as conducting their own research in the traditional sense, however, many participants – particularly those who were *already out* or who were otherwise on the "scene" – described some limited learning about safer sex and sexual health from other sources in their places of origin. Firstly, some participants, particularly from more progressive, often more urban or well-travelled contexts, were able to have positive discussions with their family and social networks about sexuality and sexual health. Secondly, participants discussed how access to the "gay world" in their places of origin, including bars, clubs, and other gay spaces, engendered both opportunities and vulnerabilities. Finally, some participants who struggled to be out or visibly gay explained how some of their earliest encounters happened "in the shadows" (Odets, 2019) of mainstream society, in private or semi-private spaces, in which more safe and inclusive sexual health perceptions and behaviours were not guaranteed. Some participants – often earlier in their coming-out journey – explained that mentorship in private spaces, often from older sexual partners, was a key source of learning about sex and occasionally sexual health. However, these encounters also occasionally left young MSM open to abuse. In the context of widespread institutional heteronormativity, these imperfect sources of sexual health guidance were often more trustworthy and accessible than other sources available to them, thus their importance in shaping the sexual health perceptions and behaviours of young MSM in restrictive settings cannot be understated. However, in the absence of a "critical mass" of gay ways of knowing and be(com)ing, being out in restrictive environments was by no means guaranteed to be a positive or empowering experience.

The term "gay world" was used by several participants to describe the ways of knowing and be(com)ing that stand in opposition to reproductive

temporality. While it may seem odd to suggest that there is a “gay world” that exists across borders, many migrant MSM – when making comparisons between places – focused less on national boundaries and more on relative ease of access to queer networks, communities and ways of life, which, whilst heterogeneous, also shared many similarities that transcended borders. The notion of a “gay world” or “gay worlds” that frequently arose during interviews reflects the transnational nature of norms, attitudes and behaviours central to non-reproductive ways of living. While the “gay world” is by no means the singular entity envisioned by colour-blind and class-blind proponents of the “Gay International” (Carrillo, 2004; Lewis, 2012; Massad, 2002; Puar 2012), “straight world” and “gay world” were legible concepts for participants in this study, many of whom employed these terms themselves.

5.3.1. Visibility within the “straight world”

While some participants characterised their places of origin in mostly hostile terms, some others hastened to highlight the ways in which their places of origin were and are tolerant or inclusive of homosexuality:

> Homosexuality in Poland was legalised in 1928 [sic - 1932] so there were never any problems with it, not even during communism… Just kept it to yourself or something… In my hometown there was a gay bar, literally on the main high road…with a massive gay flag. And when I was leaving the bar, at 1 o’clock in the morning, I never felt there would be some kind of skinhead, or anyone, standing there. You know?
>
> (Poland, city, 2005 (19), already-out, gravitational)

Rather than discussing their home countries in totalising terms, participants often noted the heterogeneity of attitudes and behaviours within the nation. Urban places were often described as generally more accepting than rural places:

> We had some gay guys at school, and they were popular…it was never really a big issue… We were so close to the city, so we went always to, like, Düsseldorf. But I think if you were more rural, far more rural, like some rural parts of Bavaria or eastern Germany or maybe even west Germany, it would be completely different.
>
> (Germany, city, 2022 (27), already-out)

Openness to gay ways of life was often felt to be more mainstream in capital cities than elsewhere:

> The level of sex education in the country is just the bare minimum… There is no mention of homosexual relationships and sex… I mean, I guess, things are changing slowly, but it's not on a massive scale. It's not across the country. I have friends that are very much involved in the capital with organising the gay pride, and sex education and all that kind of stuff, for gay people.
>
> (Bulgaria, city, 2010 (20), coming-out)

As well as a rural/urban split, some participants reported that progressive attitudes were patterned according to other historical cultural divides:

> There's Poland A and Poland B. So, if you look at it from Gdańsk, Warsaw, kind of going south, anything to the west is Poland A, and they tend to be…socially very more progressive. And anything from Warsaw to the right, towards, like, Belarus and Lithuania, there is always Poland B… Poland B was occupied…by the Russian Empire. The west was occupied by Prussia and Austria-Hungary.
>
> (Poland, city, 2005 (19), already-out, gravitational)

Positive attitudes towards homosexuality were patterned not just spatially, but also according to other dimensions, such as exposure to different ways of life. Participants frequently alluded to the idea that people in certain places were more accepting than others because they had had more exposure to non-heterosexual individuals:

> Interviewer: So, being near to the city made people more tolerant, more accepting?
>
> Participant: Yes, absolutely. I think that's… because it's just more diverse. There's everything, right?
>
> Interviewer: So, they've just been exposed to more?
>
> Participant: Exposed. Yes, exposure. So, if you see gay people all the time (Laughter) and everything, all kinds of people, ages, everything, migrants and whatever.
>
> (Germany, city, 2022 (27), already-out)

> You didn't really have this contact with gay people unless you were living in big cities in Argentina. Of course, always the big capital is where all the gays, you know, normally…
>
> (Argentina, capital city, 2011 (28), already-out, relationship)

Similarly, the following participant linked exposure to new ways (through travel) with open-mindedness, while discussing his father's acceptance of his homosexuality:

> He moved to Germany when he was quite young, his mentality changed a lot as well. I never had any issues with any of my parents in terms of accepting my orientation, I guess.
>
> I think it comes with being well travelled, being very open to things, open minded. The place where I'm from, people can be quite small minded, unfortunately. Some of them are, and I think, in my opinion, it comes also with being well educated. If you don't understand how it works, then I guess you might have a different opinion on things.
>
> (Poland, large town, 2013 (21), coming-out)

The extent to which participants linked travel and "exposure" with openness to non-heterosexuality suggested that the two concepts were deeply entangled for many participants, as I will discuss further in the following chapter.

The possibility of envisaging life on other timelines in participants' places of origin was also associated with the presence of nearby universities, often understood by participants as sites of abrupt temporal shift, as I will detail further in the following chapter:

> If you live in maybe a bigger city…you know, where you've got a uni, and it's slightly bigger to where I'm from, then definitely, the mentality is different.
>
> (Poland, large town, 2013 (21), coming-out)

In contrast with primary and secondary education, participants frequently discussed further educational settings, such as universities, as places of acceptance, in part because they facilitated exposure both to non-heterosexual individuals and to new ways of thinking:

> [Homosexuality] was definitely something that was just accepted, or even more than accepted, it was overlooked. It wasn't just that much of a big deal…
>
> During the first [degree programme], maybe a little bit more… but then, in Theatre, it was completely different, of course… I mean, yes, mandatory. (Laughter)
>
> (Colombia, large city, 2025 (35), already-out, HIV care)

Because attitudes towards homosexuality were shaped by social factors as well as spatial ones, it was not only in gay social spaces that participants reported finding acceptance, as one participant explained while speaking of a formative experience entering a straight club in a large Polish city:

> He was checking the IDs of girls, and everything, but when he saw me, he didn't ask for an ID. He was like, "Are you out by yourself?" "Yes." And he slapped my ass, and he went, "Enjoy." Literally that way… That was a straight club! … He knew that I was gay, and he was kind of, "Are you by yourself?" "Yes." "So, go and enjoy yourself." … There was a queue, and he openly slapped my ass in front of other people. So other people saw it, and no one said anything. And that was in Poland.
>
> (Poland, city, 2005 (19), already-out, gravitational)

In contrast with common depictions of homosexuality in places with high levels of institutional homophobia, such as Central and Eastern Europe (Amirkhanian, 2012; Attwood, 1996; Binnie, 1997; Mai, 2004: 51; Mole et al, 2014: 90; Quinn, 2006; Rivkin-Fish, 1999; Štulhofer & Sandfort, 2004; Waugh, 1999), this participant refuted the idea that there was a need for him to hide his sexuality.

Although friends and family were rarely understood to be reliable sources of safer sex knowledge, participants felt they could have an important role in helping young gay men on their journey to self-acceptance. The following participant explained the importance of social circles in young people's sexual journeys:

> I was very open about [my sexuality], and there were a lot of people were open about it, and there were some people that were hiding it, and still hiding until this day… I think it's a lot to do with…the people that you surround yourself on a daily basis, in terms of your friends, people that you want to impress.
>
> (Poland, large town, 2013 (21), coming-out)

In contrast with the often fearful or stigmatising approaches reportedly taken by many participants' families in relation to sex, sexuality, and sexual health, other participants described friends and family members as important sources of acceptance and guidance. Several participants made special mention of the ways in which "cool" aunties, older sisters or female friends helped them on their journeys, often by easing them into gay spaces:

> I was very close to my auntie. And the first discussion [about my sexuality] was with her. When they opened a gay club in my city, I went on kind of a date with an owner of the club. I was in my early stage… I didn't even know what sex life is about.
>
> (Romania, city, 2017 (25), coming-out)

> I was still in high school in Wrocław… I went to Warsaw to visit my aunt… At that time, they were, like, 35… I was, like, age 17. So, we kind of just went out for drinks… They said, "Oh, we're going home because we're tired. Okay,

> so you can go now where you wanted to go, and here, have 100 złoty." My aunt who saw me maybe once or twice in life. And she said, "Okay, you probably want to go to that [gay] club, so just go… You go to your club now." How do you explain that?
>
> (Poland, city, 2005 (19), already-out, gravitational)

Family members with more distance from participants appeared less likely to presume heterosexuality. In this way, "cool" older family members often played a pivotal role in the lives of young MSM who lacked supportive role models and the space to explore the "gay world".

5.3.2. Navigating the "gay world"

While participants found many of the social spaces in their places of origin to be highly heteronormative, gay spaces sometimes offered a more relaxed environment in which many participants could be more themselves. Those who were *already out* in their places of origin, or who found little acceptance from their family or peers, sometimes reported finding respite in gay spaces. These spaces, which were often associated with causal hookups and partying, were usually accessed at night and in the early morning, when much of the "straight world" was in bed:

> Every night, even if I needed to go to school, I would leave my house at 11:00pm and I'd come back around 4:00am, sleep for two hours, go to school, and have a nap in the afternoon. My life was like this. Every night I wanted to go out, I wanted someone to adore me. I was so in need of attention and need of people that wanted me.
>
> (Italy, capital city, 2013 (31), already-out)

In this way, these often-nocturnal spaces, which were not structured around the perceived needs and values of straight people, often rejected the standard rhythms and modalities of heterosociality.

As well as being places of respite or acceptance, gay spaces were also sometimes synonymous with learning about sex and sexuality:

> Between ‘19 and then COVID came, I had a lot of hookups. So, yeah, I think during that time, it was about two years of learning, and at that time I began attending club parties.
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

Some participants reported that gay venues in their places of origin facilitated learning about sexual health more specifically. For example, for the following participant – who found little acceptance from family and peers – it was only upon entering gay venues that he first met “proper” (read: out) gay people who transmitted safer sex advice. By contrast, this had not been discussed as his previous sexual partners – bisexuals, other children, and paedophiles – were not part of the “proper” “gay world”. (I will discuss disclosures of child sex abuse in more detail later in this section):

> I started clubbing when I was 16 and you're not allowed; you need to be 18. (Laughter) And I remember they give you a lot of condoms in the toilets… There were condoms, and people talking about this. Maybe when I started clubbing, I started to use them. And I started to use them with proper…how can I say it? Gay people. Because when you are 11, 12, you fuck with random people, even if they are bisexual or paedophiles, other children, maybe on the down-low… When I started to match with the gay community, maybe that was the condom culture.
>
> (Italy, capital city, 2013 (31), already-out)

As well as the physical provision of condoms, this participant reported that people were "talking about this [condoms]", which reflected a generalised "condom culture" that was not, he felt, commonly shared by non-gay-identifying people. For this participant, there was a clear connection between the gay community and condom culture. This participant nonetheless seroconverted before migrating, suggesting that, while accessing gay venues played a role in transmitting awareness of safer-sex practices, their perceived salience may have been limited. While research abounds on the effectiveness of sexual health outreach programmes in clubs and sex-on-premises venues (Bonnell et al, 2006; Debattista, 2015; Prost et al, 2007; Woods et al, 2010), understanding the ways in which gay spaces facilitate more organic forms of knowledge transfer between laypeople would be a worthwhile piste of further research.

As well as gay venues, gay social circles were another frequently described aspect of the "gay world" in participants' places of origin. Gay social circles did not always have a positive impact on participants' learning about sexual health. The following participant, who acquired HIV before migrating, reported that increased discussions about HIV in "the gay community" in Romania often took the form of gossip rather than practical knowledge around HIV, safer sex, and testing. Consequently, increased exposure to these topics *tout court* did not cause a significant change in his sexual health perceptions and behaviours:

Interviewer:	How did you know what [HIV] was if you hadn't been taught about it?
Participant:	Being part of the gay community, it was a lot like, "Oh, that one has HIV, but the other one just got HIV." Sometimes in the club they were talking about testing, you know? Like before we were opening. But I didn't read much about it… In the club, they were saying that

> everyone should test, because HIV, gonorrhoea and all these other- And I never did it, because I was thinking, "Why should I…?" I just knew, "It's a virus, and you will have it for all your life. There's not like a treatment. It's just something that will keep it under control. But still you're going to die soon." (Laughter)
>
> (Romania, city, 2017 (25), coming-out)

For this participant, the erroneous beliefs both that HIV infection was unlikely to affect him and that it would be profoundly life-limiting were not challenged through discussions in gay spaces.

As well as failing to undo erroneous health beliefs, some participants framed gay social circles in their places of origin (and, as I will show, in London) as deleterious to their wellbeing. The following participants explained how a smaller "scene" and "gossipy" gay networks made them more visible, potentially forcing them "out" before it was safe for them:

> The scene is quite small [in Bulgaria], so you tell two or three people, and suddenly, everybody knows. Whereas [in London], you feel like you're not so visible… The gay scene is divided. Every neighbourhood basically has its own gay scene.
>
> (Bulgaria, city, 2010 (20), coming-out)

> I was preparing to have sex with someone that doesn't really know me or doesn't know me very well…because I don't want all the gay community from my city to know about my adventures, to know who I'm having sex with. You know? Because they were very gossipy.
>
> (Romania, city, 2017 (25), coming-out)

This latter participant's desire to pass by unnoticed led him to avoid gay clubs altogether, preferring to find partners in straight venues:

> Yeah. I was trying to avoid this. I was trying to keep my privacy. I was going to straight clubs. Because I was looking as a woman, I had sex with straight guys most of the time.
>
> (Romania, city, 2017 (25), coming-out)

The above excerpt demonstrates once again how the "straight world" is not necessarily incompatible with gay ways of life, and, indeed, may bear other advantages and opportunities.

Participants accessing HIV treatment in their places of origin frequently reported that the design of HIV services there made them feel exposed, causing people to gossip and potentially outing them as living with HIV:

> The only problem was that…when you were waiting, you would see people that you know. "Oh, my God," and they gossip about you. "Oh, [participant]'s got HIV," and you felt so exposed… Every time I needed to go there, I was anxious that I might meet people.
>
> (Italy, capital city, 2013 (31), already-out)

Similarly, stigma and lack of awareness about HIV and sexual health within gay social circles meant that honestly disclosing HIV status entailed an increased risk of gossip:

> Many people don't [understand what undetectable means]… I was like, "Okay, you have to know this" … Some people got very, very scared. They were very judgemental. They would tell their other friends. One day, I was in a nearby park and I was being [glared at by their friends]…and I understood…that the information had travelled… I was being looked at like, "You are this disease-carrying boy who is getting it across everyone."
>
> (Colombia, large city, 2025 (35), already-out, HIV care)

For this participant, widespread HIV stigma and lack of knowledge about undetectability in his home city made him a source of gossip even within the "gay world", such that it mirrored the assumptions and stereotypes of the "straight world".

5.3.3. Private spaces and shadow worlds

Whereas those who were out in their places of origin were able to navigate explicitly gay spaces, other participants explained how their earliest encounters often took place "in the shadows" (Odets, 2019) of mainstream society:

> Back home, I would sneak out and meet guys in the park, because everybody was hiding… And then, coming here [London], everybody's out, and everybody's super camp. You get everything.
>
> (Bulgaria, city, 2010 (20), coming-out)

It was often in these spaces that participants made their sexual debut. Given their lack of experience, participants often relied on the mentorship of older gay men in these spaces. This usually took the form of "latent mentorship", that is, knowledge made available implicitly or informally through actions, behaviours, or know-how (Thomeer, 2025).

Of course, gay intergenerational mentorship did not take place solely in participants' places of origin. Indeed – and, again, in the interests of positional transparency – I entered a relationship with an older man during my own doctoral journey, over the course of which it became very clear to me that "gayness" is, in many ways, something which must be learnt (Halperin, 2012), often from mentors with more experience on a queer timeline. However, following discussions with my interlocutors, I realised retrospectively just how significant older men had been to my own gay education at various key moments, a fact which had been unfortunately obscured by learnt, heteronormative attitudes to the "dangers of older men", which had caused me to selectively forget positive encounters, while amplifying negative ones. In this way, participants in this study helped me to exhume forgotten aspects of my own temporal migrations.

There were often practical reasons for which older gay men often became important conduits in the absence of other sources of sexual health guidance. Where the social context made public meetings difficult, it was often older men who were out, and who had houses to themselves:

> I would go for older guys…because no-one was really out… The older guys had places. The older guys, they knew what to do with us.
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

Similarly, one Polish participant who was an adolescent during the noughties explained how older men were more likely to have mobile phones, highlighting the ways in which older people's access to technology may shape the formative sexual experiences of MSM:

> Only [older] people tended to have, like, mobile phones, and stuff like that, or would be so confident… I am kind of unique, in my area of Poland…to come out [at school]. So, there were only older people that I could have sex with.

(Poland, city, 2005 (19), already-out, gravitational)

Some participants' earliest practical sexual health knowledge came from older men, implying that intergenerational mentorship – that is, the transmission of past, often forgotten, knowledges to younger generations – may play an important role in knowledge transmission in settings where there are few other reliable sources. Indeed, Hammoud et al (2019) and Schueler et al (2019) find that knowing other MSM is positively correlated with sexual health-seeking behaviours (although it should be noted that both these studies were conducted in queer hubs, and neither of them focused explicitly on age differences). The following participant explained how a conversation with an older man in a cruising park may have shaped his sexual health perceptions and behaviours:

> My first conversation about condoms? I remember I had a conversation with an older man in a park, like a cruising park. This man was talking about a lot of things like, "Don't be scared, you're not alone." But I knew already. And he was like, "You need to use a condom," and this and that… That was new.
>
> (Italy, capital city, 2013 (31), already-out)

Other participants reported that, while their discussions with older gay men did not cover disease prevention in detail, the encounters nonetheless provided them with an opportunity to explore thitherto undiscussed aspects of gay life, with potentially liberating effects:

> [My first sexual partner] was an older guy that I met before. We were talking about a lot of stuff, and he told me a few things. Maybe not the most important, but yeah, he told me a few things…about the gay world. About sex… Not *that* much. We didn't get in so much detail about disease prevention… I used a condom when I had sex with him for the first time. It

> wasn't my most romantic adventure, my most romantic first time. I just wanted to do it.
>
> (Romania, city, 2017 (25), coming-out)

> It was exciting [when I became sexually active at 17]. I guess I started by talking only. I would talk with older guys. (Laughter) That was really exciting. A few relationships here and there. Yeah, until I began versing, and then bottoming…
>
> I didn't know anything about it. There's nowhere you can see this, unless on porn, and porn just shows you- It doesn't show you everything… I didn't know anything. I just knew I wanted to do what these guys were doing. And I guess, the first three people I bottomed for didn't really tell me anything, they would just do their thing, get done, and I'd go home. Until I met one guy [who] showed me how to douche and showed me all this stuff… [He] taught me a lot that day. I guess all I knew was I knew about lube.
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

While these participants' "gay education" did not relate to sexual health directly, meeting other gay men provided them with an opportunity to discuss homosexual sex more openly, which was conducive to having more positive or neutral conversations about safer sex. Further research would do well to more clearly elucidate the links between "gay education" and sexual health perceptions and behaviours.

The potential for power imbalances and abuse was one aspect which emerged from participants' accounts of some intergenerational encounters, particularly when they occurred "in the shadows" (Odets, 2019) because of shame, stigma, or criminality. Somewhat unexpectedly, however, participants often spoke in highly positive terms about experiences that may otherwise be considered grossly abusive. As a researcher and a survivor of grooming, it was at times extremely challenging to accept the extent to which such

encounters were described in positive, even liberating, terms. (This tension, of course, gave me pause to reckon with my own positionality. On the one hand, it became much clearer to me the extent to which my assumptions of the risks associated with the "gay world" and intergenerational mentorship had been shaped by the emotional weight of traumatic experiences. On the other hand, I began to understand that some of my encounters with older mentors in the gay world had in fact been rendered "traumatic" by internalised, heteronormative understandings of intergenerational mentorship as necessarily inappropriate or unsafe.) One Polish participant recounted his first sexual encounter – which was, in legal terms, statutory rape – as a positive experience:

> He was 28… [I was] 13 and a half. In Poland, it is legal from the age of fifteen… I would say that everyone should have their first- or at least I remember it that way. Everyone should have a first time like I had, with everything included… It was very positive… I was like, "Ah, so that's sex." Like, "Yes. Can I see you tomorrow?" No, seriously, it was kind of- yeah.
>
> (Poland, city, 2005 (19), already-out, gravitational)

The participant made pains to explain that this, for him, had not been a scarring experience, but rather an educational one:

> I wasn't scarred by this, so I kind of just was, "Okay, so I want more," and I started looking for more guys… I was chatting with one of the girls at work, and she kind of said, "Oh no, I was waiting for my boyfriend, it was love," and stuff like that, and she was sixteen. I said, "Okay, but how was the first time?" She said, "Awful."
>
> I think if I might have gone with someone closer to my age or inexperienced…I might be in a similar situation. Maybe I would not be so open about being gay, and having sex, like I am at the moment. And he's

> had a big impact on this, that actually the sex with him was very good, I enjoyed it… I have chosen him because I have chosen him, and that's made…the journey much easier, I think, for me being gay.
>
> (Poland, city, 2005 (19), already-out, gravitational)

Having encounters with a more experienced older man made "the much journey easier…for me being gay", implying that, for this participant, it was a key moment of resocialisation outside of the "straight world". In a reversal of mainstream understandings of vulnerability and agency, the participant went on to speak in similarly liberating terms about encounters with a priest during his adolescence:

> I think I was 15 when…I had a fuck buddy who was a Catholic priest, he was 20 and good looking, I'd kind of chosen him… So, [I went to confession and] I kind of pretended that I have something on my soul, like I don't know how to talk about it, just to try to pull him. You see, I was 15, I was already so devious…
>
> And he was kind of openly gay. Because, you know, like, the churches have the living quarters at the back, and we were just easily walking, at the end of the night, or during the day…the cleaners, everyone kind of knew. Yeah. There was never any hiding.
>
> (Poland, city, 2005 (19), already-out, gravitational)

Once again, despite the clear ethical concerns that such an encounter would raise, the participant described it in positive terms, as a liberating experience that did not involve any of the usual "hiding". This may in part have been because his sexual socialisation in the "straight world" normalised the idea that sex happened this way in the "gay world". Interestingly, this participant also remembered this encounter as an important opportunity to learn more

about safer sex, because, to the participant's surprise, the Catholic priest – of all people – wished to use a condom:

> "Why are you using condoms?" "Oh, to protect myself." "So why don't you allow straight people to protect themselves?" "Oh, but they should not be having sex." "But shouldn't you either?"
>
> (Poland, city, 2005 (19), already-out, gravitational)

While encounters with older men were often narrated in positive terms, one participant exhibited a more ambivalent attitude. On the one hand, he described his first sex with a much older man in the following terms:

> I had my first sex with a man when I was 11 until 14. So, I was, like, groomed by this man, and some friends of his. I always say, and I don't have to say this because it's a little bit [grimace]… I always say that was the best sex of my life. But from 11 to 14 it was a lot of sex with this man who was much older than me, and his friends.
>
> (Italy, capital city, 2013 (31), already-out)

While the participant characterised it as "the best sex of my life", he also wished not to acknowledge that feeling "because it's a little bit [grimace]…", implying that his own understanding of what happened stood in tension with socially acceptable framings. The participant's feelings about the encounters did appear to change over time, and, as the interview progressed, he started to narrate the experience in more negative terms:

> It was quite painful… When I was 14 and I went there, he didn't want me because I was too old. And I remember at some point, he disappeared… And

> he appeared after, like, seven months, one year, and he said, “Oh, I travelled around the world.” And I realised, after, that maybe he went to prison.
>
> (Italy, capital city, 2013 (31), already-out)

Clearly, while many individuals learnt about their sexuality and, sometimes, sexual health, through experiences with older men, there was no guarantee that these interactions would be safe or empowering. Both the above participants, for example, acquired HIV in adulthood.

Whilst some participants’ understandings of formative experiences with older men may be challenging to accept, it is vital to make sense of the experiences of migrant MSM *on their own terms* if we wish to meet them “where they are at”. Without doing so, it will not be possible to correctly frame their sexual journeys and respond to their healthcare needs. I felt the difficulty of this task acutely, and accepting participants’ understandings of their sexual journeys on their own terms was, at times, no mean feat. After an interview with one participant, for example, I broke down in tears, before rushing home to be violently sick. I was ill for weeks; no cause was ever identified. The participant’s casual acceptance of what I felt as a violation was an affront, and a trigger, but it was also his lived reality. Indeed, while posing some psychological and physical risks to young MSM exploring their sexuality in restrictive contexts, intergenerational mentorship – which often took place in the shadows of mainstream society – was, for many, a positive experience that was central to their “gay education”.

5.4. Complicating outness as protective factor

In this chapter, I have explored the ways in which the heteronormative institutions of socialisation shaped the sexual health perceptions and behaviours of study participants in their places of origin. I have argued that participants’ temporal migrations – from presumed heterosexuality and reproductive temporality towards non-normative sexualities and new

temporal configurations – often commenced well before participants chose to relocate to London. These temporal shifts, which were patterned differently according to how and when individuals "came out", influenced and continue to influence participants' sexual health trajectories. The degree to which participants were visibly "out" influenced how they experienced the "straight world" and the "gay world". Importantly, outness was not revealed to be a protective factor in itself. Where individuals *temporally migrated* within restrictive contexts where a *critical mass* of gay ways of knowing and be(com)ing had not been reached, coming out in fact exposed them to several risks, not just in the "straight world", but also in the *shadow worlds* in which homosexual practices could take shape. As I will show in the following chapters, asynchronous *temporal* and *spatial* migration processes may pose other risks in terms of gay identity and flourishing (Chapter Six) and sexual health perceptions and behaviours (Chapter Seven).

In discussing the ways in which heteronormative institutions across borders reproduce certain understandings of the heterosexual life-course (Edelman, 2004; Halberstam, 2005), I showed how participants' formative understandings of sexual health and HIV were shaped by heteronormative educational, medical, and socio-cultural institutions of socialisation, which treated homosexuality as an "extra", if at all. Sex education curricula and educators – in both the global south and east, and north and west – were understood to reproduce heteronormative assumptions that placed participants on a reproductive timeline in the context of which discussions about non-normative sexual practices were foreclosed. For this reason, there appeared to be a pressing need to make sexual health curricula more inclusive of non-reproductive futures (O'Farrell, 2021).

Homosexuality was also often ignored or actively discouraged in formative healthcare experiences and public health campaigns, further exacerbating difficulties navigating safer sex. Similarly, participants' families often left participants with incomplete, unhelpful, or stigmatising sexual health perceptions and behaviours, thereby leaving those participants who became sexually active at a younger age ill-informed. Shame and stigma meant that

family discussions of sexual health often took the form of hints and coded messages that did little to change participants' sexual behaviours. While media sources were not guaranteed to challenge sexual health norms centring on presumed heterosexuality, other media sources were described in more positive terms as some of the only sources of inclusive and practical sexual health advice available. Given that educational, socio-cultural, and health institutions had limited success in transmitting key messages around safer sex and sexuality, some participants reported looking online. Interestingly, outness did not appear to make people more likely to conduct proactive research about sexual health in the absence of other sources. In fact, the inverse appeared to be true: *discovery migrants* often appeared to show interest in (and anxiety about) sexual health topics well before becoming sexually active, suggesting potentially fruitful avenues for further research into coming out and perceived candidacy for sexual health interventions.

The heteronormative lens through which instruction on safer sex and sexuality took place reinforced inaccurate sexual health perceptions and higher-risk sexual health behaviours, giving us pause to consider Odets' claim that the threat of HIV does not haunt younger gay men as it does older ones (2019: 106). HIV was commonly understood to be a "gay disease", a "death sentence", or an inevitability. Such understandings reflected heteronormative moralisations of homosexuality as wasteful or "the end of the line" (Bersani, 1987; Edelman, 2004; Halberstam, 2005; Rohy, 2009; Watney, 1987). Because of these moralisations, some participants reported relying more on ineffective precedent-based and trust-based lay epidemiologies, rather than on consistent safer sex strategies and regular sexual health testing. High levels of stigma caused other participants – particularly those who were already out or navigating the scene – to feel that HIV acquisition was unavoidable or deserved, and thus to fail to take protective measures. In a mirroring of misogynistic sexual decision-making norms, condom use was frequently reported to be difficult to navigate, with decisions often falling to "tops". Participants reported engaging in sexual health testing only when symptomatic, again mirroring the testing norms of

the “straight world”. Given the high rates of HIV and other STIs in London, these perceptions and behaviours place sexually active individuals at even greater HIV risk upon arrival (Evans et al, 2011; Burns et al, 2011; Mole et al, 2014). Whilst these perceptions and behaviours often shifted after moving to London, as I will show in the coming chapters, this shift was by no means immediate, suggesting that spatial shifts alone do not explain sexual acculturation after migrating.

Whilst all participants described their origins in institutionally heteronormative terms, it would be untrue to suggest that their places of origin were totally devoid of queer visibility and flourishing. Indeed, participants often complicated oversimplifications of their place of origin as a “perennial closet” by noting the various ways in which gay ways of life were visible there. Gay ways of life were sometimes visible even in the “straight world”, especially in communities that had experienced more travel and “exposure”. Furthermore, participants often described the “gay world” as a source of learning about sexual health, as well as of ways of knowing and be(com)ing that stand in opposition to reproductive timelines. Encounters with the “gay world” engendered both vulnerabilities and opportunities. While bars, clubs, and other gay spaces offered a forum in which sexuality and safer sex became acceptable and legible topics of conversation, their role in transmitting safer sex knowledge and behaviours was inconsistent, often taking the form of harmful gossip. Other participants – often earlier in their coming-out journey – explained that mentorship in private spaces, often from older sexual partners, was a key source of learning about sex and occasionally sexual health. In the context of widespread institutional heteronormativity, these imperfect sources of sexual health guidance were often more trustworthy and accessible than other sources available to them, thus their importance in shaping the sexual health perceptions and behaviours of young MSM in restrictive settings cannot be understated. Nonetheless, navigating sex and sexuality from places of invisibility also entailed the possibility of profound power imbalances and abuse.

In contrast, then, with the dominant narrative that being “out” or having gay or queer networks may increase sexual health knowledge and adherence to safer sex behaviours (Hammoud et al, 2019; Schueler et al, 2019), being out in their place of origin did not appear to protect individuals from deleterious health beliefs (Gios et al, 2019). Where individuals *temporally migrated* within restrictive contexts where a *critical mass of gay ways of knowing and be(com)ing* had not been reached, “coming out” in fact exposed them to several risks, not just in the “straight world”, but also in the shadow worlds in which homosexual practices could take shape. Given that those who were *already out* in their place of origin were often sexually active upon arrival in London – where HIV and STI rates are high – arriving with deleterious sexual health perceptions and behaviours is liable to increase the risks faced by migrants who are *already out* or who are otherwise ready to become more sexually active following their relocation. Furthermore, the potential vulnerabilities brought about by encounters in both the “public” and the “private” “gay world” in people’s places of origin reveal several ways in which “outness” – often assumed to be a sort of gold standard for queer fulfilment and wellbeing – may be a double-edged sword that potentially exposes people to greater sexual health risk. Indeed, access to gay people and gay spaces alone does not appear to guarantee gay flourishing in contexts where a *critical mass of gay ways of knowing and be(com)ing* has not been reached. In such cases, encounters are forced into the shadows (Odets, 2019), wherein power-knowledge imbalances abound, and norms and behaviours carried over from the heteronormative timeline go unchallenged.

If I may return at this juncture to the risk categories that emerged in *Consultation Room 7*, it appears as though one piece of the puzzle about the partial invisibility of risk dynamics falls into place. For, whilst my sexual partner’s “gay education” had been assured by the *critical mass* of gay ways of knowing and be(com)ing that surrounded him, the majority of my sexual encounters – both in my hometown and in London – had occurred “in the shadows”, because I was too ashamed to mix in gay circles or to accept a new timeline for myself. Consequently, I continued to hold inappropriate

sexual health perceptions and behaviours that were not made legible through the scripts available to the registrar with whom I spoke. Insofar as “becoming gay” often relies on a rejection of learnt ways of knowing and being (Halperin, 2012), the relationship between the length of time spent outside of home contexts and shifts in sexual health perceptions and behaviours cannot be understated. Had the registrar in *Consultation Room 7* had the conceptual tools with which to gauge the abrupt timeline shifts associated with coming-out journeys, the sexual health risks I faced following my arrival in the “big city” may well have been more legible to her.

6. Gay Identity and Belonging in London

"The reason for moving wasn't to do with sexuality… I think it just turned out that moving actually opened up my sexuality. I think had I not made that decision, it would've taken me an awful lot longer to find who I was."

English participant, village, 2008 (21), discovery

"[There are] middle-class migrants, ex-pats, as we like to call ourselves… And then there are these people who have been there for generations… We arrive at a certain point in our lives and probably most of us move on before then. I do realise that there is this parallel world going on under me, and they don't feel the sexual freedom or lack of judgment that I can enjoy in London, even though we're both living on the same street."

US participant, large town, 2016 (39), already-out, HIV care

In the previous chapter, I demonstrated that the sexual and sexual health journeys of my interlocutors were informed not only by the spaces they occupied – schools, family homes, gay venues, cruising sites, *etc*. – but, more importantly, by the temporal configurations associated with those spaces. Many participants' institutions of socialisation, for example, were spaces which were structured around reproductive framings of time, centring on certain milestones associated with heterosexual reproduction. In such contexts, common understandings of sex and sexuality were shaped by the perceived needs of heterosexual families and were often informed by a series of heteronormative or homophobic assumptions or stereotypes. I argued that exposure to gay spaces and gay intergenerational mentorship in participants' places of origin often facilitated access to ways of being and knowing that centred less on reproductive temporal expectations, which

sometimes helped participants in their coming-out journeys. However, given that gay ways of being and knowing were often forced into the shadows by hostile social or political climates, it was by no means guaranteed that exposure to the "gay world" in participants' places of origin would be a liberating experience.

In the next chapter, I will explore the ways in which sexual health perceptions and behaviours of my interlocutors shifted after migrating to London, exploring the ways in which these shifts were a result of temporal as well as spatial movements. Firstly, however, I explore in this chapter the ways in which the sexual *identities* of my participants shifted after migrating to London. In the first part of the chapter, I discuss the relationship between spatial migration and sexual identity. While it is my stated position that shifts in sexual identity cannot be explained in terms of spatial movements alone, it is necessary to discuss the significance of spatiality in shaping the coming-out journeys of my interlocutors. I will discuss the relationship between spatial movement and sexuality, complicating notions that they are necessarily unidirectional and liberatory affairs, and putting into question theories of queer migration that centre on intentional decisions to move to queer hubs in order to live more freely as out gay men (Gorman-Murray, 2007, 2009). I will discuss participants' range of motivations for moving to London, which only sometimes included the intention to come out or "be" out there. I will show that, whether or not participants moved to London in order to come out, most found that new aspects of their sexuality emerged because of the migratory process. I will also discuss how, because the concepts of "sexuality" and "mobility" were sometimes deeply intertwined in the minds of participants, it was not always straightforward to attribute a causal chain from spatial shift to sexual shift (*i.e.* changes in outness and visibility) or vice versa. I will show that, while sexual difference appeared to orient participants outwards – often towards the urban imaginary (Weston, 1995) – making them more likely to see migration as a viable option, some participants felt that it was only *through* migration that potential transformations were realised. I will also show, meanwhile, that realising

one's sexual difference in the first place appeared to depend on opportunities to see and move beyond the "straight world".

In the second part of this chapter, I will explore the ways in which participants made sense of their migrations in temporal as well as spatial terms. Given that simply moving to London did not in itself produce immediate shifts in outness and gay visibility, I will discuss the ways in which access to new spaces and contexts in which the reproductive temporal expectations and assumptions of previous times became replaced with new temporal configurations produced shifts in outness and, as I will show in the next chapter, in sexual health perceptions and behaviours. I will discuss some of the notable features of the temporally re-configured spaces and contexts to which my interlocutors were exposed after moving to London. I will show that participants often described London in terms of a change of pace, which allowed for more freedom to "make up for lost time" outside the temporal constraints on life in their places of origin. I will show that participants' nocturnal adventures often took place under the influence of substances, which further separated them from the rhythms of rest and recuperation associated with the (re)productive world, the embrace of belated childhood in place of a long-touted, supposedly desirable maturity (Halberstam in Dinshaw et al, 2007: 182). I will also show that moving to London was associated with certain situations or contexts of particular importance in the sexual and coming-out journeys of participants, such as starting university, moments of what I term "abrupt temporal shift". I will also explore the reasons for which some participants remained more attuned to reproductive temporality in London.

In the third part of the chapter, I will explore another face of London, understanding it as a community which, like all communities, is segmented. I will discuss the reasons for which participants felt certain segments of London were more gay-friendly than others, paying particular attention to the role of socio-economic status in shaping the coming-out journeys of both migrant and local MSM. I will also explore the ways in which London's workplaces served as sites of encounter with heteronormative or homophobic discourses. I will also examine the extent to which gay spaces and contexts

can prove deleterious to participants' sexual flourishing or self-discovery, paying particular attention to the role of anti-HIV and anti-asylum stigma in the lives of my interlocutors.

6.1. Spatial migration and sexual identity

While I contend that shifts in outness and visibility cannot be explained in terms of spatial movements alone, spatiality was nonetheless an often-important factor in the coming-out journeys of my interlocutors. Contrary to theorisations of queer migration that foreground individuals' intention to move to gay or queer "hubs" to live more freely (Gorman-Murray, 2007, 2009), the relationship between spatial movement and sexual shift was not always straightforward, nor were my interlocutors' migrations necessarily emancipatory in nature. While some participants – notably *coming-out migrants* and a *queer asylum-seeker* – described their migration to London in terms of an intentional decision to "come out" or to live as out gay men, most participants migrated for a variety of reasons, chief among which was *not* the decision to come out or *be* out. Furthermore, nearly all participants experienced a shift in outness as a consequence of migrating to London, with sexuality emerging in the wake of relocating (Carrillo, 2004; Mole et al, 2017), as well as sexual health perceptions and behaviours, as I will discuss in the following chapter. However, insofar as "coming out" and "moving away" were sometimes concepts which were closely related in the minds of my interlocutors, attempts to determine a linear temporal sequence from spatial shift to sexual shift or vice versa often failed, with neither chicken nor egg taking precedence. On the one hand, sexual difference appeared to orient participants outwards – often towards the urban imaginary (Weston, 1995) – making them more likely to see migration as a viable option, through which they became further transformed. On the other hand, realising one's sexual difference also appeared to depend on opportunities to see and move beyond the "straight world".

6.1.1. Queer migration as an intentional act

Some participants spoke of their migrations to London in terms of a desire to come out or to be out to more people, living more legibly as "gay men". Indeed, the story of queer migration has been most frequently characterised until now – as I argued in Chapter Two – by the *coming-out migrant*, fleeing the "perennial closet" in search of a better life in the "big city": a journey that certainly also resembles my own. Given that my own migration to the "big city" over a decade ago could most accurately be characterised a coming-out migration, I had to remain vigilant not to overlay my own migratory experience onto those of my participants during the analysis of their journeys. Nonetheless, seven of the 20 journeys explored in this study could be characterised as coming-out migrations, that is, journeys wherein individuals who are already aware of their gayness or queerness seek a better life for themselves elsewhere, where they can live as out gay or queer men. Gorman-Murray, for example, imagines sexual migrations as "embodied queer identity quests" (2007: 105), with coming out or being out underpinning the decision to migrate to implicitly emancipatory urban locations. Such were the stories of some participants with whom I spoke, particularly *coming-out migrants*:

> Yes, sexuality is a part of my decision to migrate, because, yes, this could be difficult there [in Poland]… I realised I was gay when I was 16, so that was quite dangerous… When I was 17, 18, I came out to friends, and when I was in this week in London, I came out to my sister and my brother.
>
> (Poland, village, 2010 (19), coming-out)

The desire to move away to live more freely often intensified when participants became sexually or romantically active in places where heteronormativity or homophobia were widespread:

> I always knew I wanted to move out of Uganda. I knew I was going to leave and not go back. I began thinking about leaving in A-level. I was sure that I wanted to leave so badly.
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

Participants who had made the conscious decision to migrate because of their sexuality often described feeling from an early age that they did not "fit in" in their places of origin, and that "getting out" was therefore inevitable. For these smalltown boys, "getting out" and "coming out" were broadly parallel processes, spatial migration the vehicle that allowed thitherto thwarted gay identities to flourish:

Participant:	I feel really uncomfortable there [in Poland]. I can't be there for a long time. That's not my country. I don't know why.
Interviewer:	When you were 19 [age at time of migration], was it your country?
Participant:	No. That's why I'm here.
Interviewer:	When you were any age, was it your country?
Participant:	No.
Interviewer:	You never felt like you fit in?
Participant:	Yes. I was quite unhappy there. There were no opportunities, and I was drinking a lot… I think I'm much happier here.

(Poland, village, 2010 (19), coming-out)

Of course, *coming-out migrants* often had a range of motivations for moving, but the desire to come out or be "free" was of particular importance.

The following participant, for example, explained how his motivations for moving to London differed from those of his heterosexual siblings:

> My brother and my sister were here [London] for about two years, three years, before I moved… It was all about money for them. There were opportunities here, and far better money.
>
> *I* was after freedom. More of this- Part of- To be far away from parents, for example, so I would have my life.
>
> (Poland, village, 2010 (19), coming-out)

There was a belief that, while many Poles who come to the UK for "general" reasons also return to Poland eventually, gay Poles – whose identities are often changed or affirmed by their time in London – rarely go back:

> Polish people migrate… That's general – it doesn't do anything with sex or sexual health or anything like that… But now they are going back. My family, my friends all went back to Poland. I'm alone.
>
> (Poland, village, 2010 (19), coming-out)

In this sense, London was seen as a good place in which to come out and be out, as implied by the following participant's surprise at the fact that his uncle, who lives in London, remains "in the closet":

> He is not as open as I am. So, even my grandmother, about ten years ago, she actually called him, or even later, or earlier, and said something like, "Why won't you come out to us finally? Why are you still hiding from us?" (Laughter) You think, "Come on, what's the delay now?"
>
> (Poland, city, 2005 (19), already-out, gravitational)

Participants sometimes suggested that gayness was more acceptable after migrating to the “big city”, even to figures of the “straight world”, such as the above participant’s grandmother. In this way, spatial migration to a queer hub was tacitly understood – in the “gay world” and the “straight world” – to sanction the act of coming out.

6.1.2. Sexuality as emergent

While some participants’ migration to London was motivated explicitly by their intention to come out or *be* out here, very few, if any, participants in general felt that they were able to be out to more people after relocating to London. New aspects of nearly all participants’ – including *coming-out migrants* – sexualities emerged following their relocation to London, meaning that their sexual identity changed as a result of the migratory process (Carrillo, 2004; Mole et al, 2017). Some participants – particularly *discovery migrants* – felt that their sexuality *emerged* through the spatial migration, that coming out only became an option thanks to “getting away” in the first place:

> The reason for moving wasn’t to do with sexuality. That was purely to do with the course, and I liked the place. I think it just turned out that moving actually opened up my sexuality. I think had I not made that decision, it would’ve taken me an awful lot longer to find who I was. I hope, touch wood, I would’ve done eventually, but I think it would’ve taken a lot longer. Because at that point, I was still very confused about my sexuality.
>
> (England, village, 2008 (21), discovery)

For these participants, then, a shift in felt sexuality was more a result of the migration than the key factor driving it. Coming out, for such individuals, was understood as a serendipitous arrival, rather than a long-awaited destination:

> Who did I come out to first? Probably my first boyfriend [in London]. (Laughter)… Because I was straight at the time. And he took me to like- where did he take me to? He took me to one of the clubs in London, and then I kissed him. And then, he stayed over mine, and then…
>
> (Wales, small town, 2012 (18), discovery)

While migration to the "big city" offered *discovery migrants* a means by which to discover new aspects of their sexuality, other "types" of migrant MSM also experienced shifts in their sexual identity. For *coming-out migrants*, for example, moving to London often prompted the seeds of sexual difference that had been sown earlier in their lives to thaw and, eventually, blossom:

> It [migrating] has changed me a lot. I'm not the same person.
>
> (Poland, village, 2010 (19), coming-out)

> When I finished school, I haven't really found myself, my sexual identity. Only after I moved to the US and I met gay people and I was, like, "Okay this is more…" I mean, as a child, I just knew I liked men. When you're 14 years, "Oh, maybe bisexual," and then really- once I was 17 years old, that's it. I can be- "Oh, I'm gay." Yeah.
>
> (UAE, large city, 2012 (17), coming-out)

> London obviously changed me a lot, for example I started being even more expressive. Like I didn't care anymore… I knew that no one was going to hit me on the road or anything like that, which in Greece never happened either, but it was a more possible scenario to happen, which is lingering in the back of your brain.
>
> (Greece, village, 2019 (18), coming-out)

Whereas the lingering threat of violence had previously discouraged the above participant from making his inner world visible, moving to London enabled him to externalise his gayness – to put it out there – for the first time. The sexual shifts associated with migrating to London were, for this reason, often also associated with shifts in gender expression:

> The main impression that I got is that it is nice that everyone can get to express their style here without any harsh judgement, I would say… I actually struggled a lot with it back in Greece.
>
> I do feel much more comfortable being myself here… I saw some men much more camp than me wearing much more feminine attire than me, and they still identified as men, and they were men. So, I realised, "Yeah, this is 100% true, a man can express a style that is not typically described as masculine and still be a man."
>
> (Greece, village, 2019 (18), coming-out)

While this research is more focused on questions of sexuality than gender expression, the two phenomena are evidently closely linked. For example, whereas queer practices had been commonly characterised as a denigration of masculinity in this participant's place of origin, he discovered that, in London, gender non-conformity appeared to be less of a threat to the social and sexual order. While I touch on them here, the complex relationships between migration and gender expression are worthy of further dedicated study.

Perhaps contrary to my expectations, those who considered themselves *already out* at the time of migration nonetheless often felt able to be out to more people in London, and to engage in more "gay practices". For some, *stated* sexual identity was sometimes understood to diverge from *felt* sexuality in certain locations. In this way, whereas the sexual identity of *already-out* migrants did not shift after moving to London, aspects of their felt

sexuality were re-calibrated. For the following participant, for example, the lights of London enabled him to live "as a gay man" proper:

> When I came to London in 2016, then I felt like I'm more obviously gay. I'd do more gay things… There was nothing to do in Pittsburgh anyway, there were two bars, and they were tragic. Why would I spend time in there?
>
> And at that point, I was just like, "Oh look, I can actually live as a gay man and do gay things, not just be 'I'm on paper gay', which is kind of how I felt.
>
> (USA, large town, 2016 (39), already-out, HIV care)

> I had to come to London if I want to do things. London really was the place to come for actually *being* a gay. (Laughter)
>
> (Greece, village, 2016 (24), coming-out, gravitational)

These participants' assessments serve as a valuable reminder that not all urban spaces served equally as "queer hubs", with Pittsburgh's "tragic" scene, for example, limiting the former participant's options and confining him to "on paper gay" status.

For some *already-out migrants*, sexuality in London became both more visible and less important to others, especially in the workplace context, with the act of "coming out" becoming irrelevant or obsolete, and heterosexuality no longer presumed as standard:

> The biggest difference – and I was already very comfortable with my sexuality when I moved – but it was moving into a space where if you introduce yourself as having a male partner or whatever, that's not even questioned and it's part of normal life… I never had to come out to anyone in the UK, or it never felt like coming out.

> When I started working where I did in Lisbon, I was comfortable with my sexuality…but I separated that from work. It all had to do with role models. There was minimal to no other openly gay, openly queer people at work. Whereas when I moved here, it wasn't even a question, I was like, "Yes, I have a partner," and have a beer, and then half of them are gay or whatever.
>
> (Portugal, capital city, 2020 (30), already-out)

It was often evident to these individuals that coming out was not a simple, once-and-for-all process (Lewis, 2012; Orne, 2011), but rather something that happened multiple times across the life-course as new aspects of their sexuality emerged:

> The coming-out had two phases. A very short one where I communicated to a few key relevant people in a few months, and then a second phase of a few years where slowly other people started to realise. On and off, someone would ask me directly.
>
> (Portugal, capital city, 2020 (30), already-out)

> When I came out at 19 or 20 or whatever it was- I could probably figure it out. It would have been second half of me being 19, was when I started coming out. And then…I did come out more.
>
> But then there was this weird thing that happened after a couple of years. I was kind of single for a year and then dated another guy, another year. I did somehow stop- I felt like I was less out.
>
> You know, I think it was still a complicated time, where tech- It wasn't that it was homophobic or something like that, but it was straight-coded. It was just like, "That's the default here, I'm not going to- I honestly just don't give a shit enough to bother." But I do feel then there was a time where I thought, "Gosh, I would actually need to come out to these people again." Because now they're new people, my networks kind of shifted. So, I feel like I became less out.

(USA, large town, 2016 (39), already-out, HIV care)

It is clear from the diverse stories of my participants that, far from arriving in London pre-queered, the city continued to shape them well beyond their initial emergence. For some participants, such as *discovery migrants*, moving to London was the vehicle by which homosexual desires were first realised. For others, moving to London enabled them to be out to more people and to engage more in gay practices.

6.1.3. Re-thinking "orientation"

Migration and identity formation remain strongly interlinked for many gay men (Lewis, 2014: 232). Insofar as "coming out" and "moving out" were sometimes deeply entangled in the minds of participants, attempts to map a linear temporal sequence from spatial shift to sexual shift or vice versa were often unsuccessful, with neither the chicken nor the egg taking priority. In this way, sexuality and mobility were, for some participants, not just correlated, but mutually, onto-epistemologically co-constituting. For these participants, non-normative sexualities only become knowable, learnable, and liveable through the act of spatial migration. Meanwhile, embodied sexual shifts produced new cartographies of safety and risk that de-centre national or urban boundaries and focus instead on contexts in which the "gay world" can flourish unhindered. Indeed, it was out of such re-figured cartographies that the concepts of gay and straight "worlds", unaligned with national borders, arose. These worlds did not just apply – as discussed in Chapter Four – to participants' places of origin, but also to their destination. Focusing less on qualitative aspects of the destination, and more on the act of migrating *per se*, some participants touched on the idea that queer people need to migrate simply because it offers them the distance necessary – literal and metaphorical – to re-discover themselves outside of heteronormative and/or homophobic contexts. Indeed, it is unsurprising that gender and sexual transitions are so often conceptualised as "journeys", and so often necessitate them too (Aizura, 2018). The following participant explained how

sexual difference oriented him outwards, towards the urban imaginary (Weston, 1995), making him more likely to see migration – through which he would become further transformed – as a viable option:

> I grew up in a pretty homophobic environment, in the sense it was East Texas, a lot of very religious people, the gays were fruits on TV at best. And I think you just come up realising, "I'm looking for something very different", and you imagine getting away from that for all that time. And then you just sort of realise that getting away and changing your environment is an option that you've always been aware of, that maybe other people aren't quite as aware of.
>
> (USA, large town, 2016 (39), already-out, HIV care)

According to this account, spatial shifts produce new lived experiences, while new lived experiences produce new possibilities, which are not *necessarily* sexual, but which *often* are. Of course, such shifts in lived experiences may also affect heterosexual migrants. The above participant goes on to explain how his identity was able to flourish only after gaining distance from arbitrary, "local anxieties":

> What are the benefits [of moving]? I'm not burdened by people making me feel awkward about my sexuality here, but I'm also not burdened by a lot of judgmental postures from other people about just everything. Because it's just a little bit easier, you don't see how judgment is coded quite so easily, when you come to a new place, I suppose.
>
> It's not that Britain or America is more free, or something like that, it's that, when you're in a different environment, it's easier. All of these local anxieties that people have, you realise their arbitrariness, when you're in a new place.
>
> (USA, large town, 2016 (39), already-out, HIV care)

"Moving away", especially to gay or queer "hubs", was often implicitly linked not just with coming out, but also with *being* more out, re-affirming that gayness is a way of life that must be learnt, usually away from home (Halperin, 2012). Speaking of his parents' perception that moving away "made him gay", as they had prophesised, the following participant gleefully embraced homophobic assertions that migration had corrupted him:

> I "arrived" [came out], and they weren't accepting. I think this had to do with- This suddenly became sort of a thing with their disconnection to- That I had moved away. When I was gay, it was like, "Oh God. See? This is what happens when you move away." (Laughter)
>
> (USA, large town, 2016 (39), already-out, HIV care)

However, as already noted, realising one's sexual difference in the first place depended on one's opportunities to see and move beyond the "straight world". Expanding further on his understanding of the relationship between outness and migration, the above participant explained that there is a need for young queer people to leave the "provincial" and "parochial" in favour of sexual and social autonomy in the city:

> Do I think I would have moved less, if I could have been out at home? Well, I think it really comes down to, do you see the benefit of being able to get away from those parochial, provincial kinds of priorities or anxieties, or whatever else around sex and relationships? But they're around *everything*. Maybe the underlying decision model is: there are enough of these stressors [violence, homophobia etc.] that it eventually pushes people to discover, "Oh, this is really good [away from home]."
>
> (USA, large town, 2016 (39), already-out, HIV care)

For this participant, sexual flourishing could not be achieved by staying put. According to such a conception, MSM who have insufficient opportunities to explore beyond the "parochial" may remain in a stated of arrested development, held *in stasis*, unsanctioned, between the norms of gayness and straightness. I will discuss later in the chapter how the emergence of new cartographies such as these may modulate access to "Gay London", throwing into question understandings of so-called "queer hubs" as utopias of gay men's flourishing. In the final section of this chapter, I will discuss how, for my interlocutors, London was not a singular, homogeneous place; rather, there existed multiple Londons across which pathways to "coming out" were very unevenly patterned.

6.2. Temporal migration and sexual identity

As I have already argued, spatial migration was associated with a shift in sexual identity for many of my interlocutors. However, participants did not make sense of their migrations in solely spatial terms; they also made sense of them in temporal terms. After all, simply moving to London did not produce immediate sexual shifts. Rather, access to new spaces and contexts in which the reproductive temporal expectations and assumptions of previous times became replaced with new temporal configurations produced shifts in sexual identity and, as I will show in the next chapter, in sexual health perceptions and behaviours. Because access to these temporal configurations was unevenly patterned, some participants' sexual identity shifted sooner than others'. There were several notable features of the temporally re-configured spaces and contexts to which my interlocutors were exposed after moving to London. Firstly, participants described London in terms of a change of pace, which allowed for greater exploration of new ways of life outside the temporal constraints on life in their places of origin. In the context of the "bright lights" of the city, participants had more freedom to "make up for" time lost during a closeted youth (Clemons, 2016). Participants' nocturnal adventures often took place under the influence of substances, which further separated participants from the rhythms of rest and recuperation associated with the

(re)productive world (Halberstam in Dinshaw et al, 2007: 182). Moving to London was also associated with certain situations or contexts of particular importance in the sexual and coming-out journeys of participants, moments of what I term “abrupt temporal shift”. Universities, halls of residence, and other educational spaces were often key sites in which participants felt safe enough to explore new ways of being beyond the reproductive timelines set out for them. Nonetheless, my interlocutors’ lives in London were not necessarily associated with a wholesale rejection of reproductive temporality. Many participants found more joy in day-to-day tasks of repair, regeneration, and reproduction than in the bursts of immediacy commonly associated with London’s nightlife.

6.2.1. A change of pace

While spatial migration could be said to have prompted sexual shifts among many participants, temporal shifts were also of great importance in their coming-out journeys. Many participants experienced a change of pace after moving to London, which allowed for greater exploration of new ways of life outside the temporal constraints on life in their places of origin. For many of my interlocutors, there was a sense in which life sped up in London:

> The pace here is just… When I look back at how many things have been done in my life, it’s just like I was 20, I don’t know, a year ago. I’m 35, almost… There’s definitely something in the city that makes it like, “Time flies here.” There are so many things to do, constantly busy, constantly doing something.
>
> (Poland, village, 2010 (19), coming-out)

> I don't know if it's a London thing or- Compared to Dubai, I think it does feel faster. You’re just- Your next steps are coming sooner, for example.
>
> (UAE, large city, 2012 (17), coming-out)

Participants did not always find adjusting to the fast pace of London straightforward, however, with London life often understood to be a double-edged sword:

> I was scared of coming to London… I was living in Aylesbury where everything was kind of slow, which I liked. But I would say now, “Where am I going? This is going to be every day. It’s a big city,” and all of this. But I dared to do it, and now I'm here.
>
> (Poland, city, 2005 (19), already-out, gravitational)

> Yes, I want to get out of London. I have a love-hate relationship with London. But the moment I am out in that countryside 24 hours later I am scratching at the walls saying, “Get me back into London.”
>
> (England, village, 2005 (21), already-out)

Indeed, while participants often relished the opportunities offered by temporal patterns that decentred traditional family life, many also acknowledged growing weary of the London “rush”. People in London were often understood to be disconnected from the rhythms of the natural world:

> Everyone is rushing. And you know sometimes I'm like, “Oh, just stop and smile for a second. Or just walk a bit slower. Walk fast but with a smile.” I don't know. And everyone is with a phone. Like, “This is how you enjoy life? Just being on your phone all day long. No. Just go outside. Enjoy the sun.”
>
> (Romania, city, 2017 (25), coming-out)

Some participants expressed a feeling that time was closely measured and counted in London, with several participants suggesting that it was necessary

to plan their movements here carefully. In this sense, London was associated with an altogether different kind of “planning” from that to which many participants were used. Where many participants’ socialisations had emphasised the needs of long-term “family planning”, planning in London was often a more day-by-day task. Participants frequently reported needing to do more planning in order to effectively structure their day-to-day lives in London:

> London, because things are more far away, I do have to be more organised about my time. I don’t necessarily spend more time at work but I spend more time commuting…
>
> So, I do organise my time differently, and it feels like it’s, I don’t know if that’s part of ageing, but I feel like in Lisbon I always had some friend around to do something. And now it feels like I have to book a month in advance… The day-to-day is a big difference.
>
> (Portugal, capital city, 2020 (30), already-out)

As in the case of the participant above, many of my interlocutors described their “productive” lives in London in terms of a monotonous drudgery. Quotidian routines were often recited like shopping lists punctuated with specific timings and numerical values:

> Ugh, in an average week I just work, mainly. So, waking up around 7:00 and working, coming back home around 5:00, then just some sort of lunch. I play games now. After that, Netflix and sleep.
>
> (Germany, small town, 2019 (23), discovery)

Tales of their “unproductive” lives, meanwhile, tended to be recounted with an altogether more spirited timbre. The flipside of the increased day-to-day planning associated with my participants’ “productive” lives was the

impulsiveness with which they often described leisure activities. Indeed, participants often described sexual encounters in London in terms of bursts of immediacy that broke up the otherwise dreary flow of time:

> I don't need to have sex for two weeks and suddenly I need to go. I need to go immediately, and this is what I do.
>
> (Poland, village, 2010 (19), coming-out)

These bursts of immediacy were explicitly linked to the need for some kind of "movement" to add "spice" to monotonous city life:

> Yes, [I will move] constantly… When I'm static or I'm bored in life, I need to change something.
>
> Maybe that's this kind of movement that I need, something to change, because when you've got this kind of static life, let's say, it's exciting to have something different. I think that's it… It's a way of adding spice to life.
>
> (Poland, village, 2010 (19), coming-out)

Just as moving to London was often associated with acceleration, participants described returning to their places of origin in terms of a deceleration. This return to slower rhythms was often understood to offer recuperation from city life, suggesting, as I will argue later, that urban "liberation" may be dual-edged:

> It's sometimes what I need [returning home] because I do life at a million miles an hour here, and I'm constantly tired.
>
> Back home, for example, I would spend all day on the settee, and not do anything, and sleep pretty much three days straight, just with the TV on in

> the background, and with your mother bringing you some food now and again. Doing the washing.
>
> And then, coming back, I think- I mean, weekends are usually very heavy. And then, I'm usually working a good eight hours-plus a day, Monday to Friday.
>
> (Wales, small town, 2012 (18), discovery)

It was not just their surroundings that were differently temporally configured when participants returned home. Participants frequently alluded to the idea that they somehow "reverted" or "regressed" to another time when they returned home:

> I think if I were to move back to Lisbon, I would revert to how I used to be because it just can work like that, I guess.
>
> (Portugal, capital city, 2020 (30), already-out)

> So being back in Warwickshire, that was a very- Even now, if I go to visit family, I suppose my behaviours would be very different. So, I almost regress back to that time, to a degree. Yes, my family are aware, and they're very accepting… But I don't talk about my relationships. I've started to talk about them a bit more recently, but not… They don't know about my casual past. I don't think my family would understand that concept. So, I suppose, in that sense, I've regressed back to that time.
>
> (England, village, 2008 (21), discovery)

The notion that my interlocutors might "revert" or "regress" when returning home would appear to confirm that spaces do not exist in themselves, but rather in conjunction with temporalities, together with which time-spaces or space-times, also known as "chronotopes", are constituted (Bakhtin, 1981; Barad, 2015; Eribon, 2009; Hadžimuhamedović, 2018).

6.2.2. Lost time, any time

Participants experienced time in new ways in London, the familiar routines and milestones of family life replaced with unpredictable and changeable patterns. This allowed for greater exploration of new ways of life outside the temporal constraints on life in their places of origin. London's nightlife was frequently associated with sexual openness and self-discovery:

> I knew how open London was. I had looked up about the life, the nightlife, and things like that. I knew that it was very open.
>
> (Greece, village, 2019 (18), coming-out)

Indeed, the "bright lights" of the city's nightlife were often used as a metonymic shorthand for "the pursuit of new opportunities". In this way, the queer imaginary remained rooted in urban spaces (Weston, 1995):

> I'm definitely not a country boy. I like the cities. I like the noise. Not so much the people, but yeah, the bright lights and just the opportunities. So that was the main driver for me coming here.
>
> (England, village, 2005 (21), already-out)

Although life in the city often dovetailed with their career or life goals, the new opportunities described by participants were frequently related to their newfound ability to discover themselves as gay men, particularly by night. Participants reported that many opportunities for self-discovery arose at nighttime, whereas, by day, their lives were often rigidly ordered:

> I was working working working, and I was always skint because I was always spending the money partying, buying things.
>
> (Romania, city, 2017 (25), coming-out)

> When I first came to London me and my ex-best friend would be going out Monday to Sunday. I would sometimes get home at 7:00. He would text me. “What time are we going out?” “No. Not tonight. I've got to concentrate. I've got to work. I need to be fresh for tomorrow.” An hour later, “See you in half an hour.” And that’s how it was. And we had a great time. Always going out.
>
> So, yeah, I think the initial 10 years of being in London I would say it was all about being very social. Going out. Meeting new people. Having a great time.
>
> (England, village, 2005 (21), already-out)

In the context of this onslaught of social and sexual opportunities, at all hours, some participants described feeling overwhelmed. Insofar as my interlocutors – like so many gay men – felt the need to “make up for” time lost during a closeted youth (Clemons, 2016), being released from the demands of reproductive time provided ample opportunities to “try every candy” in the shop:

> But yeah, coming to the UK from that, I was like a kid in a candy shop basically. Yeah, I just wanted to try every candy. (Laughter)
>
> (Bulgaria, city, 2010 (20), coming-out)

> London, I was like, “Oh my God, gays everywhere, all the time” you know. It was a big opening.
>
> (Argentina, capital city, 2011 (28), already-out, relationship)

The nocturnal adventures of my interlocutors often took place under the influence of substances. Alcohol was a feature common to many migrant MSM's tales of moving to London – especially at a younger age – playing a particularly important role in momentous occasions such as comings-out:

> All of my coming-out, alcohol and partying were involved in this.
>
> (Poland, village, 2010 (19), coming-out)

While alcohol generally reduces people's abilities to negotiate condom use and other health-seeking behaviours assertively (Allen et al, 2016; Wray et al, 2020), it was often viewed as somewhat salutary to the sexual exploration and flourishing of my interlocutors, particularly those who were in the earlier stages of their coming-out journeys.

Participants noted the proliferation in more recent years of chemsex contexts. While not always understood in negative terms, chemsex was generally understood to be more deleterious than alcohol to the mental and physical wellbeing of London's MSM:

> I would see myself doing chemsex every weekend…and it would make me really feel down after that, obviously.
>
> (Bulgaria, city, 2010 (20), coming-out)

Indeed, participants sometimes found it hard even to *be* in London without being drawn back into the world of chemsex:

> I was like, "Well, I need to stop this [chemsex] because it's not- I'm doing it every weekend. So, it's not healthy." And I would remove myself from- I'd go

> away for a month, and I wouldn't do anything. And then, as soon as I came back, it started again.
>
> It's like a double-edged sword. As much as it gives you, it also takes a lot. And if you're not careful, it can really go down the wrong path. (Laughter)…
>
> (Bulgaria, city, 2010 (20), coming-out)

Chemsex was understood to perpetuate and be perpetuated by the monotony of gay urban life, as the following participant implies when he claims "doing the same drugs" in the "same places, with the same people" is part of the (gay) "culture":

> For some people, that's their life. They know each other, so every weekend, they end up at the same places, with the same people… Doing the same drugs. And it's part of the culture. And it's like, "that's it".
>
> (Bulgaria, city, 2010 (20), coming-out)

With chemsex and partying happening at times usually associated with rest in the (re)productive world, the freeing up of time in the gay spaces of the "big city" often facilitated the emergence of a flattened, empty time, devoid of any "sacred" rhythms of rest or recuperation (c.f. Benjamin, 1942; Hadžimuhamedović, 2018). In this sense, the timelines of "Gay London" were not necessarily liberating; rather, they had the potential to lead participants, particularly those with fewer social networks outside of "the culture", into harmful patterns of behaviour.

Reflecting on the reasons for which chemsex has become a key part of gay culture, one participant explained – as discussed in the previous chapter – how the heteronormative institutions of socialisation greatened the need for substances to inhibit internalised shame:

> I do believe that, more than because of sexuality, it's [chemsex] because of the whole social context. The things that you have to experience being queer and growing up, those things make you very vulnerable towards drugs. They pretty much draw you there and they determine you going there because of isolation, because of the lack of communication. You're not actually getting to build that many meaningful bonds with your friends. You don't get to enjoy a romantic life that could be celebrated in the way that others can have it. You know? If you are 15 years old and you get a girlfriend, you are going to be celebrated and praised about that, but if you get a boyfriend, you are not going to be celebrated… I do believe that's why we are so drawn into degrading ourselves because we lose this notion of self-value.
>
> (Colombia, large city, 2025 (35), already-out, HIV care)

This participant's claim that a lack of positive self-regard causes some MSM to engage impulsively in chemsex echoes research on the ways in which MSM may engage in sexualised drug use to reduce feelings of shame and distress (Smolenski et al, 2011), which leads to greater sexual risk-taking (Ross et al, 2011) and higher chances of acquiring HIV (Koblin et al, 2006). As I will show in the following chapter, the potential risks posed by initial exposure to such spaces may render shifts from heteronormative to queer environments as dangerous as they are liberating (Mole et al, 2014; Gios et al, 2019).

6.2.3. Moments of abrupt temporal shift

As I have shown, moving to London facilitated a change of pace in the lives of many of my interlocutors, as well as providing opportunities for many of them to "make up for lost time". Further to this, moving to London was also associated with certain situations or contexts of particular importance in the coming-out journeys of many participants, moments of what I term *abrupt temporal shift*. Universities, halls of residence, and other educational spaces were often key sites in which participants felt safe enough to explore new ways of being beyond the reproductive timelines set out for them. This is

because universities were understood to be very open-minded and “queer” places in which it became much easier for participants to disclose their sexuality:

> So, the first couple of weeks, in the halls, everyone around me was super queer. Even the teachers, the professors, and all that. So, for me, it was like, “Oh, that’s quite cool. Maybe I should be straightforward with people, and tell them that I’m gay as well.” And I remember- because the girls were already- (Laughter) Everybody was like super flirty, especially the first two weeks. It’s like everybody’s getting to know each other.
>
> (Romania, city, 2017 (25), coming-out)

> I moved into halls of residence. We were sat there, in the flat, on the first night, and we were introducing ourselves, and talked a bit about ourselves. I remember, for the first time, I said, “Hi, I’m [redacted], blah, blah, blah, and I’m gay.” That was the first time I’d actually said it. That was a very liberating moment, I think, and I think that was a very defining moment in my life.
>
> (England, village, 2008 (21), discovery)

> Some people would come out during uni. I feel like some people, obviously, it takes longer. Sometimes, you need, yeah, more time, or sometimes you just need to be surrounded by the right people, the right crowd, and you feel comfortable, and you do it. And if you don’t have that, I guess then you might stay in.
>
> (Poland, large town, 2013 (21), coming-out)

The start of university was associated not just with coming out; it was also the moment of some participants’ first sexual encounters:

> The first day immediately I had a group of friends. And there's one guy in there who was gay, and he was out. I think the first weekend, I just told him I was gay. Then that was my first sexual experience.
>
> (UAE, large city, 2012 (17), coming-out)

Often noted, too, was the perception that universities were filled with young queer people “in the same position” as my interlocutors, who had made journeys to “the big city” in search of more:

> I met people at uni who were studying fashion. They were going through, like, really, the same thing that I did… I met, yeah, more people that were in the same position, in a way. Left smaller cities, usually, went to a big city to start uni, whether that was fashion or not fashion related.
>
> (Poland, large town, 2013 (21), coming-out)

There were limits, however, on the abrupt temporal shifts associated with starting university in London. While moving to London was associated with a change of pace and the removal of many reproductive milestones, even gay urban lives could be put on hold by cyclical calendars, as the following participant expressed in relation to his first Christmas holiday of university, which he had been eager, with his newfound freedom, to spend away from home, only to discover that even London stands sometimes still and empty:

> I was just so keen to make it here, and I was avoiding all contact with Bulgarians. Because I just wanted to immerse myself fully. So, I decided to not go back home for Christmas. I decided to stay in halls. And that was the worst decision ever. Because it was too soon. I was like, “I’m not leaving. I’m going to stay.” And yeah, everybody left. (Laughter) And I had no idea that the shops would be closed. So, I actually couldn’t buy any food. And I think I

> had Pot Noodles on Christmas, just by myself. I was like, “Oh, my God, how did I do this to myself?” And I was just in a really low state of mental health, at that time. And I think I did some very stupid things, I feel like. Yeah, I met guys that I shouldn’t have met.
>
> (Bulgaria, city, 2010 (20), coming-out)

The isolation experienced by the above participant during a moment of “abrupt temporal shift” had important implications for his sexual health decision-making, as I will go on to discuss in the following section. This story, incidentally, resonated strongly with my first Christmas of university. While all my straight friends were impatient to return to their hometowns for this sacred moment in the family calendar, I remained, alone, aghast, in London, the place to which I had, until that moment, assumed we had all been running for similar reasons (to seek refuge from stultifying family timelines). Instead, something fundamentally different about my “way of life” was revealed (Halberstam, 2005; Halperin, 2012; Foucault, 1996).

Another moment of abrupt temporal shift came for some participants when they received an HIV diagnosis, an event which sometimes caused a sudden recalibration of their life goals and milestones. The following participant, whose HIV diagnosis in London prompted him to embrace a more fatalistic approach to life, explained the renewed importance he placed on “living in the moment”:

> At that time [of diagnosis], I was thinking, “You know what? I will die soon, so I should enjoy my life.” Yeah, so I started to have more fun, to do the things that I enjoy. I was thinking, “So I have only one life. And this one I don't know how long it will be. At least I should enjoy it. I should do things that I have never done.” Even now, I think the same, because this is the truth. We only live once.
>
> (Romania, city, 2017 (25), coming-out)

For the above participant, a *longer* life did not necessarily equate to a *better* life. His rejection of a longer life for its own ((re)productive) sake also implies a re-evaluation of *death* not just as a physiological reality, but a metaphorical one too, that is, the queer death engendered by gradual, often unconscious concessions to heteronormative institutions (Bateman, 2017). In this sense, abrupt temporal shifts in the city – even those prompted by an HIV diagnosis – were capable of sparking new *life* among my participants.

6.2.4. Remaining attuned to reproductive temporality

It should be noted that my interlocutors' lives in London were not necessarily associated with a wholesale rejection of reproductive temporality. Many participants found more joy in day-to-day tasks of maintenance, repair, and regeneration than in the bursts of immediacy associated with London's nightlife, which were not always viewed in positive terms:

> There is a lot of chaos here. People lead very nihilistic lives. They are very much disconnected from life itself, like, yes, you go to work and then, because you have to find an outlet for that, you go into sex and drugs.
>
> (Colombia, large city, 2025 (35), already-out, HIV care)

For participants such as these, there were many ways to "enjoy the moment" in a place like London:

> I mean I'm getting old, and I'm a bit quieter now. I still think that we only live once and we should enjoy it, but I enjoy it in a different way now. It's not like I'm going clubbing every weekend. Because I feel like I've done it when it was the time. Now I should focus on something else. I should enjoy life in a different way.
>
> (Romania, city, 2017 (25), coming-out)

Indeed, several participants, particularly older participants, did not find life in London to be incompatible with reproductive temporality, insofar as "maturing" or "settling down" was not always seen as undesirable, especially for those who had had ample opportunities to explore the "gay world". Many of my interlocutors saw London – where they felt safe and comfortable, sometimes for the first time – as a place to "put down roots":

> [I've had a] Very mobile life. And part of London now is putting down roots somewhere. There were these moves that were basically career-driven, including the one to London. But I also was like, "I need to put roots down somewhere, I don't want to chase the next whatever." Because I kind of realised that it's kind of nice to have a career you're invested in, but it's not all that I wanted from life. So, I felt London- It was a combination of it is a good job that I came here for, but it could be long-term, if I wish.
>
> (USA, large town, 2016 (39), already-out, HIV care)

> Yeah, started off partying really, really hard. It was all new. Bright lights. A great time. But now I've really, really calmed down.
>
> It has slowed down. I very rarely leave the house, because I have no reason to. I just can't even bring myself to just go out for a walk. I just can't do it. I love buying stuff for the house. I love all the little useful things for the kitchen. And some of them I just use them once when I buy then, just to try it.
>
> (Romania, city, 2017 (25), coming-out)

Far from accelerating their day-to-day lives unrelentingly, the above participants felt that London opened up space for them to "enjoy life in a different way".

As already noted, many participants associated returning to their places of origin with a decelerated pace of life and an increased attunement

to reproductive temporal rhythms. What is more, however, several participants appeared to welcome the switch back to reproductive timelines in their places of origin, as the following participant implies when discussing how he was confidently able to stop taking PrEP during “family time”:

> I visit them [family] in May for two weeks and then I always come for Christmas, also two weeks, late December… It’s just family time. Just family. I even go off PrEP. I’m- nothing, right? I don’t plan to have any sex while we’re all there, and I don’t really want to.
>
> (Germany, small town, 2019 (23), discovery)

Other instances of participants remaining attuned to the reproductive timelines of family life after moving to London arose through discussions of HIV diagnoses, insofar as some participants reported expressing grave fears that they would not be able to have children in the future:

> I remember the doctor said, “What if it is positive?” The first thing I said was, “Yeah, it means I'm going to die.” She's, like, “No, you live a normal life” … And my next question was, “But I'll never have children.” And then she was, like, “Actually, no, nowadays there's this thing called sperm washing where you take your sperm and then you somehow make sure there's no HIV.”
>
> (UAE, large city, 2012 (17), coming-out)

> I really want to have children one day. That was a big concern at the time. That was one of my first questions, on the phone, actually. I said, “Can I have healthy children, or will I necessarily transmit the virus?” I know, now, that I do not transmit the virus. They immediately told me like, “No, once you get undetectable there is no risk of transmission to the children.”
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

Clearly, there was no guarantee that participants would be more attuned to queer temporality than reproductive temporality, nor was it guaranteed that they would find the former temporal configuration more liberating. This finding gives cause to challenge understandings of queer temporality as necessarily emancipatory in nature (c.f. Halberstam, 2005).

6.3. One city, many worlds

I have argued that the sexual shifts that occurred after participants moved to London can be explained in temporal terms, as more or less sustained moves away from spaces associated with heteronormativity and reproductive temporality. London, however, was not understood as a unitary, homogeneous entity; rather, like all communities, it was segmented, and certain segments were more gay-friendly than others. In other words, London was no gay paradise. Participants often highlighted that there were multiple different Londons, within some of which gay or queer liberation was far from guaranteed. The coming-out journeys of both migrants and locals were often felt to depend on social class in particular. Participants often felt that their workplaces were key sites of encounter with straight (or closeted) people who reproduced heteronormative or homophobic discourses. It was not only predominantly straight spaces that could prove deleterious to participants' willingness or ability to come out or *be* out, however. High levels of HIV stigma were still reported from within London's gay world, and anti-asylum stigma was also noted.

6.3.1. Parallel worlds

Participants often pointed out that there was not *one* London, but rather multiple Londons, within some of which gay or queer liberation was far from guaranteed. While London was, for many, associated with sexual flourishing and self-discovery, it is important to note that not everyone was willing or able to access "Gay London" in the same way. This perhaps obvious point is central to demonstrating that places are not liberating in themselves; rather, gay or queer flourishing may depend on other factors that

mediate the way places are experienced. Factors like social class, for instance, were often seen to shape the coming-out journeys of both migrants and locals, as the following participant noted:

> It also has to do with, I believe, the socioeconomic context that you belong to… I was reading a book and there was this huge line in which it said, "The difference between being a senior homosexual and being a *pobre marica*" – which is like a poor, queer kid – "is just the size of the numbers in your bank account." And I do believe that's true.
>
> (Colombia, large city, 2025 (35), already-out, HIV care)

Indeed, while London was the site of a prolific "gay world", my interlocutors often suggested that few native Londoners were socialised in this world, with working-class Londoners often understood to be the furthest away from it. The following participant, who, as I discussed earlier, felt that moving away was central to gay flourishing, explained his belief that "local lads" often struggle to access the "queer temporality" associated with "Gay London":

> I look at these people, like this guy is secretly gay, but is one of the local lads, grew up on the estate. I think if he gets out and goes somewhere else, he could easily become another living that queer temporality. But I don't think he could do it in London. He needs that distance, is the thing… That he would feel capable of finding that anonymity that facilitates that with a lack of judgment.
>
> (USA, large town, 2016 (39), already-out, HIV care)

According to these participants, access to the "gay world" depended more on factors like class and income than nationality. Indeed, as I argued in the previous chapter, the gay world was often understood to transcend national borders. The following participant explained his belief that working-class

Londoners lack access to the “gay world,” a world which he understood to be inherently privileged and trans-national in nature:

> You have these middle-class migrants, ex-pats, as we like to call ourselves. The sort of people who book Airbnbs that all look the same wherever they go. And then there are these people who have been there for generations. We don’t know what it’s like for them. I do realise that there is this parallel world going on under me, and they don’t feel the sexual freedom or lack of judgment that I can enjoy in London, even though we’re both living on the same street, in some cases.
>
> (USA, large town, 2016 (39), already-out, HIV care)

The participant here juxtaposes two worlds: on the one hand, there is the trans-national gay world in which sexual freedom can flourish, on the other, a parochial world of “local anxieties”, to re-cite an earlier quotation from the same participant. In this juxtaposition, the gay migrant starts to seem less like a nomad than a settler, enjoying more sexual freedom than socioeconomically disadvantaged “local lads”. Expanding on the idea of parallel worlds each with their own independent timeline, the participant explained that the ostensibly obvious gayness of Islington’s migrant MSM was hidden in plain sight for people from worlds where gayness was unrecognisable:

> I have some friends who grew up on the housing estate in Islington, that will probably live in that flat for the rest of their lives. He is not gay, but he’s very curious about gay people. And he’s always like, “Oh, I found out one of my school friends is gay,” and being super-secretive about it. His dad would be freaked out about this, and all this.
>
> And I’m like, “Well… weirdly, there are all these people around here who have moved here” – Islington is full of American gays. And it’s like these two parallel lives, that we just- It’s so easy to just completely be oblivious to other

> people. And the longer I stay here, the more conflicted I am, frankly, about that situation.
>
> (USA, large town, 2016 (39), already-out, HIV care)

The vastly different sexual worlds experienced by migrants and locals indicate the ways in which migrant status *tout court* may not be enough to determine vulnerability among London's MSM. Other characteristics, such as wealth, education, and class, all colluded to determine how accessible "Gay London" was.

It should be noted that participants did not only describe London as having multiple layers, but also Britain more broadly, as well as, indeed, their places of origin. Descriptions of Britain's north-south divide echoed those of similar divides in other countries:

> I did actually live up North as well, in the UK, and definitely, you can see that divide.
>
> (Poland, large town, 2013 (21), coming-out)

> There's Poland A and Poland B. So, if you look at it from Gdańsk, Warsaw, kind of going south, anything to the west is Poland A, and they tend to be…socially very more progressive. And anything from Warsaw to the right, towards, like, Belarus and Lithuania, there is always Poland B… Poland B was occupied…by the Russian Empire. The west was occupied by Prussia and Austria-Hungary.
>
> (Poland, city, 2005 (19), already-out, gravitational)

Other participants, meanwhile, noted how rural-urban divides echo one another beyond national borders:

Participant: When in Poland, I'm in the village, in the middle of nowhere. So long – I'm so bored there, there is nothing to do.

Interviewer: And if you were in an English village?

Participant: Very similar.

(Poland, village, 2010 (19), coming-out)

Life in rural places across borders was usually associated with far more internalised homophobia than life in the city, as exemplified by the following two participants' descriptions of returning from the "big city" to their hometowns:

Interviewer: So, there's still maybe some sense of shame, of hiding, when you go back?

Participant: For me? Yes. And from everyone else, yes. Yeah, from both angles, really.

(Wales, small town, 2012 (18), discovery)

When I moved back, it wasn't so much that I couldn't continue to be openly queer, which I could, it was just that the other queer people that I would meet would be very, in a way, narrow-minded even towards themselves. And I was single back then and to find other people to relate to, to have sex, to whatever, was nearly impossible.

(Spain, small town, 2005 (17), discovery)

While the former participant still felt the need to hide his sexuality upon return to his place of origin, city life had re-socialised the latter participant in such a way that, on return to his hometown, he no longer expressed his sexuality in the same ways as before.

6.3.2. The workplace

The workplace was often a principal site of encounters between migrant MSM and straight (or closeted) people who reproduced heteronormative discourses, but who also often expressed curiosity about homosexuality and viewed migrant MSM as teachers. One Polish participant explained this in relation to a prior workplace outside of London, once again implying a link between heterosexist worldviews and rural upbringings:

> The office was in Tring, and the people working there were mainly people from the two villages. They didn't make me feel bad, or anything. Actually, they were all nice people. But one day, the head of the warehouse…took me aside, and he started asking me questions just about being gay… He was brought up by his father as a white man, you know, with a van, kind of going to the pub, calling "poof", and stuff like that, but when his son was born, he started…thinking about…if his son would be gay, or "like me", he would not want his son to go through that kind of name calling.
>
> (Poland, city, 2005 (19), already-out, gravitational)

In another reversal of common understandings of vulnerable migrants learning from empowered locals, the participant explained that he welcomed the possibility to help his colleague (and potentially his colleague's son) on their sexual journeys:

> I said, "My God, ask me questions, I will tell you everything," after he said stuff like that, because you could see kind of growth in those people. I was like, "Dude, literally, ask."
>
> (Poland, city, 2005 (19), already-out, gravitational)

Unsurprisingly, many participants expressed a belief that straight co-workers were generally not *au fait* with gay and queer issues. Indeed, workplaces were described as sites of stigma more frequently than as sites of learning, particularly where sexual health and HIV were concerned:

> One of my bosses was talking to me in the gym, “Why do you go all the time [to the clinic]?” “Because I need PrEP.” “Are you HIV positive?” I know he didn’t do it in a bad way, but you can imagine if I was really HIV positive… They’re not sensitive. Even when you’re a manager… I think gays are more…sensitive about this kind of thing.
>
> (Argentina, capital city, 2011 (28), already-out, relationship)

Indeed, participants frequently spoke of feeling unsafe to disclose their HIV status – and, sometimes, their sexuality – in the workplace:

> My status and my career are two completely separate things that should not- There's no need…
>
> (UAE, large city, 2012 (17), coming-out)

The decision to avoid workplace disclosures was understandable in the context of the discrimination often reported by participants. Indeed, one participant explained how both his sexuality and his HIV status had been sources of workplace discrimination for him:

> I've had two problems since I've been in London regarding- One my sexuality. That was way back in 2006. I had a massive, big argument with the company at the time. And then, very recently, and this one stung the most, I was working for a company… I was the top performer. Always getting the biggest bonus out of the entire team. And the day I got HIV, I became

> enemy of state. And they gave me a settlement agreement and told me to fuck off, basically.
>
> (England, village, 2005 (21), already-out)

Interestingly, workplace stigma was noted even in gay-dominated industries like fashion, as the following participant noted:

> I've been in a situation where people were talking about it [HIV]… Because they didn't know that I'm positive, I didn't want to come across like I know everything about it. But, sometimes, I really regret that I didn't react to the information they were spreading. It was crazy… These were gay people…
>
> I don't want to be judgemental. I could be that, so I don't want to judge, because if I wouldn't be exposed to what I'm exposed to, it could be that I don't have the knowledge that I have now. So, because they didn't have experience of that, maybe they don't have the right knowledge, and they don't feel like they should educate themselves.
>
> (Romania, city, 2017 (25), coming-out)

While the above participant expressed frustration at the HIV misinformation spread by his gay colleagues, he also expressed sympathy with their positionality, acknowledging that a lack of HIV knowledge is explicable in terms of a blameless lack of exposure to the topic among people not on queer timelines.

6.3.3. Out on the scene

It was not only predominantly straight spaces that could prove deleterious to participants' willingness or ability to come out or *be* out. Most notably, high levels of HIV stigma were still reported from within London's gay

world. One participant explained how the “shameful,” stigmatising behaviours of “the gay community” caused him to “disassociate” from his gay identity:

> The gay community as a whole. I wouldn’t say the ones that campaign for HIV rights etc. and HIV awareness. They’ve definitely got their head screwed on a lot better. But if I went to Soho now and said, “Oh, by the way, I'm undetectable,” I can guarantee you that their backs would be turned on me instantly… You will probably find two or three people out of a hundred that will say, “Yeah, it’s not a problem. Are you taking your medication? Undetectable? Fine. No worries.” But the vast majority…
>
> When I was first diagnosed and getting all of those knockbacks constantly, constantly being blocked on Grindr, then not telling them, and then when I'm on WhatsApp telling them, being blocked and removed, I just find that behaviour so shameful. And I just find, forgive me, the gay community the world’s biggest fucking hypocrites when it comes to this subject. And that’s why I've disassociated myself from them.
>
> (England, village, 2005 (21), already-out)

Indeed, participants frequently described hiding their status not just from their sexual partners, but also from their social circles:

> I don't say it, not even my best friend. No-one knows… I don't talk about it. I have maybe some internal shame or stigma. My family doesn’t know… There are no friends that know. I just told it once to one friend. More than a friend, it was here in London, an Italian, we were just dating, and they disappeared.
>
> (Italy, capital city, 2013 (31), already-out)

Understanding HIV stigma to persist particularly in the “straight world”, the following participant explained how he used his own erstwhile stigma as a

benchmark from which to predict how straight friends might react to HIV disclosure:

> Not even friends, I don't. If I do say, there's going to be this big shock… Most people, especially straight people, I don't know what stigma they have, but I also used to have the same stigma of what people who are positive are. You think it's dirty, for example. It's the same, when people ask about, "Are you clean?" when they mean HIV.
>
> (UAE, large city, 2012 (17), coming-out)

Even where participants described friends as supportive and understanding, their fears remained strong enough to prevent them from disclosing their HIV status, even to other gay friends who shared their own sexual health concerns with them:

> I had some friends, they told me they are HIV, and I didn't say about me. I just listened to them.
>
> (Italy, capital city, 2013 (31), already-out)

> My best friend, he's gay and whenever he has a sexual health problem, he always comes to me. We've spoken about HIV as well. He doesn't know. But I think it's more, like, maybe I'll be scared if he speaks to people or tells me, I don't know, or one day if I'm not friends with him again, that he knows this information about me.
>
> (UAE, large city, 2012 (17), coming-out)

The following participant remained adamant, however, that the inability to be open about is serostatus with friends was not a problem, even though it was something which would come to bear – according to him – on his life-course:

> They don't need to know. I'm not fucking them… It's something that doesn't affect me at this stage of my life. I take my pill in the morning, I don't think about myself as an HIV person. I know that I'm going to live 7 years less, 10 years less than others.
>
> (Italy, capital city, 2013 (31), already-out)

As a result of HIV stigma from within the gay world itself, many participants with undetectable viral loads found it simpler not to disclose their status on hook-up apps, a behaviour that was felt to have become even more common since the introduction of PrEP:

> I didn't put in my profile that I'm positive… There were all the time a lot of people on dating apps saying they're negative on PrEP. I don't know, to be honest, if they were on PrEP or they were just undetectable, they were on treatment, and they say they are on PrEP… They ask me, "Are you on PrEP?" "Yes." I mean I'm not on PrEP. I'm just on medication… I know my status, I know that I am undetectable, I don't pose a threat for transmission… This is 100% my own issue, not theirs.
>
> (Romania, city, 2017 (25), coming-out)

It was not only HIV stigma that was associated with London's gay population, however. As well as experiencing significant stigma around HIV, the following participant also explained the ways in which stigma around asylum-seeking impacted his sex life in London, for example, by prompting judgemental questions about his temporary accommodation:

> People are very judgmental… I know people have a lot to say about it [asylum hotels]. I don't want to be judged by that. So, I don't mention it a

> lot… I always say, “Oh, I travel,” because I don't want you coming to the hotel and asking, “Why? What’s all this? What’s with all the security?”
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

The participant lamented the degree to which other gay people continued to make assumptions about him based on his immigration status, challenging the simplistic, gay liberationist notion that gay men would necessarily want to move to a more “enlightened” place like the UK (c.f. Carrillo, 2017):

> I'm trying to…get out of that bracket of asylum. I don't like that. Being put in that bracket, like “asylum seekers”, you know? Everyone thinks, “They have left their country because they have nothing, they have come here for.” I have left a very good life back home, because of who I am, because I don't want to be arrested. In a heartbeat, I would love to go back home. If I could find a way to be straight, I would go back…
>
> It’s the best in Uganda, it’s better than anywhere else. I grew up, hiding who I was, my sexuality. So that’s the downside, but everything else was fine.
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

Clearly, then, London was no paradise of gay and queer flourishing. Rather, participants continued to experience multi-dimensional stigma from both the “gay world” and the “straight world”.

6.4. “Critical mass” in the gay hub

In this chapter, I have examined the ways in which participants’ sexual identities shifted after migrating to London, and how this shaped their sense of belonging in the “big city”. I have shown that, while shifts in sexual identity cannot be explained in terms of spatial movements alone, spatial migration continued to be central to some of my interlocutors’ coming-out journeys, in

particular *coming-out migrants* and a *queer asylum-seeker*, who described their migrations to London in terms of an intention to come out or "be" out there. Such accounts resonate broadly with theories of gay migration that centre on intentional decisions to move to gay or queer "hubs" in order to live more freely as out gay men (Gorman-Murray, 2007, 2009). Nonetheless, the relationship between spatial movement and sexuality was not always straightforward, nor were my interlocutors' migrations necessarily liberatory affairs. Furthermore, most participants found that new aspects of their sexual identity or sexual practices emerged because of their migration to London, whether or not they moved there with the intention of coming out. However, complications emerged when attempting to determine whether spatial movement or "sexual movement" came first in the causal chain, as the concepts of "sexuality" and "mobility" were often deeply intertwined in the minds of participants, and were therefore hard to disentangle. While sexual difference appeared to orient participants outwards – often towards the urban imaginary (Weston, 1995) – making them more likely to see migration as a viable option, some participants felt that it was only *through* migration that potential transformations were realised. Meanwhile, realising one's sexual difference in the first place also appeared to depend on opportunities to see and move beyond the "straight world".

In the second part of this chapter, I explored the ways in which participants made sense of their migrations in temporal as well as spatial terms. Given that simply moving to London in itself did not produce immediate sexual shifts, I discussed the ways in which access to new spaces and contexts in which the reproductive temporal expectations and assumptions of previous times came to be replaced with new temporal configurations that produced shifts in sexual identity. There were several notable features of the temporally re-configured spaces and contexts to which my interlocutors were exposed after moving to London. Firstly, participants often described London in terms of a change of pace, which allowed for greater exploration of new ways of life outside the temporal constraints on life in their places of origin. In the "bright lights" of the city, participants had more freedom to "make up for" time lost during a closeted

youth (Clemons, 2016). Participants' nocturnal adventures often took place under the influence of substances, which further separated participants from the rhythms of rest and recuperation associated with the (re)productive world. Furthermore, moving to London was associated with certain situations or contexts of particular importance in the sexual and coming-out journeys of participants, moments of what I term "abrupt temporal shift". Universities, halls of residence, and other educational spaces were often key sites in which participants first felt safe enough to explore new ways of being beyond the reproductive timelines set out for them. Nonetheless, my interlocutors' lives in London were not necessarily associated with a wholesale rejection of reproductive temporality. Many participants found more joy in day-to-day tasks of maintenance, repair and regeneration than in the bursts of immediacy commonly associated with London's nightlife.

In the third part of the chapter, I argued that London was far from a gay haven; rather, like all communities, it was segmented, with certain segments being more gay-friendly than others. I discussed the ways in which my interlocutors made sense of the relationship between socioeconomic status and outness among native Londoners. I showed that the coming-out journeys of both migrants and locals were often felt to depend on social class in particular. I showed that workplaces were key sites of encounter with people who reproduced heteronormative or homophobic discourses. I showed, however, that it was not only predominantly straight spaces that could prove deleterious to people's willingness or ability to come out or *be* out, with high levels of HIV stigma and anti-asylum stigma also emerging from within London's "gay world".

In this chapter, then, I have demonstrated the limitations of unidirectional accounts of sexual migration that assume that pre-queered individuals migrate to the city in order to come out (Gorman-Murray, 2007, 2009). Indeed, in line with the findings of Carrillo (2004), I have shown that my interlocutors often understood their "sexual migrations" in terms of both a spatial and a temporal shift. In other words, many participants did not move to London in order to come out, nor was their sexuality already settled before their relocation; rather, for many, new aspects of sexuality emerged from the

migration itself (Carrillo, 2004; Mole et al, 2017). “Moving out” and “coming out” were far from parallel processes for many of my interlocutors (Lewis, 2012); rather, coming out, and being out, depended on a range of factors, including the ability to gain distance from heteronormative and reproductive assumptions and expectations. These findings suggest that gay identity and belonging flourished most readily in social contexts where reproductive temporal expectations were more thoroughly disrupted. Gay identity – and the accompanying identifications with gay men’s sexual health needs – may therefore be more readily fostered once a “critical mass” of gay ways of knowing and be(com)ing is reached. With this in mind, let us proceed to an analysis in the following chapter of the ways in which both spatial and temporal shifts shaped the sexual health perceptions and behaviours of my interlocutors.

The findings of this chapter further support my rejection of the risk categories that I encountered in *Consultation Room 7*. Interestingly, it was through the process of analysis presented here that I re-reckoned with my understanding of my own outness over time. While I had previously internalised my then-belief that I was already out when I moved to London, the more I considered what it meant for my participants to come out and “be” out, the more I realised how partial my own coming-out journey had been in the lead-up to that grey Thursday in 2015. Because my encounters had so often taken place “in the shadows”, and because I was not surrounded by a *critical mass of gay ways of knowing and be(com)ing*, I had yet to accept a queer timeline as liveable. Consequently, I, unlike my Nigerian sexual partner, had not yet identified with or accepted the sexual health needs of gay men. In other words, while my spatial migration had taken place over a year prior, I was still stuck somewhere between timelines, pulled back and forth in either torturous direction. However, whereas patterns of spatial risk dynamics were supposedly well-established, the registrar sitting across from me did not have the conceptual toolkit with which to make sense of the risks produced by my coming-out journey.

7. Navigating Sexual Health and Care in the "Big City"

"I started to think more about sexual health after a year, maybe more… In the clubs, there were posters there, so this was how you just clicked, "Oh, something is… Maybe I should go there." I think they gave away condoms and lube for free, and that was just really strange, like "Why are you giving this away for free?"

Polish participant, city, 2005 (19), already-out, gravitational

"It was risky – I wasn't really practising safe sex. I didn't really engage with sexual health services. Not because I was burying my head; I just didn't really see myself as high risk. Because you don't think of yourself as that. "I'm not doing risky things. Not me. Oh, no, I just… It's those *ones… He seemed like a nice guy."*

English participant, village, 2008 (21), discovery

In the fifth chapter of this thesis, I demonstrated that the sexual health perceptions and behaviours of my interlocutors were informed not only by the spaces they occupied – schools, family homes, gay venues, cruising sites, *etc*. – but, more importantly, by the temporal configurations associated with those spaces. Many participants' institutions of socialisation, for example, were spaces which were structured around reproductive framings of time, centring on certain milestones associated with heterosexual reproduction. In such contexts, sexual health perceptions and behaviours were shaped by the perceived needs of heterosexual families and were often informed by a series of heteronormative or homophobic assumptions or stereotypes around sexual health and HIV. I argued that exposure to gay spaces and gay intergenerational mentorship in participants' places of origin often facilitated

access to ways of being and knowing that centred less on reproductive temporal expectations, which increased the salience of gay men's sexual health needs among participants. However, given that gay ways of being and knowing were often forced into the shadows by hostile social or political climates, the transmission of more inclusive sexual health perceptions and behaviours in participants' places of origin was inconsistent.

In the sixth chapter, I showed that my interlocutors often understood their "sexual migrations" in terms of both a spatial and a temporal shift. While London offered access to a range of new spaces, these spaces also facilitated access to new ways of knowing and be(com)ing that centred less on reproductive temporal expectations. These new approaches, in turn, increased the accessibility of gay spaces. In this way, gay identity and belonging flourished in social contexts in which reproductive temporal expectations were more widely disrupted, implying that gay identity – and the accompanying *identifications* with gay men's sexual health needs – may be much more readily fostered once a "critical mass" of gay ways of knowing and be(com)ing is reached (Halperin, 2012). However, London was no gay paradise, with many participants reporting that migrants' (and locals') access to the non-reproductive timelines associated with "Gay London" depended on a range of factors, including class and socioeconomic status.

In this chapter, I will explore in greater detail the ways in which participants' sexual health perceptions and behaviours shifted in the period after moving to London. These shifts, I contend, are not explicable in terms of a spatial migration alone. Rather, shifts in sexual health perceptions and behaviours depended largely on participants' ability to access "Gay London", and its accompanying sexual health norms. (Clearly, participants' perceptions and behaviours did not shift as soon as they arrived in London. Nor does being *from* London guarantee a certain sexual value set; as I will show, other factors, such as social class, play a role.) In the first part of this chapter, I examine shifts in sexual health perceptions and behaviours from the "out and proud" perspective. I demonstrate that, for many of my interlocutors, (spatially) migrating to London was associated with access to new approaches to sex and sexuality, as well as to new sexual healthcare spaces

and therapies, both of which centred less on the presumed timelines of heterosexual men. Inclusive and openminded discussions of sex and sexuality in gay spaces following relocation to London led to changes in sexual health perceptions and behaviours, including testing behaviours. The centrality of events such as pregnancy and conception, for example, gave way to greater consideration of HIV and other STIs, while the importance of reproducing the family line gave way to greater valorisation of sexual maintenance behaviours such as frequent sexual health testing. In the context of increased PrEP access in London, shifts in condom use patterns appeared to facilitate a sort of sexual democratisation insofar as participants' perceived need to delineate "safe" bodies from "unsafe" ones gave way to significantly expanded sexual eligibility. Increased access to preventative therapies also appeared to foster increased engagement with sexual healthcare services. Interactions with sexual healthcare services in London were often positive because these spaces were felt to be accessible, flexible, inclusive, and welcoming, while access to new therapies allowed participants to take greater control over their sexual (and mental) health and wellbeing. In this way, positive engagement with sexual healthcare services appeared to foster increased salience of safer-sex practices more appropriate to the needs of gay men.

In the second part of this chapter, I will explore the ways in which moving to London may have in fact heightened the vulnerabilities of my interlocutors, particularly for those who had migrated recently or who were early in their coming-out journeys. I will consider the ways in which spatial migrations may present migrant MSM with abrupt temporal shifts that are difficult to navigate safely. I will also demonstrate that some of the sexual health perceptions and behaviours of participants were more resistant to change, particularly in the period immediately after their relocation to London. In this way, they constituted temporal hangovers from an earlier time. Indeed, participants often reported that changes in their sexual health perceptions and behaviours depended on the length of time they had spent away from home, echoing established findings on sexual risk behaviours following migration to queer hubs (Burns et al, 2011; Evans et al, 2011;

Ganczak et al, 2017; Gosselin et al, 2020; Mole et al, 2014; Schmidt et al, 2023) and following exposure to more gay or queer people (Hammoud et al, 2019; Schueler et al, 2019). Some participants, particularly those earlier in their coming-out journey, expressed hesitancy and even stigma towards new therapies like PrEP and DoxyPEP, often exhibiting recalcitrant fears about HIV, "temporal hangovers" that were emotionally rooted to the realities of earlier times (Dennermalm et al, 2024; Freeman, 2010). What is more, access to higher risk sexual contexts posed especial threats to those without adequate safer sex knowledge, including very recent migrants. For example, increased access to settings with sexualised drug use was associated increased sexual risk. I will show that the risks faced in the context of these sexual attitudes and spaces appeared to be exacerbated by neoliberal models of care which emphasised individual responsibility and short-term outcomes. Participants also noted that healthcare access was unevenly patterned, with those of lower socioeconomic status understood as less likely to access appropriate sexual healthcare services. Furthermore, I will show that divergent access to sexual health interventions was seen to cause certain nationalities to "lag behind" in terms of sexual health perceptions and behaviours.

It should be noted that all participants in this sample were active users of sexual health services. I acknowledge that the voices of those not currently engaging with sexual health services will be missing from this account. However, several participants in this study had lived experience of previously not engaging with sexual health services and, by extension, lived experience of *becoming* users of sexual health services. While speaking with my participants, I was particularly interested to hear of first visits, as well as encounters that caused a shift in participants' self-reported patterns of engagement with sexual health services. I should also be clear that references to healthcare institutions in this chapter refer to the specialties of HIV and sexual health only. Participants who took PrEP or HIV medications did mention – on several occasions – difficulties accessing well-informed, inclusive care elsewhere in the healthcare system. However, examining

participants' many encounters with other medical specialties in detail is beyond the scope of this thesis.

7.1. Out in the open: health-seeking behaviours in "Gay London"

In this section, I will demonstrate that moving to London was, for my interlocutors, associated with access both to new sexual attitudes that centred less on the presumed needs of heterosexual men and families, and to new sexual healthcare spaces and interventions, with which, thanks to the new approaches to managing sexual health, participants were more likely to engage. The more inclusive and openminded discussions of sex and sexuality with other gay people in "Gay London" produced shifts in sexual health perceptions and behaviours, such as increased frequency of sexual health testing and, in the context of increased PrEP access in London, decreased condom use. Sometimes, these shifts were the result of direct sexual health advice, whereas, other times, they were prompted to do their own research (sometimes for the first time) because a "critical mass" of gay ways of knowing and be(com)ing had been achieved in "Gay London". Insofar as HIV status and sexual history became less important when choosing sexual partners, the perception and behaviour shifts reported by participants appeared to demonstrate a sort of sexual democratisation associated with more frequent modelling of more empowering sexual attitudes and increased access to preventative medicines like PrEP. Increased sexual openness also fostered increased engagement with sexual healthcare services for several reasons which I will discuss below. Engagements with sexual healthcare services in London were often positive because they were felt to be accessible, flexible, inclusive, and welcoming, while access to new therapies allowed participants to take greater control over their sexual (and mental) health and wellbeing. Positive engagement with sexual healthcare services appeared to foster increased adherence to safer-sex practices more appropriate to the needs of gay men, suggesting

the existence of a virtuous circle wherein sexual openness and service use positively reinforce one another.

7.1.1. Sexual openness on the ground in “Gay London”

Before discussing the ways in which my interlocutors’ engagement with sexual healthcare services shifted after migrating, it is necessary to briefly address participants’ understandings of the general level of awareness and openness about sex and sexual health “on the ground” in London. Indeed, engagement with sexual healthcare services did not increase in a vacuum: participants frequently described London as a “new world” in which it became easier to discuss gay men’s sexual health more openly – both with health professionals and with lay audiences – and to engage more easily with sexual healthcare services, which supports the idea that safer sex and testing behaviours shift more the longer migrant MSM have been in a “queer hub” such as London (Burns et al, 2011; Evans et al, 2011; Ganczak et al, 2017; Gosselin et al, 2020; Mole et al, 2014; Schmidt et al, 2023). Participants frequently expressed the belief that London was a place in which widespread openness about sexuality and sexual health facilitated greater access to more appropriate and inclusive sexual health knowledge and behaviours that were less anchored in the stigmas and stereotypes associated with the “straight world” or the shadow worlds often associated with sexual encounters in participants’ places of origin. While some participants – particularly those who were *already out* – had already spent much time outside of the “straight world” before arriving, for others, living in London represented an overwhelming temporal shift away from ways of knowing rooted in reproductive temporal frames. In this way, migrating to London was associated not just with a spatial shift, but also with a shift away from heterosexual practices and heteronormative ways of orienting oneself in the world.

Perhaps the most frequently noted aspect of London residents’ sexual health perceptions and behaviours was their willingness or even enthusiasm to discuss testing history and sexual history. Indeed, this had been one of the

first things I had noticed upon my own migration to London over ten years ago:

> Many people [in London] are open about their last screenings, when did they get it, what were they screened for. They are willing to speak to their hook-up partners about their screenings, their sexual-health affairs, what are they going to do, what are they into.
>
> (Colombia, large city, 2025 (35), already-out, HIV care)

> I did notice that people were more open about it… They would ask, “When was the last time you tested?” This was virtually non-existent back in Greece. No one would ask, “When was the last time you tested?”
>
> (Greece, village, 2019 (18), coming-out)

> London is super-open. Even when I meet a guy or whatever, we talk about it super-openly and he’s, like, “Yes, I just got tested a week ago,” whatever. And I say, “I got tested on the 26th,” and stuff. (Laughter) Like, very open about it. Far more… I’m actually happy if they tell me, “Oh, I just got tested,” or whatever.
>
> (Germany, small town, 2019 (23), discovery)

As well as sexual health more generally, my interlocutors also noted frequently how much more visible HIV was in London compared to their places of origin. Some participants reported that their first encounters with people who were open about their serostatus occurred in London:

> [After a month in London] I had a friend called David and he was living with mainly gay guys in this flatshare, and some of them, I think two of them, had HIV… This was how I got to know [about] that.

(Poland, village, 2010 (19), coming-out)

Unsurprisingly, then, being in London was also associated with an increase in HIV awareness:

> Obviously now I'm super more educated about HIV. When I'm saying "now", I mean since I came to UK.
>
> (Greece, village, 2016 (24), coming-out, gravitational)

Insofar as queer hubs increased participants' exposure to more open, informed, and non-judgemental discussions of HIV, then migrating to London was likely associated with a reduction in HIV stigma. Indeed, HIV stigma was frequently understood to be much lower in London than in participants' places of origin:

> Interviewer: I guess in Romania there had also been HIV stigma?
>
> Participant: Yeah. Much more than here.
>
> (Romania, city, 2017 (25), coming-out)

Given that a reduction in HIV stigma is clearly related to increased sexual health-seeking behaviours, such as frequent testing (Gios et al, 2019), it is reasonable to suggest that the lower levels of HIV stigma described by participants contributed significantly to the increased sexual health-seeking behaviours often observed among migrant MSM in the period following their migration to London (Burns et al, 2011; Ganczak et al, 2017; Mole et al, 2014).

As well as noting broadly high levels of openness about sexual health and HIV in London, participants also reported a shift in sexual health

perceptions and behaviours – particularly testing behaviours – following their relocation. Sexual partners and gay social circles were highlighted as key sources of more inclusive and appropriate sexual health perceptions and behaviours. Participants sometimes attributed their first ever sexual health test to interactions with partners or gay friends in London:

> He [my first partner] did mention it like, “Have you ever been in a sexual health clinic?” and I said no so he told me like, “Oh, you should visit one.” So, I looked it up and I decided I should go there because I had never done a sexual health check-up in my life.
>
> (Greece, village, 2019 (18), coming-out)

> The first time I ever had to go to Dean Street [NHS sexual health clinic] – and that’s through education through my friends, because again it’s not advertised – I was 26. They were like, “When was the last time you got tested?” “I've never been tested.”
>
> (England, village, 2005 (21), already-out)

Interactions with members of communities to which they had not been consistently exposed prior to migration often precipitated changes in the testing behaviours of my interlocutors, supporting the notion that increased exposure to gay networks and individuals results in increased sexual health-seeking behaviours (Hammoud et al, 2019; Schueler et al, 2019).

Some participants highlighted the role of London’s gay bars and venues in their shifting sexual health perceptions and behaviours. Unlike many participants’ descriptions of gay bars and venues in their places of origin, London’s venues were often associated with more open, non-stigmatised discussions of safer sex and gay men’s sexual health needs that did not centre on reproductive and heteronormative assumptions. These spaces therefore became another key arena in which the temporal shifts experienced by my interlocutors played out. They appeared to be most

widely frequented by migrants who were *already out* in their places of origin, given that these individuals were the most likely to live most visibly as out gay people immediately after relocating. While this group had often navigated sex and sexual health prior to migrating, they rarely reported consistent access to more inclusive sexual health norms and behaviours until after migrating to London. The following participant explained how London's gay and queer venues prompted greater understanding of gay men's sexual health needs:

> I started to think more about sexual health after a year, maybe more… In the clubs, there were posters there, so this was how you just clicked, "Oh, something is… Maybe I should go there." I think they gave away condoms and lube for free, and that was just really strange, like "Why are you giving this away for free?"
>
> (Poland, city, 2005 (19), already-out, gravitational)

For the above participant, gay venues helped foster new discussions about safer sex and sexuality not centred on the presumed needs of heterosexual men. The fact that something only "clicked" for this participant a year or more after arriving in London supports the notion that sexual health perceptions and behaviours change more the longer people have spent living in a queer hub (Burns et al, 2011; Evans et al, 2011; Ganczak et al, 2017; Gosselin et al, 2020; Mole et al, 2014; Schmidt et al, 2019).

Those participants who were particularly early in their coming-out journeys often expressed surprise or even alarm at the new sexual health needs revealed by the world they now occupied. This was in part because it precipitated a disidentification from learnt perceptions and behaviours designed for "family men", and an often puzzling, sometimes abrupt, reidentification not only with new sexual health perceptions and behaviours, but also with a new or evolving sexual identity. The following *coming-out*

migrant described both relief and surprise upon entering a world in which testing history was so openly discussed:

> It felt on the one hand nice because I'm thinking, "Okay, people are actually talking about this [testing history] here which is good."
>
> But at the same time, I was like, "Wow. Is this like the normal thing? Do *we* actually get tested so frequently for that here?"
>
> (Greece, village, 18, coming-out, italics added for emphasis)

For some people early in their coming-out journey, exposure to a new world in which sexual health and HIV were more visible was the cause of some distress. The following *coming-out migrant* explained how, following a sudden increase in his awareness of HIV after moving from a Polish village to London, sex for him became intrinsically associated with danger:

> Participant: [After meeting people with HIV in London], I would start thinking that "this sex can be dangerous". And this was where the testing… I think I first time tested myself after six months or something like that. Well, I was thinking that "if I'm going to go and have sex with someone that I don't know, I might catch something", so that was my main point. "I had that sex and I need to go and test myself," and I was really scared.
>
> Interviewer: So, every time you had sex, you went for a test?
>
> Participant: Kind of yes. Yes. (Laughter)
>
> (Poland, village, 2010 (19), coming-out)

The temporal shift associated with migration to London appeared to be a source of great anxiety for this participant, suggesting that the process of

entering a new sexual world may not always be experienced as a wholly "liberatory" event (Gios et al, 2019; Mole et al, 2014).

Among participants with HIV or participants taking PrEP, the frequency of reported condom use dropped significantly in recent years. Participants also frequently attributed lower condom use patterns in London more generally to the perception that most Gay Londoners without HIV now use PrEP (and sometimes also DoxyPEP):

> I don't use condoms at all, I use PrEP…and I take DoxyPEP.
>
> (Wales, small town, 2012 (18), discovery)

> I don't know when the last time was I used a condom… Everyone is on PrEP, you know what I mean? Before, you had sex with someone, you had to say, "Oh, where's the condom?" Now, no one asks about that.
>
> (Argentina, capital city, 2011 (28), already-out, relationship)

> I think now the norm is it's pretty unusual to use a condom… Barebacking is the norm. There isn't even that much discussion, I would say, and that has also changed. There used to be more, "Oh, you're on PrEP," or, "You're undetectable," or whatever else.
>
> (USA, large town, 2016 (39), already-out, HIV care)

It should be noted, however, that not all participants reported abandoning condoms as a prophylactic tool. Several of my interlocutors continued to rely on condoms, particularly to protect against bacterial STIs (while DoxyPEP use among participants remained low). This was the case for the two participants with HIV below:

> [I use condoms to protect against] bacterial infection… Most times when I decide not to use, I get gonorrhoea or something.
>
> (UAE, large city, 2012 (17), coming-out)

> I remember when PrEP actually became more available… When I would say, "Oh, I prefer safe," one of the most common things that I would hear is, "Oh, I'm on PrEP, so it's fine." Funny enough, I was HIV positive so that was the least of my concerns.
>
> (Greece, village, 2019 (18), coming-out)

Nonetheless, condom use, for the most part, was felt to have fallen significantly among MSM in London in recent years, although recent statistics on condom usage patterns among London's MSM are unavailable.

I will discuss later in this chapter how accessing PrEP via London's sexual health clinics helped participants to think differently about safer sex and sexual health, thereby reinforcing a virtuous circle between inclusive sexual healthcare and inclusive safer sex perceptions and behaviours (that do not assume a reproductive timeline). In this way, access to PrEP in London, often for the first time, changed the ways in which participants assessed the risks of certain people, practices and places deemed "unsafe" or "wasteful", and challenged heteronormative understandings of sex as something that should be, if not reproductive, at least productive. I will also discuss later in the chapter, however, how changing condom use norms may worsen health inequities when good PrEP candidates arrive in London with low HIV or PrEP knowledge, or when they do not see themselves as good candidates.

7.1.2. Clinics as role models: a virtuous circle

As I have argued, increased openness about the sexual health of gay men in London made them more likely to discuss sexual health more openly

themselves, and to engage more consistently with sexual healthcare services. In this section, I will explore how these spaces, in turn, reinforced new sets of assumptions and expectations based on the needs of those not on a reproductive timeline. In other words, I will show that the high standards of care received in these sexual health services caused a shift towards more inclusive sexual health perceptions and behaviours appropriate to the (non-reproductive) needs of gay men. In this way, I will argue, there exists a mutually reinforcing relationship – a virtuous circle – between gay-friendly sexual health perceptions and behaviours and engagement with gay-friendly sexual health services and interventions.

Participants frequently expressed the belief that London's sexual health services offered broadly excellent care:

> A role model for any other country, to be honest.
>
> (Portugal, capital city, 2020 (30), already-out)

> The clinics are very good… It's the strive for improvement, the follow-up… They also keep quite good records.
>
> (Greece, village, 2016 (24), coming-out, gravitational)

> I have a really high view of the NHS. [Despite] being extremely underfunded and everything. It's still an excellent service.
>
> (Germany, small town, 2019 (23), discovery)

Participants frequently noted that the accessibility and flexibility of sexual health services in London enabled them to take greater control of their sexual health and wellbeing, which reverberated across their sexual health behaviours in various ways. Highly accessible services, for example, increased the ease and frequency of sexual health testing:

> The best sex clinic was here in London. You have to queue [in Spain]. They give you…an appointment for like, two months' time. I never see [anyone] in Spain. I mean, you can pay and the next day you get the results, but look at Dean Street [rapid NHS service]!
>
> (Argentina, capital city, 2011 (28), already-out, relationship)

> The service is great. It's easy to get tested. Accessible – it's everywhere. So, wherever you live in London, a sexual health service is there.
>
> (Poland, village, 2010 (19), coming-out)

Furthermore, participants lauded the wide range of service modalities in London, including online testing, which was understood to enable greater flexibility and anonymity in sexual health testing:

> I like, for example, that now they incorporate the SHL [online test kits]…giving this hybrid option [where] people choose what they want and…what is more appropriate.
>
> (Greece, village, 2016 (24), coming-out, gravitational)

> Ease of access, quickness to access, and the different modalities that you can…mix it as you like, you can do it online, you can visit, you can call. It's very straightforward.
>
> (Portugal, capital city, 2020 (30), already-out)

HIV care in London was also understood to be highly accessible and flexible. Participants often opted to travel further for HIV services that offered care that was better suited to their needs:

> I'm with Royal Free since [arriving in London]. Even if I move to West London it takes me almost one hour to get there sometimes, but I prefer to stay there…
>
> I was thinking to move somewhere closer, but even the nurse from occupational health, when I had to do some vaccines, she told me that she knows my consultant and she's really good, so I shouldn't change it. And I took her advice.
>
> (Romania, city, 2017 (25), coming-out)

While care in London was sometimes understood to be poorly standardised, participants often noted that sexual health and HIV clinics remain open to anyone, regardless of postcode, thereby offering (more proactive) individuals the flexibility to change clinic:

> But here it doesn't have to be postcode, because here you can be South London and still come into this one. So, it's only which clinic you kind of decided to be.
>
> (Poland, city, 2005 (19), already-out, gravitational)

The flexibility and accessibility of London's sexual health and HIV services significantly reduced the barriers to accessing care among my interlocutors.

Beyond the physical accessibility and flexibility of the clinic, however, participants also highlighted the importance of the inclusive attitudes of clinicians, which helped allay deeply embedded fears and undo internalised stigmas. For many of my interlocutors, engagement with sexual healthcare services in London played an indisputable part in the shift away from sexual health perceptions and behaviours rooted in reproductive and heteronormative ways of knowing, which supports the idea of a mutually reinforcing relationship between gay-inclusive spaces and gay-inclusive

temporalities. One participant recounted his surprise upon not being "made to feel dirty" during his first-ever clinic visit:

> My first impressions were, "Actually, I probably should've done this a long time ago…" It was a very positive experience. I didn't feel ashamed. I wasn't made to feel dirty.
>
> (England, village, 2008 (21), discovery)

Rather than being met with moralised judgements of their sexual encounters, participants often reported that clinicians employed evidence-based and fact-driven approaches. The previous participant, for example, went on to explain how the clinician's confident presentation of statistical data about HIV helped not only to put his mind at ease, but also to set him on the journey towards becoming a "regular attender":

> I went in, and I said, "I may have had exposure to HIV. Highly unlikely, because we used condoms, but you never know." They were like, "Yeah… the statistics," and they went through all the different stuff that it was highly unlikely, but, "We'll do a test, anyway." That came back negative, as did all the other tests. Since then, I've always been a regular attender.
>
> (England, village, 2008 (21), discovery)

In a similar vein, the following Greek participant recounted how he found London's sexual health clinics – for the most part – to be sites not just of mainstays like testing and treatment, but also sites of education that helped service users to be "more knowledgeable":

> [The clinics] are more open to learning. They are more open to talk about these things [sex between men]. Although there is some minority of people

> [working in clinics] who are living in their own civilisation, world, however you want to call it. And they refuse-
>
> I think the laws are also very strict regarding the guidelines for the clinics: like, “This is what you need to do: when you have a patient, you educate him.” Yeah. Sexual health clinics operate here quite well. And as a result, people are more knowledgeable.
>
> (Greece, village, 2016 (24), coming-out, gravitational)

Clinics were understood by this participant to generally be key sites of knowledge transfer, notwithstanding the “minority” of clinic workers “living in their own [heteronormative] world”.

Moving to London was associated with more positive feelings about HIV care, with London’s HIV clinics generally understood to be inclusive environments. Participants sometimes expressed the belief that, if sexual healthcare was a “space apart” from the rest of healthcare, so too was HIV healthcare a space apart from sexual healthcare, in which service users feel particularly welcomed and well represented:

> Yeah, it’s a much more natural environment… It’s different than a clinic at the sexual health, you know. HIV, that separates it, because people come here [over extended time periods], they know the doctors, they know the nurses, they perceive that this is a welcoming environment. Sometimes I walk in and one of the nurses is like, “Hey, do you need any Doxy?” (Laughter) “No, I’m fine.”
>
> (Portugal, capital city, 2020 (30), already-out)

Participants frequently commended the high level of authenticity and openness among HIV clinicians, which usually left them feeling more represented and cared for than they did in their places of origin:

> She's [my HIV doctor] so honest and authentic… I don't see authenticity in… Not in medical people.
>
> (Italy, capital city, 2013 (31), already-out)

According to my interlocutors, London's HIV services helped make medical interactions more welcoming for gay people and people with HIV. Indeed, one participant with HIV, who had refused to commence treatment before moving to London, explained how the way in which information was presented to him by clinicians in London convinced him that he could safely start treatment:

> [I didn't start treatment] until I came to the UK…
>
> I think I'd maybe seen one doctor at first, and then I eventually moved to [redacted]. And I'm so grateful for that, you know, because I ended up in really good hands.
>
> She provided with so much knowledge, and the risk factors, and what can potentially happen. You know, everything was presented, this complex information was presented so well that, yeah, I said, "I think it will be safe for me to do it".
>
> (Poland, large town, 2013 (21), coming-out)

Given that reduced medical HIV stigma is correlated with increased health-seeking behaviours (Gios et al, 2019), positive encounters in HIV clinics may play a significant role in encouraging sexual health-seeking behaviours among service users. Indeed, the above participant's experience reaffirms the notion that London's sexual health and HIV clinics were often understood as key sites of knowledge transfer which enabled migrant MSM to more safely make the most of life in the "queer hub".

As well as offering broadly accessible, flexible, inclusive, and welcoming care, London's sexual health and HIV services facilitated access

to new HIV therapies and to new preventative therapies, such as PrEP, which, as already noted, caused significant shifts in participants' sexual health perceptions and behaviours, as well as improving their mental wellbeing. Many participants, particularly those who had migrated in more recent years, first accessed PrEP in London. (This was unsurprising, given the limited availability of PrEP in many participants' places of origin, particularly at the time of migrating.) Alongside routine testing, PrEP was the other main reason for which people without HIV reported using sexual health services in London. Increased engagement with sexual healthcare services, of course, also enabled participants to have more discussions about sexual health and safer sex. PrEP appeared particularly empowering insofar as it alleviated many of the anxieties around sexual health and HIV that had been reinforced by the expectations, stigmas, and stereotypes of the "straight world" and the shadow worlds in which many sexual encounters happened in participants' places of origin. In this way, accessing PrEP in London enabled many participants to have more of the sex they wanted, sometimes for the first time. It also changed the ways in which participants assessed the risks associated with certain people, practices and places deemed "unsafe" or "bad" based on perceptions acquired in the "straight world".

Participants articulated the value of PrEP as much in terms of relieving their very real *anxieties* around acquiring HIV as in terms of preventing HIV acquisition, the latter being the use for which it is, in strictly medical terms, indicated. Indeed, although the medical case for PrEP is usually made in terms of physical, and not mental, health outcomes, participants without HIV tended to frame PrEP use in terms of a large reduction in anxiety:

> PrEP is miraculous in that way. There's no anxiety.
>
> (Spain, small town, 2005 (17), discovery)

> Much relief. Much, much relief. You remember, like, years ago, I don't know how long you've lived in London, but, before, it was like, I don't know, out of 10 people, 1 or 2 have HIV. When you're horny, you…
>
> And then PrEP was the best thing, you know what I mean?
>
> (Argentina, capital city, 2011 (28), already-out, relationship)

PrEP was particularly empowering for individuals who worried that asking for a condom would "kill the mood", particularly receptive sexual partners who, as noted in Chapter Four, were disproportionately affected by the belief that condom use was the "man's" (top's) decision, a fear that reflected misogynistic beliefs that sexual and reproductive health decisions should fall to "men":

> I had a lot of instances where I was not asking for condoms because I didn't know how to ask for it. And the reasons were the same, not to kill the mood. PrEP has actually helped.
>
> (Greece, village, 2016 (24), coming-out, gravitational)

Due to the physical and mental protection afforded by PrEP, many participants began employing different sexual health behaviours. Participants both with and without HIV explained that it was no longer common to determine casual partners' HIV status, and that having HIV or engaging in condomless sex were no longer exclusion criteria when choosing sexual partners. By opening up the possibility of worriless serodiscordant sexual encounters, my interlocutors frequently understood PrEP as a sort of socio-sexual leveller with the power to sanction sexual practices and sexual partners that had previously been "off-limits":

> I think [on PrEP] you are more open to have sex with anyone, and I have a lot of sex, so I'm going to events, sex bars, yes…

(Poland, village, 2010 (19), coming-out)

> The main thing [since PrEP was introduced] would be that people don't ask for your status… Maybe there was a period at the beginning, but then it kind of just stopped.
>
> (Poland, city, 2005 (19), already-out, gravitational)

As well as introducing the possibility of new sexual partners, PrEP use also allowed some people to have sex in *places* that had been previously deemed too high-risk, such as saunas and sex parties, which offered access to new ways of thinking about (safer) sex and sexuality:

> Participant: Since I got on PrEP, I went there [to saunas] a few times…
>
> Interviewer: "Since you got on PrEP" because you wouldn't have gone there if you weren't on PrEP?
>
> Participant: Probably not, no. It's probably too high a risk.
>
> (Germany, small town, 2019 (23), discovery)

> Interviewer: When did you start going to more of the sex parties?
>
> Participant: Probably from August last year.
>
> Interviewer: Did PrEP play a part in your-?
>
> Participant: Yes, absolutely. (Laughter)
>
> (Wales, small town, 2012 (18), discovery)

As discussed in Chapter Four, many of my interlocutors reported at some point having had deeply ingrained fears of people with HIV as "bad", "mad",

or somehow the “end of the line” (Bersani, 1987; Edelman, 2004; Halberstam, 2005; Watney, 1987). However, by opening up the possibility of new sexual practices with new people in new ways and places, participants often understood PrEP as a tool of (sexual) democratisation capable of dismantling such fears. The new ways of being and knowing brought by PrEP access have the potential to challenge understandings of people with HIV as contagious (both, as Botnick (2000a, 2000b, 2000c) notes, in their serostatus and in their sexual deviance), thereby breaking down the divisions between “good gays” and “bad gays” that have frequently been reinforced by the “gay mainstream” since at least the 1990s (Botnick, 2000a, 2000c). These divisions, between healthy innocents and contagious deviants, closely mirror those that existed between the healthy “straight world” and the contagious “gay world” at the beginning of the first AIDS crisis (Bersani, 1987; Watney, 1987). In this way, PrEP enabled participants to undo heteronormative and reproductive understandings of sex anchored in perceived physical and moral hygiene, and the continuation of a “healthy line”. While PrEP access may not be an entirely straightforward and unproblematic social leveller, as I will argue later in the chapter, it can certainly be said that PrEP advances more inclusive and less stigmatising approaches to sexual health and HIV.

As well as offering access to new prophylactic treatments, such as PrEP, many participants with HIV spoke positively of the ability to switch to newer HIV treatment regimens after migrating to London:

> My experience has been very positive… They suggested I changed my medication because I was taking a different cocktail, which actually did have some side effects to it. I tried to change it back in Colombia, but my doctor was very reluctant about it.
>
> (Colombia, large city, 2025 (35), already-out, HIV care)

As well as enabling a switch to new oral medications, some participants had already been able to switch to injectable HIV treatments for the first time,

which boosted their confidence in many ways, for example, by enabling them to withhold their serostatus in potentially stigmatising settings, such as nightclubs:

> Interviewer: No side effects?
>
> Participant: Maybe happiness, because I'm really happy now. It has really helped my confidence.
>
> Interviewer: That's great.
>
> Participant: I don't have to carry tablets to the club and be outed. I hated that so much.
>
> (Uganda, capital city, 2024 (23), queer asylum-seeker)

Another participant expressed his relief and happiness about the way in which injectable therapies enabled him to pace his treatment differently:

> Every three months. However, there might be a potential for them to be injected on a six months basis, or eight months basis, which is something I'm like, "Wow." So different to what it used to be, when I had to take loads of tablets.
>
> (Poland, large town, 2013 (21), coming-out)

The new prophylactic and HIV therapies available to my interlocutors after their migration to London bolstered more empowered, less stigmatising approaches to sex and sexuality, which in turn increased sexual healthcare engagement and adherence to safer sex behaviours. As we will soon see, however, some spaces and temporalities encountered in London had the capacity to reinforce not only more inclusive, but also more damaging, sexual health perceptions and behaviours.

7.2. Abrupt temporal shifts, vulnerabilities, and health inequities

Evidently, many participants associated life in “Gay London” with increased openness about sex, safer sex, and sexuality. However, participants’ ability or willingness to engage with “Gay London”, and its associated safer sex perceptions and behaviours, was not evenly patterned. Where my interlocutors had migrated from particularly heteronormative or homophobic contexts, the shift from one world to the next was often particularly abrupt, especially in the period immediately after their migration to London, and when they were early in their coming-out journey. In this section, therefore, I will explore the ways in which migrating to London was associated not with safer and more informed sexual decision-making, but rather with continued or even increased sexual health vulnerabilities, particularly in the period immediately after their relocation to London. This echoes the findings of existing research on migration to queer hubs (Burns et al, 2011; Evans et al, 2011; Ganczak et al, 2017; Gosselin et al, 2020; Mole et al, 2014; Schmidt et al, 2023) and exposure to gay people over time (Hammoud et al, 2019; Schueler et al, 2019). Indeed, given the extent to which sexual health perceptions and behaviours of participants in this study had been shaped by heteronormative stereotypes and reproductive assumptions in their places of origin, it was unsurprising that my interlocutors frequently described their sexual health decision-making in the period immediately after their migration to London as particularly flawed or risky. Indeed, many participants began to explore new, often potentially higher risk, sexual practices in the absence of comprehensive and inclusive safer sex knowledge, which had the potential to engender sexual and mental health vulnerabilities. Some participants, particularly those earlier in their coming-out journey, continued to express hesitancy and even stigma towards new therapies like PrEP and DoxyPEP.

Access to higher risk sexual contexts posed especial threats to those without adequate safer sex knowledge. Increased access to settings with

sexualised drug use was seen to make sexual wellbeing harder to maintain. Given the uneven patterning of the temporal shifts experienced by my interlocutors, and the resultant shifts in sexual health perceptions and behaviours, some participants reported difficulties accessing timely and appropriate care, especially in the period following their migration, during which access to "Gay London" was often still being negotiated. Participants felt that the risks faced in the context of these sexual attitudes and spaces were exacerbated by neoliberal models of care which emphasised individual responsibility and short-term outcomes. Participants noted that uneven healthcare access left certain groups less likely to access appropriate sexual healthcare services, although race and class were felt to be more important factors than sexuality or nationality. Nationality *was* important, however, insofar as differential access to sexual health interventions was sometimes understood by participants to cause certain nationalities to "lag behind" in terms of sexual health perceptions and behaviours, constituting a form of temporal othering whereby certain groups are discursively produced as stunted, backward, or in a state of "arrested development" (Hansen, 2006). Of course, othering and stigma are frequently linked with poorer, not better, health outcomes, implying that uneven access to new approaches to sex and sexuality may continue to perpetuate health inequities, both within the UK and internationally.

7.2.1. Temporal hangovers in the wake of arrival

Unlike migration through space – from there to here – the temporal states of "sexual migrations" – from then to now – could not be so clearly and absolutely delineated by participants, because their inner worlds – their perceptions and behaviours – often remained strongly and viscerally anchored in the (heteronormative and reproductive) realities of earlier times (Dennermalm et al, 2024). In this way, it could be said that participants' perceptions and behaviours were sometimes caught in a sort of "temporal drag" (Freeman, 2010) that may have put them at odds with the mainstream that now surrounded them in the "queer hub", particularly during the period immediately after their relocation to London. Thus, when it came to the

sexual health of my interlocutors, both time and timing were important aspects determining the risks they faced after moving to London, and how their "seasons of risk" were patterned (Baeten et al, 2013; Corneli et al, 2022; Elsesser et al, 2015; Namey et al, 2016; Willie et al, 2021).

Frequently, and of particular importance when understanding the temporal mismatch experienced by my interlocutors after relocating to London was how early they were in their coming-out journey, with *discovery migrants* particularly at odds with the new timelines associated with "Gay London". Those who had recently come out or who had not come out appeared particularly likely to rely on misleading safer sex strategies rooted in heteronormative and homophobic assumptions and stereotypes. One particularly recalcitrant safer sex strategy among *discovery migrants* and *coming-out migrants*, who were earlier in their coming-out journeys, was permissive condom (or PrEP) use, according to the degree to which sexual partners seemed "trustworthy", implying, erroneously, that sexual health status might be linked to an individual's trustworthiness:

> I have unprotected anal sex… If you know the person, I think there's an element of trust… I only have, now, anal sex with people that I know and have that trust with.
>
> That's not to say that we have the conversation: "Have you got any STIs? Have you got HIV?" I don't think I've ever had that conversation.
>
> (England, village, 2008 (21), discovery)

One participant who was early in his coming-out journey at the time of migration explained the consequences of his reliance on trust-based sexual health decision-making after moving to London:

> Eventually, I became more comfortable with him [ex in London]…and I knew that he was taking his sexual health quite seriously himself. He was testing quite regularly…

> In my first year [in London], at 19, I did contract HIV, so that was not a great experience.
>
> (Greece, village, 2019 (18), coming-out)

Interestingly, the tendency to base sexual health-seeking behaviours on trust was particularly common among individuals from smaller settlements like villages, where participants reported that futures were often understood as shared and jointly secured, rather than individual and self-directed. It is possible that a lack of anonymity in these settings may have fostered increased reliance on collective moral codes based on shared responsibility. Indeed, the tensions between different understandings of collective versus individual responsibility frequently emerged in relation to PrEP use, which I will discuss in greater detail shortly. Participants noted that PrEP and other innovations in sexual health transferred the responsibility for sexual health promotion from the community to the individual, echoing arguments that PrEP and other preventative health interventions reinforce notions of individual responsibility and rationality, potentially bolstering inequities in health and wellbeing (Dean, 2015; Schubert, 2019). In this shifting landscape, explained the following participant, norms around things like partner notification are “spotty”, compared to behaviours directly affecting individual wellbeing, such as PrEP use or testing:

> The norms are kind of changing; people are figuring it out, it was a very- I think it has gotten better now… I think we’re still figuring out norms around how often people get tested for everything. Partner notification and things like that, is spotty.
>
> (USA, large town, 2016 (39), already-out, HIV care)

In the context of shifting sexual health norms, some participants expressed a belief that certain individuals from cultural and sexual contexts more centred on collective responsibility may be “left behind”.

As well as trust, several participants – again, particularly those from small settlements and particularly during the earlier part of their coming-out journey – reported continuing to base sexual health decision-making after migrating on aspects of their sexual partners’ appearance. Participants often reported trying to determine sexual partners’ HIV status based on their perceived goodness or virtue, echoing understandings that HIV only affects those who are “bad”, “mad” or somehow at the “end of the line” (Bersani, 1987; Edelman, 2004; Halberstam, 2005; Mai, 2004; Watney, 1987), understandings anchored in heteronormative framings of (promiscuous) gays as pools of contagion (Botnick, 2000b; Knauer, 2000). One participant explained how, despite having higher-risk sex following his migration, he did not perceive it as such because he was only having sex with “nice guys”:

> I started to explore casual sex… It was risky – I wasn’t really practising safe sex.
>
> I didn’t really engage with sexual health services. Not because I was burying my head; I just didn’t really see myself as high risk. Because you don’t think of yourself as that. “I’m not doing risky things. Not me. Oh, no, I just… It’s *those* ones. I know we didn’t use a condom, but why do we need one? He seemed like a nice guy.” Yeah. “I haven’t got anything so far,” and this, that and the other. I was in that mindset.
>
> (England, village, 2008 (21), discovery)

Some participants only questioned the inherited belief that HIV status could be determined by physical appearance for the first time following their own HIV diagnosis. Reflecting on how appraisals of HIV risk based on physical beauty led to his eventual HIV diagnosis, one participant noted:

> It is a harmful behaviour… What you're doing is you're judging a book by its cover. You're saying, "Well, you look like you've got HIV, so I'm not going to sleep with you." And, "You've got a body like a Greek god. I'm going to sleep with you." And lo and behold, who gave me HIV? The Greek god. So yeah. I stop[ped] having that kind of thought, probably in my late 20s [several years after moving to London].
>
> (England, village, 2005 (21), already-out)

As already noted, those participants who had been earlier in their coming-out journey tended to be the most acutely aware of the risks of contagion, and to associate sexual risk with the physical appearance of sexual partners. Indeed, *discovery migrants* frequently linked sexual health decision-making with clear visible signs, which often served not just as symptoms of a possible illness, but as stigmata of gayness itself, in all its infectivity (Crewe, 2018):

> Participant: If I see something that I'm suspicious of, I insist on a condom. If I see, like, a wart or something.
>
> Interviewer: A wart?
>
> Participant: Yes, something like that. If it's a first encounter.
>
> Interviewer: So, physical symptoms. Rash, warts.
>
> Participant: Stuff like that, yes.
>
> (Germany, small town, 2019 (23), discovery)

Sexual position was another axis on which judgements about the sexual health of partners in London sometimes turned, mirroring the notion that receptive partners are the main transmission source of sexually transmitted infections (Mai, 2004; McKay, 2017). Interestingly, some participants continued to see tops (regardless of circumcision status) as

being much lower risk, contrary to contemporary understandings of HIV transmission risk:

> Participant: If someone says they're versatile then the risks are there. If someone says they are top and they are top only then as far as I'm concerned there's little to no risk there, because HIV is one of those things that it's not that easy to contract, but at the same time it kind of is. I know it's a-
>
> Interviewer: It's easier than people imagine to get it as a top.
>
> Participant: Oh, really? Okay. But yeah. So, for me if someone said they are strictly top then I saw them as a low to no risk. Those that were versatile I would sometimes question whether that was someone I would want to sleep with.
>
> (England, village, 2005 (21), already-out)

For others, particularly more recent migrants or those who were not out or recently out, sexual position continued to play a role in sexual health decision-making insofar as decisions about condom use were seen to fall to tops, mirroring masculinist understandings of "men" as being in charge (Mai, 2004; McKay, 2017):

> I would use condoms but, on a few occasions, I wouldn't. And then, I don't know, I would just hope for the best, which was a terrible approach… It was on [up to] the top, really.
>
> (Bulgaria, city, 2010 (20), coming-out)

Clearly, heteronormative sexual health perceptions and behaviours continued to weigh on the decision-making of my interlocutors well after they migrated to London, but particularly in the period immediately after their migration.

Those from small settlements like villages, or who were early in the coming-out journey, were particularly likely to feel the effects of the "temporal drag" of earlier times (Freeman, 2010), as they had not spent as much time living on a queer timeline in which sexual wellbeing becomes a central part of one's general wellbeing and engagement with healthcare institutions.

7.2.2. Toxic meanings: PrEP stigma and hesitancy

Participants who were earlier in their coming-out journey often expressed hesitancy around PrEP and other prophylactic medications. In fact, those participants who had remained more deeply rooted in heteronormative sexual health norms after their migration often stigmatised PrEP use as a facilitator of unnecessary promiscuity. Despite the advent of a range of new prophylactic therapies and new approaches to sexual health decision-making that radically shifted the sexual possibilities of gay men, some participants continued to exhibit profound resistance to these therapies and approaches, which were often anchored in reproductive judgements of promiscuous or bareback sex as "wasteful", "harmful", or "unnecessary" (Botnick, 2000a, 2000c; Halberstam, 2005). Such instances were painfully resonant with my own refusal of appropriate prophylactic treatments after moving to London. One participant outlined his strong belief that PrEP use fostered a harmfully lax attitude towards unprotected sex, even though he reported that it also allowed more freedom and pleasure:

> I'm against PrEP… Maybe not against PrEP, but what people are using it for… To have unprotected sex… It's just- It doesn't sit right with me. I don't know… Is that the purpose of PrEP? I don't think so.
>
> I think it can be easily overused. I have friends who take PrEP just to be able to have the pleasure, and it's just only that. It's nothing else. They will use PrEP, and they will go out there and have loads of unsafe, unprotected sex still. Instead of treating sometimes, in that case, sex addiction.

> It gives you, you know, more freedom, I guess, [which] is good, it is, but it has to be done wisely, you know? … I don't think it's a tablet that I should take just to sleep with anyone around, and, you know…
>
> (Poland, large town, 2013 (21), coming-out)

As well as the belief that engaging in condomless sex for pleasure was inherently bad, several participants expounded concerns that PrEP overuse may lead to an increase in STI transmission rates:

> I think it gave also a false sense of security for some people. It's as if we only care about HIV… I don't think they understood how detrimental it is to get reoccurring infections of like…chlamydia, having to use antibiotics on a constant basis… I think some people think that, since HIV is out of the way, everything else is curable, so it's no big deal.
>
> (Greece, village, 18, coming-out, acquired HIV before PrEP was available)

> I'm against people who use the PrEP in the wrong way. It prevents just HIV infection. But then, it doesn't stop you from getting any other or spreading any other STDs.
>
> (Poland, large town, 21, coming-out, acquired HIV before PrEP was available)

> We know that it does reduce HIV infection, which is great, but it doesn't reduce other STIs. We've seen other STIs, particularly within the gay community, on the rise… It makes it sound like I think PrEP is terrible… I think it's very good, but I don't think we're using it in quite the right way. But, as I said, I'm not sure what that right way is… It's like the over-use of antibiotics. I don't agree with dishing out like sweets.
>
> (England, village, 21, discovery, frequently engaged in condomless and PrEP-less sex)

It should be noted that the relationship between STI rates and increased sexual health testing associated with PrEP use is as yet unclear (McManus et al, 2020), with some arguing that PrEP use has little to no statistical effect on STI rates (Williams, 2023)). Understandings of condomless sex as wasteful, harmful, or unnecessary remain rooted to the realities of earlier times when HIV and AIDS hung heavier in the air, and when it was not possible to use other therapies to reduce the likelihood of STIs, such as DoxyPEP or routine vaccinations.

Especially among participants who had only recently migrated or who were earlier in their coming-out journeys, it often seemed as though deeply embedded historical fears and stigmas about HIV caused them to attach toxic or even contagious meanings to pills made for people with HIV. The above participant went on to articulate his PrEP refusal in terms of somewhat amorphous fears centring on drug resistance and transmitted resistance, giving far greater weight to unlikely worst-case scenarios rather than the likely health benefits of PrEP use:

> What I don't want to see is, in the future, that we have strains of HIV where they're resistant… I see that as a general- Not me, personally- I'm talking about the general thing. I wouldn't take it, because I don't want to take a drug on and off…
>
> I suppose, actually, yes, thinking about it, I don't want to do that, because I don't want to develop that resistance. So, I suppose, actually, yes, I probably would, thinking about it, because I don't want to develop resistance in the future… You just don't know how things are going to change… Transmitted resistance is a huge thing in itself.
>
> (England, village, 2008 (21), discovery)

This participant's decision to avoid using PrEP because of fears about later HIV-related complications seemed illogical and rooted in stigma. Of course,

they also opened him up to additional sexual risk. When I probed why, if he was concerned about acquiring HIV – drug-resistant or otherwise – he did not use PrEP to prevent HIV infection, he acknowledged "slight hypocrisy":

> Yes, a transmitted virus as well [as transmitted resistance]. Yes, having risky behaviour, I am at risk of that.
>
> So, in a sense, there is a slight level of, perhaps, hypocrisy there, because if a person that I'm supposedly trusting is HIV negative turns out to be positive, they could be hugely resistant… But for me, I don't agree [with PrEP use].
>
> (England, village, 2008 (21), discovery)

For this participant and for some others, it seemed as though there was a general discomfort around pills made for bodies with HIV, suggesting potential barriers to perceived PrEP candidacy among people from highly stigmatising contexts, with a potential impact on sexual health outcomes.

Another concern occasionally expressed by participants about new prophylactic therapies was the belief that they would somehow be ineffective or cause very bad side effects. This concern appeared to affect *discovery migrants* disproportionately, perhaps because they had been newer to the scene, or because of deeply ingrained fears around contagion in the gay world (Botnick, 2000b; Knauer, 2000). One participant who often engaged in condomless and PrEP-less sex – making him an excellent candidate for PrEP – and who understood PrEP to be effective, chose instead to continue engaging in anal intercourse that was both PrEP-less and condomless. For him, the relative risk of using PrEP was greater than the relative risk of not using it:

> As I've got older – again, it's not the best thing for me to admit to – I've probably got worse, in the sense that I've been more- I think it comes from the whole risqué thing. Actually, I prefer having sex without a condom… I've never used PrEP… I think, as a theory, PrEP is a very important thing. So,

> from a scientific perspective, it's fantastic that we know you can use this as a preventative measure.
>
> (England, village, 2008 (21), discovery)

In fact, during the research, it became increasingly clear that some ostensibly good candidates for PrEP did not consider themselves as such. Sometimes, it seemed as though participants' perceived ineligibility for PrEP centred on their belief that they were not sufficiently "high-risk" (thereby relationally constructing an image of who *was* "high-risk"). Recall, once more, the tools by which this participant determined the riskiness of his sexual encounters:

> I didn't really engage with sexual health services. Not because I was burying my head; I just didn't really see myself as high risk. Because you don't think of yourself as that. "I'm not doing risky things. Not me. Oh, no, I just… It's *those* ones. I know we didn't use a condom, but why do we need one? He seemed like a nice guy." Yeah. "I haven't got anything so far," and this, that and the other. I was in that mindset.
>
> (England, village, 2008 (21), discovery)

Several participants, including one cited above, also expressed vaccine hesitancy, a fact which puts in sharp focus the ways in which some participants' judgements around the riskiness of other people based on characteristics such as perceived promiscuity may serve to deflect attention from the risk associated with their own actions (or inaction) (Wald, 2008). As already noted, those who had more recently moved to the "queer hub", or who were earlier in their coming-out journey, tended to more frequently express paradoxical health perceptions and behaviours such as those outlined above, placing them at heightened risk of being excluded from the gay mainstream here.

Certain groups were identified as more likely to express PrEP hesitancy, or to not know about PrEP. Young gay people, who – as noted in Chapter Four – frequently lacked reference points or role models for sexual health perceptions and behaviours that were appropriate to them, were identified as another group whose greater temporal proximity to the heteronormative institutions of socialisation places them at greater risk of not accessing appropriate services and treatments, such as PrEP. This was felt to particularly be the case for those young men who were earlier in their coming-out journey:

> Participant: The young people of 18, 19, they want to use a condom, which is… Yeah.
>
> Interviewer: But probably they're not on PrEP?
>
> Participant: They're not on PrEP. Yeah.
>
> (Italy, capital city, 2013 (31), already-out)

As well as the failure of heteronormative institutions of socialisation to instil in young people the importance of PrEP, some participants also noted that, with time, fewer and fewer young people appear to understand the risks of HIV and the importance of PrEP and PEP:

> I think that fear is more real for people that grew up with HIV being difficult to manage, PrEP not existing, and PEP. But younger people perhaps have the same [fear] exactly.
>
> (Spain, small town, 2005 (17), discovery)

As well as young people, other groups were described as more likely to express PrEP hesitancy. Individuals with religious families and highly

religious contexts in their places of origin were sometimes described as less likely to access PrEP and to stigmatise its use:

> I had a few friends that are not very good at deciding that they should be on PrEP. I had this one friend, Portuguese also… He was very sexually active… He would wear condoms but not take PrEP. I remember having this discussion with him a few times, "Why not? That doesn't make sense." "If I get HIV I get HIV, whatever, I'll treat it but I'm not taking medication to prevent something that I can wear a condom for." I just couldn't convince him otherwise. "What will be the harm?" I don't know, some stigma, I still see with that. His parents are very religious, and he had a very religious upbringing, and he sort of ruled out PrEP. So, I would imagine this stigma associated with it.
>
> (Portugal, capital city, 2020 (30), already-out)

In his discussion, the above participant affirms the widely supported notion that medical racism continues to limit PrEP access by certain groups:

> There is definitely a group of people that do not want to take medication, and perhaps there will be a group of people that distrust the overarching health system, mostly minoritised people that have reasons to distrust the health system…people that have been prejudiced against by racism in the system, they're having trials that treated non-white people as animals or tried without consent. I think those people are very mistrusting.
>
> (Portugal, capital city, 2020 (30), already-out)

Given the widespread racialisation within the gay mainstream, the relationship between racial stigma, HIV stigma, and low sexual healthcare engagement cannot be understated.

Interestingly, deep-seated beliefs around the perceived inevitability of HIV infection emerged as fears about PrEP failure in the context of HIV

testing, demonstrating one way in which fears about HIV remained emotionally rooted to the realities of earlier times (Dennermalm et al, 2024). For many participants – sometimes even PrEP-users – the HIV test was a site of "irrational" reckoning with the fears and stigmas inherited from the "straight world":

> Growing up, it sort of became ingrained that HIV will always be a risk in our lives. But there was nothing else, I mean there was the condom, there was nothing else. Celibacy, I guess. There was nothing else to mitigate that. So, I sort of got used to that feeling that there will always be a chance…
>
> Now, even though I knew everything I'd done was all right in terms of preventing HIV, every time I was going to get tests, I'm like, "You're going to be positive." There's always a little bit of that. It's irrational, to be honest. Did I forget to take PrEP on that day or did I, I don't know, didn't pay attention to something? It's irrational, it's not…
>
> (Portugal, capital city, 2020 (30), already-out)

For this participant, the "irrational" fears associated with PrEP failure were strong enough to cause him to delay sexual health testing:

> I'm going to get married in May and I was thinking- "Do I really need to do this test, then it tells me that I'm positive, then I have to live with this before I get married?" No. Is there a reason for me to test positive? No. So do I want to go through with it? No. And there's no rational reason for it.
>
> (Portugal, capital city, 2020 (30), already-out)

The ways in which the sexual health perceptions and behaviours of my interlocutors remained anchored in deep-seated fears that continued to shape their realities constituted a form of "temporal drag" whereby the past

continues to have weight in the present (Freeman, 2010), and even to reconfigure people's futures (Assmann, 2020).

7.2.3. Sexual risk in the shadows

As well as retaining some higher-risk sexual health perceptions and behaviours from before their (spatial) migration to London – "temporal hangovers" from heteronormative socialisation in their places of origin – participants also more frequently found themselves in higher risk sexual scenarios in London, which exacerbated existing physical and mental health vulnerabilities. In this way, the experiences of my interlocutors gave cause to complicate the idea of a singular, sexually open, progressive, health-seeking "Gay London".

Frequently associated with gay life in London was increased access to sex parties, often – as in my own case – in the absence of any meaningful guidance on how to stay safe in such spaces. Participants were often taken by surprise by the seeming range of sexual possibilities facing them after arriving in London:

> There were so many sex parties, I could not believe it. Literally, they are everywhere. It's ridiculous!
>
> (Poland, city, 2005 (19), already-out, gravitational)

Sex parties were not always viewed as a source of danger in themselves, but participants often associated sex parties with chemsex, a practice which often had negative connotations, but with which many participants nonetheless engaged at least occasionally. Frequent chemsex, however, was often understood to have extremely deleterious effects on the lives of partygoers:

> I've seen some people around me that would really go in this downward spiral with the drugs.
>
> (Bulgaria, city, 2010 (20), coming-out)

> You see people…lying down on the floor, G-ed out [unconscious from GHB use]. I mean, and you see the horror stories, don't you, where people just leave people there.
>
> (Wales, small town, 2012 (18), discovery)

The tone with which participants usually described London's chemsex scene was suggestive of the idea that, for many, sexualised drug use was closely linked with feelings of shame or embarrassment, often rooted in internalised homophobia (Koblin et al, 2006; Ross et al, 2011; Smolenski et al, 2011). One participant linked his poor mental state immediately after his migration to London with "stupidly" meeting people he "shouldn't have met", engaging in sexualised drug use, and acquiring HIV:

> I was just in a really low state of mental health, at that time. I did some very stupid things. Yeah, I met guys that I shouldn't have met. I remember going in the middle of the night to a hook-up… It was two guys. Everything was so dodgy, and they were doing drugs, and stuff.
>
> I was incredibly shy as a younger guy. I would just avoid conflict, at all costs… I was just too scared, too shy to say no. So, I feel like I just ended up doing things that I shouldn't have done, and I knew I shouldn't have done. And that's how it led to me getting HIV.
>
> (Bulgaria, city, 2010 (20), coming-out)

Such accounts resonate with findings that the loneliness, isolation, and loss of friend and family networks, especially in the period immediately after

migration, may heighten higher-risk sexual decision-making (Bianchi et al, 2007; Dzomba et al 2019; Egan et al, 2011; Muñoz-Laboy, 2009; Lindstrom & Franco, 2005).

As well as drugs commonly associated with chemsex, such as GHB, alcohol was another tool on which my interlocutors commonly relied in order to cope with their homosexual desires, particularly if they had recently migrated or if they were not out or newly out:

> Interviewer: You say you started drinking when you moved away?
>
> Participant: Yeah.
>
> Interviewer: Why do you think that was?
>
> Participant: I mean, the question that's going to be asked is I did drink more to accept myself? Yes, I did. I found it really difficult to adjust to what I was feeling, and what I'd "become". (Laughter)
>
> (Wales, small town, 2012 (18), discovery)

> Alcohol didn't change my sex life, but it definitely changed- I was having probably just as much sex before as I then did. It just made it easier. It just made it *a lot* easier.
>
> (England, village, 2005 (21), already-out)

While participants were quick to acknowledge the role of alcohol in helping navigate the often-tumultuous transition towards a new way of life, it is known that alcohol may reduce the ability of MSM to negotiate condom use and other health-seeking behaviours assertively (Allen et al, 2016; Wray et al, 2020). Interestingly, however, participants were generally less forthcoming about their experiences of chemsex, bolstering the notion that significant

shame and embarrassment prevail around this topic, potentially in part due to the frequently misperceived illegality of *consuming* illicit substances:

Interviewer:	Do you drink more around sex?
Participant:	Yes.
Interviewer:	Drug use?
Participant:	Go with no.
Interviewer:	And if I were to ask again? (Laughter)
Participant:	Sometimes.

(Wales, small town, 2012 (18), discovery)

The links between internalised homophobia, shame and sexualised drug and alcohol use suggest that, for those MSM earlier in their coming-out journeys, migrating to London may both offer a means to explore new and exciting sexual scenarios while also remaining shrouded in a secrecy that limits open discussions of the risks and benefits associated with (safer) chemsex. In this context, the stigma surrounding sexualised drug use may limit people's ability to have the open discussions necessary to tackle the health threats posed by London's "chemsex epidemic", as one English participant termed it.

The contexts in which chemsex occurred were associated with less informed sexual health decision-making and higher risk sexual practices (Ross et al, 2011; Koblin et al, 2006). Drugs and alcohol were frequently understood to make safer-sex practices difficult or impossible to adhere to, even where participants did already have some safer sex knowledge. Furthermore, the (often unexpected) presence of drugs in sex party settings was understood to have compromised the safety of attendees and even to have facilitated manipulation or abuse, especially among participants who had recently migrated or who were not out or newly out:

> People take advantage of other people. They don't always have pure intentions. And to me, I think, it took some time for me to realise that, coming to London… I feel like I found myself in lots of situations with people who just take advantage of me. I was quite naïve.
>
> People offered me drugs, and I was like, "Okay, well, I'll try it." I had some really horrible experiences, where I would- they would give me G. And I would pass out. And then, I would wake up with vomit everywhere… So, yeah, that's like London for you. (Laughter)
>
> (Bulgaria, city, 2010 (20), coming-out)

While drug use may affect anyone's sexual health decision-making, chemsex appeared to place certain individuals, such as recent migrants or newly out or not-out individuals, at higher risk than others, not least because they often lacked up-to-date, inclusive knowledge of HIV and HIV prevention that was not based on fears and stigmas that "drag" from earlier times (Dennermalm et al, 2024; Freeman, 2010). For example, the above participant's ability to act self-protectively after accessing this higher-risk sexual space was limited by his own lack of knowledge about PEP, which would likely have prevented HIV seroconversion:

> The thing is, even after leaving said encounter, I didn't even know that PEP was available.
>
> (Bulgaria, city, 2010 (20), coming-out)

Indeed, very few of my interlocutors were taught about PEP, due to its irrelevance to the straight, reproductive timeline on which they had been presumed to sit, a timeline on which HIV risk was presumably more associated with needlestick injuries than condomless anal intercourse. Nonetheless, the above participant blamed himself for acquiring HIV – a

common response among participants – despite the knowledge and power asymmetries he had so clearly described:

> But it [the risk] was so obvious! So, yeah, I blame it on just me not being very prepared. And not recognising the red flags, and just running away from them. And just like, “Oh, I’m just going to see how it goes.” And hope for the best. That was my approach. But also, again, I was in a very vulnerable state.
>
> (Bulgaria, city, 2010 (20), coming-out)

The degree to which participants blamed themselves was reflective of the extent to which participants individualised responsibility for HIV acquisition even though the collective institutions of socialisation failed to adequately prepare them due to the assumption of normative sexual practices centred on the need for heterosexual reproduction. The shame and stigma that continue to surround chemsex and HIV constitute significant mental health threats (Ross et al, 2011; Koblin et al, 2006), especially among vulnerable recent migrant MSM or those who are not out or recently out (Smolenski et al, 2011).

7.2.4. The gaps left by “flexible care”

It was not only access to higher-risk sexual spaces that exacerbated the vulnerabilities felt by many of my interlocutors. Participants frequently alluded to the ways in which the healthcare system hindered their ability to access timely and appropriate sexual healthcare (Baroudi et al 2021; Phung et al 2020). While London’s sexual health services were often praised for their flexibility, choice, and inclusivity, participants often highlighted drawbacks with neoliberal models of care that emphasise individual proactivity, self-interestedness, pre-existing healthcare knowledge, and the ability to navigate complex systems of health and care (Al-Chami, 2025; Sinno et al, 2024). Indeed, those participants coming from different

healthcare systems often reported relying on the assistance of external advocacy organisations to signpost them towards NHS services for which they did not know they were eligible, suggesting that less proactive individuals may struggle to find the care they need:

> I was given the number [of a clinic] by a Colombian organisation, so I called there… So, they are willing to help migrant populations, but if you are a tourist, they have to charge around £300.
>
> (Colombia, large city, 2025 (35), already-out, HIV care)

Even among those who knew where to find free sexual health services, the care they received was understood to be limited by factors beyond individual control. One recurrent theme, for example, was the perceived untimeliness and limited effectiveness of PrEP rollout on the NHS, which was widely felt to have serious public health consequences:

> It wasn't something that we advertised as a country. We should have been doing that. You spend all this money telling us about the risks of sex. Why aren't you advertising the fact that we've actually been able to counter one of those risks? My mind boggles.
>
> (England, village, 2005 (21), already-out)

> In 2016 in New York, they were much more open there. There was literally, for straight and gay people, on the Tube, on the Subway, everywhere. So, I was surprised, coming from London, that we didn't have it here. I was really, really shocked. Because, in New York, you would expect, like, they don't have the health service. And to have PrEP advert even for straight couples on the Subway? I was quite surprised we didn't have that here.
>
> (USA, large town, 2016 (39), already-out, HIV care)

> If they had this medication that we knew had such a positive impact in sexual health, especially among gay men who are susceptible to HIV, they should have made it more available sooner… It could have saved me and a lot of people.
>
> (Greece, village, 2019 (18), coming-out)

Indeed, several participants felt they would not have acquired HIV if PrEP had been available on the NHS sooner and more readily, demonstrating the importance of sexual healthcare spaces in allowing (or preventing) people to enact new sexual health behaviours rooted in the needs and realities of gay men's lives:

> Do you know what? I absolutely said, "Yeah. I really think I should be starting to use PrEP. I will think about it, and I will sort it out." But you had to go onto the 'I want PrEP Now' website, and that was just- it should never have been like that. HIV is a serious public health risk. And if the government were really serious about trying to combat it, they would have made that available from day one for free.
>
> (England, village, 2005 (21), already-out)

> I had requested if I could be on PrEP before I was diagnosed with HIV. At the time, it wasn't available for everyone in England. It was available in Scotland. They said, "You can either buy it, or you can request, maybe you can participate in the [Impact] trial." I didn't get access to it.
>
> After two or three months I got HIV… I was quite upset about that, actually. I thought, I don't know, "Maybe if I had chased it more, if I had done something I wouldn't have to live with this now."
>
> (Greece, village, 2019 (18), coming-out)

Once again, this latter participant struggled not to blame himself for acquiring HIV, even though the institutions of both socialisation and medicalisation failed to adequately prepare him for the needs and realities of gay men. The failure of the NHS to deliver PrEP in a timely and effective way contributed to a diagnosis which remained associated with significant stigma and othering. The experiences of PrEP-enthusiastic seroconverters point to the limits of healthcare and healthcare research models that emphasise individual responsibility and market mechanisms. Despite being available privately, the participants cited above did not, by their own acknowledgements, have sufficient understanding of sexual health risks or ability to negotiate safer sex behaviours to consider a private PrEP prescription worthwhile. Furthermore, several participants expressed hesitancy around obtaining medications off-label, once again highlighting the important signalling role of sexual health services.

The modalities of neoliberal healthcare models appeared to allow participants to fall through the cracks of care provision at times. For example, the emphasis on testing and treating, instead of risk reduction and health promotion more broadly, was sometimes understood to limit the effectiveness of neoliberal healthcare models. Even though many participants recognised sexual health clinics as places of re-socialisation towards sexual health perceptions and behaviours more suited to the needs of gay men, there was often a feeling that much more work could be usefully done. Some participants described their early engagements with London's sexual health services solely in terms of testing and treating, and not in terms of more in-depth conversations. The following participant with HIV recalled how a negative HIV result on his first clinic visit, in the absence of any further risk reduction advice, led to continued non-adherence to safer sex strategies:

> I was shaking [during my first visit to the sexual health clinic]. (Laughter) "Oh, my God. Oh, my God." And the wait. And the wait. And then to be told, "Yeah, you're fine. You're negative." (Makes noise).

> But even after that first anxious one it still didn't, for some reason, hit home that I should be more careful. It's just like, "Well, whatever I'm doing is working." I mean I was sexually active from the age of 14.
>
> (England, village, 2005 (21), already-out)

The way in which engagement with sexual health services did not translate into increased sexual health-seeking behaviours for this participant and others demonstrates the potential weaknesses of neoliberal healthcare models focussing on short-term outcomes, rather than longer-term, harder-to-measure, risk reduction work, in the absence of which, a diagnosis that resulted in othering and stigma, particularly from the "straight world", became hard to avoid.

There was also a sense in which neoliberal models of care promote a race to maximise the health of the most privileged at the expense of equalising health outcomes. This emerged interestingly during one participant's discussion of their HIV care. While most participants found their HIV care provider to be at the higher end of their care excellence spectrum, some participants, notably one participant who had accessed HIV care (with health insurance) in the USA, continued to find their HIV care in London to be lacking in terms of frequency of contact, doctor availability, including ability to see the same doctor, and availability of medicines, mirroring in reverse how participants from other parts of the world assessed HIV care in their places of origin compared to London:

> Then I came here, and, like, you meet once every six months, but then sometimes depending on the doctor's availability, there's not enough staff to get an appointment.
>
> I was so used to my previous doctor [in USA], we had such a personal relationship. Then when I went to this one, they don't even know your name. It's just, in the last few years with the same doctor that actually knows me [in UK]. I think this does not happen to most patients here.

> And also- the treatment I was on before, many years ago, they were, like, “Oh, because we don't have that much money for this medicine, it’s becoming too expensive, we're going to split it into- instead of one tablet, you take the same medicine in two pills, but it's the generic one.” I was, like, “Oh my God, this is going to be a big change.”
>
> (USA, large town, 2016 (39), already-out, HIV care)

The lack of service standardisation observed even within London was another way in which neoliberal care models were felt to foster inequality. The above participant also noted that the standard of care differed from clinic to clinic, such that accessing the best care was seen to depend on participants’ degree of proactivity:

> Before, I was in a different hospital that was much smaller. They only had two doctors. And I was trying to get in for a month, I was like, “Okay, no, I'm leaving there.” So, I moved here and then it's much better because there's a lot more doctors here.
>
> (USA, large town, 2016 (39), already-out, HIV care)

This participant’s difficulty in accepting changes in the care he had come to expect prior to migrating is indicative of the resentment that can arise out of neoliberal models of care that emphasise individual rights and responsibilities and the continuous improvement of both service standards and individual health-seeking behaviours.

While the previously mentioned participant’s negative impressions of HIV care in London made him less likely to engage in empowering health conversations with clinicians, this individual was fortunate to already demonstrate a high degree of sexual health self-efficacy, and access to key knowledge networks, as demonstrated by his ability to game the

"paternalistic" system to access off-label DoxyPEP following conversations with a medically trained friend:

> My friend who is a medic, he's like, "Just go, just order on… Superdrug, say you're going to…Nigeria. And they will send you however many you need. And I did. I had never felt empowered like- In some sense, I have always felt the medics want to have this paternalistic take or something… So, I'm just like… I feel like… And this is my super-gay ophthalmologist friend. He was just like, "Yes, you just lie."
>
> (USA, large town, 2016 (39), already-out, HIV care)

The difference between participants' open and widespread discussions of PrEP use and the quasi-secretive tone with which participants described DoxyPEP use was another telling reminder of the important signalling function of sexual health services. While this participant drew on knowledge from the medical world to access DoxyPEP off-label, some migrant MSM will be more confident than others in gaming the system in this way. Unlike PrEP, participants still had to obtain DoxyPEP privately, and under false pretences (as an anti-malaria drug). DoxyPEP was not freely available from NHS sexual health clinics at the time of interviews, but it has started to be rolled out at certain clinics through 2025 (private correspondence, 1 August 2025), further indicating the individualisation of responsibility results in differential care, access to treatments, and outcomes, which perpetuates a vicious circle of stigma, othering, and non-engagement with services. Clearly, for more equitable health outcomes and experiences, appropriate interventions should be available to all, regardless of access to medical knowledge networks and self-advocacy skills, factors which – in this participant's and in my own personal experience – fundamentally change the way in which healthcare is sought.

Frequently expressed by participants was the belief that unequal access both to sexual health services and treatments, and the sexual health behaviours associated with them, meant that certain gay people continued to

be “left behind” by gay modernity, re-affirming that gay cartographies are just as much temporally as spatially structured. One way in which such “lags” played out related to the non-standardisation of sexual health & HIV services. One participant, for example, reflected on the differences between his HIV treatment and those who attended clinics in outer London, which had the potential to result in a postcode lottery for some, ultimately perpetuating health inequities by creating a multi-tiered access to the “gay world”:

> This clinic is very good… When I speak with certain English people, even, like sometimes when you open the cabinet when you are at someone’s, and you’re just like, “Oh, you’re on three tablets? Where do you go?” “Oh, South London.” “Eh? Mine only give me one.”
>
> If they just sometimes pop into Dean Street [very large HIV clinic], they won’t have the bone scans like we have, they won’t have…the two doctors, they won’t have the same thing, you know, they don’t have phlebotomists.
>
> I know one guy who, he said that if he can’t come in, he can email the doctor, speaking over the phone, there is this interaction. I don’t think that someone at Dean Street would be like, yeah, and known by their names.
>
> (Poland, city, 2005 (19), already-out, gravitational)

Such “lags” were not described solely in relation to the intra-London context, but also to the broader national and international context of sexual health and HIV provision. Participants with knowledge of different healthcare systems alluded to the ways in which geographical considerations continued to inform their choice of sexual partners. For example, differential access to medications such as PrEP appeared to be a potential cause of inequality between the “haves” and “have-nots”, as individuals with access began to pass over sexual partners they assumed to not have access to PrEP, in much the same way participants with HIV reported being passed over by people without HIV, particularly before the age of PrEP:

> I met this one guy and he's on PrEP. I still insisted on condoms because I was, like, first of all, I know that PrEP is not free in Poland. So, can I really trust him? No, I can't. Can I really trust that he paid? You know how expensive PrEP is. Like, you have to go completely private in Poland. So, you pay, like, £300 a month, or whatever. I don't know how much it is but it's expensive. So, can I trust this? And the salaries are not that good. Can I trust this guy to pay £300 a month for PrEP? Like, no. So, I insisted on condoms.
>
> (Germany, small town, 2019 (23), discovery)

In the above excerpt, it can be seen how condom use – for so long a norm unquestioned by the gay mainstream – has become the site of a renewed "battle of sexual ethics" (Schubert, 2019), wherein those with unequal access to new treatments and approaches may be othered or excluded, reproducing homonationalist lay delineations between "good" gays and "bad" or "backward" gays (Halperin, 2012; Pérez, 2015; Puar, 2007; Rohy, 2009; Trofimov, 2019), where backwardness was determined according to access to the latest sexual health perceptions and behaviours. In this way, the uneven spatial patterning of sexual healthcare access may render nationality another important axis along which migrant MSM may be othered.

Another sense in which neoliberal sexual healthcare models – emphasising testing and treating over risk reduction – could be argued to impose unequal barriers to access is in their widely perceived (in)ability to foster potentially important conversations with people outside of the "gay world", or those navigating a transition towards it. As already noted in Chapter Six, those who were unable to come out or be out, or who were otherwise unable to enter a new world of perceptions and behaviours surrounding sex and sexuality, were understood to "lag behind" other gay men. This meant that – in a reversal of many mainstream understandings of sexual liberation – participants often found born-and-bred working-class Londoners, for example, less likely to be "out" and more likely to exhibit heteronormative assumptions and homophobic stigmas. Participants

frequently alluded to the worlds inhabited by working-class MSM Londoners in terms of risk, danger, and stigma:

> I did some very stupid things. Yeah, I met guys that I shouldn't have met. I remember going…to a hook-up. And it was this really scary-looking council flat. One of these big, tall buildings. And it was two guys. And it was just so dodgy. Everything was so dodgy, and they were doing drugs, and stuff… And that's how it led to me getting HIV.
>
> (Bulgaria, city, 2010 (20), coming-out)

Unsurprisingly, then, participants also found that sexual health literacy and sexual healthcare engagement were limited among this group. One participant, whose understandings of the importance of socioeconomic position to sexual identity formation were explored in the previous chapter, discussed the HIV stigma exhibited by London's native "not-out" MSM:

> I had this experience with one man… He is bisexual, and it was just the most surreal experience. He was this big, bulky male London guy who is very much into sports and lifting weights. He had a girlfriend, but he really also wants someone to go and fuck him.
>
> He was very, very misinformed about HIV. The first idea that he gave me, he was like, "I am this closeted guy who is not properly informed." … We met, I told him [I had HIV] and he was very, very scared. Actually, the thing died there.
>
> (Colombia, large city, 2025 (35), already-out, HIV care)

Despite frustrating his sexual intentions, however, the participant understood this as a good experience insofar as it enabled him to transmit highly appropriate sexual health knowledge in a form of mentorship – albeit not intergenerational – similar to that described in Chapter Four:

> But the good thing was that he was so confronted by the information that I gave him that he went to the clinic, he spoke to the specialists, he actually admitted to the things that he did and he started taking the PrEP. Which is excellent. I don't feel that was a bad experience. I actually feel happy that it didn't go any further.
>
> (Colombia, large city, 2025 (35), already-out, HIV care)

The mentorship exhibited by the participant in the passage above turns on its head the notion of privileged natives educating marginalised migrants, demonstrating how access to inclusive and gay-appropriate sexual health perceptions and behaviours is not determined simply by one's country of origin, but by a range of social, economic, cultural and political factors. It also demonstrates the ways in which, in the context of profit-driven care models, safer sex knowledge more suited to the needs of gay men may be more successfully transmitted "on the ground" by those armed with vital lay expertise thanks to their spatial and temporal journeys towards gay life.

7.3. Uneven pathways of sexual shift

In this chapter, I have demonstrated, on the one hand, the existence of a virtuous circle, like that discussed in Chapter Six, wherein access to new sexual health spaces and to new sexual attitudes centring on the timelines of gay men mutually reinforced one another. Sexual openness and inclusivity "on the ground" in "Gay London" fostered shifts in sexual health perceptions and behaviours, such as increased frequency of sexual health testing and, in the context of increased PrEP access in London, decreased condom use. Increased sexual openness also fostered increased engagement with sexual healthcare services. Positive engagement with sexual healthcare and HIV services encouraged greater adherence to safer-sex practices more appropriate to the needs of gay men.

My findings may also suggest, however, the existence of a vicious circle wherein the sexual health perceptions and behaviours of recent migrants, particularly those early in their coming-out journey, remained rooted to the fears and misconceptions of earlier times, potentially increasing stigma and discouraging service use (Gios et al, 2019). As a result of these fears and misconceptions, participants frequently reported that they or people they knew turned down potentially appropriate therapies, such as PrEP. Chemsex was also associated with recent migration, especially among those earlier in their coming-out journeys. In these ways, migrating to London was sometimes associated not with safer and more informed sexual decision-making, but rather with continued or even increased sexual health vulnerabilities, particularly in the period immediately after their relocation to London, echoing the findings of existing research on migration to queer hubs. These vulnerabilities are heightened further by neoliberal models of care that demand high degrees of individual proactivity from people early in their gay sexual health journeys (Al-Chami, 2025; Sinno et al, 2024). Furthermore, those who fall through the net of sexual health provisions may face further stigma and othering.

Evidently, (spatial) migration to London does not in itself explain shifts in the sexual health perceptions and behaviours of London's migrant MSM. For this reason, there emerges a clear need to complicate the notion of the "queer hub" or "gay hub" in sexuality and sexual health research, focussing on hubs not as homogenous blocs, but rather as deeply striated spaces with unevenly patterned temporal configurations that enable significant diversity in sexual health perceptions and behaviours, with differing norms often patterned along the lines of "outness". According to such an understanding, we see that a "gay hub" like London – whilst, in the most general terms, conducive to increased sexual openness and lay sexual health knowledge – is in fact no panacea of gay flourishing, especially for individuals undergoing an *abrupt temporal shift*, such as *coming-out migrants*. Rather, when one slices through London, one finds a multiplicity of actors, spaces, and temporalities that reveal different patterns of sociality and sexuality depending on where the cut is made.

Once again, the experiences of my interlocutors shed light on the journey that took me to *Consultation Room 7*. While I had already been in London for a year before that autumn day, “sexual acculturation” is a lengthy process. Despite the best efforts of sexual health clinics to be inclusive, temporal hangovers from the straight world continued to hang over me, preventing me from engaging more fully and honestly with clinicians. My lack of self-acceptance caused me to continue looking “in the shadows” for sex, meaning I frequently found myself – often unexpectedly – in chemsex settings, where informed sexual health decision-making was hard to ensure. Because I tried my best to be “100% safe, 100% of the time”, I thought it would be greedy or unnecessary to seek PrEP, worrying that it might make me a burden or a drain. Even when I eventually started using PrEP, I worried constantly that it would fail, that I was somehow “taking it wrong”. None of this, however, was readily evident to the registrar with whom I spoke, who, in all likelihood, understood such worries, but did not assume that they applied to someone who seemed, on the face of it, like a confident enough native with negligible difficulties accessing care.

8. Conclusion: Drawing Better Maps

"Coming-out journeys are not just unilateral 'quests' for identity formation… Future research must therefore consider coming-out journeys not just as linear escapes or embodied quests, but as complex, dialectic interactions in which 'knowing oneself as gay' involves multiple moves, places, and (re-)negotiations."

Nathaniel Lewis, "Remapping disclosure" (2012: 227)

"To everything there is a season, and a time to every purpose under the heaven:…

A time to cast away stones, and a time to gather stones together; a time to embrace, and a time to refrain from embracing;

A time to get, and a time to lose; a time to keep, and a time to cast away;

A time to rend, and a time to sew; a time to keep silence, and a time to speak;

A time to love, and a time to hate; a time of war, and a time of peace."

Ecclesiastes 3:1, 5-8, *King James Bible* (2017) [1769]

Let me return once more to the questions posed at the beginning of this thesis. How might we usefully incorporate a temporal dimension into our understanding of the migrations of MSM? How might our understandings of sexual risk and sexual health promotion change if we supplemented our focus on migrant status with an understanding of life-course stages? How can we draw better maps, if we even need to draw maps at all? I have, in this work, made a case for understanding the journeys of migrant MSM in both spatial and temporal terms. While research finds migrant MSM to have typically worse sexual health outcomes and experiences than non-migrant MSM, I have argued that this difference is better explained in terms of other

factors affecting migrants, aside from their migrant status. Indeed, several of my interlocutors felt that many gay migrants to London (often understood to be either middle class or socioeconomically ascendent) faced fewer barriers to accessing sexual healthcare and adhering to safer sexual practices than "local lads", evidencing the so-called "migrant health paradox" wherein migrants are "healthier" than natives (Carrillo, 2004: 67). Paying closer attention to the temporal aspects of migrant MSM's journeys could more meaningfully explain differences in outcomes. As I have argued, an understanding of migrant MSM's sexual and sexual health journeys reveals that "coming out" represents a momentous life-course shift, *i.e.* a switch of timelines. Contrary to mainstream *coming-out migration* discourses, however, "coming out" and "moving out/away" were not always parallel journeys for participants in this study, but rather "complex, dialectic" journeys, as Nathaniel Lewis reminds us in the epigraph to this chapter (2012: 227). Furthermore, as I have shown, the timing of these various, segmented processes of spatial migration and temporal migration may produce "seasons of risk". Whereas institutions of health and care often (inadvertently) treat identity categories and risk categories as static, seasonality appears immutable. While seasonality may feel incompatible with the dull, constant thrum of big city life, unarrestable internal streams of movement – as Ecclesiastes reminds us – give the life-course its shape and texture, shape and texture that are flattened by the simplistic categories that dominate positivist research.

8.1. Summary of findings

Before discussing the contributions to knowledge and practice that this work provides, let me briefly summarise the findings of this transdisciplinary research project. Through the review of the literature, I revealed the limitations of spatiality as a dimension through which to make sense of sexual risk and wellbeing among migrant MSM. I showed the existence of a split among gay migration theorists over the relationship between gay identity and migration. While scholars such as Gorman-Murray (2009) assume

migrant MSM to have a well-defined gay identity prior to migration, others, such as Carrillo (2004) and Lewis (2014), show convincingly that coming-out journeys are often segmented. Nonetheless, when it came to the literature on the sexual health of migrant MSM, discussions of sexual identity over time barely made an appearance, with researchers instead echoing Gorman-Murray's assumption that migrant MSM arrive "out and proud". Reviewing this literature nonetheless produced fruitful insights, particularly on the ways in which many migrant MSM experience significant sexual health risks in the period *immediately after* relocation due to a range of factors, including sexual health knowledge asymmetry and the situations of loneliness and anonymity often produced by migration itself. While much of the research in this area focuses on international migrations, a growing volume of work shows that these processes may also affect internal migrants.

I also found, however, that migrant status *tout court* does not fully explain the dynamics of sexual risk affecting migrant MSM. I reviewed work from theorists of temporality in order to elucidate another face of the ways in which the "worlds" of migrant MSM are constituted. Turning to the literature on queer temporality, notably the work of Halberstam (2005), I showed that migrant MSM migrate not just through space, but also between timelines. This literature demonstrates that the journeys of gay and queer subjects often represent a shift away from reproductive futures, as well as the fact that they often experience stigma and othering precisely because of the perception that they have no future, or represent "the end of the line", particularly in the wake of AIDS. Acknowledging the challenges in operationalising temporality as a concept in this study, I turned finally to the concept of outness, which came to serve as a useful proxy for *temporal shifts* in this research, a proxy through which my interlocutors and I made mutual sense of the links between sexual identity, sexual health behaviours, and migration. Notwithstanding the concept's inability to fully capture the variation in people's *ability* to be visibly gay, I found that research on outness provided a good roadmap for conceptualising the ways in which the "worlds" inhabited by my interlocutors at various moments shaped their sexual health perceptions and behaviours.

Before proceeding to the analysis of the interviews proper, I presented in Chapter Four a summary of the typology of gay migration that emerged over the course of the iterative data collection and data analysis processes. This typology, which incorporates both established queer migrant "types" and three novel "types", may be usefully understood as a foundational "finding" that shaped and informed the other, more detailed theoretical findings presented in the chapters that followed. These "types", I suggested, more fully capture the interplay between spatial migration and the significant temporal reconfiguration produced by coming out or otherwise starting to live an openly gay life.

In the fifth chapter of this work, I considered the ways in which participants' temporal migrations – from presumed heterosexuality and reproductive temporality towards non-normative sexualities and new temporal configurations – often commenced well before their relocation to London. I showed that these temporal shifts, which were patterned differently according to how and when individuals "came out", influenced and continue to influence participants' sexual health trajectories. I also discussed the ways in which participants negotiated outness and visibility in their places of origin, examining the role of the "gay world" there in shaping perceptions and behaviours. In contrast with the dominant narrative that being "out" or having gay or queer networks may increase sexual health knowledge and adherence to safer sex behaviours (Hammoud et al, 2019; Schueler et al, 2019), "outness" was not necessarily found to be a protective factor in itself. In fact, coming out exposed some participants to more risks, not just in the "straight world", but also in the shadow worlds out of which many participants' sexual trajectories grew. I found that occasional encounters with the "gay world" in participants' places of origin by no means guaranteed awareness of or adherence to safer sex behaviours, as a *critical mass of gay ways of knowing and be(com)ing* had not been reached. The potential vulnerabilities brought about by encounters in both the "gay world" and in private and semi-private spaces in participants' places of origin reveal several ways in which "outness" – often assumed to be a sort of gold standard for queer fulfilment and wellbeing – may be a double-edged sword.

In the sixth chapter, I examined the ways in which participants' sexual identities and sense of belonging shifted after relocating to London. I found that, while shifts in outness and identity cannot be explained in terms of spatial movements alone, some participants described their migrations to London in terms of an intention to come out or be out to more people, typical of the *coming-out migrant* archetype. However, I also found that the relationship between spatial movement and sexuality was rarely straightforward and unidirectional. Whether or not they migrated with the intention of "coming out", new aspects of participants' sexual identity emerged following their relocations. Discussing participants' migrations from a non-spatial perspective was more fruitful in explaining the timing of these shifts. Indeed, simply moving to London did not produce immediate sexual shifts. Rather, these shifts appeared to be induced by, or at least coterminous with, new spaces and contexts in which the reproductive temporal assumptions of previous times came to be replaced with new temporal configurations. In London, many participants felt able to "make up for lost time", prompting a rapid, often tumultuous period of learning about the sexual practices and sexual health needs of gay men, moments of what I termed *abrupt temporal shift*. However, access to these new spatiotemporal contexts was not found to be equitable, with many participants highlighting the relationship between gay identity and belonging and higher socioeconomic status. Given that gay identity – and the accompanying identifications with gay men's sexual health needs – appeared to be much more readily fostered once a *critical mass of gay ways of knowing and be(com)ing* is reached, unequal access to gay ways of knowing and be(com)ing constitutes a genuine barrier to the task of reducing health inequities.

In the seventh chapter, I considered the interplay of spatiality and temporality in the context of navigating sexual health and care in the "big city". I found evidence, on the one hand, of a virtuous circle wherein access to new sexual health spaces and sexual attitudes centring on the timelines of gay men mutually reinforced one another. Sexual openness and inclusivity in "Gay London" fostered shifts in sexual health perceptions and behaviours, such as increased frequency of engagement with sexual health and HIV

services. In turn, positive engagement with sexual healthcare and HIV services encouraged greater adherence to safer-sex practices more appropriate to the needs of gay men. On the flipside, however, certain behaviours and perceptions persisted as *temporal hangovers* from the straight world, especially among recent migrants and those earlier in their coming-out journeys. These, I showed, can affect migrants and non-migrants alike. The associated risks are heightened further by neoliberal models of care that demand high degrees of proactivity from people early in their gay journeys, while those who fall through the net of sexual health provisions may face further stigma and othering. Thus, I found that understandings of London as a locus of gay and queer flourishing are one-sided. When one slices through London, one finds a multiplicity of actors, spaces, and temporalities that reveal different patterns of sociality and sexuality depending on where the cut is made. According to such an understanding, we see that a “gay hub” like London – whilst, in the most general terms, propitious to increased sexual openness and lay sexual health knowledge – is no gay utopia.

Of course, no piece of research can do everything, and there are limitations to the findings I present here. As the recruiting locations were both in central London, the geographical spread of participants was limited, although some participants did travel from outside London for their care. Participants tended to be of higher socioeconomic status, thereby skewing the findings towards the experiences of this echelon. Perhaps unsurprisingly, then, given the links between outness and social class, my participants were heavily skewed in terms of sexuality, with only gay-identifying cis-men participating. Similarly, as participants needed to take time out of their day to participate, those in more precarious situations were potentially excluded. Non-English speakers were excluded from the study following the assessment of the *NHS* research ethics committee, meaning that the perspectives of already under-represented non-English speakers were not gathered. The stories of those who were not engaging with sexual health & HIV services at the time of interview were not gathered. However, the life journeys taken by my interlocutors meant that, while they were all accessing

care through an *NHS* sexual health or HIV service at the time of interview, nearly all participants had historical experience of non-engagement with sexual health services. Finally, whilst heterosexuals were not involved in this research, many of the processes I described may well affect straight people moving away from sexually restrictive contexts. Future work would do well to take up the mantle of exploring the ways in which temporal migration affects women, over whose heads the notion of the "biological clock" so frequently hangs.

8.2. Contributions to knowledge and practice

This research contributes to existing theoretical knowledge in several ways. Firstly, whereas previous research has tended to focus on "movement" in a purely spatial sense, important new understandings of sexuality and mobility emerge out of this re-examination of the meanings attached to "movement" in the lives of my interlocutors. According to these new understandings, MSM migrate not just through space, but also between timelines, from reproductive to queer, and back again. Rather than spatially moving within a fixed temporal plane, the relocations of MSM are often accompanied by a redefinition of time itself – a reappraisal of rhythms and milestones facilitated in part by the pace and anonymity of urban living, as well as by the increased access to other people leading non-reproductive lifestyles. As a result of this, the demands of home or family life often give way to the feeling of being, as one of my interlocutors put it, "a kid in a candy shop". The degree of abruptness of this "switch of timelines" has a bearing on many aspects of life, including, as I have shown, sexual health perceptions and behaviours. The centrality of events such as pregnancy and conception, for example, gives way to greater consideration of HIV and other STIs; the centrality of reproducing the family line, meanwhile, gives way to greater valorisation of sexual maintenance behaviours such as frequent sexual health testing. I have coined several terms in this work to explain various aspects of the movement between timelines. The term *abrupt temporal shift*, for instance, refers to the often-tumultuous process of switching from one

"timeline" to another, with consequences for sexual health decision-making. I have referred to (sexual health) perceptions and behaviours rooted in the realities of earlier times – such as the belief that HIV is a death sentence – as *temporal hangovers*, similar to the phenomenon of "temporal drag" described by Freeman (2010). I have also argued on multiple occasions that being surrounded by a *critical mass of gay ways of knowing and be(com)ing* – that is, gay sexual and social practices unaligned to reproductive timelines – catalyses this shift. In the absence of such a *critical mass*, sexual encounters are more likely to take place in *shadow worlds* in which identifications with gay men's sexual health needs are far from guaranteed.

Another way in which this work offers a significantly expanded conceptual arsenal to researchers seeking to understand the sexual health trajectories of migrant MSM is through the elaboration of a novel set of gay migration categories beyond established ones like *coming-out migration*, which dominate the field and which make the assumption that MSM arrive with static, fully formed, pre-queered sexualities. In addition to existing conceptual categories, I proposed three new ones in this work. Noting that not all gay migrants are *coming-out migrants*, I elaborated terms *already-out migrants* and *discovery migrants* to capture other trajectories of sexuality, sexual health, and migration. Whereas previous research has tended to foreground the experiences of those MSM whose spatial migrations overlay neatly onto their temporal migration (i.e. coming out), in this work I have sought to consider other pathways. Furthermore, I have proposed the novel category of *HIV care migration* to refer to those who migrate for reasons related to their HIV care. All these categories have the potential to usefully reshape understandings of the variety of experiences that are flattened into the category "migrant MSM". Attuning future research to these new categories may produce fruitful outcomes.

In a direct challenge to an assumption that reverberates across much healthcare research, I show in this work that "outness" is by no means a straightforwardly protective factor for migrant MSM. For example, those who were visibly out to more people in their – often restrictive – places of origin were often exposed to homophobia, abuse, and sexual health risks, the

various consequences of which they carried with them to London and beyond. What is more, given the lack of gay sexual health knowledge to which these participants had had access, many of those who were sexually active in their places of origin acquired HIV, often before relocating to London. Those individuals for whom “coming out” and “moving out/away” were simultaneous processes – that is, *coming-out migrants* – faced yet different vulnerabilities still. Coterminous *abrupt temporal shifts* and spatial shifts produced an overwhelm of new sexual opportunities, often in the absence of relevant sexual health knowledge learnt over the course of one’s “gay education”, or “coming out”, in the more traditional sense of the young debutante entering a society governed by new rules and codes. Those in the midst of an *abrupt temporal shift*, such as many *coming-out migrants*, appear to be particularly likely to engage in chemsex following their migration, often due to a perceived inability to spot these codes or to say “no”. Intriguingly, meanwhile, *discovery migrants* in this study did not tend to report especially higher-risk behaviours after migrating, with many remaining hesitant to dip their toe in the new pools of sexual opportunity. It should be noted, however, that most of the *discovery migrants* in this study grew up in Western European contexts, which may skew the cultural sensitivity of this contribution to knowledge. Patterns of sexual risk-taking among those who come out later in life merit further investigation.

Given that gay identity – and the accompanying identifications with gay men’s sexual health needs – appeared to be much more readily fostered once a *critical mass of gay ways of knowing and be(com)ing* is reached, unequal access to gay ways of knowing and be(com)ing, even within the gay or queer “hub”, constitutes a genuine barrier to the task of reducing health inequities. This work therefore provides a timely impetus to re-politicise our understandings of sexuality, migration, and sexual health. Behind idealised, cookie-cutter portrayals of a welcoming and inclusive “Gay London” lies the murky, complicated reality of an unevenly tolerant city. Understandings of London as a locus of gay and queer flourishing are one-sided. When one slices through London, one finds a multiplicity of actors, spaces, and temporalities that reveal different patterns of sociality and sexuality

depending on where the cut is made. According to such an understanding, we see that a “gay hub” like London – whilst, in the most general terms, propitious to increased sexual openness and lay sexual health knowledge – is no gay utopia. As (spatial) migration to London does not in itself explain shifts in the sexual health perceptions and behaviours of London’s migrant MSM, there emerges a clear need to complicate the notion of the “queer hub” or “gay hub” in sexuality and sexual health research, focussing on hubs not as homogenous blocs, but rather as deeply striated spaces with unevenly patterned temporal configurations that produce significant diversity in sexual health perceptions and behaviours, with differing norms often patterned along the lines of “outness”.

As well as delivering theoretical impact by building on key conceptual gaps in existing medical and social scientific research on “sexual migration”, this work also has the potential to be impactful in the realm of policy. Indeed, given the Government’s ambitious goal of eliminating new HIV transmissions in the UK by 2030 (DHSC, 2023), it is vital that steps are taken at all levels to meet MSM *where they are at*, not where we imagine them to be. Healthcare providers and practitioners would do well to consider more systematically the ways in which “temporal migrations”, such as coming out, contribute to “seasons” of heightened sexual health risk, especially at certain life stages and when accompanied by certain spatial movements. In this regard, flagging “temporal migrants” earlier in their clinical journeys, and offering them additional tailored support, would be highly salutary.

Furthermore, at the level of practice, this research reaffirms the fundamental importance of not presuming “outness” among MSM in health research and clinical practice, instead recognising the diverse ways in which sexual identities overlay onto sexual behaviours throughout the life-course, and ensuring MSM “in the closet” continue to receive services sensitive to their needs, including, often, the need for anonymity. By providing an empirical basis from which to better understand the unmet needs of migrant MSM, dissemination of these findings supports the broader goal of both maximising and equalising health outcomes in sexual health and beyond. Indeed, the insights generated by this work about the need to meet people on

their own terms, *where they are at*, apply not just to gay migrants, but to a wide range of groups and individuals navigating their own abrupt temporal shifts. Just as there is great diversity within ostensibly clearly delineated identities, so too do commonalities between ostensibly separate populations exist.

Let me now return once more to the questions I posed at the beginning of this thesis about my puzzling realisation in *Consultation Room 7*. From the analysis presented here, it can be seen that certain migrants are assumed to face (and pose) greater sexual health risk than others because of the risks associated with their country of origin. Such flattened accounts caused my older Nigerian partner to be characterised as risky, even though he had more or less completed his “gay education” – his coming out, in the fullest sense – and, as a result, found himself in a world of newer, safer sexual health perceptions and behaviours. I, meanwhile, may have been coded as less risky, but I had only recently embarked on a tumultuous journey of self-discovery, in the absence of clear guidance, and with sexual health perceptions and behaviours anchored in stereotypes and assumptions about gay people, rather than based on actual risk practices. Unlike my sexual partner’s (historic) spatial journey, my (ongoing) coming-out journey was not deemed clinically relevant. If it had been, the registrar sitting in front of me may have been more able to offer better tailored support. The world map splashed with red and green risk zones could usefully have been supplemented with a timeline of potentially critical life phases, thereby reflecting the various dimensions that give texture to patterns of sexual risk-taking across the life-course. When mapping risk among migrant (and non-migrant) MSM, temporality must be the fourth dimension.

9. Reference List

ABC. (1982, December 17). “AIDS” [Video file]. *News Nightline*. https://www.youtube.com/watch?v=5FREjnYV_aM&t=31s

Adam, B. D., Husbands, W., Murray, J., & Maxwell, J. (2008). “Silence, assent and HIV risk.” *Culture, Health & Sexuality* 10 (8): 759–772. https://doi.org/10.1080/13691050802172157

Adelman, M., & Woods, K. (2006). “Identification without intervention: Transforming the Anti-LGBTQ school climate.” *Journal of Poverty* 10 (2): 5–26. https://doi.org/10.1300/J134v10n02_02

Ahmadi, N. (2003). “Rocking Sexualities: Iranian migrants’ views on sexuality”. *Archives of Sexual Behavior* 32 (4): 317–326. https://doi.org/10.1023/A:1024038931202

Aizura, A. Z. (2018). *Mobile Subjects: Transnational Imaginaries of Gender Reassignment.* Durham, NC: Duke University Press.

Albarracín, D., Gillette, J. C., Earl, A. N., Glasman, L. R., Durantini, M. R., & Ho, M. H. (2005). “A test of major assumptions about behavior change: a comprehensive look at the effects of passive and active HIV-prevention interventions since the beginning of the epidemic.” *Psychological Bulletin* 131 (6): 856–897. https://doi.org/10.1037/0033-2909.131.6.856

Al-Chami M. H. (2025). “Neoliberal Rationality: A Primary Impetus for Reification and Derecognition of the Patient in Nursing Care.” *Nursing Philosophy: an international journal for healthcare professionals* 26 (2): e70021. https://doi.org/10.1111/nup.70021

Allen, V. C., Myers, H. F., & Ray, L. (2015). “The Association Between Alcohol Consumption and Condom Use: Considering Correlates of HIV Risk Among Black Men Who Have Sex with Men.” *AIDS and Behavior* 19: 1689–1700. https://doi.org/10.1007/s10461-015-1075-1

Altman, D. (1999). “Globalization, political economy, and HIV/ AIDS” in *Theory and Society* 28: 559–584. https://doi.org/10.1023/A:1007061910035

Amirkhanian, Y. A. (2012). “Review of HIV Vulnerability and Condom Use in Central and Eastern Europe.” *Sexual Health* 9 (1): 34–43. https://doi.org/10.1071/SH11025

Anderson, J., & Doyal, L. (2004). “Women from Africa living with HIV in London: a descriptive study”. *AIDS Care* 16 (1): 95–105. https://doi.org/10.1080/09540120310001634001

Anzaldúa, G. E. (1987). *Borderlands/La Frontera: The New Mestiza*. San Francisco, CA: Aunt Lute Books.

Assmann, A. 2020. *Is Time Out of Joint? On the Rise and Fall of the Modern Time Regime*. (S. Clift, Trans.) Ithaca, NY: Cornell University Press. (Original work published 2013).

Association of Social Anthropologists of the UK (ASA). (2011, September 15). “Ethical Guidelines for Good Research Practice.” [Conference notes]. *ASA* extraordinary general meeting, Lampeter, UK. https://www.theasa.org/downloads/ASA%20ethics%20guidelines%202011.pdf

Attwood, L. (1996). “Young People, Sex and Sexual Identity.” In H. Pilkington (Ed.), *Gender, Generation and Identity in Contemporary Russia*. London, UK: Routledge.

Ayhan, C. H. B., Bilgin, H., Uluman, O. T., Sukut, O., Yilmaz, S., & Buzlu, S. (2019). “A Systematic Review of the Discrimination Against Sexual and Gender Minority in Health Care Settings.” *International Journal of Health Services* 50 (1): 44–61. https://doi.org/10.1177/0020731419885093

Baeten, J. M., Haberer, J. E., Liu, A. Y., & Sista, N. (2013). “Preexposure Prophylaxis for HIV Prevention: Where Have We Been and Where Are We Going?” *Journal of Acquired Immune Deficiency Syndromes* 63: S122–S129. https://doi.org/10.1097/QAI.0b013e3182986f69

Bakhtin, M. (1981). *The Dialogic Imagination*. Austin, TX: University of Texas Press.

Balfe, M., & Brugha, R. (2009). “What prompts young adults in Ireland to attend health services for STI testing?” *BMC Public Health* 9 (311). https://doi.org/10.1186/1471-2458-9-311

Barad, K. (2007). *Meeting the Universe Halfway: Quantum Physics and the Entanglement of Matter and Meaning*. Durham, NC: Duke University Press.

Barad, K. (2012). “Nature’s Queer Performativity”. *Kvinder Køn og Forskning* 1–2: 25–54. https://doi.org/10.7146/kkf.v0i1-2.28067

Barad, K. (2015). “Transmaterialities: Trans*/Matter/Realities and Queer Political Imaginings.” *GLQ* 21 (2-3): 387-422. https://doi.org/10.1215/10642684-2843239

Barad, K. (2017). “Troubling Time/s and ecologies of nothingness: re-turning, re-membering, and facing the incalculable”. *New Formations* 92 (5). https://doi.org/10.3898/NEWF:92.05.2017

Baroudi, M., Nkulu-Kalengayi, F., Goicolea, I., Jonzon, R., San Sebastian, M., Hurtig, A-K. (2022). “Access of Migrant Youths in Sweden to Sexual and Reproductive Healthcare: A Cross-sectional Survey”. *International Journal of Health Policy and Management* 11 (3): 287–298. https://doi.org/10.34172/ijhpm.2020.123

Bell, D., & Valentine, G. (1995). *Mapping Desire: Geographies of Sexualities*. London, UK: Routledge.

Benjamin, W. 1968. *Theses on the Philosophy of History*. (H. Zohn, Trans.) New York City, NY: Harcourt. (Original work published 1942).

Berg, R. C., & Ross, M. W. (2014). “The Second Closet: A Qualitative Study of HIV Stigma Among Seropositive Gay Men in a Southern U.S. City.” *International Journal of Sexual Health* 26 (3): 186–199. https://doi.org/10.1080/19317611.2013.853720

Berg, R. C., Weatherburn, P., Ross, M. W., & Schmidt, A. J. (2015). “The Relationship of Internalized Homonegativity to Sexual Health and Well-Being Among Men in 38 European Countries Who Have Sex With Men.” *Journal of Gay and Lesbian Mental Health* 19 (3): 285–302. https://doi.org/10.1080/19359705.2015.1024375

Bersani, L. (1987). “Is the Rectum a Grave?” *AIDS: Cultural Analysis/Cultural Activism* 43: 197–222. https://doi.org/10.7208/chicago/9780226043449.001.0001

Bianchi, F. T., Reisen, C. A., Zea, M. C., Poppen, P. J., Shedlin, M. G., Penha, M. M. (2007). “The sexual experiences of Latino men who have sex with men who migrated to a gay epicentre in the USA.” *Culture, Health & Sexuality* 9: 505–518. https://doi.org/10.1080/13691050701243547

Binnie, J. (1997). “Invisible Europeans: Sexual Citizenship in the New Europe.” *Environment and Planning* A29 (2): 237–248. https://doi.org/10.1068/a290237

Boellstorff, T. (1999). “The perfect path: Gay men, marriage, Indonesia.” *GLQ: A Journal of Lesbian and Gay Studies* 5 (4): 475–510. https://doi.org/10.1215/10642684-5-4-475

Bonell, C., Strange, V., Allen, E., & Barnett-Page, E. (2006). “HIV prevention outreach in commercial gay venues in large cities: evaluation findings from London.” *Health Education Research* 21 (4): 452–464. https://doi.org/10.1093/her/cyh071

Botnick, M. R. (2000a). “Part 1: HIV as ‘the Line in the Sand’.” *The Journal of Homosexuality* 38 (4): 39–76. https://doi.org/10.1300/J082v38n04_03

Botnick, M. R. (2000b). “Part 2: Fear of Contagion, Fear of Intimacy.” *The Journal of Homosexuality* 38 (4): 77–101. https://doi.org/10.1300/J082v38n04_04

Botnick, M. R. (2000c). “Part 3: A Community Divided.” *The Journal of Homosexuality* 38 (4): 103–132. https://doi.org/10.1300/J082v38n04_05

Boussalem, A., & Di Feliciantonio, C. (2023). "'Like a piece of meat in a pack of wolves': gay/bisexual men and sexual racialization." *Gender, Place & Culture* 31 (4): 505–522. https://doi.org/10.1080/0966369X.2023.2200579

Braidotti, R. (2018). "A Theoretical Framework for the Critical Posthumanities." *Theory, Culture & Society* 36 (6): 31–61. https://doi.org/10.1177/0263276418771486

Brown, G. (2008). "Urban (Homo)Sexualities: Ordinary Cities and Ordinary Sexualities." *Geography Compass* 2: 1215–1231. https://doi.org/10.1111/j.1749-8198.2008.00127.x

Burns, F., Evans, A., Mercer, C. H., Parutis, V., Gerry, C. J., Mole, R. C. M., French, R. S., Imrie, J., & Hart, G. J. (2011). "Sexual and HIV risk behaviour in Central and Eastern European migrants in London." *Sexually Transmitted Infections* 87: 318–324. https://doi.org/10.1136/sti.2010.047209

Campbell, D. (1998). *Writing Security: United States Foreign Policy and Politics of Identity*. Minneapolis, MN: University of Minnesota Press.

Cantú, L. (2002). "De ambiente: Queer tourism and the shifting boundaries of Mexican male sexualities". *GLQ: A Journal of Lesbian and Gay Studies* 8 (1–2): 139–166. https://doi.org/10.1215/10642684-8-1-2-139

CARAM Asia. (2018). "A Review of HIV Policy Progression and Migrants' Health Rights in Five Origin Countries." [Report]. http://caram-asia.org/pdf/Review_of_HIV_Policies.pdf

Carballo-Diéguez, A. (1998). "The challenge of staying HIV-negative for Latin American immigrants". *Journal of Gay and Lesbian Social Services* 8: 61–82. https://doi.org/10.1300/J041v08n01_05

Carrillo, H, & Fontdevila, J. (2014). "Border crossing and shifting sexualities among Mexican gay immigrant men: Beyond monolithic conceptions". *Sexualities* 17 (8): 919–938. https://doi.org/10.1177/136346071455224

Carrillo, H. (2004). “Sexual Migration, Cross-Cultural Sexual Encounters, and Sexual Health”. *Sexuality Research & Social Policy* 1 (3): 58–70. https://doi.org/10.1525/srsp.2004.1.3.58

Carrillo, H. (2018). *Pathways of Desire: The Sexual Migration of Mexican Gay Men.* Chicago, IL: University of Chicago Press.

Cassels, S., Camlin, C. S., Seeley, J. (2018). “One step ahead: timing and sexual networks in population mobility and HIV prevention and care”. *Journal of the International AIDS Society* 21 (S4): 98–100. https://doi.org/10.1002/jia2.25140

Castells, M. (1983). *The City and the Grassroots*. Berkeley, CA: University of California Press.

Castro-Vázquez, G., & Tarui, M. (2006). ““I am not a guinea pig”: Quality of Life and Methodological Issues in the Research with Latin American Men Living with HIV/AIDS in Japan”. *International Journal of Qualitative Studies on Health and Wellbeing* 1 (2): 78–90. https://doi.org/10.1080/17482620600677468

Causevic, S., Salazar, M., Orsini, N., Kågesten, A., & Ekström, A. M. (2022). “Sexual risk-taking behaviors among young migrant populations in Sweden”. *BMC Public Health* 22: 625. https://doi.org/10.1186/s12889-022-12996-2

Chapman, J., Cai, Y., Hillier, S., & Estcourt, C. (2009). “Sex and Sexuality in the Shenzhen Tongzhi Circle: HIV Risk Context and Migrant Men Who Have Sex with Men in China”. *Culture, Health and Sexuality* 11 (7): 689–702. https://doi.org/10.1080/13691050902977562

Chapman, S. (2018). “Is It Unethical to Use Fear in Public Health Campaigns?” *American Journal of Public Health* 108 (9): 1120–1122. https://doi.org/10.2105/AJPH.2018.304630

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. London, UK: Sage Publications.

Charmaz, K., & Belgrave, L. L. (2012). “Qualitative Interviewing and Grounded Theory Analysis.” In J. Gubrium, J. Holstein, A. Marvasti, & K. McKinney (Eds.), *The SAGE Handbook of Interview Research: The Complexity of the Craft*. London, UK: Sage. https://doi.org/10.4135/9781452218403

Chauncey, G. (1994). *Gay New York: Gender, Urban Culture, and the Making of the Gay Male World*. New York City, NY: Basic Books.

Chauncey, G., & Povinelli, E. A. (1999). “Thinking Sexuality Transnationally: An Introduction”. *GLQ* 5 (4): 439–449. https://doi.org/10.1215/10642684-5-4-439

Chen, Y., Tang, W., Chen, L., Shi, L., Liu, X., Xu, J., Hu, H., Yang, H., Huan, X., & Fu, G. (2017). “Changing Epidemic of HIV and Syphilis Among Resident and Migrant Men Who Have Sex with Men in Jiangsu, China”. *Scientific Reports* 7 (Article no. 9478). https://doi.org/10.1038/s41598-017-08671-x

Clark, J., Coates, T., & Salvatierra, J. (2013). “Moderno Love: Sexual Role-Based Identities and HIV/STI Prevention Among Men Who Have Sex With Men in Lima, Peru.” *AIDS and Behavior* 17 (4): 1313–1328. https://doi.org/10.1007/s10461-012-0210-5

Clarke, A. E. (2005). *Situational Analysis: Grounded Theory after the Postmodern Turn*. Thousand Oaks, CA: Sage.

Corneli, A., Perry, B., Ngoje, D. O., Molokwu, N., Strack, R., & Agot, K. (2022). “Episodic Use of Pre-Exposure Prophylaxis Among Young Cisgender Women in Siaya County, Kenya.” *AIDS Patient Care and STDs* 36 (10): 379-388. https://doi.org/10.1089/apc.2022.0076

Crewe, T. (2018, September 27). “Here was a plague”. *London Review of Books* 40 (18). https://www.lrb.co.uk/the-paper/v40/n18/tom-crewe/here-was-a-plague

Cummings, J. (2024). “Queer presence/absence on the periphery: Insights from Hainan.” *Sexualities OnlineFirst*. https://doi.org/10.1177/13634607241293929

D'Emilio, J. (1983). *Sexual Politics, Sexual Communities*. Chicago, IL: University of Chicago Press.

Danisi, C., Dustin, M., Ferreira, N., & Held, N. (2021). *Queering Asylum in Europe: Legal and Social Experiences of Seeking International Protection on Grounds of Sexual Orientation and Gender Identity.* London, UK: Springer Books.

Darrigol, O. (2005). "The Genesis of the Theory of Relativity." In T. Damour, O. Darrigol, B. Duplantier, & V. Rivasseau (Eds.), *Einstein, 1905–2005. Progress in Mathematical Physics, vol 47.* Birkhäuser Basel. https://doi.org/10.1007/3-7643-7436-5_1

Davies, R. T. (Writer), Harding, S., Huda, M., & McDougall, C. (Directors). (1999, March 23). Series 1, Episode 5. [TV series episode]. In N. Shindler (Executive Producer), *Queer as Folk*. Red Production Company.

Dean, T. (2015). "Mediated intimacies: Raw sex, Truvada, and the biopolitics of chemoprophylaxis." *Sexualities* 18 (1–2): 224–246. https://doi.org/10.1177/1363460715569137

Debattista, J. (2015). "Health promotion within a sex on premises venue: notes from the field." *International Journal of STD & AIDS* 26 (14): 1017–1021. https://doi.org/10.1177/0956462414568395

Dennermalm, N., Sjöland, C. F., Christiansen, M., Nilsson Schönnesson, L., Laine, K., Kanon, E., Suarez, D., Ekström, A. M., & Mølsted Alvesson, H. (2024). "Growing up in the shadow of HIV: post-AIDS generation of HIV-negative men who have sex with men in Sweden and their perceptions of HIV and stigma." *Culture, Health & Sexuality* 27 (4): 389–403. https://doi.org/10.1080/13691058.2024.2375608

DePalma, R., & Atkinson, E. (2017). "The nature of institutional heteronormativity in primary schools and practice-based responses." *Teaching and Teacher Education* 26 (8): 1669–1676. https://doi.org/10.1016/j.tate.2010.06.018

Department for Education (DfE). (2021, November). "Experiences of Relationships and Sex Education (RSE), and sexual risk taking: Young

people's views from LSYPE2." [Report]. https://assets.publishing.service.gov.uk/media/619e65e68fa8f5038358c04a/SRE_and_sexual_risk-taking_research_brief_Nov21.pdf

Department of Health and Social Care (DHSC). (2023). *The first annual update to the 'HIV Action Plan for England, 2022 to 2025'*. https://www.gov.uk/government/publications/hiv-action-plan-annual-update-to-parliament/hiv-action-plan-annual-update-to-parliament

DiFeliciantonio, C. (2020). "Migration as an active strategy to escape the 'second closet' for HIV-positive gay men in Barcelona and Rome." *Social and Cultural Geography* 21 (9): 1177–1196. https://doi.org/10.1080/14649365.2018.1541248

Díaz, R. M., Reisen, C. A., & Zea, M. C. (2003). "Methodological Issues in Research on Sexual Behaviour with Latino Gay and Bisexual Men." *American Journal of Community Psychology* 31 (3–4): 281–291. https://doi.org/10.1023/A:1023962805064

Dinshaw, C., Edelman, L., Ferguson, R., Freccero, C., Freeman, E., & Halberstam, J., Jagose, A., Nealon, C., & Hoan, N. T. (2007). "Theorizing Queer Temporalities: A Roundtable Discussion." *GLQ: A Journal of Lesbian and Gay Studies* 13: 177–195. https://doi.org/10.1215/10642684-2006-030

Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, E., Arthur, A., Harvey, J., Hsu, R., Katbamna, S., Olsen, R., Smith, L., Riley, R., & Sutton, A. J. "Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups." *BMC Medical Research Methodology* 6 (35): https://doi.org/10.1186/1471-2288-6-35

Doan, P. L. (2010). "The Tyranny of Gendered Spaces – Reflections from beyond the Gender Dichotomy". *Gender, Place & Culture: A Journal of Feminist Geography* 17 (5): 635–654. https://doi.org/10.1080/0966369X.2010.503121

Donnelly, J. (2001, June 7). "Prevention urged in AIDS fight; Natsios says fund should spend less on HIV treatment". *Boston Globe*.

Dzomba, A., Tomita, A., Govender, K., & Tanser, F. (2019). “Effects of Migration on Risky Sexual Behavior and HIV Acquisition in South Africa: A Systematic Review and Meta-analysis, 2000-2017”. *AIDS and Behavior* 23 (6): 1396–1430. https://doi.org/10.1007/s10461-018-2367-z

Earl, A., & Albarracín, D. (2007). “Nature, decay, and spiraling of the effects of fear-inducing arguments and HIV counseling and testing: a meta-analysis of the short- and long-term outcomes of HIV-prevention interventions.” *Health Psychology* 26 (4): 496–506. https://doi.org/10.1037/0278-6133.26.4.496

Edelman, L. (2004). *No Future: Queer Theory and the Death Drive*. Durham, NC: Duke University Press.

Egan, J. E., Frye, V., Kurtz, S. P., Latkin, C., Chen, M., Tobin, K., Yang, C., & Koblin, B. A. (2011). “Migration, neighborhoods, and networks: approaches to understanding how urban environmental conditions affect syndemic adverse health outcomes among gay, bisexual and other men who have sex with men.” *AIDS and Behavior* 15 (1): 35–50. https://doi.org/10.1007/s10461-011-9902-5

Elford, J., Doerner, R., McKeown, E., Nelson, S., Anderson, J., & Low, N. (2012). “HIV Infection Among Ethnic Minority and Migrant Men Who Have Sex With Men in Britain.” *Sexually Transmitted Diseases* 39 (9): 678–86. https://doi.org/10.1097/OLQ.0b013e31825c8018

Ellis, M., & Muschkin, C. (1996). “Migration of persons with AIDS – a search for support from elderly parents?” Social Science & Medicine 43 (7): 1109–1118. https://doi.org/10.1016/0277-9536(96)00031-7

Elsesser, S. A., Oldenburg, C. E., Biello, K. B., Mimiaga, M. J., Safren, S. A., Egan, J. E., Novak, D. S., Krakower, D. S., Stall, R., & Mayer, K. H. (2016). “Seasons of Risk: Anticipated Behavior on Vacation and Interest in Episodic Antiretroviral Pre-exposure Prophylaxis (PrEP) Among a Large National Sample of U.S. Men Who have Sex with Men (MSM).” *AIDS and Behavior* 20: 1400–1407. https://doi.org/10.1007/s10461-015-1238-0

Endsjø, D. O. (2008). “The Queer Periphery: Sexual Deviancy and the Cultural Understanding of Space.” *Journal of Homosexuality* 54 (1–2): 9–20. https://doi.org/10.1080/00918360801951939

Eribon, D. 2013. *Returning to Reims*. (M. Lucey, Trans.) Cambridge, MA: MIT Press. (Original work published 2009).

Escoffier, J. (1985). “Sexual Revolution and the Politics of Gay Identity.” *Socialist Review* 15 (4/5): 119–153.

European Centre for Disease Prevention and Control (ECDC). (2024). “HIV/AIDS surveillance in Europe, 2024 (2023 data).” https://www.ecdc.europa.eu/sites/default/files/documents/HIV_Surveillance_Report_2024.pdf

Evans, A. R., Parutis, V., Hart, G., Mercer, C. H., Gerry, C. Mole, R., French, R. S., Imrie, J., & Burns, F. M. (2009). “The sexual attitudes and lifestyles of London’s Eastern Europeans (SALLEE Project): design and methods.” *BMC Public Health* 9: 399. https://doi.org/10.1186/1471-2458-9-399

Evans, A., Burns, F., Mercer, C. H., Parutis, V., Gerry, C. J., Mole, R. C. M., Imrie, J., & Hart, G. J. (2011). “Central and East European migrant men who have sex with men: an exploration of sexual risk in the UK.” *Sexually Transmitted Infections* 87: 325–330. https://doi.org/10.1136/sti.2010.046409

Fakoya, I., Reynolds, R., Caswell, G., & Shiripinda, I. (2008). “Barriers to HIV Testing for Migrant Black Africans in Western Europe.” *HIV Medicine* 9 (2): 23–5. https://doi.org/10.1111/j.1468-1293.2008.00587.x

Finnerty, F., Azad, Y., & Orkin, C. (2019). “Hostile health-care environment could increase migrants’ risk of HIV and prevent access to vital services”. *The Lancet HIV* 6 (2). https://doi.org/10.1016/S2352-3018(19)30004-9

Floyd, F., & Bakeman, R. (2006). “Coming-Out Across the Life Course: Implications of Age and Historical Context.” *Archives of Sexual Behavior* 35: 287–296. https://doi.org/10.1007/s10508-006-9022-x

Ford, N., & Kittisuksathit, S. (1996). “Mobility, Love and Vulnerability: Sexual Lifestyles of Young and Single Factory Workers in Thailand”. *International Journal of Population Geography* 2 (1): 23–33. https://doi.org/10.1002/(SICI)1099-1220(199603)2:1%3C23::AID-IJPG13%3E3.0.CO;2-K

Foucault, M. (1973). *The Birth of the Clinic: An Archaeology of Medical Perception*. New York City, NY: Pantheon Books.

Foucault, M. (1996). “Friendship as a Way of Life.” In S. Lotringer (Ed.), *Foucault Live: Collected Interviews, 1961–1984.* New York City, NY: Semiotext(e).

Freeman, E. (2010). *Time Binds: Queer Temporalities, Queer Histories*. Durham, NC: Duke University Press.

Frost, S. (2011). *Feminist Epistemology and Philosophy of Science*. Dordrecht, Netherlands: Springer.

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). “Using the framework method for the analysis of qualitative data in multi-disciplinary health research.” BMC Medical Research Methodology 13 (117). https://doi.org/10.1186/1471-2288-13-117

Ganczak, M., Czubińska., Korzeń, M., & Szych, Z. (2017). “A Cross-Sectional Study on Selected Correlates od High Risk Sexual Behavior in Polish Migrants Resident in the United Kingdom.” *International Journal of Environmental Research and Public Health* 14 (4): 422. https://doi.org/10.3390/ijerph14040422

Garett, R., & Young, S. D. (2022). “The Impact of Misinformation and Health Literacy on HIV Prevention and Service Usage.” *The Journal of the Association of Nurses in AIDS Care* 33 (1): e1–e5. https://doi.org/10.1097/JNC.0000000000000298

Gillibrand, R., & Turner, K. (2013). “‘Let’s talk about sex’: A post-structuralist discourse analysis into the meanings and experiences of anal sex for gay men.” *Psychology of Sexualities Review* 4 (1): 53–67. https://doi.org/10.53841/bpssex.2013.4.1.53

Gios, L., Mirandola, M., Sherriff, N., Toskin, I., Blondeel, K., Dias, S., Staneková, D., Folch, C., Schink, S. B., Nöstlinger, C., van den Berghe, W., Naseva, E., & Alexiev, I. (2019). “Being in the Closet. Correlates of Outness Among MSM in 13 European Cities.” *Journal of Homosexuality* 68 (3): 415–433. https://doi.org/10.1080/00918369.2019.1656033

Glaude-Hosch, J. A., Smith, M. L., Heckman, T. G., Miles, T. P., Olubajo, B. A., & Ory, M. G. (2015). “Sexual Behaviors, Healthcare Interactions, and HIV-Related Perceptions Among Adults Age 60 Years and Older: An Investigation by Race/Ethnicity.” *Current HIV Research* 13 (5): 359–68. https://doi.org/10.2174/1570162x13666150511124959

Gorman-Murray, A. (2007). “Rethinking Queer Migration Through the Body.” *Social and Cultural Geography* 8 (1): 105–121. https://doi.org/10.1080/14649360701251858

Gorman-Murray, A. (2007). “Rethinking queer migration through the body.” *Social & Cultural Geography* 8 (1): 105–121. https://doi.org/10.1080/14649360701251858

Gorman-Murray, A. (2009). “Intimate Mobilities: Emotional Embodiment and Queer Migration”. *Social and Cultural Geography* 10 (4): 441–460. https://doi.org/10.1080/14649360902853262

Gosselin, A., Ravalihasy, A., Pannetier, J., Lert, F., & Desgrées du Loû, A. (2020). “When and why? Timing of post-migration HIV acquisition among sub-Saharan migrants in France.” *Sexually Transmitted Infections* 96: 227–231. https://doi.org/10.1136/sextrans-2019-054080

Graham, C. (2007, July 1). “Gay Poles Head for UK to Escape State Crackdown.” *The Guardian.* https://www.theguardian.com/world/2007/jul/01/gayrights.uk

Gray, M. L. (2009). *Out in the Country: Youth, Media, and Queer Visibility in Rural America.* New York City, NY: NYU Press.

Hadžimuhamedović, S. (2018). *Waiting for Elijah: Time and Encounter in the Bosnian Landscape.* Oxford, UK: Berghahn Books.

Halberstam, J. (2005). *In a Queer Time and Place: Transgender Bodies, Subcultural Lives*. New York City, NY: NYU Press.

Halperin, D. M. (2012). *How to Be Gay*. Cambridge, MA: Harvard University Press.

Hammoud, M. A., Vaccher, S., Jin, F., Bourne, A., Maher, L., Holt, M., Bavinton, B. R., Haire, B., Degenhardt, L., Grulich, A., & Prestage, G. P. (2019). "HIV Pre-exposure Prophylaxis (PrEP) Uptake Among Gay and Bisexual Men in Australia and Factors Associated With the Nonuse of PrEP Among Eligible Men: Results From a Prospective Cohort Study." Journal of Acquired Immune Deficiency Syndrome 81 (3): e73–e84. https://doi.org/10.1097/QAI.0000000000002047

Hansen, L. (2006). *Security as Practice: Discourse Analysis and the Bosnian War*. Oxford, UK: Routledge.

Haour-Knipe, M., & Rector, R. (1996). *Crossing Borders: Migration, Ethnicity and AIDS.* Exeter, UK: Taylor & Francis.

Haraway, D. (1988). "Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective." *Feminist Studies* 14 (3): 575–599. https://doi.org/10.2307/3178066

Harding, S. (1986). *The Science Question in Feminism*. Ithaca, NY: Cornell University Press.

Hatzenbuehler, M. L., Phelan, J. C., Link, B. G. (2013). "Stigma as a Fundamental Cause of Population Health Inequalities." *American Journal of Public Health* 103 (5): 813–821. https://doi.org/10.2105/AJPH.2012.301069

Heffner, P. S. (2017). "The Exploration of Homophobia within Institutional Settings: Exploration of Homophobia in Schools." [Doctoral dissertation, University of Pennsylvania]. Scholarly Commons. https://repository.upenn.edu/entities/publication/fcff3849-9ac2-4751-a498-98aef85caff6

Herdt, G. H. (1997). *Sexual Cultures and Migration in the Era of AIDS: Anthropological and Demographic Perspectives*. Oxford, UK: Clarendon Press.

Herring, S. (2010). *Another Country: Queer Anti-Urbanism*. New York City, NY: NYU Press.

Horak, L. (2014). “Trans on YouTube: Intimacy, Visibility, Temporality”. *Transgender Studies Quarterly* 1 (4): 572–585. https://doi.org/10.1215/23289252-2815255

Howard, J. (1999). *Men Like That: A Southern Queer History.* Chicago, IL: University of Chicago Press.

Hubbard, P. (2001). “Sex Zones: Intimacy, Citizenship and Public Space.” *Sexualities* 4 (1): 51–71. https://doi.org/10.1177/136346001004001003

Hunter, L. M., & Simon, D. H. (2017). “Might climate change the “healthy migrant” effect?” *Global Environmental Change* 47: 133–142. https://doi.org/10.1016/j.gloenvcha.2017.10.003

Jain, S. L. (2020). “The WetNet: What the Oral Polio Vaccine Hypothesis Exposes about Globalized Interspecies Fluid Bonds.” *Medical Anthropology Quarterly: International Journal for the Analysis of Health* 34 (4): 504–524. https://doi.org/10.1111/maq.12587

Johnson, M. A. (2013). “More Than Pop Culture: Depictions of HIV in the Media and the Effect on Viewer’s Perception of Risk.” *Journal of Homosexuality* 60 (8): 1117–1142. https://doi.org/10.1080/00918369.2013.776423

Kafer, A. (2013). *Feminist, Queer, Crip*. Indianapolis, IN: Indiana University Press.

Kazyak, E. (2010). “The space and place of sexuality: How rural lesbians and gays narrate identity.” [Doctoral dissertation, University of Michigan]. University of Michigan Library. https://hdl.handle.net/2027.42/77837

Kelley, P., Pebody, R., & Scott, P. (1996). *How Far Will You Go: A Survey of London Gay Men's Migration and Mobility* [Data set]. London, UK: ¿Queery? (research arm of *Gay Men Fighting AIDS*).

King James Bible. (2017). King James Bible Online. (Original work published 1769). https://www.kingjamesbibleonline.org/

Knauer, N. J. (2000). "Homosexuality as Contagion: From the Well of Loneliness to the Boy Scouts". *Hofstra Law Review* 29 (2): 401–502. https://doi.org/10.1057/9781137535269_1

Kumar B., Kaushal, I., Narayanan, B., & Narang, T. (2025). "Sexually transmitted infections in the elderly: A growing concern in geriatric care." *Indian Journal of Sexually Transmitted Diseases and AIDS* 46 (1): 16–21. https://doi.org/10.4103/ijstd.ijstd_108_24

Kushner, T. (1993). *Angels in America: A Gay Fantasia on National Themes* [Work of theatre]. New York City, NY: Theatre Communications Group. https://archive.org/details/angelsinamericag0000kush/mode/2up

Laclau, E., & Mouffe, C. (1985). *Hegemony and Socialist Strategy: Towards a Radical Democratic Politics*. London, UK: Verso Books.

LaMonaca, K., Dumchev, K., Dvoriak, S., Azbel, L., Morozova, O., & Altice, F. L. (2019). "HIV, Drug Injection, and Harm Reduction Trends in Eastern Europe and Central Asia: Implications for International and Domestic Policy." *Current Psychiatry Reports* 21 (47). https://doi.org/10.1007/s11920-019-1038-8

Latour, B. (1987). *Science in Action: How to Follow Scientists and Engineers through Society.* Cambridge, MA: Harvard University Press.

Latour, B. (2003). "The promises of constructivism." In D. Ihde (Ed.), *Chasing Technology: Matrix and Materiality*. Bloomington, IN: Indiana University Press. http://www.bruno-latour.fr/sites/default/files/87-CONSTRUCTIVISM-GB.pdf

Levitan, J., Carr-Chellman, D., & Carr-Chellman, A. (2017). “Accidental ethnography: A method for practitioner-based education research.” *Action Research* 18 (3): 336–352. https://doi.org/10.1177/1476750317709078

Lewis, N. M. (2014). “Moving “Out,” Moving On: Gay Men’s Migrations Through the Life Course.” *Annals of the Association of American Geographers* 104 (2): 225–233. https://doi.org/10.1080/00045608.2013.873325

Lewis, N. M. (2012). “Remapping Disclosure: gay men's segmented journeys of moving out and coming out.” *Social & Cultural Geography* 13 (3): 211–231. https://doi.org/10.1080/14649365.2012.677469

Li, C-C., Matthews, A. K., Aranda, F., Patel, C., & Patel, M. (2015). “Predictors and Consequences of Negative Patient-Provider Interactions Among a Sample of African American Sexual Minority Women.” *LGBT Health* 2 (2):140–6. https://doi.org/10.1089/lgbt.2014.0127

Lindstrom, D., & Munoz-Franco, E. (2005). “Migration and the diffusion of modern contraceptive knowledge and use in rural Guatemala”. *Studies in Family Planning* 36 (4): 277–288. https://doi.org/10.1111/j.1728-4465.2005.00070.x

Lisle, D. (2006). *The Global Politics of Contemporary Travel Writing*. Cambridge, UK: Cambridge University Press.

Ljuslinder, K., Ellis, K., & Vikström, L. (2020). “Cripping Time: Understanding the Life Course through the Lens of Ableism”. *Scandinavian Journal of Disability Research* 22 (1): 35–38. https://doi.org/10.16993/sjdr.710

MacLure, M. (2013). “Researching without representation? Language and materiality in post-qualitative methodology”. *International Journal of Qualitative Studies in Education* 16 (6): 658–667. https://doi.org/10.1080/09518398.2013.788755

Mai, N. (2004). “Albanian masculinities, sex-work and migration: homosexuality, AIDS and other moral threats.” In M. Worton, & N. Wilson-Tagoe (Eds.), *National Healths*. London, UK: UCL Press. https://doi.org/10.4324/9781315066608

Manalansan, M. F. (2006). “Queer Intersections: Sexuality and Gender in Migration Studies”. *International Migration Review* 40 (1): 224–249. https://doi.org/10.1111/j.1747-7379.2006.00009.x

Mangold, J. (Director) (1999). *Girl, Interrupted* [Film]. Columbia Pictures, Red Wagon Entertainment.

Marsicano, E., Lydie, N., & Bajos, N. (2011). “Gender and Migration: The Sexual Debut of Sub-Saharan African Migrants in France”. *Population* 66 (2): 275–301. https://doi.org/10.3917/popu.1102.0313

Massad, J. A. (2002). “Re-Orienting Desire: The Gay International and the Arab World.” *Public Culture* 14 (2): 361–385. https://doi.org/10.1215/08992363-14-2-361

Mawson, R. L., Hodges, V., Salway, S., & Mitchell, C. (2025). “Understanding access to sexual and reproductive health in general practice using an adapted Candidacy Framework: a systematic review and qualitative evidence synthesis.” *British Journal of General Practice* 75 (758): e637–e647. https://doi.org/10.3399/BJGP.2024.0522

Mbeda, C., Ogendo, A., Lando, R., Schnabel, D., Gust, D. A., Guo, X., Akelo, V., Dominguez, K., Panchia, R., Mbilizi, Y., Chen, Y., Chege, W., & Sandfort, T. (2020). “Healthcare-related stigma among men who have sex with men and transgender women in sub-Saharan Africa participating in HIV Prevention Trials Network (HPTN) 075 study.” *AIDS Care* 32 (8): 1052–1060. https://doi.org/10.1080/09540121.2020.1776824

Mbiti, J. S. (1969). *African Religions & Philosophy*. London, UK: Heinemann Publishing.

McDaniel, D. Y. (2016, June 4). “Sex and Seniors – STDs a New Reality for the Elderly.” *The Huffington Post*. https://www.huffpost.com/entry/sex-and-seniors-stds-a-ne_b_9619778

McGlynn, N. (2014). “In the Shadow of the Gay Capital: Lesbian, Gay, Bisexual and Trans Equalities in ‘Rural’ and ‘Non-Urban’ East Sussex.” [Doctoral dissertation, University of Brighton]. University of Brighton Student Theses.

https://cris.brighton.ac.uk/ws/portalfiles/portal/4757733/In%20the%20Shadow%20of%20the%20Gay%20Capital%20binding.pdf

McGlynn, N. (2018). “Slippery geographies of the urban and the rural: Public sector LGBT equalities work in the shadow of the ‘Gay Capital’”. *Journal of Rural Studies* 57: 65–77. https://doi.org/10.1016/j.jrurstud.2017.10.008

McKay, R. (2017). *Patient Zero and the Making of the AIDS Epidemic*. Chicago IL: University of Chicago Press.

McManus, H., Grulich, A. E., Amin, J., Selvey, C., Vickers, T., Bavinton, B., Zablotska, I., Vaccher, S., Jin, F., Holden, J., Price, K., Yeung, B., Cabrera Quichua, G., Ogilvie, E., McNulty, A., Smith, D., & Guy, R. (2020). “Comparison of Trends in Rates of Sexually Transmitted Infections Before vs After Initiation of HIV Preexposure Prophylaxis Among Men Who Have Sex With Men.” *JAMA Network Open* 3 (12): e2030806. https://doi.org/10.1001/jamanetworkopen.2020.30806

Miller, W. C., Rosenberg, N. E., Rutstein, S. E., & Powers, K. A. (2010). “The Role of Acute and Early HIV Infection in the Sexual Transmission of HIV”. *Current Opinion in HIV and AIDS* 5 (4): 277–282. https://doi.org/10.1097/COH.0b013e32833a0d3a

Mol, A. (2002). *The Body Multiple: Ontology in medical practice*. Durham, NC: Duke University Press.

Mole, R. C. M. (2021). *Queer Migration and Asylum in Europe.* London, UK: UCL Press.

Mole, R. C. M., Gerry, C. J., Parutis, V., & Burns, F. M. (2017). “Migration and Sexual Resocialisation: The Case of Central and East Europeans in London.” *East European Politics and Societies* 31 (1): 201–222. https://doi.org/10.1177/0888325416682813

Mole, R. C. M., Parutis, V., Gerry, C. J., & Burns, F. M. (2014). “The impact of migration on the sexual health, behaviours and attitudes of Central and East European gay/bisexual men in London.” *Ethnicity & Health* 19 (1): 86–99. https://doi.org/10.1080/13557858.2013.789829

Monteiro, S., Villela, W., Soares, P., Pinho, A., & Fraga, L. (2018). "'Protective' silence surrounding AIDS: Reasons and implications of non-disclosure among pregnant women living with HIV in Rio de Janeiro (Brazil)." *Global Public Health* 13 (1): 51–64. https://doi.org/10.1080/17441692.2016.1211163

Müller, A., Spencer, S., Meer, T., & Daskilewicz, K. (2018). "The no-go zone: a qualitative study of access to sexual and reproductive health services for sexual and gender minority adolescents in Southern Africa." *Reproductive Health* 15 (12). https://doi.org/10.1186/s12978-018-0462-2

Muñoz, E. (2009). *Cruising Utopia: The Then and There of Queer Futurity*. New York City, NY: NYU Press.

Muñoz-Laboy, M., Hirsch, J. S., & Quispe Lazaro, A. (2009). "Loneliness as a Sexual Risk Factor for Male Mexican Migrant Workers". *American Journal of Public Health* 99 (5): 802–810. https://doi.org/10.2105/AJPH.2007.122283

Murphy, D. (2020, June 16). "Experience of HIV among overseas-born men who have sex with men (MSM) and MSM from migrant backgrounds." [Report]. *Australian Federation of AIDS Organisations.* https://napwha.org.au/wp-content/uploads/2021/10/Experience-of-HIV-among-overseas-born-MSM-and-MSM-from-migrant-backgrounds-Dean-Murphy.pdf

Namey, E., Agot, K., Ahmed, K., Odhiambo, J., Skhosana, J., Guest, G., & Corneli, A. (2016). "When and why women might suspend PrEP use according to perceived seasons of risk: implications for PrEP-specific risk-reduction counselling." *Culture, Health & Sexuality* 18 (9): 1081–1091. https://doi.org/10.1080/13691058.2016.1164899

NBC. (1982, June 17). "Cancer Study". *Nightly News*. https://www.youtube.com/watch?v=1LKJ5ZzzL0w

Nelkin, D. (1994). "Promotional Metaphors and Their Popular Appeal." *Public Understanding of Science* 3 (1): 25–31. https://doi.org/10.1088/0963-6625/3/1/002

Newcomb, M. D., Wyatt, G. E., Romero, G. J., Tucker, M. B., Wayment, H. A., Carmona, J. V., Solis, B., & Mitchell-Kernan, C. (1998). “Acculturation, sexual risk taking, and HIV health promotion among Latinas”. *Journal of Counseling Psychology* 45 (4): 454–467. https://doi.org/10.1037/0022-0167.45.4.454

Nyhan, B., Reifler, J., Richey, S., & Freed, G. L. (2014). “Effective Messages in Vaccine Promotion: A Randomized Trial.” *Pediatrics* 133 (4): e835–e842. https://doi.org/10.1542/peds.2013-2365

O’Farrell, M., Corcoran, P., & Davoren, M. P. (2021). “Examining LGBTI+ inclusive sexual health education from the perspective of both youth and facilitators: a systematic review.” *BMJ Open* 11 (9): e047856. https://doi.org/10.1136/bmjopen-2020-047856

Olaore, I. B., & Olaore, A. Y. (2014). “Is HIV/AIDS a consequence or divine judgment? Implications for faith-based social services. A Nigerian faith-based university’s study.” *SAHARA: Journal of Social Aspects of HIV/AIDS Research Alliance*, 11 (1): 20–25. https://doi.org/10.1080/17290376.2014.910134

Otolok-Tanga, E., Atuyambe, L., Murphy, C. K., Ringheim, K. E., & Woldehanna, S. (2007). “Examining the actions of faith-based organizations and their influence on HIV/AIDS-related stigma: a case study of Uganda.” *African Health Sciences* 7 (1): 55–60. https://doi.org/10.5555/afhs.2007.7.1.55

Pachankis, J. E., Hatzenbuehler, M. L., Berg, R. C., Fernandez-Davila, P., Mirandola, M., Marcus, U., Weatherburn, P., & Schmidt, A. J. (2017). “Anti-LGBT and Anti-Immigrant Structural Stigma: An Intersectional Analysis of Sexual Minority Men’s HIV Risk When Migrating to or Within Europe”. *The Journal of Acquired Immune Deficiency Syndrome* 76 (4): 356–366. https://doi.org/10.1097/QAI.0000000000001519

Pantelic, M., Boyes, M., Cluver, L., & Thabeng, M. (2018). “‘They Say HIV is a Punishment from God or from Ancestors’: Cross-Cultural Adaptation and Psychometric Assessment of an HIV Stigma Scale for South African

Adolescents Living with HIV (ALHIV-SS).” *Child Indicators Research* 11 (1): 207–223. https://doi.org/10.1007/s12187-016-9428-5

Parrado, E. A., & Flippen, C. A. (2010). “Migration and Sexuality: A Comparison of Mexicans in Sending and Receiving Communities”. *The Journal of Social Issues* 66 (1): 175–195. https://doi.org/10.1111/j.1540-4560.2009.01639.x

Patel, P., Borkowf, C. B., Brooks, J. T., Lasry, A., Lansky, A., & Mermin, J. (2014). “Estimating per-act HIV transmission risk: a systematic review.” *AIDS* 28 (10): 1509–1519. https://doi.org/10.1097/QAD.0000000000000298

Pérez, H. (2015). *A Taste for Brown Bodies: Gay Modernity and Cosmopolitan Desire*. New York City, NY: NYU Press.

Perone, A. K., Toman, L., Glover Reed, B., Coldon, T., Osborne, A., & Cook, J. (2025). “Aging and Mentorship in the Margins: Multigenerational Knowledge Transfer Among LGBTQ+ Chosen Families.” *The Journals of Gerontology B: Psychological Sciences and Social Sciences* 80 (6): gbaf027. https://doi.org/10.1093/geronb/gbaf027

Phung, V-H., Asghar, Z., Matiti, M., & Siriwardena, A. N. (2020). “Understanding how Eastern European migrants use and experience UK health services: a systematic review”. *BMC Health Services Research* 20: 173. https://doi.org/10.1186/s12913-020-4987-z

Pineda, J. E. R. (2020). “Vulnerability to HIV/AIDS in gay and bisexual individuals during migration: the case of Colombian immigrants residing in Spain”. *Saude e Sociedade* 29 (3): 1–12. https://doi.org/10.1590/S0104-12902020190298

Porter, K., Babiker, A., Bhaskaran, K., Darbyshire, J., Pezzotti, P., Porter, K., & Walker, A. S. (2003). “Determinants of survival following HIV-1 seroconversion after the introduction of HAART”. *The Lancet* 362 (9392): 1267–1274. https://doi.org/10.1016/s0140-6736(03)14570-9

Povinelli, E. (2006). *The Empire of Love: Towards a theory of intimacy, genealogy and carnality.* Durham, NC: Duke University Press.

Preciado, P. 2013. *Testo Junkie: Sex, Drugs and Biopolitics in the Pharmacopornographic Era*. (B. Benderson, Trans.) New York City, NY: The Feminist Press. (Original work published 2008).

Prost, A., Chopin, M., McOwan, A., Elam, G., Dodds, J., Macdonald, N., & Imrie, J. (2007). ""There is such a thing as asking for trouble": taking rapid HIV testing to gay venues is fraught with challenges." *Sexually Transmitted Infections* 83: 185–188. https://doi.org/10.1136/sti.2006.023341

Puar, J. K. (2007). *Terrorist Assemblages: Homonationalism in Queer Times*. Durham, NC: Duke University Press. https://doi.org/10.2307/j.ctv1131fg5

Puar, J. K. (2012). ""I would rather be a cyborg than a goddess": Becoming-Intersectional in Assemblage Theory." *PhiloSOPHIA* 2 (1): 49–66. https://doi.org/10.1353/phi.2012.a486621

Puar, J., Rushbrook, D., & Schein, L. (2003). "Sexuality and Space: Queering Geographies of Globalization." *Environment and Planning D: Society & Space* 21: 383–387. https://doi.org/10.1068/d2104ed

Pulk, K. (2022). *Time and Temporality in Organisations: Theory and Development*. London, UK: Springer Books. https://doi.org/10.1007/978-3-030-90696-2

Quinn, S. (2006). "Accessing Health: the Context and the Challenges for LGBT People in Central and Eastern Europe." [Report]. *ILGA-Europe*. https://www.ilga-europe.org/files/uploads/2022/05/accessing-health-context-and-challenges-lgbt-People-Central-Eastern-Europe.pdf

Rao, R. (2020). *Out of Time: The Queer Politics of Postcoloniality*. Oxford, UK: Oxford University Press. https://doi.org/10.1093/oso/9780190865511.001.0001

Ravier, A. (2025). "Barriers to belonging: race and class in the spatial socialisation of gay men residing in French working-class neighbourhoods." *French Politics*. https://doi.org/10.1057/s41253-025-00283-6

Reynolds, A. L., Manges, M. E., McCabe, E. A., Kashani, B., Mercado Irizarry, E., & Reslink, A. (2025). “Examining the Intersection of Sexual Orientation and Gender on Outness and Identity.” *Journal of LGBTQ Issues in Counseling* 19 (2): 197–215. https://doi.org/10.1080/26924951.2025.2471751

Rivkin-Fish, M. (1999). “Sexuality Education in Russia: Defining Pleasure and Danger for a Fledgling Democratic Society.” *Social Science & Medicine* 49: 801–814. https://doi.org/10.1016/s0277-9536(99)00168-9

Rivkin-Fish, M. (2006). “From ‘demographic crisis’ to ‘dying nation’ the Politics of Language and Reproduction in Russia.” In H. Goscilo, & A. Lanoux (Eds.), *Gender and National Identity in Twentieth-Century Russian Culture*. DeKalb, IL: Northern Illinois University Press.

Rohy, V. (2009). *Anachronism and its Others: Sexuality, Race, Temporality.* New York City, NY: State University of New York Press.

Ross M. W., Berg, R. C., Schmidt, A. J., Hospers, H. J., Breveglieri, M., Furegato, M., & Weatherburn, P. (2013). “Internalised homonegativity predicts HIV-associated risk behavior in European men who have sex with men in a 38-country cross-sectional study: some public health implications of homophobia.” *BMJ Open* 3: e001928. https://doi.org/10.1136/bmjopen-2012-001928

Roura, M., Nsigaye, R., Nhandi, B., Wamoyi, J., Busza, J., Urassa, M., Todd, J., & Zaba, T. (2010). ““Driving the devil away”: qualitative insights into miraculous cures for AIDS in a rural Tanzanian ward.” *BMC Public Health* 10 (427). https://doi.org/10.1186/1471-2458-10-427

Rubin, G. (1993). “Thinking sex: notes for a radical theory of the politics of sexuality.” In H. Abelove, M. A. Barale, & D. M. Halperin (Eds.), *The Lesbian and Gay Studies Reader*. London, UK: Routledge.

Samkange-Zeeb, F., Mikolajczyk, R. T., & Zeeb, H. (2013). “Awareness and knowledge of sexually transmitted diseases among secondary school students in two German cities.” *Journal of Community Health* 38 (2): 293–300. https://doi.org/10.1007/s10900-012-9614-4

Schmidt, A. J., Ross, M., Berg, R. C., & Altan, P. (2023). “Impact of Migration and Acculturation on Turkish Men Who Have Sex with Men in Germany: Results from the 2010 European MSM Internet Survey.” *Archives of Sexual Behavior* 52: 283–290 https://doi.org/10.1007/s10508-022-02468-4

Schubert, K. (2019). “The Democratic Biopolitics of PrEP.” In: Gerhards, H., & Braun, K. (Eds.), *Biopolitiken – Regierungen des Lebens heute. Politologische Aufklärung – konstruktivistische Perspektiven*. Wiesbaden, Germany: Springer VS. https://doi.org/10.1007/978-3-658-25769-9_5

Schueler, K., Ferreira, M., Nikolopoulos, G., Skaathun, B., Paraskevis, D., Hatzakis, A., Friedman, S. R., & Schneider, J. A. (2019). “Pre-exposure Prophylaxis (PrEP) Awareness and Use Within High HIV Transmission Networks.” *AIDS and Behavior* 23 (7): 1893–1903. https://doi.org/10.1007/s10461-019-02411-0

Schwartz-Shea, P., & Yanow, D. (2012). *Interpretive Research Design: Concepts and Processes*. Oxford, UK: Routledge.

Selik, R. M., & Linley, L. (2018). “Viral Loads Within 6 Weeks After Diagnosis of HIV Infection in Early and Later Stages: Observational Study Using National Surveillance Data”. *JMIR Public Health and Surveillance* 4 (4): e10770. https://doi.org/10.2196/10770

Sex Education Forum (SEF). (2022, November). “Relationships and Sex Education: The Evidence.” [Report]. https://www.sexeducationforum.org.uk/sites/default/files/field/attachment/RSE%20The%20Evidence%20-%20SEF%202022.pdf

Sinno, J., Daroya, E., Wells, A., Hull, M., Lachowsky, N. J., Tan, D. H. S., & Grace, D. (2024). ““To do so in a patient-centred way is not particularly lucrative”: The effects of neoliberal health care on PrEP implementation and delivery.” *Social Science & Medicine* 347: 116749. https://doi.org/10.1016/j.socscimed.2024.116749

Skolbekken, J. A. (1995). “The Risk Epidemic in Medical Journals”. *Social Science & Medicine* 40 (3): 291–305. https://doi.org/10.1016/0277-9536(94)00262-r

Smith, M. L., Bergeron, C. D., Goltz, H. H., Coffey, T., & Boolani, A. (2020). “Sexually Transmitted Infection Knowledge among Older Adults: Psychometrics and Test-Retest Reliability.” *International Journal of Environmental Research and Public Health* 17 (7): 2462. https://doi.org/10.3390/ijerph17072462

Soames Job, R. F. (1988). “Effective and ineffective use of fear in health promotion campaigns.” *American Journal of Public Health* 78 (2): 163–167. https://doi.org/10.2105/ajph.78.2.163

Štulhofer, A., & Sandfort, T. (2004). *Sexuality and Gender in Postcommunist Eastern Europe and Russia.* New York City, NY: Haworth Press.

Sudhinaraset, M., Astone, N. M., & Blum, R. (2012). “Migration and Unprotected Sex in Shanghai, China: Correlates of Condom Use and Contraceptive Consistency Across Migrant and Nonmigrant Youth”. *Journal of Adolescent Health* 50 (3): S68–74. https://doi.org/10.1016/j.jadohealth.2011.12.007

Tamiru, M., Hailemariam, D., Mitike, G., & Haidar, J. (2011). “HIV-Related Sexual Behaviors among Migrants and Non-Migrants in Rural Ethiopia: Role of Rural to Urban Migration in HIV Transmission”. *International Journal of Biomedical Science* 7 (4): 295–303. https://pmc.ncbi.nlm.nih.gov/articles/PMC3614846/

Thomann, M. (2016). “HIV vulnerability and the erasure of sexual and gender diversity in Abidjan, Côte d'Ivoire.” *Global Public Health* 11 (7–8): 994–1009. https://doi.org/10.1080/17441692.2016.1143524

Thompson, E. P. (1967). “Time, Work-Discipline, and Industrial Capitalism”. *Past & Present* 38 (1): 56–97. https://doi.org/10.1093/past/38.1.56

Trofimov, V. (2019). “Stop it, f*ggot!: Producing East European Geosexual Backwardness in the Drop-in Centre for Male Sex Workers in Berlin.”

Anthropological Journal of European Cultures 28(1): 39–57. https://www.jstor.org/stable/26879476

Turner, M. (2003). *Backward Glances: Cruising the Queer Streets of New York and London.* London, UK: Reaktion Books.

UK Health Security Agency (UKHSA). (2024, October 1). "HIV testing, PrEP, new HIV diagnoses and care outcomes for people accessing HIV services: 2024 report." [Report]. https://webarchive.nationalarchives.gov.uk/ukgwa/20250904220157/https://www.gov.uk/government/statistics/hiv-annual-data-tables/hiv-testing-prep-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2024-report

UK Health Security Agency (UKHSA). (2025, October 7). "HIV testing, PrEP, new HIV diagnoses and care outcomes for people accessing HIV services: 2025 report." [Report]. https://www.gov.uk/government/statistics/hiv-annual-data-tables/hiv-testing-prep-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2025-report

USAID. (2019, February). "Strategic Program for Analyzing Complexity and Evaluating Systems (SPACES): Zambia Cross-Border Health Seeking Behavior." [Report]. https://linclocal.org/wp-content/uploads/2019/05/Zambia_Final-Report_5.14.pdf

Usta, D. D., & Ozbilgin, M. F. (2023). "The hidden side of migration: Understanding sexuality as an aspiration to migrate." *Frontiers in Sociology* 7. https://doi.org/10.3389/fsoc.2022.1027268

Wald, P. (2008). *Contagious: Cultures, Carriers, and the Outbreak Narrative*. Durham, NC: Duke University Press.

Ward, Z., Stone, J., Bishop, C., Ivakin, V., Eritsyan, K., Deryabina, A., Low, A., Cepeda, J., Kelly, S. L., Heimer, R., Cook, R., Altice, F. L., Litz, T., Terlikbayeva, A., El-Bassel, N., Havarkov, D., Fisenka, A., Boshnakova, A., Klepikov, A., Saliuk, T., Deshko, T., & Vickerman, P. (2022). "Costs and impact on HIV transmission of a switch from a criminalisation to a

public health approach to injecting drug use in eastern Europe and central Asia: a modelling analysis." *The Lancet HIV* 9 (1): e42–e53. https://doi.org/10.1016/S2352-3018(21)00274-5

Watney, S. (1987). *Policing Desire: Pornography, AIDS and the Media.* Madison, WI: University of Minnesota Press.

Waugh, M. A. (1999). "Task Force for the Urgent Response to the Epidemics of Sexually Transmitted Diseases in Eastern Europe and Central Asia." *Sexually Transmitted Infections* 75 (1): 72–73. https://doi.org/10.1258/0956462991912962

Weeks, J. (1985). *Sexuality and its Discontents: Meanings, Myths and Modern Sexualities.* London, UK: Routledge.

Weston, K. (1995). "Get Thee to a Big City: Sexual Imaginary and the Great Gay Migration". *GLQ* 2 (3): 253–277. https://doi.org/10.1215/10642684-2-3-253

Whitehead, J., Shaver, J., & Stephenson, R. (2016). "Outness, Stigma, and Primary Health Care Utilization among Rural LGBT Populations." *PLOS ONE* 11 (1): e0146139. https://doi.org/10.1371/journal.pone.0146139

Williams, A. D. N. (2023, October). "Understanding the Relationship Between HIV Pre-Exposure Prophylaxis, Sexually Transmitted Infections, and Antimicrobial Resistance." [Doctoral dissertation, University of Cardiff]. Orca Cardiff. https://orca.cardiff.ac.uk/id/eprint/165851/

Willie, T. C., Keene, D. E., Kershaw, T. S., & Stockman, J. K. (2020). ""You Never Know What Could Happen": Women's Perspectives of Pre-Exposure Prophylaxis in the Context of Recent Intimate Partner Violence." *Women's Health Issues: Official Publication of the Jacobs Institute of Women's Health* 30 (1): 41–48. https://doi.org/10.1016/j.whi.2019.08.001

Wilson, E. (1991). *The Sphinx in the City: Urban Life, the Control of Disobedience, and Women.* Berkeley, CA: University of California Press.

Woods, W. J., Euren, J., Pollack, L. M., & Binson, D. (2010). “HIV Prevention in Gay Bathhouses and Sex Clubs across the United States.” *Journal of Acquired Immune Deficiency Syndrome* 15 (55) (S2): S88–S90. https://doi.org/10.1097/QAI.0b013e3181fbca1b

Wray, T. B., Celio, M. A., Pérez, A. E., DiGuiseppi, G. T., Carr, D. J., Allison Woods, L., & Monti, P. M. (2019). “Causal Effects of Alcohol Intoxication on Sexual Risk Intentions and Condom Negotiation Skills Among High-Risk Men Who Have Sex with Men (MSM).” *AIDS and Behavior* 23: 161–174. https://doi.org/10.1007/s10461-018-2243-x

Wu, J., Wu, H., Li, P., & Wu, C. L. (2016). “HIV/STIs risks between migrant MSM and local MSM: a cross-sectional comparison study in China.” *PeerJ* 4: e2169. https://doi.org/10.7717/peerj.2169

Xu, C. X., & Xu, Y. (2022). “HIV testing among LGBTQIA+ individuals: the impact of outness and peer openness.” *International Journal of Adolescence and Youth* 27 (1): 541–554. https://doi.org/10.1080/02673843.2022.2152718

Yang, X. Y., Kelly, B. C., & Yang, T. (2016). “Together we have fun: native-place networks and sexual risk behaviours among Chinese male rural-urban migrants”. *Sociology of Health and Illness* 38 (4): 559–575. https://doi.org/10.1111/1467-9566.12380

Zea, M. C. (1999). “Latino HIV–positive gay men’s narratives on disclosure of serostatus.” [Conference presentation]. 127th *American Public Health Association* annual meeting, Chicago, IL.

Zea, M. C. (2000, August 04-08). “Anticipated consequences as barriers and facilitators of disclosure.” [Conference presentation]. In M. C. Zea (Chair), *HIV risk among Latino and Asian gay men: Recent findings*. Symposium presented at the 108th *American Psychological Association* annual convention, Washington, DC.