MONASH University

Risk, safety, stigma, liberation, and pleasure: The experience of sex in the era of pre-exposure prophylaxis

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Abstract

HIV pre-exposure prophylaxis (PrEP) involves the use of antiretroviral therapy by people who are HIV-negative. PrEP has been shown in trials to be highly efficacious at preventing HIV transmission. Given this efficacy, PrEP enables men who have sex with men (MSM) to experience condomless anal sex with significantly reduced risk of HIV infection. Drawing on ethnographic fieldwork conducted in Melbourne, Australia, this thesis explores the emergence and use of PrEP by MSM and, more specifically, how PrEP shapes and reshapes the experience of sex. Multi-sited ethnographic fieldwork was conducted between November 2017 and August 2018 at sites including a male-only bar in Melbourne's inner city, various community events aimed at MSM, and PrEP medical panels and advocacy sessions. Observations were also undertaken on the social media pages of two Australian-based PrEP advocacy groups, and interviews conducted with PrEP advocates, PrEP users, and people living with HIV.

PrEP has displaced condoms as the primary means of HIV prevention among MSM. In doing so, it has shifted previous norms of how sexual risk and safety can be understood. Unlike condoms which to be effective must be used during sex, PrEP can be used outside of sex and continue to provide protection against HIV. By removing HIV risk from sexual activity, PrEP opens the possibility for condomless anal sex to be conceptualised as "safe." After providing context of the HIV and PrEP landscape in Australia, this thesis discusses PrEP users' conceptualisations of sexual risk and safety. I argue that epidemiological approaches to sexual health which prioritise the prevention of STIs are too narrow to adequately account for how sexual risk and safety are experienced. PrEP users in this study took a more holistic approach to sexual health and emphasised the importance of sexual pleasure and intimacy, a sense of empowerment and control, and as being able to embrace and celebrate one's sexuality. In the second part of this thesis, I highlight how in shifting conceptualisations of sexual risk, PrEP opens new possibilities for experiencing sexual pleasure and intimacy. I argue that by displacing HIV prevention from sex, PrEP also displaces HIV and HIV risk as part of the sexual experience. The protection against HIV offered by PrEP can disrupt associations of sexual partners as potential sites of danger, such that HIV status can become seemingly irrelevant. Through displacing HIV, PrEP offers the possibility of experiencing

sex through assemblages that foreground pleasure and not, importantly, through assemblages that include HIV risk and danger.

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Throughout my PhD journey, I have been privileged to have had the support, guidance, love, and care of a huge team of people. While my name appears as the sole author of this thesis, it is a product of the work and energy of a huge team of people. Of these, my husband Sebastian has been my greatest cheerleader. Through the many highs and the many lows, you have stood by me, encouraged me, and forced me take a break when I needed. You became so invested that you even managed to accurately describe what I was researching before I submitted! Thank you.

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Unlike many PhD and post-graduate students, I have had the privilege of studying in a department that does not seem to differentiate between academic staff, professional staff, or postgraduate students. In particular, the support and encouragement of Lesley Hawes and Annette Peart has helped me get this thesis over the line. I have also been lucky enough to have the support of Natalie Amos in the final stages of this project. Nat, I look forward to the day we are working together. Thanks also to my PhD colleagues: Pallavi Prathivadi, Sajal Saha, Daniel Epstein, Karen Price, and Pip Buckingham. Thank you as well to Timothy Staunton-Smith, Nilakshi Gunatillaka, Sharon Clifford, Grant Russell, and Clare Beeby. Each of you in different ways have impacted this project.

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To my family, you have been a constant source of support. Your love has never wavered, and you have always encouraged me to pursue what my passions.

Finally, and at the risk of seeming flippant, I must also thank my two furry, feline companions – Madam and The Dude. You have both been a huge inconvenience throughout this project, sat on my keyboard, deleted entire documents, re-formatted my references, and just got in the way generally. At the same time, you have both made the often-lonely task of writing enjoyable, providing with company, and listening to me as I talked through ideas. You have also served as a constant reminder that there is always something more important to do in life than work: enjoy the sun, give affect, and stare into space to contemplate the world. You both bring so much joy to my life.

Declaration

This thesis is an original work of my research and contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Signature:

Print Name: Nathanael Wells

Date: Friday 20 November 2020

COVID-19 Preamble

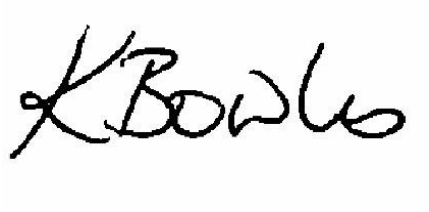
The COVID-19 pandemic has had a significant impact on individuals' lives. Academia and research have not been exempt from this virus, and for some, this period of time has affected the progress and outputs of their research program. Candidates within the School of Primary and Allied Health Care may have experienced impacts on their research progress and outputs from:

- Closure of research laboratories limiting the collection of complete data sets;
- Requirements to work (or prepare to work) in a surge health workforce limiting time to commit to studies;
- Health services ceasing or limiting research not related to COVID-19;
- Additional parental responsibilities as school closures resulted in remote learning for dependent children;
- Closure of child care centres and restrictions on child care arrangements;
- Travel restrictions (both overseas and locally) affecting research progress;
- Additional responsibilities as academic teaching was restructured to an online model;
- Financial restraints to funding research costs;
- Effective closure of on-campus offices for staff and students; and,
- Any of the above issues affecting access to timely feedback from or engagement with supervisors.

Monash University and the School of Primary and Allied Health Care has implemented a range of measures to support candidates through this period, however there are issues beyond the candidate's or University's control. We do ask that when reviewing this thesis, you remain mindful of the challenges our candidatures have faced and assess their work relative to the time in which they are studying. Below is a paragraph prepared by the student to explain the direct effect of COVID-19 on their studies and the preparation of their thesis.

Yours thankfully.

Dr Kelly-Ann Bowles



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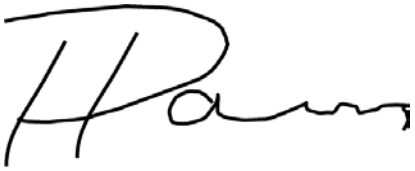

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Student Impact Statement

Like many research students in Australia, this project has been affected by the COVID-19 pandemic and the disruption caused by the virus. Between February 20 and March 7, 2020, I was in the United States. Upon returning, I developed cold and flu like symptoms and it was recommended I be tested for COVID-19. Given my recent return from the US and despite my returning a negative result, I was (rightly) asked by my department to not return to campus for a full two weeks. At the conclusion of this time, state and federal governments requested people work from home. Given the extended lockdowns in Melbourne, I have been unable to return to campus and access campus resources for the final 9 months of writing this thesis. Working from home has also meant working alongside my husband, who has been involved in the Victorian government's COVID-19 response. This has caused significant disruption to our home and work lives as we negotiated working and living in our small apartment. This, coupled with a lack of access to university resources and services, added an extra layer of complexity to the already difficult task of finishing a PhD thesis.

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List of Acronyms

ACRONYM	REFERS TO
ACT UP	AIDS Coalition to Unleash Power
AFAO	Australian Federation of AIDS Organisation
AIDS	Acquired Immune Deficiency Syndrome
AZT	Azidothymidine
BBRTS	Bareback Realtime Sex
CDC	Centers for Disease Control
HIV	Human Immunodeficiency Virus
LGBTIQ	Lesbian, Gay, Bisexual, Trans*, Intersex and Queer
MSM	Men who have sex with Men
PAN	PrEP Access Now
PBS	Pharmaceutical Benefits Scheme – a list of therapeutic goods supplied at subsidised rates to eligible Australians.
PEP	Post-exposure Prophylaxis
PLHIV	People Living with HIV
PrEP	Pre-exposure Prophylaxis
RCT	Randomised Control Trial
STI	Sexually Transmitted Infection
TGA	Therapeutic Goods Administration – Australia's regulatory body for therapeutic goods.
U=U	Undetectable equals Untransmittible
UNAIDS	Joint United Nations Programme on HIV/AIDS
VAC	Victorian AIDS Council
WHO	World Health Organisation

Introduction

"YOU CAN FUCK RAW. PrEP WORKS. NO MORE HIV." This was the message of a guerrilla poster campaign appearing in Melbourne's inner city on September 18, 2015. Designed for maximum impact, these posters were positioned in various locations across Melbourne including directly opposite Flinders Street Station, a central transport hub and one of Melbourne's most iconic buildings. Evoking the tactics of activist organisations such as the *AIDS Coalition to Unleash Power* (*ACT UP*), the FUCK RAW campaign, in its celebration of condomless anal sex, was designed to cause controversy, raise awareness of HIV pre-exposure prophylaxis (PrEP), and challenge the authority of already-established HIV/AIDS organisations. Almost immediately after appearing, media outlets began reporting on the campaign. These reports sparked an intense and polarised debate on social media. Some celebrated the campaign for provocatively starting a public discussion on PrEP. One commentator on social media described it as being "brilliant and bold and will do what was intended – that is to start a conversation about PrEP." The overwhelming public reaction to these posters was, however, negative. Among those critical of the campaign, while some recognised that although PrEP might have significant benefits, it might also contribute to a decline in rates of condom use. Others judged the campaign more harshly, lambasting it for perpetuation stereotypes of gay men as promiscuous, of prioritising hedonistic sexual pleasure over their own health and the health of the broader community. One social media respondent stated: "disgusting … gays who want to fuck raw and be complete idiots can do so but don't involve the wider community and make us out to be disgusting whores!" Some even claimed that by potentially contributing to these stereotypes, the "FUCK RAW" campaign had the potential to undermine the campaign for marriage equality, a campaign that was reaching its peak just as awareness of PrEP in Australia was growing.

The emergence and uptake of PrEP has had a significant impact on gay and MSM communities[1] in Melbourne. Throughout the HIV/AIDS epidemic, various HIV prevention strategies have emerged, including the use of condoms, routine HIV testing, the use of antiretrovirals by people living with HIV, and the negotiation of condomless anal sex with those of the same HIV status. In casual sexual encounters, however, it has been the use of condoms most ardently promoted, with condoms establishing themselves as a core aspect of

[1] I discuss my use of "gay" and "MSM" communities later in this introduction.

gay male sexual culture. Highly effective at preventing HIV (Grant et al. 2010; McCormack et al. 2016; Molina et al. 2015), PrEP offers the potential for MSM to experience condomless sex while, at the same time, significantly reduces the risk of HIV infection. This potential has been of some concern among those who have been critical of PrEP (see Auerbach and Hoppe 2015; Blumenthal and Haubrich 2014; Calabrese et al. 2017b, 2017a; Crosby 2017; Grov et al. 2015; Holt et al. 2019, 2018; Lal et al. 2017; Rojas Castro et al. 2019). Prior to early PrEP trials demonstrating PrEP's efficacy, concerns were raised that perceptions of reduced HIV risk might result in PrEP users more frequently engaging in condomless anal sex. It was argued that, if PrEP were to have only partial efficacy, its use might instil a false sense of security among PrEP users and ultimately increase their risk of contracting HIV. As clinical trial results demonstrated PrEP as a highly efficacious HIV prevention strategy, however, these concerns became largely irrelevant.

Despite the demonstrated efficacy of PrEP at preventing HIV, the potential impact of PrEP on condom use has remained, with many PrEP critics focusing on potential increase in other STIs (Blumenthal and Haubrich 2014). More than a public health concern, the "fear about abandoning condoms … touches on core issues in [gay men's] sexual culture," and PrEP has "fuelled a new sexual moralism, particularly within gay communities" (Auerbach and Hoppe 2015, p.2). At the same time, PrEP has also been accompanied by a promise of both reducing HIV anxiety (Keen et al. 2020). PrEP is more than just an HIV prevention strategy. PrEP is also a technology imbued with the potential of challenging, disrupting, shaping, and re-shaping many of the sexual health discourses that have formed through the HIV/AIDS epidemic.

This thesis investigates the emergence and uptake of PrEP among men who have sex with men (MSM) in Melbourne, Australia. Prior to the emergence of PrEP, I argue that MSM have experienced sex and sexual relationships through assemblages of, among other things, individual bodies, HIV and its potential risk, condom-based safer sex strategies, as well as the social and moral discourses surrounding condom use. As a prevention strategy that must be used during sex to be effective, condoms firmly situate HIV and HIV risk as part of the sexual experience. In contrast, PrEP is an HIV prevention technology that can be taken outside of the sexual experience. With high levels of efficacy, PrEP has displaced the role of

condoms as the primary means by which MSM can minimise their risk of contracting HIV through sexual contact. Through this challenge, PrEP has the potential to displace both condoms and HIV risk from the sexual assemblages described above, forming new assemblages through which sex can be experienced.

In this thesis, I explore how by providing a heightened sense of protection against HIV, PrEP has the potential to shift how understandings of sexual risk and safety are conceptualised by PrEP users. In particular, I highlight how through the removal of HIV risk, PrEP has the potential to offer its users a sense of increased control and empowerment over their own sexual health. I argue that the use of PrEP has the potential to displace HIV from the experience of sex, incorporating it instead into one's everyday routine. This, coupled with a heightened sense of control and empowerment, has the effect of rendering HIV and HIV risk as almost irrelevant to the sexual encounter. While PrEP only offers protection against HIV, it nonetheless removes the risk of a virus that has caused significant concern and anxiety among many MSM. In doing so, PrEP offers the possibility of experiencing sex through discourses of heightened pleasure and intimacy and not, importantly, through discourses of risk and harm minimisation. It is these experiences that I explore in this thesis.

Pre-exposure Prophylaxis: A Short Introduction

HIV pre-exposure prophylaxis (PrEP) is the use of antiretroviral therapies by HIV-negative individuals to prevent HIV infection. In 2010, Robert Grant et al. (2010) published the results of the landmark *iPrEx* trial, a randomised control trial (RCT) testing the efficacy of the antiretroviral Truvada®[2] as PrEP. Enrolling 2,499 men who have sex with men and transgender women who have sex with men, Grant et al. (2020) found a 44% risk reduction of HIV infection among those on the study drug arm when compared with those on the placebo arm. When these results were adjusted to account for adherence, a relative risk reduction of 92% was reported among those with detectable drug levels in their blood. This study was therefore able to claim that when taken daily, Truvada® (henceforth PrEP) was highly effective at preventing HIV. Following this, PrEP was approved by the US Food and Drug Administration in 2012 (Hoff et al. 2015) and was subsequently recommended by the

[2] Truvada® is an antiretroviral medication that combines the two drugs emtricitabine (200mg) and tenofovir disoproxil (300mg) and has been used in conjunction with other HIV medications to treat HIV-1 (Gilead 2016).

World Health Organisation (WHO) for use by all those at substantial risk of HIV infection (WHO 2015). In 2016, the use of PrEP was approved by Australia's Therapeutic Goods Administration (TGA) (Wright et al. 2018) before being subsidised under the Pharmaceutical Benefits Scheme (PBS) in 2018[3].

Unlike the United States, where the uptake of PrEP was initially slow (Herron 2016), the introduction of PrEP in Australia was met with relative enthusiasm (Holt et al. 2019). Three years after its approval by the TGA, surveillance data from both Melbourne and Sydney showed approximately 25% of MSM who engaged in sex with casual partners were using PrEP (Holt et al. 2018). This made rates of PrEP uptake in Australia among the highest in the world. A detailed analysis comparing the emergence of PrEP in Australia with that in the United States is beyond the scope of this paper, however, it is important to note the different social and political health landscapes between the two countries. As was frequently suggested throughout my fieldwork, both countries had markedly different health systems, whereby the Australian system was considered much more accessible and affordable. Moreover, participants regularly commented that the dominant attitudes toward sex and sexuality were considerably more conservative in the United States when compared with those in Australia. This was largely viewed as an extension of Australia's early response to HIV/AIDS, a response regarded as among the best in the world (Dowsett 1998).

As in many other economically developed nations, HIV/AIDS in Australia has disproportionately affected gay and other men who have sex with men (Kirby Institute 2018). As such, PrEP uptake and the research exploring PrEP in Australia has been most focused in these same populations. Much of the research on PrEP has tended to be framed through a medical and/or public health policy lens. To better understand the slow uptake of PrEP in the United States, for example, a rush of research explored barriers and facilitators to uptake and adherence (Young et al. 2016). Key barriers identified were a lack of knowledge at both an individual and community level (DiStefano and Takedo 2017; Spieldenner 2016; Zablotska et al. 2016), as well as concerns over safety, side effects, financial constraints and a lack of access to appropriate health care (Brooks et al. 2012; Golub et al. 2013; Grov et al. 2015;

[3] A more detailed discussion of this appears in the following chapter.

Peng et al. 2018). In addition, the stigma associated with PrEP use was found to be a substantial barrier to PrEP implementation (Calabrese and Underhill 2015; Herron 2016; Spieldenner 2016). This stigma was underpinned by perceptions of PrEP users as promiscuous, reckless, and as engaging in perceived high risk sexual behaviours.

Given the potential for PrEP to provide a heightened sense of protection against HIV, a significant body of research has also engaged with the interactions between PrEP, condom use, and rates of STIs. Early research, particularly research drawing on clinical trial data, found little evidence to suggest a correlation between PrEP use and declining rates of condom use (Grant et al. 2010; Molina et al. 2015). However, the randomised control conditions of these trials meant that participants could not be sure as to whether they were receiving the study drug or a placebo (Spinner et al. 2016). Moreover, participants were provided with sexual counselling through these trials, an aspect that might have also influenced rates of condom use (Spinner et al. 2016). In contrast to these trials, research into rates of condom use among PrEP users in non-trial settings has suggested an association between PrEP uptake and declining rates of condom use (Collins et al. 2017; Holt et al. 2018; McCormack et al. 2016; Oldenburg et al. 2018; Traeger et al. 2018). While this does present its own challenges for STI prevention, at the time fieldwork was conducted, PrEP use was reliant on a medical prescription which in Australia required a complete STI screening. Just as declining rates of condom use presented a challenge for STI prevention, PrEP also offered opportunities for early detection of STIs through regular sexual health screenings (Refugio et al. 2016). Given PrEP was an emerging technology at the time of fieldwork, its overall impact on STI rates had yet to be determined. While it prevented potential challenges through a decline in rates of condom use, it also presented opportunities for increasing gay men's engagement with sexual health services.

While research into the potential for risk compensation and an associated increase in STIs associated with PrEP is necessary, such research largely fails to engage with how concepts of risk and safety are conceptualised by PrEP users. Kane Race (x2016, p.10) argues that within the scope of medically framed literature on PrEP, it "is difficult to appreciate … [the] processes of ontological transformation that emerge from everyday encounters, including those involving sex, drugs, and scientific practices." With its potential to offer protection

against HIV, PrEP carries with it the possibility of reshaping how concepts of risk and safety are imagined in relation to sex and sexuality. In doing, as I argue in this thesis, PrEP can open opportunities for experiencing sex through discourses of pleasure and intimacy, rather than through discourses of harm minimisation.

HIV & MSM

The first official report of what came to be known as HIV/AIDS was on June 5, 1981, when the US Centers for Disease Control (CDC) reported five previously healthy, young homosexual men had been treated for *Pneumocystis carinii* pneumonia in Los Angeles (Epstein 1996; France 2017; Patton 1990; Power 2011). These cases were unusual, as until then, *Pneumocystis* pneumonia had primarily been observed in those whose immune system was already compromised. Unable to find an underlying cause or condition leading to the development of this pneumonia, it was concluded that "[t]he fact these patients were all homosexuals suggests an association between some aspects of a homosexual lifestyle or disease acquired through sexual contact" (Gottlieb 2006, p.2). These were certainly not the first cases of *Pneumocystis* pneumonia related to HIV to be observed, and similar cases had been seen among intravenous drug users in the US prior to the 1981 report (Epstein 1996; Patton 1990). However, with little access to healthcare services, these cases often went unreported (Epstein 1996). In contrast, some gay men had relatively high levels of economic capital and, therefore, could afford to seek medical treatment (ibid. 1996). From here, their cases eventually made their way into medical journals (ibid. 1996). Such was the association between this emerging condition and gay men that, soon after the 1981 CDC, report it became known as GRID – Gay Related Immune Deficiency (Altman 1995; Bolton 1990; France 2017; Power 2011). In response to claims that such terminology was discriminatory, however, the CDC soon began using the more neutral term AIDS – Acquired Immune Deficiency Syndrome (France 2017 p.67). Despite this change, the association between HIV/AIDS and gay men remained and it was known colloquially by names such as "gay plague," "gay cancer," and "gay pneumonia" (France 2017; Power 2011).

One of the most enduring legacies of the HIV/AIDS epidemic has been promotion of condom-based safer sex guidelines (France 2017; Halperin 2016). With no effective treatments available until the development of triple-combination therapy in 1996 (Zuniga and

Ghaziani 2008), prevention remained the only way to minimise the impact of HIV/AIDS at both the individual and community level. Prior to the discovery of a causative agent between 1983 and 1984 (Crimp and Bersani 1988; Epstein 1996), two theories emerged to explain the roots of AIDS and its transmission. On the one hand, some posited that an as-yet unknown virus caused AIDS and that it could be spread through infected blood and semen (Epstein 1996). In contrast, the so-called multifactorial theory explained AIDS as occurring through "continued exposure to sperm containing large amounts of cytomegalovirus" (Callen and Berkowitz 1983). While each perspective differed in their proposed etiological cause of AIDS, both theories emphasised sex and semen as playing a central role in the transmission and development of AIDS.

Against calls for abstinence and monogamy (Kippax and Race 2003), HIV/AIDS advocates Michael Callen and Richard Berkowitz (1983) developed one of the earliest sets of HIV/AIDS prevention guidelines, *How to Have Sex in an Epidemic*. In their introduction, they claimed,

> *The advantage of this approach is that if you avoid taking in your partner(s)' body fluids, you will better protect yourself not only from the most serious diseases [HIV/AIDS] but also from many of the merely inconvenient ones [STIs]. The key to this approach is modifying what you do – not how often you do it nor with how many partners (p.3).*

Key to their guidelines was not a curtailing of sex and sexuality but, rather, the adoption of harm-minimisation strategies such as condom use. Kane Race (2008) argues that this approach built on existing sexual cultures among MSM communities, making the virus itself the concern and not, importantly, sex-negative connotations surrounding promiscuity and same sex attraction. The subject of condom-based safer sex practices is one I return to throughout this thesis. For now, however, it is enough to note that while condom use was not consistently practiced by all MSM, condoms became an almost taken-for-granted part of the sexual, cultural and moral worlds inhabited by gay men (Chambers 1993). This taken-for-grantedness had been constructed through over 30 years of condom promotion among gay men and it was against this historical background that PrEP first emerged. Challenging many of the sexual norms that had developed around the prevention of HIV, particularly those of condom use, the disruption by PrEP was a particularly significant moment within gay sexual cultures.

HIV "landscape"

Globally

In 2018, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that globally, some 37.9 million people were living with HIV (UNAIDS 2019). From a global peak in 1997, annual rates of new infections have steadily declined, with approximately 1.7 million people newly infected in 2018 (UNAIDS 2019). The development of new HIV treatments has meant that for many with access to effective treatment, HIV can be considered a manageable, chronic condition. However, access to effective treatment remains inequitable. Many of those living in the world's poorest areas lack access to even the most basic prevention strategies such as condoms, let alone pharmaceutical treatments and prevention technologies (Selemogo 2008). UNAIDS estimate that in 2018, approximately 770,000 people died of an AIDS-related illness (UNAIDS 2019).

Living with HIV (2018)	37.9 million
New infections (2018)	1.7 million
AIDS-related deaths (2018)	770,000

Figure 1: Global HIV figures 2018

Australia

In 2018 it was estimated that approximately 28,180 people were living with HIV in Australia and of these, there were 833 new HIV notifications in 2018 (Australian Federation of AIDS Organisations 2020)[4]. After peaking at 2,412 in 1987, new HIV diagnoses fell to a low of

[4] In 2016, researchers declared AIDS no longer a public health issue in Australia. Given the low rates in Australia, AIDS diagnoses are no longer monitored.

722 in 1999 (Kirby Institute 2018, p.16). This was followed by a slight and steady increase, peaking again in 2014 at 1,082 (Kirby Institute 2018, p.16). Since then, rates of HIV notifications have steadily declined, with 963 notifications[5] reported in 2017. This marked the lowest number of cases since 2011 (Kirby Institute 2018, p.16). Of these, 63% of cases were attributed to sex between men, with another 5% attributed to sex between men who were also engaging in injecting drug use (Kirby Institute 2018).

Living with HIV (2018)	28,180
New infections (2018)	833

Table 2: Australian HIV figures 2018

PrEP Use in Australia and Victoria

PrEP implementation projects had been established in all Australian states and territories, with the exception of the Northern Territory, by the end of 2017. Collectively, these projects enrolled 15,895 gay and bisexual men at high risk of HIV (Kirby Institute 2018). At the same time, a significant number of individuals were self-importing generic PrEP medications from abroad, a process facilitated by Australian-based PrEP advocacy groups[6]. As those who were self-importing generic medication were not accessing PrEP through the PBS system, the total number accessing PrEP outside of clinical trials could not be determined. However, it is certain the number of those using PrEP at the end of 2017 was higher than the official 15,895 recorded.

[5] These data from the Kirby Institute refer only to new HIV notifications where the virus was contracted in Australia. The total number of new HIV notifications in Australia, inclusive of those where HIV was acquired overseas, is 1,249 (Kirby Institute 2018, p.14).
[6] A more detailed discussion of this appears in Chapter 1.

The 90-90-90 Goals

In 2014, UNAIDS set the ambitious 90-90-90 goals: to have 90% of people living with HIV aware of their status; of those, 90% accessing HIV treatments and; 90% of those accessing treatments with an undetectable viral load (UNAIDS 2014). Due to the efficacy of treatment at stopping onward transmission, achieving these targets would see some 73% of all people living with HIV virally supressed which, it was argued, would "enable the world to end the AIDS epidemic by 2030" (UNAIDS 2014, p.2). Of the estimated 27, 545 people living with HIV in Australia (PLHIV) in Australia in 2017, approximately 89% were thought to have been diagnosed and aware of their HIV-positive status (Kirby Institute, 2018, p.4). Of those, 95% had been retained in care[7], with 95% of this group having an undetectable viral load (Kirby Institute, 2018, p.4). Given these figures, an estimated 74% of all PLHIV in Australia in 2017 had a suppressed viral load, exceeding the UNAIDS target of 73% by 2020.

The Field and Research Methods

When I began fieldwork in November 2017, the use of PrEP as an HIV prevention strategy had yet to become mainstream. Despite its status as an emerging technology, however, it was already evident that PrEP was already affecting sexual norms among MSM, particularly those centred around condom use and attitudes toward sexual risk, safety, and pleasure. Entering the field, my central research concern was to explore the interactions between PrEP, HIV and MSM and how through these interactions, particular experiences of sex emerges. To address this, my fieldwork was guided by two specific concerns: to explore the interactions between PrEP and Melbourne's gay male community; and to examine how PrEP was affecting the experience of sex among MSM adopting PrEP.

Given the social nature of my research interests, I drew on an ethnographic methodology. One of the great strengths of ethnography is that rather than searching for specific outcomes or definitive answers, ethnography instead focuses on social worlds and meanings (Warin 2010). Ethnography is "an eclectic methodological choice which privileges an engaged, contextually rich and nuanced type of qualitative research, in which fine grained daily interactions constitute the lifeblood of the data produced" (Falzon, 2009, p.1). Ethnographers

[7] Defined as having received a viral load of CD4+ cell count in the previous 12 months.

"question, unsettle, and find meaning in the ordinary and extraordinary practices of everyday lives, and then seek to make sense of these within broader sociocultural frameworks" (Warin, 2010, p.2). With its broad focus, ethnography is an ideal methodological choice to investigate both individual behaviours and beliefs, and the broader social contexts within which they are situated. In eschewing the search for reductionist answers, ethnography is well suited to address the many complexities, ambiguities, and contradictions between individual behaviours and beliefs, making it particularly well suited for research exploring the experience of sex and sexuality (see Bolton 1990).

Ethnographic fieldwork was conducted between November 2017 and August 2018. While my methodological approach did prioritise embedding myself in my community of research, it differed from how ethnography has been traditionally understood in two important ways. Firstly, traditional ethnography has been imagined as an ethnographer entering a specific site and, over an extended period, allowing for a set of concerns to emerge (Hannerz 2012). Rather than taking a specific site as my starting point, I utilised multi-sited ethnography. Following anthropologists such as George Marcus (1998), Emily Martin (1994), and Megan Warin (2010) my research involved a focus on a specific concern (HIV pre-exposure prophylaxis), and I followed this to the sites inhabited by the individuals and communities it most affects. Secondly, having embedded themselves in the field, ethnographers have traditionally relied on participant observation, a data collection technique that allows the ethnographer to gain a first-hand, embodied experience of the phenomena they explore (Bolton 1990; O'Reilly 2009). Through participation in the day-to-day activities and routines of their participants, ethnographers come "to understand things from the 'native's' point of view and to blend into the setting so as to disturb as little as possible" (O'Reilly 2009, p.150). During fieldwork, I participated in a range of activities, including attending PrEP and HIV information events; assisting PrEP advocates in the distribution of promotional material; as well as joining a small PrEP advocacy group. While participation in these activities provided great insight into the PrEP landscape more broadly, my interest in how PrEP affected the experience of sex made participant observation more challenging.

During the ten months I was conducting fieldwork, my husband and I had a relationship agreement that did not allow for sex with any person outside of our relationship. Because of

this, it was decided that engaging in any sexual contact with participants would not form part of the research design. Instead, I relied on participants' own self-reports of their sexual experiences. One of the challenges in taking such an approach, particularly around potentially sensitive topics such as sex and sexuality, is that what people *say* they do often differs markedly from what it is they *actually* do (see Bolton 1990). As my interest was primarily how participants experienced sex rather than in identifying specific behaviours, participant observation in community activities, data collection in online forums, and in-depth interviews provided appropriate data to address the question.

As stated, this thesis took PrEP as its starting point, following it to those communities it most affected. The emergence and implementation of PrEP in Melbourne was originally most concentrated among gay, bisexual, and other MSM. Initially, it was intended that a range of sexualities and genders be included, including those who identify as bisexual, trans, non-binary, and/or heterosexual. However, with the exception of one PrEP user who identified as pansexual, only those identifying as gay male agreed to participate. While these participants do not reflect a broad range of sexual and gender identities, they nonetheless reflect the early rollout and uptake of PrEP in Victoria. As an ethnographic study, then, my community of research is Melbourne's gay male community, a community that is fluid, heterogenous, complex, and multi-sited. Due to the heterogeneity of this community, I drew on a multi-sited ethnographic approach (Marcus 1998), conducting fieldwork across both physical and digital spaces (Miller *et al.*, 2016). Despite the distinctiveness of each "site", I frequently engaged with some participants in multiple sites, including physical locations, on social media, as well as digital/hook-up platforms. In the section that follows, I will briefly outline the primary sites where fieldwork was conducted.

Physical Sites

The Laird Hotel

My primary physically located field site was the Laird Hotel, a male-only bar targeting itself toward gay men[8]. Located in a quiet, tree-lined street in an inner-city suburb of Melbourne,

[8] The Laird has been granted an exemption by the Victorian Civil and Administrative Tribunal to only allow men into the venue (The Laird 2018). In the past, this extended only to same sex attracted cis males although at the time of fieldwork, the Laird had extended this policy to also include trans men. Despite this exemption, the Laird do run a small number of events each year where anyone regardless of gender are welcome. While the

the Laird is best-known as a venue targeting itself toward Melbourne's bear[9] and leather communities. Established in 1847 as the Laird O'Cockpen Hotel, it was not until 1980 that, with a change of ownership, the Laird began targeting gay men in Melbourne (The Laird 2018). To differentiate it from other venues, the new owners targeted those not wanting to attend large discos and drag shows and who instead preferred a more relaxed, hotel-like environment. From its earliest iterations as a gay male space, The Laird has been known for a hypermasculine style, with décor typical of biker and Western bars in the United States. On top of serving as an important meeting point for Melbourne's bear, leather, and kink communities, the Laird has had a strong history of supporting other community organisations, from gay male sporting and social clubs as well as various organisation focused on gay men's health.

The Laird occupies an important position in the history of Victoria's response to the HIV/AIDS epidemic. Responding to the news of a new and emerging health threat affecting gay men in the United States, a group of concerned members of Victoria's gay community gathered at the Laird in July 1983 to devise a plan of action (Power 2011). This meeting resulted in the establishment of the Victorian AIDS Action Committee, an organisation that would later operate as the Victorian AIDS Council (Power 2011, pp.44-45) and play a leading role in the Victorian and Australian response to the HIV/AIDS epidemic. Since this time, the Laird has played a leading role in both fundraising for HIV/AIDS organisations, as well as in the communication of health resources targeting gay men. Its involvement in the HIV/AIDS response, coupled with it being an important site for social gathering, made the Laird an ideal site for ethnographic observations.

Community Events

Ethnographic observations were also conducted at various community events targeted toward the lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) community. These events included Melbourne's annual *Midsumma* festival[10], *Southern Hibearnation*[11], as well

Laird has a reputation, and is styled, as a gay male bar, it is welcoming of all those who identify as male and as sexually attracted to other men.

[9] Bears are typically larger, hairier men and a sub-group of the gay male community.

[10] An annual festival promoting LGBTIQ+ arts and culture.

[11] A week-long festival aimed at bears and their admirers.

as *A Week of Leather*[12]. These events were chosen for two reasons. Firstly, these events attracted a significant number of attendees making them important social events for many MSM in Melbourne. Secondly, the Victorian AIDS Council (VAC), Victoria's primary LGBTIQ+ health organisation, maintained a presence at these events. More recently, members of Melbourne-based PrEP advocacy groups have also used these events as opportunities to further their educational work around PrEP. These events provided an opportunity to embed myself within my community of research, as well as observe how the various health organisations engage with that same community.

In addition to the events outlined above, I attended numerous panel discussions and educational events organised specifically around communicating information about PrEP and HIV/AIDS more broadly. These included events organised by community health organisations, PrEP and HIV advocacy groups, pharmaceutical companies, as well as by HIV researchers and health professionals. A multi-sited approach was particularly suited to this stage of data collection as it allowed for observations at different field sites. While each event differed in terms of physical location, they also differed in terms of which population groups were being targeted. Where some were targeted specifically to potential PrEP users, others were aimed at health professionals and potential PrEP prescribers. A multi-sited approach was particularly well-suited as it allowed me to compare and contrast the differing types of knowledge produced and approaches to knowledge communication (see Marcus 1998).

Digital Sites

Social Media Platforms

Very early into my fieldwork, it became apparent that while the Laird Hotel and large community events were important sites for face-to-face interaction, they offered limited opportunities to discuss PrEP and the experience of sex. My role as a researcher was known in many conversations I had throughout my fieldwork and these would often instigate a discussion about PrEP. However, it was evident a more target approach was needed to understand the broader conversations around PrEP that were occurring among PrEP users.

[12] A leather and fetish festival.

To do this, observations were also conducted on the social media pages of two Australian-based PrEP advocacy groups. Although digital interactions have been dismissed as not necessarily reflecting interactions occurring face-to-face, they are interactions occurring between real people albeit through a digital platform (Miller *et al.*, 2016). My aim in observing these interactions was not to understand the various relationships between individuals but, rather, to gain a sense of the concerns and conversations that were occurring around PrEP.

Two Australian-based PrEP advocacy groups with a presence on Facebook were chosen for observations. Each group had approximately 2,000-2,500 members at the time fieldwork was conducted making them the largest PrEP advocacy groups in Australia. As the earliest Australian PrEP advocacy groups, these were instrumental in both the communication of PrEP information, as well as facilitating the self-importation of PrEP prior to its listing on Australia's Pharmaceutical Benefits Scheme[13].

Upon receiving ethics approval in October 2017, all posts between then and July 2016 were manually copied and placed into Microsoft Word documents organised according to month. While both groups were established prior to July 2016, this date was chosen as the starting point for digital data collection for two primary reasons. Firstly, July 2016 marked the beginning of the Victorian-based *PrEPx* study, a large-scale demonstration project "with the primary aim of reducing HIV transmissions in Victorian MSM by 30%" (Cornelisse et al. 2018). Secondly, 16 months of posts was both an appropriate and feasible period in which to gain a sense of the dominant and shifting concerns around PrEP.

While capturing the historical data of these groups offered a good understanding of the context surrounding PrEP in Australia, Annette Markham (2013, pp.439-440) argues that approaches to digital ethnography relying solely on capturing screenshots miss "the essential point of ethnographically-oriented observation. After all, understanding culture has never been a matter of collecting everything and then analyzing it later." To move away from such a static approach, I also engaged with these groups in "real time." That is, observing the

[13] The listing of PrEP on the PBS will be discussed further in Chapter 1.

posts and discussions as they occurred. Kevin Steinmetz (2012, p.27) argues that one of the features that distinguishes digital ethnography from content analysis or archival research is "the immediacy, the emotions, and the connection to other users the researcher can feel and experience in the field site." Even as posts and discussions were captured and organised as above, interactions between group members were also treated as any other ethnographic observations, with systematic, detailed field-notes.

Steinmetz (2012) argues that one of the challenges in conducting ethnographic observations on digital message boards is that posts do not necessarily appear in order of the time and date they were posted. In my own observations, each individual post appeared in the order of last activity and, despite some posts being made prior to others, they appeared in my own field notes as if posted later. One strategy ethnographers can employ to overcome this challenge is to treat each post as having its own individual timeline, as if it existed separately to all other posts on that platform (Hine 2000; Steinmetz 2012). As the purpose of digital observations for this project was to gain a sense of the main discussions occurring around PrEP, this technique proved particularly useful. Even as some posts did not always appear consecutively, their order did not disrupt the overall flow and narrative of the major concerns around PrEP. This technique thus allowed for consideration of specific discussion on their own while, at the same time, situated those conversations in a broader social context.

My role as a researcher and observer of these groups was unknown by other group members and the only form of direct engagement I had with these groups was to make three posts to recruit interview participants. This form of observation has been described as lurking: observing the interactions between group members without their knowledge (Hine 2000). A key critique of this technique, particularly in terms of ethnographic engagement, is that the lack of engagement with one's community may inhibit the ethnographer's ability to gain an in-depth understanding of that community through participating in everyday life (Beaulieu 2004). Christine Hine (2008, p.263) argues, however, that lurking can prove a useful technique, particularly in providing ethnographers with a sense of familiarity with their field. Moreover, this approach mitigates the potential for behavioural change due to the presence of a researcher (Steinmetz 2012, p.34). While lurking as an observational technique limits the

interaction between ethnographer and those being observed, my own observations on social media became important points of discussion during semi-structured interviews.

Just as the technique of lurking raised methodological challenges, it also raised important ethical considerations. Throughout my fieldwork, the advocacy groups chosen for observation were both fully public. This meant anyone could potentially view group activity regardless of whether they had a Facebook account. University ethics approval was sought and obtained to observe these groups and to quote anonymously from posts made. This was in line with Facebook's own terms and conditions at the time of data collection, which stated that by sharing any information to such groups implies "you are allowing everyone, including people off Facebook, to access and use that information" (Facebook 2017). Partway during fieldwork, however, news of the Cambridge Analytica scandal broke, with it reported that consulting firm *Cambridge Analytica* had used the data of more than 50 million Facebook users to influence the 2016 federal election in the United States (Thompson and Stelter 2018). This caused a worldwide concern over data privacy, particularly around how Facebook data was used and who was able to access it. This scandal caused me to significantly rethink how I could most appropriately use these data for this project. Verbal permission was received by a moderator and founder of only one social media group, with the permission neither received nor denied for the other[14]. Given this, direct quotes have only been taken from the page I received direct permission to use. Recognising that group members might have participated in discussions differently if it were known these interactions could be used as data, I have avoided using comments that directly reference personal experiences. Rather, quotes and discussions have been selected to highlight attitudes and concerns of group members more broadly.

Dating/Hook-up Platforms

Profiles were created on various digital dating and hook-up platforms including *Grindr*, *Scruff* and *Bareback Real Time Sex* (*BBRTS*). The use of digital platforms has become firmly entrenched in the way MSM interact, including their use to find romantic and/or sexual partners (Mowlabocus 2010). Each profile explicitly stated my role as a researcher, including

[14] Despite several attempts to get permission from the group moderators, I had not received an answer either way by the end of my fieldwork.

my research interests, and that I was not using these platforms in search of sexual partners. Making my role on these platforms explicit reduced the likelihood of sexual solicitation, ensuring a significant proportion of my interactions were around discussions of PrEP.

Interviews and Analysis

To supplement ethnographic observations and gain a deeper understanding of the experience of PrEP, 20 semi-structured interviews were conducted with PrEP/HIV advocates and/or researchers (*n*=5), PrEP users (*n*=11) and people living with HIV (*n*=4). These were not discrete categories and, except for one participant, PrEP and HIV advocates were also PrEP users themselves or living with HIV. Interviews ranged from 30 minutes to 4 hours, with 35 interview hours in total. With one exception where the participant did not wish to be recorded[15], all interviews were recorded and transcribed verbatim by myself. In contrast to ethnographic projects whereby interviews are conducted after extensive contact with participants, interviews were often the first and only contact I had with research participants. This largely reflected participants' own expectations of the length of time they were expected to engage in this project. An initial interview schedule based on key research themes was drafted prior to entering the field. However, this schedule was broad enough to allow for a more narrow focus on key themes emerging through fieldwork and in early interviews.

Digital observations became particularly important in focussing interviews more narrowly on overarching concerns of PrEP users. In his research, Brady Robards (2012) conducted a discourse analysis of social media profiles and combined this analysis with in-depth interviews with profile creators. Robards (p.389) argues that "coupling the analysis of profiles with in-depth interviews allowed for the discourse analysis to be verified while also adding greater potential for probing in the interviews themselves." Similarly, my own analysis of social media discussions provided an important context and understanding of key concerns surrounding PrEP, a context I was able to explore in more nuance through face-to-face interviews.

[15] This will be noted throughout this thesis when data from this interview are used.

Interview participants were recruited through a range of methods including purposive sampling, personal networks, social media posts, dating/hook-up apps, as well as snowball sampling. Initially, interviews were conducted with PrEP and/or HIV advocates and researchers who were specifically targeted and contacted directly. A second recruitment drive was then conducted via social media posts to interview individuals either using PrEP or living with HIV. 3 interview participants contacted me after viewing my profile on digital dating/hook-up platforms and offered to be involved in this project. To minimise the risk of identifying participants, I have used pseudonyms throughout this thesis.

The Researcher

As stated, fieldwork for this project was conducted among Melbourne's gay community, a community I have considered myself part of since 2002. As a gay man born in 1981, I have always been medically categorised as at high risk for HIV infection and, prior to the emergence of PrEP, had only ever known a sexual landscape in which condom-based HIV prevention strategies were the norm (if not always used). HIV/AIDS and a culture of safer sex has fundamentally shaped my sexual and romantic relationships and as such, fieldwork, analysis, and writing have been conducted from the perspective of an insider anthropologist (Abu-Lughod, 2013) .

My sexual identity and prior engagement with my community of research has afforded me a level of insider access I would not otherwise have had if I did not identify as a gay man. Because of my sexual identity and gender presentation, I was able to gain access to venues exclusively for men and, importantly, move around these spaces unobtrusively and as if I were an "insider." Moreover, my experience as a gay male and proximity to HIV have given me a shared sensitivity to the impact of HIV on the broader community. This fostered a degree of trust with my participants I might otherwise not have had. In the early stages of each interview, I made a point to reflect on my own experiences of sex, HIV, and condom use. In doing so, I would disclose to participants my own history of inconsistent condom use, as well as my preference for condomless anal sex. While these reflections did risk biasing participant responses, they proved an important way to build stronger connections with participants. On the one hand, these reflections acted as a useful tool to elicit responses from participants about their own experiences of sex, HIV, and condom use. On the other hand,

they provided participants with some reassurance that discussions of condomless sex, an often-stigmatised sexual activity, would not be met with judgement.

While my position as an insider ethnographer gave me significant access to my research community, it also brought with it important limitations. As a researcher whose sexual life had been affected by HIV, my analysis cannot be separated from my own lived experience. My involvement in this community and own experiences of HIV risked my own assumptions around PrEP biasing the data. As an approach that prioritises the experiences of research participants, ethnography proved an effective way through which these biases could be minimised.

Throughout this thesis, I have consciously sought to ensure that my approach to discussions of sex and sexuality have been framed as sex positive and that my analysis contributes to a further de-stigmatisation of PrEP, HIV, and sex between men. This approach reflects the position taken by those who have advocated for PrEP in Australia. Indeed, one participant Darren (PrEP advocate & user, 50s) made this approach a condition on my use of his data:

> You're welcome to use my words for research, as long as it's presented [as] sex positive [and] HIV non-stigmatising.

Throughout this project I have sought to honour this commitment and, given the overwhelmingly positive experiences of PrEP described by participants, this has not been difficult. At the same time, however, I not shied away from taking a critical approach to my analyses of PrEP. As I argue in this thesis, even as PrEP has been of significant benefit to many MSM, it is necessary to remain cognisant of any negative experiences of PrEP among PrEP users and non-users alike.

Sex positive approaches to harm reduction and safer sex have a long history of being employed throughout the HIV/AIDS epidemic (Race 2008). Among gay communities, these approaches ran counter to mainstream, moralising discourses that called for abstinence and monogamy. At the same time, however, much of the research on HIV/AIDS and sexual behaviours has relied on public health and epidemiological approaches (Boyce et al. 2007). These approaches have prioritised measuring and categorising specific behaviours and risk

ignoring the various social meanings individuals attach to expressions of sexuality. My taking of a sex positive approach is not intended to push a particular political agenda that necessarily encourages PrEP or suggests it *should* be experienced as pleasurable. Louisa Allen and Moira Carmody (2012, p.459) argue that "political intentions cannot be harnessed to pleasure because doing so undermines its transformative potential as something that creates and recreates in ways that cannot be known in advance." Rather, my approach in this thesis has been to be sensitive to the various positive and negative experiences of PrEP, grounding my analysis in the lived experiences of participants.

Analytical Framework

Sexual Assemblages

To understand the particular experiences that emerge through the interactions between material and immaterial phenomena, this project draws on new materialist approaches to the study of sexuality. In particular, this thesis is guided by Pam Alldred and Nick Fox's (2015; see also Fox and Alldred 2013) conceptualisation of sexual assemblages where, they argue, sexuality is not an innate essence of the body but rather "an assemblage of multiple bodies, things, ideas and social formations that cut across cultural and natural realms" (Alldred and Fox 2015, p.907). Sexualities emerge, they argue, through the relations between humans and non-humans, producing "material effects including sexual capacities and desires, sexual identities, and the many 'discourses on sexualities'" (Alldred and Fox 2015, p.908). That is, sexuality and the physical act of sex itself are not only experienced through the interactions between bodies but, also, through and against cultural contexts, personal histories, as well as material phenomena and various technologies.

Ian Buchanan (2015, p.385) argues that one "of the great insights of assemblage theory … is that it shows that material objects can and frequently do have agential power." Assemblages, then, provide a useful analytical framework with which to explore the potential of sexual-pharmaceutical technologies such as PrEP to shape individuals' experiences of the world. In her work on Viagra, for example, Annie Potts (2004) proposes the existence of a sexual assemblage that consists of the drug itself, the bodies of individual Viagra users, their partners, and the enhanced and erect penis itself. These physical phenomena sit within a broader social context whereby they both affect, and are affected by, social norms around

gender, sexuality, relationships, as well as perceptions of appropriate and inappropriate Viagra use. Similarly, I propose a sexual assemblage among MSM that has consisted of individual bodies, HIV and HIV prevention, and normative moral and social discourses surrounding use of condoms. Just as in Potts' work, these phenomena exist within a broader context in which there existed a moral imperative to reduce and mitigate HIV risk (Auerbach and Hoppe 2015; Dean 2015; Mowlabocus et al. 2014; Race 2016, 2001).

Territorialisation, De-territorialisation, and Re-territorialisation

The challenge of PrEP to existing harm reduction ontologies can be usefully interrogated through the concepts of territorialisation, de-territorialisation, and re-territorialisation. According to Manuel DeLanda (2006, p.12), processes of territorialisation are those processes by which particular identities, concepts, and beliefs come to be seen as whole, as having a degree of homogeneity, and as having sharp, clear boundaries and borders. This, he argues, occurs through the interactions of various human and non-human phenomena. Through processes of territorialisation, these identities, concepts, and beliefs become legitimate truths and knowledges, functioning as ways of getting by in the world. In contrast, de-territorialisation occurs through "[a]ny process which either destabilizes spatial boundaries or increases internal heterogeneity" (DeLanda 2006, p.13). Through the destabilising of boundaries and an increasing of internal heterogeneity, assemblages that have formed previously taken-for-granted ways of operating in the world become less clear. As an object that challenges condoms as the primary HIV prevention strategy, PrEP has effectively de-territorialised sexual assemblages in which condoms have been central to the prevention of HIV. In displacing condoms from these assemblages, PrEP opens new assemblages through which sex and sexuality can be experienced.

Processes of de-territorialisation have the potential to re-territorialise, forming new assemblages that then become new taken-for-granted ways of knowing the world. Gayle Rubin (2011a, p.1) argues that "[when] new formations become the familiar terrain, it becomes difficult to recall the previous landscape with its distinctive assemblage of what could be thought and what seemed significant." The first reports of HIV/AIDS and the development of condom-based safer sex strategies are as a pertinent example. The years immediately prior to the first reports of HIV/AIDS in the United States have been

characterised as a period of sexual freedom, experimentation, liberation, and condomless sex among gay men (Rofes 1996; Shernoff 2006)[16]. The emergence of HIV/AIDS transformed the act of condomless sex such that it went from an experience to be celebrated to one associated with potential disease and death (Mowlabocus et al. 2014). The de-territorialising effect of HIV/AIDS, the introduction of condoms, and the risk of a potentially fatal condition became an almost taken-for-granted part of how sex was experienced. There are important differences in the processes of de-territorialisation caused by HIV/AIDS and PrEP. While the former introduced a new, as-yet unexperienced element of risk and danger to the experience of sex, the latter carried with it the promise of displacing that same risk. Despite these differences, the emergence of both have had significant implications for how sex can be experienced.

During the time fieldwork was conducted, PrEP was a relatively new and emerging sexual health technology in Australia and, as a field of inquiry, was rapidly shifting and changing. A major strength of assemblages as an analytical tool is the emphasis on social production as rhizomatic as opposed to linear (Fox and Alldred 2015). That is, the interactions through which assemblages form have the potential to produce multiple, conflicting, and sometimes unanticipated capacities (p.401). As PrEP was an emergent technology at the time fieldwork was conducted, its effect on Melbourne's gay community, the field of HIV prevention, and norms around sex and sexuality had yet to stabilise. This was both exciting and raised important challenges. With the landscape surrounding PrEP quickly changing, what might have appeared a key concern at one point could quickly evolve, becoming unimportant or extraneous later. The termination of the *PrEPx* demonstration project in response to PrEP's listing on the PBS in 2018 is an apt example. While the experience of this trial was an area of investigation when beginning fieldwork, its dissolution almost overnight made following this line of investigation less relevant. Drawing on assemblages as an analytic and research frame provided the flexibility to follow flows of information in ways that were sometimes unexpected.

[16] Eric Rofes (1996) and Michael Shernoff (2006) point out that the limitations of this narrative, particularly as many gay men were subject to interpersonal and state violence during this period.

Terminology

MSM and Gay Men

In his genealogy of the epidemiological category 'men who have sex with men' (MSM), Tom Boellstorff (2011) highlights the emergence of this category as "a technical phrase intended to be less stigmatizing than culturally bound terms such as gay, bisexual, or homosexual" (MSM Initiative 2008, p.9 qtd Boellstorff 2011, p.305). Recognising that not all men who engage in any person-to-person sex with other men identify as gay, HIV/AIDS researchers and public health officials began using the more neutral term MSM to highlight specific sexual behaviours, as opposed to identities, as increasing the risk of HIV. MSM became an umbrella term for all men engaging in anal sex with other men and, therefore, who were potentially at a higher risk of HIV infection. Critiquing this formulation, Boellstorff (2011, p.294) argues that while MSM does "treat identity as a social construction, [it] reifies 'men' and 'sex' as prediscursive, conflating sex with penetration (above all, anal-penile intercourse) and maleness with biology." While categories such as MSM provide necessary epidemiological information, they risk "circumnavigating the complicated social, cultural and behavioural realities such categories mask – obscuring the porous margins of these classifications, the important diversities that exist within categories, and the intersections between them" (Parker et al. 2016, p.820).

With the exception of two participants, all participants identified as gay men. Of the two exceptions, one participant was a female PrEP and HIV advocate/researcher (not using PrEP), and another identified as pansexual and gender non-binary (Mark, PrEP user, 30s. The categorisation of MSM does function as a catch-all descriptor of how participants using PrEP were medically categorised. However, its use masks the various sexual and gender identities that exist within this category. Throughout this thesis, I refer to Mark specifically with the pronoun "they." However, I also include their experiences when discussing gay men and MSM more broadly.

While the category "MSM" does function as an adequate catch-all to describe participants, its use risks overlooking the complex interactions that have existed historically between HIV/AIDS and a specifically *gay* identity. Throughout this thesis, I have used both MSM and gay men as broad categorisations. My use of MSM is primarily in the context of

epidemiological discussions of HIV, PrEP, and affected populations. In contrast, I use gay men throughout to highlight more specifically the interactions between HIV, the gay community, and identity formation.

Condomless Anal Sex and Bareback Sex

Throughout this thesis, I have used condomless anal sex, bareback sex, and condomless sex interchangeably to refer to anal sex without condoms. The use of these terms reflects participants' own descriptions of sex. While some participants specifically used the terms "bareback" and "condomless anal sex", others described anal sex without condoms simply as condomless "sex." When participants distinguished between anal and oral sex, participants referred to anal sex simply as "sex" and would specifically state "oral sex." This is reflected throughout this thesis, and unless specifically stated, the use of sex refers specifically to anal-penile penetration.

HIV and "other" STIs

As a virus transmitted sexually, HIV can certainly be categorised as a sexually transmitted infection (STI). While HIV can also be transmitted through any exchange of infected blood or breast milk, it is most commonly spread through anal or vaginal sex globally. Throughout this thesis, however, I have separated HIV from the category of STIs, referring to "HIV" and "other STIs". In part, this is due to PrEP as a sexual health technology that only offers protection against HIV infection. It therefore would not make sense to talk about PrEP in relation to STIs as broadly defined. Distinguishing between HIV as compared with other STIs also reflects the experiences and language of participants. As I demonstrate throughout this thesis, HIV had impacted the lives of participants in very different ways when compared with other STIs. Moreover, participants almost always referred to HIV specifically, grouping all other sexually transmitted infections under the umbrella term "STIs".

The Thesis

In the section that follows, I provide an overview of the thesis and overarching arguments of each chapter.

Chapter Overview

Chapter 1 – PrEP in Australia: Setting the Scene

As an ethnographic project, this chapter introduces my field site and discusses the implementation of PrEP in Australia. Rather than describing a specific location as a field site, I instead consider the emergence of PrEP in Victoria as my "field." This chapter begins by briefly outlining the history of HIV/AIDS in Victoria, including some of the developments that ultimately led to the emergence of PrEP as an HIV prevention strategy. I then trace the emergence of PrEP advocacy groups; groups whose social media pages became two key sites for conducting ethnographic projects throughout this project. This chapter provides the historical and contemporary context against that participants' experienced the use of PrEP.

Chapter 2 – Risk, Stigma, and Health: The Moral Imperative of Safer Sex

Drawing on the work of Erving Goffman (1963), Mary Douglas (1992), and Deborah Lupton (2013), this chapter explores key theoretical arguments within the literature on stigma and risk. Douglas (1992) and Lupton (2013) argue that in contemporary Western societies, individuals and groups face a moral obligation to minimise risk, particularly minimising those behaviours that are seen to harm one's health. Lupton (2013, p.22) argues that risk management functions as central to the maintenance of social and cultural norms, with those who engage in so-called risk behaviours considered as antithetical to the moral values of their broader communities. It is the perception of engaging in behaviours considered risky that underpins the stigmatisation of behaviours such as condomless sex among MSM.

Having outlined key theoretical arguments, this chapter turns to a more specific discussion of condom-based HIV prevention among MSM. Framed as a way to protect oneself as well as one's sexual partners, the use of condoms goes beyond public health concerns and has been a core part of the sexual culture among MSM (Auerbach and Hoppe 2015; Race 2001). This section emphasises that the use of condoms has been a standard against which individuals have been measured, with the non-use of condoms during anal sex considered deviant and antithetical to the values of the gay community (Race 2001; Weeks 1995). This chapter concludes by highlighting the emergence of PrEP as a threat to the use of condoms and, therefore, a threat to existing social, cultural, and moral norms of the broader gay and MSM communities.

Chapter 3 – Risk, PrEP, and Condomless Anal Sex: PrEP Users' Critiques of Risk Compensation Language

A key area of concern surrounding the introduction of PrEP has been its potential impact on rates of condom use. Framed within PrEP literature as "risk compensation", concerns have been raised that due to a reduction in HIV risk, PrEP users might be more likely to engage in condomless sex (Blumenthal and Haubrich 2014). After defining the concept of risk compensation, I explore its use in relation to sexual health interventions such as PrEP, highlighting a strong moral overlay that often accompanies these discussions. Drawing on social media discussions and interviews, I engage in PrEP users' critiques of this concept highlighting four main themes:

1. Risk is multifactorial: it was often argued that assessments of risk based solely on the use (or not) of condoms failed to account for the impact of an increase in sexual health screening.
2. Sexual populations are not distinct groups: while research has explored STI rates among PrEP users as a specific group (see Traeger et al. 2018), sexual interactions among PrEP users are not limited to within this population. Given this, claims were made of a necessity to situate PrEP and any potential increase in STIs within the context of a broader sexual community, a community that includes PrEP users and non-users alike.
3. Condom non-use and oral sex: in response to claims that condoms were an important tool to prevent other STIs, PrEP users would often point out that STIs could also be transmitted through oral sex, a form of sexual interaction for which it was said condoms were almost never used.
4. Different anxieties surrounding HIV when compared with other STIs: participants regularly described the consequences of HIV as much more significant when compared with those of other STIs. Therefore, they felt more of an imperative to minimise HIV risk, with other STIs considered more easily managed.

Chapter 4 – Beyond HIV and STI prevention: PrEP users' interpretations of sexual health

Participants widely interpreted sexual risk and safety as beyond narrowly defined, biomedical understandings where the focus is predominantly on the prevention of disease and infection

(Rhodes 1997). While participants acknowledge STI prevention as an important aspect of sexual health, they also described aspects such as sexual intimacy, pleasure, relationships to one's body, feelings of empowerment and control, as well as freedom from sexual anxieties as underpinning good sexual health. Drawing on the experiences of participants, this chapter discusses the potential impact of PrEP on how sexual health is experienced.

Chapter 5 – Risk, Stigma, and Health: Shifting Discourses Surrounding PrEP

Chapter 5 describes the potential of PrEP to reshape norms around sex and attitudes toward HIV. Specifically, this chapter highlights the promise of PrEP to reduce HIV stigma and perceptions of PrEP as a superior HIV prevention strategy when compared with condoms. While PrEP does have the potential to reduce HIV stigma and positively impact the experience of sex, it also has the potential to form new forms of stigma based on an individual's choice of HIV prevention strategy. This chapter highlights the potential of HIV pharmaceutical technologies to create new forms of subjectivity and sexual citizenship.

Chapter 6 – Liberation from HIV: Displacing HIV from the Experience of Sex

The emergence of PrEP has been accompanied by what I describe as the liberation narrative. The association between HIV and MSM has been particularly strong from the beginning of the HIV/AIDS epidemic in Australia. Given PrEP's efficacy in preventing HIV, advocates claimed that PrEP had the potential to liberate MSM from an overarching and almost constant fear of HIV. In this chapter, I draw on Bourdieu's conceptualisation of *habitus* and argue that the emergence of HIV and condom-based safer sex strategies has functioned as both a process of sexual reskilling (Scott and Freeman 1995) and a behavioural standard against which norms of responsible sexual citizenship (see Weeks 1995) are measured. The emergence of PrEP has challenged these norms, offering MSM the potential to eschew condoms during anal sex while, at the same time, remaining highly protected against HIV infection.

While the liberation narrative was particularly strong throughout my fieldwork, one participant challenged this narrative and claimed that PrEP use was motivated by a concern of HIV. As such, the concern over HIV continued to shape individual behaviours and practices,

making the extent to which PrEP users were fully "liberated" limited. Engaging with this critique, I argue that while PrEP use is in part motivated by a desire to remain HIV-negative, it effectively displaces the act of prevention from sex and, in the context of daily PrEP, shifts it to the realm of everyday routine. As PrEP users were aware of their own adherence to the drug, they frequently described feeling a degree of certainty over their protection against potential HIV infection. Given this, the HIV status of their sexual partners became largely irrelevant. In this way, PrEP effectively disrupted the association of sex and sexual partners with potential risk, offering new possibilities for PrEP users to experience sex and sexual relationships.

Chapter 7 – PrEP: Unlocking the Potential for New Experiences of Pleasure and Intimacy

PrEP users commonly described PrEP as allowing new possibilities of experiencing sexual pleasure and intimacy. Where condoms were thought to be disruptive to the sexual experience and as breaking the connection and intimacy between partners, PrEP was viewed as enabling an experience of sex that was seamless. PrEP users also described being able to experience pleasure through the exchange of semen during anal sex, an experience that had previously been considered particularly high risk and transgressive (Dean 2015; Mowlabocus et al. 2014; Race 2016). With the risk of HIV infection significantly lowered, PrEP users were able to celebrate this exchange, an exchange they associated with spirituality, forms of kinship, and the building of intimacy between partners.

Chapter 1 – PrEP in Australia: Setting the Scene

Introduction

From the first official reports of HIV in 1981, gay communities in Australia have been at the centre of the HIV/AIDS epidemic. As a population, gay men have been disproportionately affected by this epidemic. In addition, gay men were at the forefront of the response to the epidemic and were instrumental in lobbying governments, health organisations, and pharmaceutical companies for access to treatments (Sendziuk 2003; Power 2011). Arriving just after the sexual revolution and the feminist, gay, and civil rights movements of the 1960s and 1970s (Scheper-Hughes 1994), the gay community had a strong sense of political activism and pre-established activist organisations and networks (Epstein 1996). Moreover, many gay men had significant social and economic capital, making this group uniquely positioned to respond to this new and emerging threat (ibid.).

More than simply a response to an emerging health threat, the response to HIV/AIDS by gay communities was also political. There was a fear among some gay men that HIV/AIDS might justify a rolling back of recent advances in gay and lesbian rights, resulting in not only "a re-criminalisation of homosexuality, but also increased restrictions on the freedoms of gay men" (Power 2011, p.31). These fears were not unfounded, and some conservative commentators in the US called for gay men to be quarantined to reduce the perceived threat of HIV/AIDS to the broader heterosexual population (France 2017). While the devastating effects of HIV/AIDS on affected communities cannot be overstated, Dennis Altman (1988) argues that it also had the effect of tapping into a latent sense of community, bringing together previously disparate groups in response to this emerging health crisis (Power 2011). More than simply responding to a health crisis, AIDS activists "worked with gay and heterosexual [people living with HIV (PLHIV)] in the context of community organising rather than altruism, and understood their work in terms of *political resistance rather than compassion*" (Patton 1990, p.21, emphasis added).

Four decades after the first official reports of HIV/AIDS, the landscape around HIV has shifted significantly. The development of effective treatment has seen HIV shift from a potentially life-threatening virus to a chronic and manageable health condition. These same

treatments have been demonstrated as highly effective at preventing HIV transmission, through both the use of PrEP (Grant *et al.* 2010; Molina *et al.* 2015; McCormack *et al.* 2016) and Treatment as Prevention (Rodger *et al.* 2016; Bavinton *et al.* 2018). For those communities that have formed around HIV, the sense of political resistance and activism have continued to shape how they respond to the epidemic.

This chapter provides an overview of two important aspects of PrEP implementation in Australia: first, the role of grassroots community activism; second the development of HIV prevention strategies and treatment technologies. This chapter begins with a brief overview of the HIV/AIDS response in Australia. I then provide a short outline of the development of triple-combination therapies, a technological advance that would eventually lead to the implementation of PrEP. My aim here is to contextualise the emergence of PrEP and highlight the continuing relationships between community organisations, PrEP advocates, and medical researchers. This is not an exhaustive list. Drawing on ethnographic fieldwork, the second half of this chapter explores the emergence and implementation of PrEP in Australia. I outline the work of two Australian-based PrEP advocacy groups whose social media pages would later become key sites for observation.

Australian HIV/AIDS Advocacy

Australian Context

The first case of AIDS identified in Australia was in 1982 when a tourist from the United States was diagnosed at Sydney's St Vincent's Hospital (Power 2011, p.1). Six months later, it was announced that the first Australian citizen had been diagnosed with AIDS in Melbourne (Power 2011, p.1), marking the official beginning of the Australian HIV/AIDS epidemic. Jennifer Power (ibid., p.4) notes that in Australia, HIV/AIDS emerged in the context of "a long history of homophobic discrimination and a mistrust of authorities stemming from many years of legal, religious and medical efforts to control or punish homosexuality." This sparked a fear that this new health condition would see further restrictions placed on gay men. As in the United States, the emergence of HIV/AIDS in Australia sparked a strong community response and brought together various sub-populations of the gay community who, until then, had had little in common (Power 2011; see also Reynolds 2002). Responding to reports of this new health threat among gay men in the

United States, a group of concerned individuals gathered at the Laird Hotel in 1983 to plan a community response (ibid.). This resulted in the formation of the Victorian AIDS Action Committee, an organisation that would later begin operating under a more formalised, incorporated model as the Victorian AIDS Council (VAC)[17] (ibid.).

VAC would go on to become a key organisation in serving the health needs of PLHIV, as well as those of the broader LGBTIQ+ community in Victoria. Although the organisation was initially established to respond to the emerging HIV/AIDS crisis, its focus has always been on broader issues around health and wellbeing. As the organisation evolved and expanded over the years, it established programs to address mental health, alcohol and other drugs, family violence, and maintained its focus on sexual health. Underpinning the work of the organisation has been a strong focus on fighting against discrimination and stigma of sexually and gender diverse populations. Illustrative of this is VAC's response in 1987 to a proposal by the Victorian government that those engaging in "high risk" behaviour be subjected to mandatory HIV testing. VAC opposed this at the time and argued "that the delineation of 'high risk' behaviour was a highly subjective exercise – one that had potential to be an exercise in moral persecution rather than sensible public health" (Power 2014, p.245). Throughout the organisation's history, fighting against stigma and discrimination has been integral to their work in advocating for the health needs of the LGBTIQ+ population.

The Australian response to HIV/AIDS has been widely credited as one of the most effective worldwide (Dowsett 1998; Kippax and Stephenson 2016; Power 2011). Underpinning the success of the Australian response was a close collaboration between organisations such VAC, HIV/AIDS researchers, and government bodies (Power 2011; Robinson 2014). Power (2014, p.241) argues that "the history of HIV/AIDS [in Australia] is much more a story of productive collaborations emerging between object-oriented groups which previously had very different interests." The federal Labor health minister Neal Blewett proved a particularly useful ally in the early years of the epidemic. Blewett worked closely with key stakeholders, including clinicians, community activists and government representatives to

[17] At the end of my fieldwork and on their 35th anniversary, VAC announced it would change its name to Thorne Harbour Health. This change reflected the shifting landscape around HIV/AIDS and the organisations role in serving the health needs of the broader LGBTIQ+ communities. The name honours two early HIV/AIDS and LGBTIQ activists, Allison Thorne and Keith Harbour.

forge strong relationships with affected communities (Kippax and Stephenson 2016; Power 2014, 2011). Understanding the importance of focusing on prevention as much as addressing the needs of people living with HIV, he ensured that half of government funding for HIV/AIDS was spent on prevention campaigns (Kippax and Stephenson 2016).

In 1984, HIV/AIDS advocates argued that gay men needed to be responsible for producing HIV/AIDS educational material, underscoring the importance of using explicit language and images that were appropriate for other gay men (Robinson 2014, p.98). This was agreed to by Blewett who, in 1985 gave the AIDS councils of Victoria and New South Wales $56,000 and $74,000 respectively (cf. Robinson 2014, p.98). This proved particularly effective as it allowed for campaigns to be produced and shown in places such as bars and sex on premises venues where gay men gathered. On the one hand, it enabled the government to distance itself from these campaigns and the populations they were targeted to. This avoided potential controversy over the provision of funding to an otherwise marginalised and stigmatised group. On the other hand, it ensured that health information was communicated to gay men in locations and language that was appropriate.

HIV/AIDS Treatment

Treatment Activism

One of the effects of HIV/AIDS activism has been shifts in relationships between government health officials, health professionals, pharmaceutical corporations, and affected communities. Stephen Epstein (1996) notes that for gay rights activists of the 1960s and 1970s, the government was considered something to be kept away from their private lives. Similarly, there was a long history of gay men being treated to often violent and destructive conversion therapies by medical authorities (Bayer 1981; Drescher 2010). As HIV/AIDS began to impact gay communities, however, "these same men sought active governmental involvement to fund emergency AIDS research and to protect people with AIDS against discriminatory treatment" (Epstein 1996, p.187).

Writing as early as 1993, Debbie Indyk and David Reir (1993, p.30) state,

> *Grassroots AIDS knowledge production already leaves a lasting legacy: it has shown that, for threats as complex as AIDS, information cannot flow only one way, and that rich dividends for community action accrue from recognizing that not all that is scientific rests with the scientists.*

The production of HIV/AIDS knowledge, they argue, challenged existing top-down power structures in how medical knowledge was organised, becoming instead "a multisite[d] process, involving not *hierarchies* of diffusion but *webs* of exchange" (ibid., p.15 emphasis in original). It was frequently non-academic doctors, working at the frontline of the epidemic and having pre-existing relationships with affected communities, were able "to produce, organize, and spread important clinical data" (ibid., p.5). These doctors were often responsible for community-based trials of experimental HIV/AIDS drugs, trials that often achieved a wider patient enrolment than those run by drug companies (ibid., p.5).[18] For many people living with HIV, these trials represented more than simply fact-finding missions and were "an important *means of access* to otherwise unavailable drugs" (Epstein 1996, p.197 emphasis in original).

One of the most recognised HIV/AIDS activist organisations is *ACT UP* who, through engaging in direct action activism, research, and advocacy, aimed to improve the lives of those living with HIV. *ACT UP* was an HIV/AIDS activist organisation that began in the United States, and eventually established in many countries around the world including Australia. The organisation became known for a distinct type of activism which deliberately challenged notions of culturally appropriate and acceptable behaviours. These included "throwing condoms, necking[19] in public places, [and] speaking explicitly and positively about anal sex" (Gamson 1989). Relationships that organisations such as *ACT UP* established with researchers and policy makers, both in the United States and Australia proved to be particularly important (Epstein 1996; Sendziuk 2003). Epstein (1996) identifies a productive tension between activists and scientific researchers. While in public these two groups might have appeared to be in conflict, in "more private negotiations, by contrast, there was at least a tacit acknowledgement of ethical claims on both sides" (ibid., p.247). That is, just as many researchers acknowledged the importance of fast-tracking the process of developing and

[18] In Australia, Professor David Cooper was among the first to conduct research on HIV/AIDS. Professor Cooper's work in establishing Australian-based HIV clinical trials serves as an example of the close and important relationships between researchers and frontline health workers (see Kippax *et al.* 2018).
[19] Heavy kissing

trialling HIV/AIDS medication, so too were some activists sympathetic to the necessity for rigorous and robust scientific method.

Through their work in treatment activism and relationships with medical researchers, HIV/AIDS activists

> *became ever more enmeshed in the minutiae of clinical trial design … This direct engagement with the terms of clinical research would both establish the scientific credibility of the activists … and ultimately alter the pathways by which specific treatments came to seem credible in different quarters (Epstein 1996, p.246).*

Activists provided an important perspective for trial organisers and were regularly "invited onto the local community advisory boards and institutional review boards that oversaw protocols for clinical trials at hospitals and research centers" (ibid., p.249). Such was the significance of their perspective that the infectious diseases physician Dr Anthony Fauci characterised HIV/AIDS activists as having "an extraordinary instinct … about what would work in the community [and] … probably a better feel for what a workable trial was than the investigators [had]" (ibid., p.249). This perspective would remain an important feature of future drug trials for HIV/AIDS, including Australian-based PrEP trials. I return to this point shortly.

The power of activist groups in pressuring governments and pharmaceutical corporations to develop and fund new treatments is exemplified in the activism around access to azidothymidine (AZT). Under pressure from HIV/AIDS lobbyists and community organisations such as *ACT UP*, US researchers announced in 1986 that they would begin trialling AZT, a drug that was originally developed in the 1960s as a cancer treatment (Epstein 1996; Indyk and Rier 1993; Patton and Kim 2012; Power 2011; Sendziuk 2004). The use of a placebo-controlled trial drew criticism, however, and activists raised concerns over the ethics of a trial design that relied on a certain number of deaths before the drug could be deemed effective (Epstein 1996). Advocates also began "rebelling against what they saw as well-intentioned but deadly paternalism" (ibid., p.195) by government regulatory bodies in the United States who, as a result of the long-term effects of AZT being unknown, refused to approve the drug for widespread use. Activists argued that given the drug had *some* effect on AIDS, an otherwise terminal condition, it was pointless to deny the drug simply because the long-term safety of AZT had not been established (ibid.).

In Australia, branches of *ACT UP* were established in Melbourne, Sydney, and Canberra to pressure the government to hasten the approval of new HIV/AIDS drugs (Sendziuk, 2004). In addition to lobbying against governments and pharmaceutical organisations, the Australian branch of *ACT UP* had a sometimes-tense relationship with state-based HIV/AIDS organisations. Where *ACT UP* prioritised a form of direct-action activism, the organisation considered the HIV/AIDS councils as "an extension of government bureaucracy and not adequately reflective of the needs of people with AIDS" (Power 2011, p123). While *ACT UP* were critical of HIV/AIDS councils, however, many of those involved with *ACT UP* maintained strong links to HIV/AIDS organisations (Power 2011; Sendziuk 2004). Despite the tensions that existed between these organisations, each organisation was able to build on the different styles of activism and ultimately complemented the other to further the response to HIV/AIDS (Power 2011; Sendziuk 2004).

Shortly after AZT trials began in the US, an Australian trial was announced (Sendziuk 2004). Despite evidence from US trials, however, Australian health authorities refused to establish a fast-track process for drugs that had already been approved by reputable organisations in other countries (ibid.). In response to activists' demands for access to these drugs, the government amended the Therapeutic Goods Act (TGA) to allow individuals to self-import as-yet unapproved treatments, provided they had a valid prescription from an Australian doctor (ibid., p.214). This saw the establishment of Buyers' Clubs that informed "patients about the efficacy and toxicity of the treatments, assisted general practitioners in writing scripts, and arranged the bulk importation of drugs" (ibid., p.214). Echoes of this early activism and the establishment of Buyers Clubs would re-emerge almost 30 years later in the work done by activists and advocates for PrEP.

Triple-combination Therapy

The landscape of HIV/AIDS changed in 1995 when, six months prior to the 11th International AIDS Conference in Vancouver, Canada, researchers announced the results of a triple-antiretroviral drug combination trial (Zuniga and Ghaziani 2008, p.4). It was reported that this combination – a combination including one protease inhibitor and two nucleoside reverse transcriptase inhibitors – had removed detectable virus levels in 85% of the small study

cohort (ibid.). Researchers and doctors described a so-called "Lazarus Effect" associated with this new therapy, whereby AIDS patients went from being close to death to almost "normal health" soon after they began treatment (Rasmussen and Richey 2012, p.188).

Given the effectiveness of these new treatments, an HIV diagnosis was no longer considered an automatic death sentence and, provided individuals had access to appropriate healthcare, could instead be considered a chronic and manageable condition. Asha Persson et al. (2003, p.399) argue that "it was not until the so-called 'protease moment' in 1996, when a new class of drugs appeared, that the construction of HIV as a chronic illness actually coincided with a marked reduction of AIDS-related deaths" (see also Persson 2016; Stahlman et al. 2016). This was precisely how HIV was characterised when fieldwork for this project was conducted over two decades later, with HIV described as a condition that need not necessarily have a significant impact on one's life expectancy. That said, it is also necessary to note the continuing inequity of access to lifesaving drugs is not masked. As demonstrated in the introduction, approximately 770,000 people globally died of an AIDS-related illness in 2018, and many of these were among the world's most socially, economically, and politically marginalised communities (UNAIDS 2019). Just as early HIV/AIDS activism in countries such as the United States and Australia incorporated fighting against discrimination and marginalisation of affected populations, so too does contemporary advocacy for treatment access need to encompass social, economic, and political concerns.

The announcement of triple combination therapy and its success in reducing an individual's HIV viral load to undetectable levels marked a new era in the HIV epidemic, an era in which both Treatment as Prevention and PrEP could become imaginable. While early treatments were often associated with high levels of toxicity and significant side effects (Zuniga and Ghaziani 2008, p.4), continuing research over following decades produced ever more tolerable and effective treatments. These treatments became so effective that, in 2008, Pietro Vernazza et al. (2009) issued what became known as the Swiss Statement, claiming that any person living with HIV who had a sustained undetectable viral load had effectively no risk of forward-transmitting HIV. This claim was later confirmed in large-scale clinical trials which

examined HIV transmission rates among sero-discordant couples[20] (Bavinton et al. 2018; Cohen *et al.* 2011; Rodger et al. 2016). Despite over 70,000 acts of condomless sex recorded in the two studies combined, no HIV infection occurred that could be linked back to a positive partner where that partner had an undetectable viral load. These studies lay the groundwork for significantly shifting how HIV prevention was approached.

PrEP Clinical Trials

The earliest PrEP clinical trials were established in Cambodia and Cameroon in 2005 (Singh and Mills 2005). These trials drew criticism from organisations such as *ACT UP Paris* who raised concerns over the lack of community consultation (Cairns et al. 2016), access to ongoing HIV treatment for those who might seroconvert during the trial, and a lack of HIV prevention counselling (Rosengarten and Michael 2009). Due to these concerns, these trials were suspended early. Questions were also raised over the ethics of conducting trials of expensive HIV/AIDS medications, including PrEP, in some of the world's poorest areas. Mpho Selemogo (2008) argues that it is the people in the poorest areas who, often the most affected by HIV/AIDS, have contributed the most to the development of new treatments and knowledge. Despite this, he claims, it is these same people who often do not have access to HIV treatments or even the most basic and cheapest of prevention strategies such as condoms. This raises important questions over whether such trials are designed to benefit participants or, rather, whether these trials are ultimately designed to benefit those in wealthier countries. Selemogo contends that unless the ongoing implementation of PrEP in trial communities is part of trial design, these trials run the risk of being little more than fact-finding missions for PrEP implementation in wealthier contexts.

In a review of PrEP RCTs, Christoph Spinner et al. (2016) identified eight major studies testing the efficacy of Truvada for the prevention of HIV in HIV-negative people. Of these trials, three specifically tested the efficacy of PrEP among a cohort of MSM. In 2010, Grant et al. published the results of the *iPrEx* trial, an RCT conducted across six countries including Peru, Ecuador, Brazil, the United States, Thailand and South Africa. Enrolling 2,499 MSM and transgender women who have sex men, *iPrEx* was the first trial to explore both the

[20] Sero-discordance refers to couples of different HIV statuses, i.e. where one person is HIV-positive and the other HIV-negative.

efficacy of Truvada as PrEP and adherence rates among trial participants (Whitacre 2012). Grant et al. (2010) found a relative risk reduction of 44% among those on the trial's study drug arm when compared with those on the placebo arm. However, when these results were adjusted to account for adherence, a relative risk reduction of 92% was reported among those with detectable drug levels in their blood. Grant et al. (ibid.) were thus able to claim that, when taken daily, Truvada as PrEP was a highly effective HIV prevention strategy. A contributing factor to the success of this trial was its explicit inclusion of MSM and the strong historical links between HIV activism and the gay community (Whitacre 2012). This was particularly notable among participants on the San Francisco cohort for whom an important motivating factor for joining the trial was a sense of altruism and responsibility for contributing to an end of HIV (Gilmore et al. 2013).

The *PROUD* study was an open-label, randomised control pilot study to determine the merits of conducting future large-scale PrEP trials in England. This study enrolled MSM designated as high risk of HIV infection and had reported engaging in condomless anal sex within the previous 90 days (Dolling et al. 2016; McCormack et al. 2016). Participants were randomly assigned into one of two groups: the first group were given the study drug immediately while the second group were deferred. An interim analysis found PrEP to be highly effective and identified a significantly increased risk of HIV infection among the deferred group and based on this, it was recommended that PrEP be offered to all trial participants. The *PROUD* study reported an overall relative risk reduction of 86%, leading researchers to support the implementation and funding of PrEP as part of the HIV prevention landscape in the United Kingdom (Kelen and Cresswell 2017; Mayer and Beyrer 2016; McCormack et al. 2016). Despite these recommendations, as of early 2020 Scotland was the only member of the United Kingdom to have funded PrEP through their National Health Service. In other member countries of the United Kingdom, PrEP was only available through nationally funded research projects or through self-importation.

In contrast to the above clinical trials which tested the use of daily PrEP, the *IPERGAY* study sought to test the efficacy of "on-demand" PrEP among MSM (Molina et al. 2015). Recruiting a cohort of MSM in both France and Quebec, researchers proposed testing the efficacy of two tablets 2-24 hours prior to a sexual encounter, a third tablet 24 hours after first

taking the medication, and fourth tablet another 24 hours after that. The study reported a relative risk reduction of 86%, demonstrating PrEP "on-demand" as also an effective HIV prevention strategy. As fieldwork was being undertaken for this project, on-demand PrEP had not been officially approved in Australia[21].

Testing among other population groups, the *Fem-PrEP* (van Damme et al. 2012) and the *VOICE* (Marrazzo et al. 2015) trials specifically recruited heterosexual women in southern and central Africa. These trials reported extremely low efficacy rates due to low rates of adherence by participants. As a result, the *Fem-PrEP* trial was stopped early and it was recommended that two of the three study drug arms of the *VOICE* trial be abandoned (Spinner *et al.*, 2016). In contrast, the *Partners* PrEP study enrolled sero-discordant heterosexual couples in Kenya and Uganda (Baeten et al. 2012) and the *TDF 2* trial was conducted among heterosexual men and women in Botswana (Thigpen et al. 2012). These trials were more successful and found a relative risk reduction of 86% and 85% respectively for those using the study drug. Finally, the *Bangkok Tenofivir Study* tested the efficacy of PrEP among intravenous drug users, finding a relative risk reduction of 74% among those with detectable drug levels (Choopanya et al. 2013).

PrEP and the Australian PrEP Story (Victoria)

AFAO Discussion Paper

The first official mention of PrEP by an HIV/AIDS organisation in Australia was a discussion paper released by the Australian Federation of AIDS Organisations (AFAO) in June 2004. At the time of the paper's release, the Cambodian and Cameroonian trials were underway and, while the paper was not meant "to infer criticism of a valuable therapeutic agent" (AFAO 2004, p.3), it highlighted a range of issues. These included a lack of existing evidence over the efficacy of PrEP at the time; concerns over how target and eligible populations were defined; and concerns over whether the Australia's Pharmaceutical Benefits Scheme (PBS) would subsidise what some described as a "lifestyle" drug (ibid., p.4). As the

[21] In 2019, the PrEP prescribing guidelines were updated to include the recommendation for PrEP on-demand (ASHM 2019).

efficacy of PrEP was unknown when the AFAO paper was published, there was also a concern that PrEP might engender a false sense of security and could lead to a decrease in condom use. While there were implications for a potential increase in STIs with declining condom use, there was the possibility that if the efficacy of PrEP was lower than believed there might also be an increase in HIV transmission rates (AFAO 2004, p.5). Despite these concerns, AFAO nonetheless stated "it is important that Australia moves promptly to develop an appropriate policy response to PrEP" (AFAO 2004, p.1).

Despite AFAO's 2004 call for the timely development of PrEP implementation policy, it was not until June 2014 that Australia's first PrEP demonstration project, *VicPrEP*, began in Melbourne (Lal et al. 2017). This study was a small-scale demonstration project that followed 114 participants and assessed "the acceptability, safety, impact and feasibility of prescribing daily pre-exposure prophylaxis (PrEP) to people at risk of HIV infections" (VicPrEP 2018). The study also sought to explore "the uptake of PrEP among eligible individuals and the reasons people accept or decline this HIV prevention strategy" (VicPrEP 2018). This study did find a decline in rates of condom use with participants reporting positive changes to their experiences of sex (Lal et al. 2017). It was also found that, while stigma had been reported as a potential barrier to PrEP uptake (see Biello et al. 2017; Calabrese et al. 2017; Calabrese and Underhill 2015; Young et al. 2016), the VicPrEP cohort reported experiencing low levels of stigma on disclosing their PrEP use (Murphy et al. 2016).

At the time of the *VicPrEP* trial, Australia's Therapeutic Goods Administration (TGA) had yet to approve the use of any antiretroviral medications for use as PrEP. While PrEP could be accessed through two state-based trials – *VicPrEP* (Victoria) and *PRELUDE* (NSW) – the small scale of these trials meant that only limited spaces were available. At the same time, there was little public advocacy for PrEP by the established HIV/AIDS organisations. Given this, a small group of individuals came together to form PrEP advocacy groups with the aim of supporting those who wanted to use PrEP and to facilitate the importation of antiretrovirals for the use of PrEP. Drawing on interviews conducted with those involved in advocating for PrEP implementation in Melbourne, the remainder of this chapter outlines much of the work done by these groups.

PrEP'd for Change

The first Australian group to advocate for PrEP was *PrEP'd for Change* and was established in 2015 by Tim and Jacob, two early adopters of PrEP in Melbourne. Co-founder Tim described the formation of the group as being instigated by a process whereby both he and his friend Jacob had similar experiences when they began using PrEP. Describing the formation of the group, Tim stated,

> It became very apparent to us both within the first couple of months of me starting [PrEP] that the experiences Jacob had had, and some of the emotional journey and the psychological journey, was repeating [with me]. That I was going through very, very similar – uncannily so – very similar thought processes. And, when we kind of debriefed with each other, we were then able to kind of piece bits together and go: "but that's exactly what I thought even though I didn't tell you at the time." And "that's how I felt and that's what I was doing." So, we recognized that … from the two people that we knew were doing it, which was us, we thought if other people are going to do this there's going to need to be support structures to help people. Because it seemed like this warranted, if it was going to be a success, it warranted some TLC [tender loving care] to make sure it could be a success. And that meant making sure that people were supported and ready for it.

Alongside his flatmate, Tim identified a need for those interested in PrEP to have access to information as well as the support to empower potential users in their decision to begin PrEP. This support was particularly important given the experience of PrEP stigma in the United States, where some users reported experiences of sexual rejection and stereotyping as promiscuous due to their PrEP use (Dubov et al., 2018). Tim also described an "emotional" and "psychological journey," a process whereby he needed to acknowledge and accept his own preference for condomless anal sex even in casual contexts. Similarly, Race (2016, p.23) argues that PrEP "relies on the sense of a predictive and intentional subject whose propensity to err is fully present and apprehensible to that subject in advance." In this way, PrEP also requires its users to confront their potential for engaging in forms of sex such as casual condomless anal sex that that have been considered as irresponsible and deviant.

Tim went on to describe that both himself and Jacob felt comfortable in discussing their own experiences of PrEP:

> We just updated our Grindr profiles [and] our Scruff profiles with an invitation to say "you're very welcome to talk to us about PrEP if you want to. It's this thing, it protects against HIV, ask anything you want." And we got *inundated*. We were flooded with messages to the point that we couldn't speak to each other for a week because we were just buried in phones trying to talk to people. And that was a kind of indicator of, there was a huge amount of interest in this – and we had no idea how big at that point. From then, it was Jacob's idea to create some kind of sustainable means of being able to have that conversation on a much larger scale. Because it was not sustainable for us to do it as a single-point, one-person conversation on apps. So, Jacob did some research and one night over glass of wine said, "hey, [do] you want to create a Facebook group?" [I responded]: "sure, let's do that." And that's how PrEP'd for Change was born really.

Tim and Jacob began by inviting approximately 300 people they knew through their own social networks and who they also thought might be interested in PrEP. The group quickly expanded and as of August 2020 had over 2,800 members. While the group had members from various parts of the world, the majority were living in Australia.

An important feature of *PrEP'd for Change*'s Facebook group is that it was open. This meant that regardless of whether an individual was a member of the group, anyone with a Facebook account could view the interactions that occurred on its page. For some group members, this raised concerns particularly given the associations of HIV, PrEP, and a gay male identity. Some felt that the membership of this group might identify them as same sex attracted. For others, there was a belief that their sexual health strategies should remain private, regardless of whether they were open about their sexuality or not. Tim recognised these concerns as important. However, he also believed that the benefits of the group being open outweighed any potential privacy implications. He justified keeping the group open:

> We had the intention of having the group as an open group and there's been maybe only one or two people over the years that have kind of sent private messages to say: "Hey, would you make it a closed group?" And my response has always been, "look, I understand what you're saying, and you can always chat to me privately." But *PrEP'd for Change* was intended to be open and my intention is to keep it open. It's important that we don't hide. It needs to be visible and public, and there's nothing dodgy or shameful about it.

Tim's comments here address two important aspects that have contributed to the success of PrEP implementation in Victoria. On a very practical level, through having the group as open anyone was able to view its social media page without needing to necessarily disclose their interest in PrEP. Therefore, even those who had concerns over being identified as same sex attracted could continue to access the resources posted to this page. On a more political level, the group's founders aimed to send a message that there was nothing to be ashamed of in using PrEP to prevent HIV. This was particularly important given the experience of PrEP stigma that had emerged in the United States (Calabrese and Underhill 2015). Implicit in the decision to keep the group public was an attempt to make a statement whereby PrEP could be considered a legitimate sexual health strategy.

PrEPaccessNow (PAN)

Tim considered one of the benefits of *PrEP'd for Change* and its use of social media as its potential to bring together individuals who might not have otherwise interacted:

> the group facilitated bringing people together in a digital space. Which is, I mean digital spaces are amazing because they bring people together [that] wouldn't ordinarily be physically in front of each other. And through a conversation that was had by, by people saying: "I think we should be doing that," and, "I want to make sure that everybody can get access to affordable PrEP," and, "I know the supplier over here." We had a consortium of people that got together on the platform [who] started having a conversation. They took that conversation offline and met up in the pub because they all happened to be in Melbourne. And [*PrEPAccessNow*] was born as a result of meeting on that platform, you know, fostering that kind of innovation and that kind of social space.

Shortly after *PrEP'd for Change* was established, one member made a post to the group's Facebook page in which they identified access to PrEP as an important factor for the successful implementation of PrEP in Australia:

> Access is a massive issue for the most vulnerable groups some of which may not have money for food or shelter. As community members how can we create radical, revolutionary ideas about PrEP access in our community and turn them into direct action? The ACT UP legends of our queer history worked hard and laid the foundations of where we are today. What does this activism look like today?

This post sparked a lengthy discussion between several other members of *PrEP'd for Change* who identified a range of issues, including how to motivate people to want PrEP; providing PrEP access to vulnerable communities; cost; and lack of support from the conservative federal Liberal government who were in power at the time. Responding to this post, one *PrEP'd for Change* member suggested,

> in terms of access for people who can't afford it, a community-based pharmacy – online – selling generics with a loading to support people who can't afford the drug. Lots of administrative overheads perhaps … *ACT UP* needs to be rebuilt locally.

The call for radical action of *ACT UP* was echoed by another respondent:

> The wheels of bureaucracy are heavy and slow. I trust that there are very capable and motivated people pushing that where they can. In the meantime, I'm suggesting a 'radical' view where we look at the resources [that] we already have an[d] leverage those in a more direct way to solve the immediate problem … We don't have to play by the rules or follow the traditional path. People can get PrEP right now.

The suggestion of not having to "play by the rules or follow the traditional path" was particularly significant. Acting without institutional affiliation, these individuals had the opportunity to engage in forms of activism that could bypass much of the bureaucratic processes faced by organisations reliant on public funding. While this brought challenges in terms of lack of resources and established reputation, it also afforded the opportunity to respond rapidly to the quickly changing landscape around PrEP implementation. Moreover, as these organisations were not reliant on external financial support, they were able to engage in a more controversial style of activism modelled on organisations such as *ACT UP* with no risk of losing external funding. I return to this in the following section.

Through the Facebook conversation above, a meeting was organised at the Laird Hotel in Melbourne, the same site at which the first meeting of what became VAC was held. This resulted in the founding of *PrEPaccessNow* (*PAN*). Describing the original purpose of the group, Luke stated,

> we had a few things we really wanted to do. The first one was to be able to get PrEP into the hands of people who weren't in a study and who couldn't afford it … I can't even remember how much it was. What was it, forty dollars a month to be able to get it? So, we wanted to be able to get drugs to people if they wanted to use it [sic]. We were also concerned about, having been exposed to the US experience, the stigma that PrEP users were experiencing. "Truvada Whore" classically came out of the journalists' writing, in a serious way, that people were going to become whores … But also [we] wanted to promote positive sex messages, sex positivity. And we also want to impact the established organisations like AIDS councils, and AFAO and so forth, who were in a position of either needing to, or waiting until, TGA approval for the drug before they went further.

I address the interactions between PAN and established HIV/AIDS organisations in the following section. Where *PrEP'd for Change* was primarily focused on advocacy and support for PrEP and PrEP users, a primary focus of *PAN* included facilitating access to PrEP medications. Leveraging an already-established relationship with an international pharmaceutical provider, *PAN*-founder Kevin described:

> I approached a friend of mine who owns pharmacies in [Africa] and told her about PrEP and the fact that we'd formed the organisation and that what we wanted to do was to bring it into Australia at a low cost. One of the generics was being manufactured in South Africa and she went and did her homework in terms of the legalities from her side of exporting. I contacted the TGA and had very in-depth conversations with them to ensure that we wouldn't be breaking any rules in terms of what we were doing and got exactly the process that would be acceptable for us to follow. And yeah, we set it up from there within about six or seven weeks. We had the website ready. We were ready to rock and roll.

The short space of time needed for *PAN* to be established is illustrative of the benefits of not relying on government funding. *PAN*'s founding was described by co-founder Jason as a way in which the gay community could "look after its own." Jason expressed a degree of distrust in government bodies and believed that despite the Australian government's commitment to PrEP and a belief in its efficacy, they could revoke their approval at a moment's notice. With marriage equality a high-stakes political issue at the time, and with then-Prime Minister Tony Abbott a well-known anti-marriage equality campaigner, this sentiment was justified. Self-importation therefore represented a strategy to minimise this risk.

The self-importation of PrEP medications offered an affordable way through which PrEP could be accessed. However, members of PAN recognised that for some, even this cost might be a barrier. To address this, members of PAN negotiated an assistance scheme with

their online pharmaceutical provider whereby individuals could access PrEP at significantly reduced rates. This scheme was ultimately agreed to by the pharmaceutical company, and 10 percent of the cost of each order was set aside to fund PrEP for those unable to afford it. This scheme remained important even after PrEP was approved for subsidy under the PBS. When PrEP was ultimately subsidised under the PBS in April 2018, it did not include those ineligible for Medicare subsidy. This meant that for those who were ineligible for Medicare, a population group that included international students and non-citizens, the cost of PrEP was prohibitively high. In contrast, *PAN*'s access scheme was open to everyone regardless of citizenship status, ensuring that all those who might otherwise have had difficult access PrEP were able to access it.

While the PBS listing of PrEP was welcomed, there were concerns that the monthly price of A$39.50 might prove a barrier for some, particularly for those on low incomes but not eligible for further low-income subsidies. Moreover, the PBS cost of A$39.50 was not available for those on certain visa types such as those on international student visas. This was particularly problematic given the increasing rates of new HIV infections among this population group (Stardust et al. 2017). Those who were not eligible for PBS subsidised medications were directed by the centre to contact *PAN* and *PrEP'd for Change*. The facilitation of self-importation of PrEP medication has therefore remained important, even as PBS subsidies gave the impression of making PrEP widely accessible.

Challenging Established HIV/AIDS Organisations

As stated in the introduction to this thesis, in September 2015 a group of activists engaged in a guerrilla poster campaign stating: "YOU CAN FUCK RAW, PrEP WORKS, NO MORE HIV." This campaign was organised by a group calling themselves *SeeItClearly2020* who, in a statement claimed: "Our message is that if you're going to fuck raw without a condom, you need to be on PrEP – raw sex on PrEP is safe sex" (*SeeItClearly2020* qtd Wade 2015). One activist involved with the group described the poster as

> An atomic bomb … shattering the expectations of people around at the time. And the power of it was to say one true thing – one true thing that shocked the crap out of everyone. You know, you can fuck raw on PrEP. There's no problem in terms of HIV with fucking raw on PrEP. There's a lot of emotional baggage that goes with that and to say it bluntly is to challenge all that emotional baggage.

Given the over 30 years of condom-based safer sex promotion, the suggestion of "raw sex" as "safe sex" appeared to run counter to the dominant safer sex messaging that had been constructed throughout the HIV/AIDS epidemic. This was particularly so as the posters did not distinguish between other HIV prevention strategies such as negotiated safety and instead, promoted *any* condomless sex while using PrEP as safe.

As discussed in the introduction, the Fuck Raw campaign drew criticism for its explicit messaging and what some considered as reinforcing stereotypes of gay men as promiscuous. Importantly, the language employed for this campaign reflects a history of using sexualised language and imaging to promote gay men's sexual health in Australia (Sendziuk 2004). However, such campaigns have usually been more targeted, appearing primarily in spaces such as gay bars, clubs, and sex on premises venues. Others, however, were critical of the lack of information contained in this campaign specifically about PrEP or ways to access it. One PrEP advocate, for example, commented,

> The posters are still a bit of a sore point for me – and I think there was a point because they challenged everything. As much as I disliked what was done [and] how it was done … It was a very confusing message even to somebody that knew what PrEP was … There was no additional information on those posters that actually enabled somebody who was interested to do anything about that. There was no website, there was no kind of information to say speak to your GP or anything like that.

This criticism was acknowledged by those involved in the campaign, some of whom recognised a lack of resources to effectively support individuals in learning more about PrEP. Given the media coverage and ensuing discussion on social media, however, the campaign achieved what its organisers set out to do: to start a very public dialogue on PrEP.

Despite the controversy caused by the "FUCK RAW" campaign, established HIV/AIDS organisations were able to use it to their advantage. In a joint press release by VAC and Living Positive Victoria, they stated,

> *While we have concerns about the appropriateness of the messages conveyed by this campaign, we think it shows a level of interest in and demand for more effective HIV prevention in our community … it's pretty clear that we cannot ignore this call to action, and we have no desire to silence those who rightly demand access to lifesaving forms of proven HIV prevention (VAC 2015).*

While there was no direct collaboration between *SeeItClearly2020* and the established HIV/AIDS organisations, the response of VAC and Living Positive Victoria illustrates the synergistic potential of relationships between organisations such as VAC who rely on

government funding and advocates who employ a more direct approach to activism. Shirleene Robinson (2014) notes a productive tension in the 1990s between *ACT UP* and more formal HIV/AIDS organisations. Robinson notes that *ACT UP* engaged in forms of activism that might potentially damage the reputation of HIV/AIDS organisations and their relationships with government bodies. At the same time, however, HIV/AIDS organisations were able to use the actions of *ACT UP* to illustrate the needs and demands of their communities. Robinson (ibid. p.192) argues that "ACT UP changed the nature of lesbian and gay activism by ushering in a direct action model that was not constrained by ties to existing organisations." Similarly, VAC and Living Positive Victoria were able to leverage the "FUCK RAW" campaign, citing it as evidence of community demand for PrEP and placing pressure on the government to make PrEP available.

PrEP Accord

The 'FUCK RAW' campaign ultimately inspired the PrEP Accord, a document that was signed on December 7, 2105, between grassroots activists, medical researchers, and community organisations such as *PrEP'd for Change* and *PrEPaccessNow.* The accord lay out a "set of shared principles around the adoption of PrEP as an important HIV-prevention tool" (VAC 2015). The focus of the PrEP Accord was on ensuring that there was a consistency of messaging from all those who were involved in PrEP advocacy, particularly around education, challenging PrEP and HIV stigma, ensuring information was based on rigorous medical and social research, and supporting efforts to have PrEP approved under the TGA and listed on the PBS.

Luke described an additional benefit of the Accord was in providing a degree of legitimacy to the work of *PrEP'd for Change* and *PAN*:

> It was also for the community … a power statement. It's one thing to have community activists running around … saying PrEP's the answer to everything. It's another thing to have established, respected organisations bring us on board in some way.

The power of the Accord lay in bringing together various groups that were working at different levels of PrEP research, policy, and advocacy. Just as a degree of legitimacy was given to organisations such as *PrEP'd for Change* and *PAN* through their alignment with established organisations, so too were those working at the research and policy level able to

get an insight into community attitudes and concerns almost in real time. PrEP researcher Sam commented,

> I need to hear from people like [PrEP Advocate] Tim because I can go and talk at scientific meetings about intimacy and sexuality and, anecdotally, how people are feeling on PrEP and [that] it takes several months for the things to change and the fear to drop … I find it's sort of a camaraderie. It's just being, we're all in it together … If you get the community involved, man, it makes all the difference … That sort of camaraderie is very important, and it will be important for delivering other things … Imagine if we have some new, hideous epidemic or new infectious disease … And we'll have networks, in a sense, in place that will allow appropriate information to get out.

With our interview occurring in early 2018, it is unlikely Sam was predicting the global COVID-19 pandemic in 2020 which caused worldwide disruption. This disruption extended to my fieldsites as, for the first time in their history, AIDS councils across Australia encouraged MSM to *not* engage in casual sex. Both *PrEP'd for Change* and *PAN* proved useful platforms through which sexual health information in the context of COVID-19 could flow. Significantly, Sam highlights the importance of having the perspective of how PrEP is experienced by its users. While each group focussed on different aspects of PrEP rollout, as Sam states, all were working toward the common goal of preventing HIV and improving the lives of affected communities.

Far from information only flowing from the grassroots to the institutional level, there was a reciprocal interaction between researchers and grassroots advocacy organisations. Tim described the benefits of the relationships built through the PrEP Accord:

> Through that kind of alliance, we've all therefore had open communication, so we haven't needed to, haven't really had to advocate or kind of demand anything because we've always been involved in the communication to know that, hey, it's coming anyway. So, you know, Sam wanted to do something. They always wanted to do something beyond *VicPrEP* – to create *PrEPX*. So, that was already in the pipeline and they'd already shared that internal knowledge with us that it was coming. So, we weren't in a situation where we were kind of going, "I demand this" because we were going, "well, it's happening anyway. It's already there."

This was reflected in the activity occurring on *PrEP'd for Change* and *PAN* around the implementation of state-based PrEP trials. Given their close relationship with trial organisers and HIV/AIDS organisations, the moderators of these two groups were able to provide up-to-date information as to the status of Australian PrEP trials. This proved particularly effective in disseminating information about trial enrolments which, through social media, could be communicated to a broad audience. This contributed to the fast enrolment rates of the PrEPx study which, according to the lead investigator Edwina Wright, was among the fastest enrolling PrEP trials worldwide (Wright 2016).

Conclusion

From the first official reports in 1981, community advocacy and activism has played a central role in the response to the HIV/AIDS epidemic (Epstein 1996). Even as gay communities were devastated by the epidemic, they were also uniquely positioned to respond to it. Treating HIV/AIDS as *both* a health and political issue, they drew on existing activist networks to respond to the unfolding health challenge. In Australia, the work of HIV/AIDS activists resulted in a change to regulations to the importation of as-yet unapproved medications that had shown efficacy in clinical trials abroad. This would prove particularly important 30 years later, allowing PrEP advocacy groups to facilitate the importation of PrEP medications.

The early activism occurring around HIV/AIDS has been reflected in the work done by those advocating for PrEP in Australia. Working outside of the already-established community health organisations and through social media, PrEP advocates provided support for those interested in or already using PrEP. In addition to raising awareness of PrEP, these groups provided an important means of access to PrEP both before and after PrEP was listed on the PBS. This included access to PrEP for those who could not otherwise afford it as well as those who were ineligible for further government support or access to PBS subsidised medications.

Throughout the history of HIV/AIDS in Australia, a productive tension has existed between activists, community health organisations, researchers, and government health departments. Just as these relationships proved important in addressing the HIV/AIDS epidemic, so too have they been effectively used to implement PrEP in Australia. Each stakeholder approached PrEP implementation from a different perspective. Through the PrEP Accord, however, each group was able to work together with each approach to implementation able to support and complement the other. While activists were able to employ a form of direct-action advocacy such as the "FUCK RAW" poster campaign, HIV/AIDS organisations reliant on government funding could use that campaign as demonstrative of the community desire for PrEP. Similarly, researchers and PrEP advocacy groups developed a productive

relationship whereby information flowed in both directions. Through this, PrEP researchers gained insider knowledge of how PrEP was experienced while, at the same time, were able to provide information quickly and effectively about PrEP and PrEP trials through the social media pages of PrEP advocacy groups. This collaboration has underpinned the successful rollout of PrEP in Australia.

Chapter 2 – Risk, Stigma, and Health: The Moral Imperative of Safer Sex

Introduction

Significant controversy has surrounded the emergence of PrEP and has focused on its potential to disrupt condom use as the primary HIV prevention strategy. Given the efficacy of PrEP at preventing HIV, concerns were raised that PrEP users would forgo the use of condoms. While for some these concerns were motivated by a concern over the potential for increased rates of STIs[22], others characterised PrEP users as prioritising hedonistic bodily pleasure over health. These moralistic concerns were captured in the comments of Michael Weinstein, President of the Los Angeles-based AIDS Healthcare Foundation, who described PrEP

> *as a party drug, because I believe that people will take it on a Friday night to have a good time on the weekend … It facilitates doing whatever you please. The whole idea behind a party is that you let your hair down, and you throw care to the wind, and you have a good time (qtd. Cohen 2014).*

Throughout the HIV/AIDS epidemic, condom use has functioned as a means by which gay men could reduce their risk of HIV infection as well as being a standard by which notions of responsible sexual citizenship have been measured (Weeks 1995). Nathan Lee (2013, p.5) argues that gay men have "inherited an official safer sex discourse with little but condemnation for sexual contact unmediated by [latex] prophylaxis," with condomless sex considered only acceptable in the context of committed and monogamous relationships. Any condomless anal sex occurring outside of this context was considered high risk for HIV infection and, as a result, a particularly deviant act.[23]

Characterisations PrEP users as prioritising sexual pleasure over sexual health have contributed to the stigmatisation of those using PrEP as promiscuous and irresponsible. This chapter explores these characterisations, highlighting the interactions between PrEP stigma and perceptions of so-called risk behaviours. After discussing Irving Goffman's (1963) theorisation of stigma, this chapter draws on Mary Douglas' (1992, 1966) concept of "matter out of place" and work on risk to argue that stigma and risk are intimately tied, particularly in

[22] The concern over increased STI rates associated with PrEP is the focus of Chapter 3.
[23] Since the 1980s, the bareback sex was positioned as deviant due to the potential HIV risk. As both PrEP and Treatment as Prevention effectively remove this risk, the deliberate forgoing of condoms during anal sex has lost much of its subversiveness (see Dean 2015).

relation to one's health. The second half of this chapter engages more specifically with the stigma attached to those who engage in condomless anal sex. An extensive body of literature has explored the phenomenon of barebacking (the deliberate forgoing of condoms during anal sex) as a particularly subversive act within gay communities (Brisson 2019; Dean 2015, 2009; Holmes and Warner 2018; Mowlabocus 2010; Race 2016). This literature highlights the ways in which the figure of the barebacker is cast as deliberately going against health norms, as posing a threat to the social cohesion of the gay community broadly defined and, therefore, a legitimate site of social control.

A significant body of research has explored the experience of PrEP stigma in the United States (Arnold *et al.* 2017; Biello *et al.* 2017; Cahill *et al.* 2017; Calabrese and Underhill 2015; Dubov *et al.* 2018; Spieldenner 2016). Given this experience, I was curious as to how stigma was experienced by PrEP users in Australia. While participants were overwhelmingly aware of this stigma, it was widely reported that they had only experienced low levels of it. When it had been experienced, it was believed that this stigma was based on perceptions of PrEP users as both promiscuous and as engaging in high risk sexual behaviour: condomless anal sex. This should not imply that PrEP stigma did not exist in Australia. Rather, as participants frequently pointed out, it reflects their relative social privilege. Most participants lived in Melbourne's inner-city suburbs, an area with a high concentration of gay and bisexual men, as well as LGBTIQ-friendly businesses, organisations, and healthcare services. Accordingly, most participants felt comfortable in their own decision to use PrEP such that any stigma experienced left them largely unaffected.

While participants reported experiencing only low levels of stigma, the interactions between stigma and risk were an important backdrop against which PrEP was implemented in Australia. As described in the previous chapter, challenging PrEP stigma underpinned much of the work done by PrEP advocates in Australia. This was particularly important given the potential barrier stigma presented to PrEP uptake (Calabrese and Underhill 2015). Andrew Spieldenner (2016) and Katie Biello (2017), for example, show that despite some MSM reporting condomless anal sex with casual partners, they would often reject PrEP because they did not consider themselves as part of an "at risk" population. According to these reports, these individuals considered PrEP as suitable for those who were highly promiscuous

and in need of close medical surveillance. I discuss PrEP users' attitudes toward concepts of risk and risk compensation in the next chapter. This chapter contextualises the interactions between stigma, risk, and condomless sex through which PrEP stigma emerged.

Stigma

Goffman's Lens

Goffman (1963) defines stigma as "an attribute that is significantly discrediting" (ibid. p.3). Goffman argues that discrediting attributes function to delegitimate an individual's standing in society, reducing the possessor of such attributes "from a whole and usual person to a tainted, discounted one" (ibid., p.3). Central to Goffman's thesis is the relationship between discrediting attributes and stereotypes, whereby an attribute links "a person to a set of undesirable characteristics that form a stereotype" (Link and Phelan, 2001). For Goffman (1963), stigma arises through the social interactions between individuals, whereby individuals are marked and thus stereotyped according to physical, emotional, and/or mental characteristics that they are perceived as possessing (Hannem 2012; Walby 2012). Through this process, individuals become stereotyped as having the same characteristics as others who are also considered as possessing these discrediting attributes, ultimately coming to occupy "spoiled identities" (Goffman 1963). Richard Parker and Peter Aggleton (2003, p.14) claim that stigma, understood through Goffman's lens, "has led to a focus on stigma as though it were *a kind of thing* … a relatively static characteristic or feature, albeit one that is at some level culturally constructed" (emphasis in original). They argue that discrediting attributes, recognised as belonging to an individual, manifest themselves as spoiled identities and stigma is "mapped onto people, who in turn by virtue of their difference, are understood to be negatively valued in society" (ibid., p.14).

The interpretation of stigma as an attribute possessed by the individual has become particularly salient within the field of social psychology (Link and Phelan 2001; Walby 2012). However, scholars and theorists of stigma have critiqued this approach as one that too narrowly focusses on stigmatised individuals and ignores the social, cultural, and historical contexts within which particular stigmas emerge (see Hannem 2012; Link and Phelan 2001; Parker and Aggleton 2003; Walby 2012). Parker and Aggleton (2003, p.15) argue that in such static understandings, "stigma comes to be seen as something *in* the person stigmatized,

rather than as a designation that others attach *to* that individual" (emphasis in original). Similarly, scholars such as Bruce Link and Jo Phelan (2001), and Stacey Hannem (2012) have called for analyses that not only look at the origins of stigma, but also examine the power dynamics inherent in the processes through which stigma attaches to certain individuals.

Link and Phelan (2001) are critical of analyses of stigma that focus too narrowly on the relationships between discrediting attributes and stereotypes. They argue that any analysis that does not account for the power dynamics between the stigmatiser and stigmatised are too broad to reflect how the effects of stigma map differently depending on one's social position. To illustrate this, Link and Phelan (2001, p.367) draw on a compelling example of the relationships between health workers and patients in treatment programs. They claim that within such contexts, patients might differentiate between health workers, labelling some as "pill pushers" and applying "stereotypes with the labels they create such that pill pushers are cold, paternalistic, and arrogant" (ibid., p.367). In doing so, patients may act on these stereotypes and actively avoid contact with these health workers. This analysis, narrowly focused on the relationship between attribute and stereotype, could be interpreted as the patients engaging in a process of stigmatisation. Link and Phelan argue, however, that the "patients simply do not possess the social, cultural, economic, and political power to imbue their cognitions about the staff with any serious discriminatory consequences" (ibid., p.367). In other words, even as the actions of one group toward another might constitute what could be defined as stigmatising, without access to social and cultural capital, the effects of such actions would most likely be minimal.

In accounting for the role of power relations in the ways in which stigma is experienced, it is necessary that flows of power are not considered unidirectional. While the example of Link and Phelan (2001) above serves as an important reminder of this, it risks representing patients as being without the power to challenge medical authority and effect social change. A different reading of the account above might also consider the actions of patients as a form of resistance. In this reading, by drawing on tropes of pill pushers as cold and uncaring, patients could potentially discredit health workers and call into question their expertise. Illustrative of this is much of the early HIV/AIDS activism within gay communities, a population that had a

long history of marginalisation by medical and political institutions (Bayer 1981; Drescher 2010). Through their challenging of medical institutions and production of medical knowledge, however, an already marginalised population of gay men and PLHIV became core participants in the development and running of HIV treatment trials.

To account for the association between stigma and power, some scholars have called for a Foucauldian approach to analyses of stigma alongside that of Goffman (Hannem 2012; Parker and Aggleton 2003). Parker and Aggleton (2003, p.24) contend that while

> *Goffman's work on stigma hardly even mentions the notion of power, and Foucault's work on power seems altogether unconcerned with stigma … when read together their two bodies of work offer a compelling case for the role of culturally constituted stigmatization … as central to the establishment and maintenance of the social order.*

As a symbolic interactionist, Goffman's primary concern is with the processes by which meaning is derived through interactions between individuals, symbols, and objects (ibid., p.17). In contrast, Foucault's analysis demonstrates how different forms of knowledge, including stereotypes, "come to be constituted in distinct historical periods" (ibid., p.17). In calling for a more situated analysis of stigma, Imogen Tyler and Tom Slater (2018, p.728) characterise Goffman's theory as a "decidedly ahistorical and apolitical formulation of stigma." Also critical of Goffman's formulation, Parker and Aggleton (2003, p.17) argue that

> *[s]tigma and stigmatization function, quite literally, at the point of intersection between culture, power and difference – and it is only by exploring the relationships between those different categories that it becomes possible to understand stigma and stigmatization not merely as an isolated phenomenon, or expressions of individual attitudes or of cultural values, but as central to the constitution of the social order.*

That is, in addition to an examination of how stigma is experienced, any formulation of stigma must also account for how it functions to maintain a particular social, cultural, and political status quo.

Mary Douglas, matter out of place, and the maintenance of the social order

Situating analyses of stigma within specific cultural contexts is central to the work of anthropologist Mary Douglas and her formulation of "matter out of place" (1966). In her later work, *Risk and Blame,* Douglas (1992, p.3) argues that

> *the ideal order of society is guarded by dangers which threaten transgressors. These danger-beliefs are as much threats which one man [sic] uses to coerce another as dangers which he himself fears to incur by his own lapses for righteousness. They are a strong language of mutual exhortation. At this level the*

> *laws of nature are dragged in to sanction the moral code: this kind of disease is caused by adultery, that by incest; this meteorological disaster is the effect of political disloyalty, that the effect of impiety. The whole universe is harnessed to men's attempts to force one another into good citizenship. Thus we find that certain moral values are upheld and certain social rules defined by beliefs in contagion, as when the glance or touch of an adulterer is held to bring illness to his neighbours or his children.*

Elaborating on the function of the social order, Douglas (ibid., p.48) further contends that

> *[c]ulture, in the sense of the public, standardized values of a community, mediates the experience of individuals. It provides in advance some basic categories, a positive pattern in which ideas and values are tidily ordered. And above all, it has authority, since each is induced to assent because of the assent of others. But its public character makes its categories more rigid. A private person may revise his [sic] pattern of assumptions or not. It is a private matter. But cultural categories are public matters. They challenge aberrant forms … this is why, I suggest, we find in any culture worthy of the name various provisions for dealing with ambiguous or anomalous events.*

According to Douglas, culture functions to maintain a particular order, laying down a set of seemingly shared principles that govern the behaviour of individuals. To illustrate this, Douglas (ibid., p.36) draws on the example of dirt viewed as a pollutant and claims that "[d]irt is the by-product of a systematic ordering and classification of matter, in so far as ordering involves rejecting inappropriate elements." Crucially for Douglas, there is no one single element that exists in and of itself that can be classified as inherently dirty. Rather, dirt is defined as "matter out of place" (ibid., p.36), that which sits outside of specific classifications and, by virtue of this, threatens the existence of particular ways of knowing and ordering the world. Similarly, considerations of what is and is not polluting "behaviour is the reaction which condemns any object or idea likely to confuse or contradict cherished classifications" (ibid., p.37). In other words, pollutants are those which threaten existing classifications that have shaped how life-worlds are understood.

One of the insights offered by anthropological formulations of stigma, such as that of Douglas, are their situating of stigma as developing in specific social and cultural contexts (Yang et al. 2007). Lawrence Yang et al. (ibid., p.1528) claim,

> *[b]uilding on other theorists' notions of stigma as a social, interpretive, or cultural process, anthropologists have pushed us to conceive of stigma as a fundamental moral issue in which stigmatized conditions threaten what really matters for sufferers. In turn, responses arise out of what matters to those observing, giving care, or stigmatizing.*

In this analysis, stigma of certain individuals and categories of person emerge as a response to their perceived threat to social and cultural norms. In this way, stigma functions as justification for the exertion of social control over those who are considered unable or unwilling to conform to a perceived fixed and stable social order. Douglas (1966, p.4) argues that

> *ideas about separating, purifying, demarcating and punishing transgressions have as their main function to impose system on an inherently untidy experience. It is only by exaggerating the difference between within and without, above and below, male and female, with and against, that a semblance of order is created.*

According to Douglas, the body is the site upon which social systems are mapped, with "any kind of unregulated permeability [constituting] a site of pollution and endangerment" (Butler 1990, p.179). Thomas Buckley and Alma Gottlieb (1988, p.26) suggest that for Douglas,

> *the symbolic system has functional goals in the maintenance of society. Hence the acknowledgement of pollutants in cultural systems is accompanied by prohibitions the intent of which is the protection of social order from disruptive forces symbolized by culturally anomalous substances.*

Pollutants, both physical substances and certain categories of person, thus function as a threat to the social order and, in turn, are met with prohibitions and sanctions.

Numerous examples exist of how stigma is operationalised against individuals and groups to maintain political, cultural, and social hegemony, particularly its role in justifying increased surveillance and control over certain populations. For example, some migrant groups have been portrayed as possessing a system of beliefs which are considered antithetical to those belonging to a dominant national culture (Butler 2004; Puar 2013). Similarly, stereotypes of some welfare recipients as lazy and unwilling to make economic contributions (Seccombe et al. 1988) function as a justification for reducing and/or eradicating welfare programs. It is the stigma attached to the figure of the homosexual, however, that serves as a particularly useful example with which to explore the ways in which stigma functions to maintain a hegemonic and heteronormative social order.

By virtue of their attraction to the same gender, gay men challenge heteronormative assumptions of sexual desire. At the same time, they also present a potential threat to normative definitions of masculinity itself. Butler (1990, p.180) argues that as any penetrative sex between men constitutes a permeability of the male body "unsanctioned by the hegemonic order, male homosexuality would, within such a hegemonic point of view, constitute a site of danger and pollution, prior to and *regardless* of the cultural presence of AIDS" (emphasis added). Within Western cultures such as Australia, a significant taboo has surrounded the sexual penetration of normatively male bodies. In the late 20th and early 21st centuries, "the anal taboo gained new meaning as a sexual border dividing heterosexual/masculine/normal men from homosexual/feminine/abnormal men" (Branfman

and Ekberg Stiritz 2012, p.409). As men who are perceived as being sexually penetrated, gay men "violate masculinity by exposing all men's penetrability and the instability of heteronormative desire" (Dowsett 1998, p.174). Drawing on Douglas (1966), gay men can be described as matter out of place and as individuals who destabilise established and idealised norms of gendered embodiment.

The emergence of HIV/AIDS and its impact on gay communities added a new layer to the stigma experienced by gay men (Branfman and Ekberg Stiritz 2012). Describing HIV/AIDS as an "epidemic of signification," Paula Treichler (1987, p.19) argues that "AIDS is a nexus where multiple meanings, stories, and discourses intersect and overlap, reinforce and subvert each other." The emergence of HIV/AIDS in the early 1980s shifted how gay men were thought of. No longer just a symbolic threat to gender and sexuality norms, gay men were portrayed as a literal threat to the physical health and wellbeing of the broader, heterosexual population. Power (2011, p.31) notes:

> in the early 1980s, before HIV was discovered, [beliefs] were that it was contagious and deadly. This merged with existing homophobic attitudes to produce an image of gay men as diseased and dangerous – guilty not only of misdirected sexual predilections but of their newfound potential to infect and kill 'normal' Australians.

HIV/AIDS primarily affected gay men, a group of individuals that was already socially marginalised and stigmatised. Gary Dowsett (1998) argues that the convergence between HIV/AIDS and gay men was so significant that, in countries such as Australia, the two became almost inseparable. Dowsett (ibid., pp.173-174) claims that "[t]here is no other disease in recent times … where the most affected population has been regarded as at fault in the way gay men have been" throughout the HIV/AIDS pandemic. Epstein (1996, p.11) argues that the association of HIV/AIDS with particular categories of person has resulted in the pandemic being "bound up with the cultural understanding of what such groups are like, while the very identity of the groups has been shaped by the perception of them as 'the sort of people who get this illness'."

In the United States and Australia, HIV/AIDS was characterised by some conservatives as a form of divine retribution, a punishment for so-called unhealthy and unnatural forms of sexual expression. Treichler (1987, pp.21) highlights the claims of one US conservative commentator who argued that, where women "had evolved over the millennia so that their

bodies can deal with these foreign invaders [sperm]; men, not thus blessed by nature, become vulnerable to the 'killer sperm' of other men." Treichler (1987, pp.22-23) goes on to argue that one of the appeals "of thinking of AIDS as a gay disease is that it protects not only the sexual practices of heterosexuality but also heterosexuality's ideological superiority." The convergence of stigma against gay men and that of HIV/AIDS functioned to delegitimise same sex sexual relations as unnatural and, therefore dangerous. At the same time, this stigma reinforced heterosexual sex as the ideal form of sexual expression.

The stigmatisation of HIV/AIDS was not limited solely to those living with the virus and extended to all gay men by virtue of their categorisation as an at-risk population. In his articulation of stigma, Goffman (1963, p.4) notes that through sharing particular identity categories, stigma "can be transmitted through lineages and equally contaminate all members of a family." As HIV/AIDS disproportionately affected gay men, gay men as a group were marked by their *potential* for HIV infection. It was the reports of the "Queensland babies" story, however, that provoked one of the most notorious instances of public backlash and moralism in Australia (Power 2011, p.40; Ware 2017, p.477-478). In November 1984, it was announced that three infants had died in Queensland after receiving a blood transfusion that contained the blood of an HIV-positive gay man. Responding to these reports, then-Queensland premier Joh Bjelke-Peterson described gay men as "insulting evil animals" (qtd. Robinson 2010, p.187). Melbourne-based tabloid *Mid-week Truth* published a letter written by a father of one child titled "Die, You Deviate!" In this letter, the father expressed his "revulsion and hatred for this individual [donor] and his kind", stating that "the only honourable thing for the murderer … to do is to commit suicide" (qtd. Ware 2017, p.187).

Reports such as those above fed into an already-existing homophobia and, as Lupton (1994, p.45) contends, marked the beginning of a distinction between the "innocent" and "guilty" HIV-positive person (see also Robinson 2010). Those who contracted HIV through engaging in casual sex or intravenous drug use were framed as deserving of the virus, as being both irresponsible and reckless. Innocent victims such as blood transfusion patients or heterosexual women, however, were characterised as innocent and as having contracted HIV through no fault of their own. Power (2011, p.32) argues that the conflation of HIV/AIDS with gay men, in particular their portrayal as a threat to the health of the broader population,

ultimately contributed to an increase in discrimination directed at gay men. Power (ibid.) notes that in addition to calls for mandatory HIV testing of all gay men and quarantining of those living with the virus, an increase in violent attacks against gay men was also reported. By their association with an at-risk group, gay men became the target of heightened stigma, sanctions, and violent attacks.

Risk & Stigma

To this point, I have discussed the ways in which stigma attaches to particular groups and individuals who, categorised as deviant, represent a threat to an already existing social order. In this section I engage with the interactions between stigma and risk. Historically, risk has been used to describe the likelihood of a potential outcome whether desired or not (Douglas 1992; Lupton 2013). In some contexts, such as the taking of financial risks by entrepreneurs, risk can be considered as desirable and something to be encouraged. However, risk has increasingly become associated with a potential for dangerous and undesirable outcomes (Douglas 1992). Lupton (2013, p.3) argues that

> *In contemporary Western societies, where control over one's life has become increasingly viewed as important, the concept of "risk" is now widely used to explain deviations from the norm, misfortune and frightening events. This concept assumes human responsibility and that "something can be done" to prevent misfortune.*

Given this imperative to maintain control over one's life, and the underlying assumption that misfortune can be avoided, the concept of risk is inseparable from normative understandings of moral citizenship (ibid., p.10). Lupton (p.21-22) goes on to suggest that

> *Those phenomena that we single out and identify as "risks" have an important ontological status in our understandings of selfhood and the social and material worlds … Risk selection and the activities associated with the management of risk are central to ordering, function and individual and cultural identity.*

In this way, the taking of risks is akin to the transgression of social, cultural and moral boundaries, such that the individual risk taker themselves is seen as a potential threat to social order (Lupton 2013, p.61). In Douglas' (1966) terms, those that engage in risk behaviour become polluting persons, with social sanctions enacted against such persons in order to maintain the hegemonic order.

While the associations between risk and danger have taken on new forms of moralism in contemporary Western cultures, these associations can be historically traced. Ulrich Beck

(1992, p.92) argues that initially, "risk' had a note of bravery and adventure, not the threat of self-destruction of all life on Earth." Beck's argument here is important for understanding the associations between risk and morals and how risk has been deployed to justify increased sanctions against, and surveillance of, bodies that have been considered as risky. Lupton (2013, p.56) argues that

> *Douglas' theorizing about purity, pollution and danger underpins her understanding of the cultural role and importance of risk in contemporary Western society, particularly the use of risk as a concept for blaming and marginalizing an Other who is positioned as posing a threat (and thus a risk) to the integrity of the self.*

Lupton (ibid., p.62) further suggests that when used as justification for punitive action, "'risk' may be understood as the cultural response to transgression: the outcome of breaking a taboo, crossing a boundary, committing a sin." Where previously these sanctions were justified by notions of sin, in contemporary Western societies "it can be seen that people may sometimes be blamed for being 'at risk' just as they were once blamed for being 'in sin'" (Lupton 2013, p.67).

HIV, risk, and stigma

The associations between risk, sin, and calls for punitive action are particularly evident in discourses surrounding HIV/AIDS. I have already described the ways in which HIV/AIDS was interpreted by some conservative commentators as a form of retribution for so-called unnatural sexual behaviours and how the perceived risk posed by gay men underpinned calls for social sanctions (Treichler 1999). Far from existing only outside gay communities, however, the stigma of HIV/AIDS has also been particularly strong among gay men. Even within gay male communities, HIV has been framed as a consequence of transgressing appropriate expressions of sexuality. That is, a failure to use condoms during anal sex and, more specifically, casual anal sex. Paul Flowers (2001, p.68) argues that "processes of risk construction are far from innocuous, they provide a readily available framework of responsibility and blame which posits the burden of the epidemic increasingly upon the shoulders of the infected." HIV is thus framed as a consequence of failing to maintain bodily control (Ávila 2015, p.533).

A fine exemplar of this was a comment made by HIV activist Ethan (HIV advocate and PLHIV, 30) who I interviewed in early 2018. Drawing on firsthand experiences of stigma, Ethan stated,

> The positive person *is* painted as a vector of disease, someone who is not to be trusted. Someone who has, at least at one point in their life, prioritised pleasure over responsibility. *At least* once. Or failing that, is a victim of their own inability to trust others.

Described as "a vector of disease," the HIV-positive person described by Ethan is characterised as a potential threat and source of danger. This danger is described as both their own failure to protect themselves, as well as the potential threat they pose to others. One significant manifestation of HIV stigma has been the use of the word "clean" to describe those who are HIV-negative. Used colloquially by some gay men, "clean" is considered by many as highly offensive and stigmatising of PLHIV. As if inspired by Douglas herself, this description of those who are HIV-negative implies that those living with the virus are dirty and as polluted by the virus. Douglas (1966, p.113) characterises a polluting person as

> *always in the wrong. He [sic] has developed some wrong condition or simply crossed some line which should not have been crossed and this displacement unleashes danger for someone.*

In the context of contracting HIV, the boundaries of acceptable behaviour can be said to have been transgressed through the forgoing of condoms. Whether defined as divine punishment, a consequence of inappropriate behaviour, or simply misfortune, there is an underlying assumption that a positive diagnosis could have been avoided had appropriate norms of sexual behaviour been adhered to.

Through their perceived failure at maintaining bodily control as described by Ethan above, PLHIV are characterised as a potential threat to the broader community and, therefore, increased surveillance and control over those bodies becomes justified. In her analysis of Douglas' *Purity and Danger*, Lupton (2013, p.57) argues,

> *For Douglas, bodily control is an expression of social control … One of the central problematics of Purity and Danger was the identification of fixed systems by which notions of hygiene are understood and upon which they are acted. Thus, for example, ideas about what substances should be incorporated in the fleshy body – what is pure, and therefore safe, to ingest – mirror notions about the body politic and how the boundaries of a society are maintained, regulating the entry of certain types of people 'in' and keeping other 'outside' the body politic. Ideas about order and disorder fundamentally underlie beliefs about what is 'dirty' and what is 'clean'.*

Through contracting HIV, the body of the individual living with the virus becomes unfit for full citizenship in the broader community. Hannem (2012, p.25) contends that

> *the perception of risk or danger is commonly based on cultural understandings of purity and defilement … [and] defining a group of persons as a collective risk in this manner serves to increase stigma at both symbolic and structural levels.*

Risk and risk-taking have "important ontological status in our understandings of selfhood and the social and material worlds (Lupton 2013, p.21) which "are central to ordering, function and individual and cultural identity" (p.22).

More than simply a physical threat, the body of the HIV-positive gay man has also represented a symbolic threat to how gay men have been perceived more broadly. That is, by virtue of a perceived prioritisation of pleasure over health, PLHIV have been stereotyped as promiscuous, reckless, and irresponsible citizens that are seemingly unable or unwilling to adhere to the values of the broader heterosexual community. Lawrence Yang et al. (2007, p.1530) suggest that a

> *focus on moral experience allows us to adequately understand the behaviours of both the stigmatized and those doing the stigmatizing, for it allows us to see both as interpreting, living, and reacting with regard to what is vitally at stake and what is most crucially threatened.*

Given the already-existing stigmatisation of gay men as HIV/AIDS impacted gay communities, condom-based safer sex strategies to prevent HIV became more than just a way to protect the health of individuals and their sexual partners. They were also a measure of responsible citizenship. As I now discuss, this stigma has underpinned perceptions of barebacking as a particularly deviant act, an act considered antithetical to the dominant values of gay communities.

Barebacking

A wide body of literature has examined the phenomenon of bareback sex among gay men. The emergence of "bareback" as a term to describe condomless anal sex has been traced to the 1990s in the United States where it emerged as a distinct sexual practice and subculture among gay men (Adam 2005; Carballo-Diéguez and Bauermeister 2004; Hammond et al. 2016; Mowlabocus et al. 2014). Distinct from the non-use of condoms as a result of drugs, alcohol, or simply getting caught up in the moment, bareback sex is defined as the deliberate and premeditated eschewing of condoms in full knowledge of any potential risk of HIV (Adam 2005; Ávila 2015; Dean 2015, 2009; Gauthier and Forsyth 1999; Mowlabocus et al.

2014). As a practice, bareback sex emerged in direct relation to HIV and HIV risk. Rubén Ávila (2015) claims that

> *it is not by chance that intentional unprotected sex has emerged as a new social category among MSM, whereas it is just another practice for other groups that have not been historically related to AIDS.*

That is, even though practices such as condomless oral and vaginal sex have occurred, they have not been described as a specific subculture in the same way that bareback has been used to describe condomless anal sex between MSM.

Multiple hypotheses have sought to explain the phenomenon of condomless anal sex among MSM, particularly given the potential for the risk of HIV transmission. These hypothesis make an important distinction between the phenomenon of bareback sex and a more general decline in consistent condom use among gay men. On the one hand, some have argued that a significant part of the appeal of bareback sex is precisely the potential risk associated with contracting HIV (Carballo-Diéguez and Bauermeister 2004). Coupled with the taboo that has existed around bareback sex within gay communities, this hypothesis positions risk as adding a sense of danger and excitement to the experience of condomless anal sex. On the other hand, some have noted a more general decline in consistent condom use among gay men since the mid-1990s. The condom fatigue hypothesis, for example, explains this decline as a result of a shift whereby an HIV diagnosis went from being considered a terminal illness to a manageable chronic condition (Macapagal et al. 2017). As the consequences of a positive diagnosis diminished, so too did the imperative to use condoms (Adam et al. 2005). Coupled with a weariness over repeated exposure to safer sex messaging and the self-discipline required to ensure consistent condom use, the diminished physical impact of HIV was said to make the prioritisation of pleasure over HIV risk minimisation more appealing (Adam et al. 2005; Macapagal et al. 2017). It is important to emphasise that while both accounts above describe the non-use of condoms, the phenomenon of barebacking, as distinct from condomless anal sex, has existed as a relatively small subculture among gay men.

In *Unlimited Intimacy*, Tim Dean (2009) suggested that a subculture of barebacking emerged as a challenge to health messages that encouraged the use of condoms among MSM. Dean considered barebacking as an act of resistance to forms of governmentality that both encouraged and demanded the constant use of condoms during casual anal sex. Critical of

explanations explaining the non-use of condoms as pathological (see Gretemen 2018), Dean argued that "[p]urposeful unprotected sex among gay men has become very complex and highly meaningful behavior. It cannot be dismissed simply as pathology or argued away with one-dimensional explanations" (Dean 2009, p.x). Dean claimed that

> *Barebackers' abandonment of condoms is motivated not only by a lust for enhanced physical sensation but also by a desire for certain emotional sensations, particularly the symbolic significance attached to experiences of vulnerability or risk. Rather than mindless fucking, bareback sex is an activity deeply invested in meaning. Despite the emphasis on raw, unmediated contact, barebacking often works most powerfully for its practitioners as a metaphor. Physical contact becomes a way of achieving less tangible forms of contact* (ibid., pp.45-46).

In highlighting the various and multiple meanings of bareback sex, Dean provided an important counterpoint to conceptualisations of those engaging in bareback sex as recklessly pursuing hedonistic pleasure or, as Dean put it, engaging in "mindless fucking."

Dean's (2009) analysis of barebacking as a form of resistance draws attention to the multiple meanings and experiences of bareback sex. The participation in behaviours such as bareback sex that are considered high risk have tended to be understood "as the product of ignorance or irrationality" (Lupton and Tulloch 1996, p.113). This implies that with the right interventions, whether through educational campaigns or forms of counselling, individuals engaging in such acts might be convinced to change their behaviours. Framed as resistance, however, bareback sex becomes a conscious act done in full knowledge of, and against, safer sex messaging. In this understanding, barebacking is not an irrational act nor motivated by an inability to control one's bodily urges but, rather, is a deliberate act against institutionalised harm reduction discourses.

Within gay communities, bareback sex has been considered a particularly deviant act and, given the imperative to minimise the risk of HIV, a practice seen as antithetical to sexual values centred on condom use (Adam 2005; Ávila 2015; Gretemen 2018). Ávila (2015, p.530) argues that "establishing homosexual men as those who were responsible for new HIV infections easily constructed the gay community and its practices – especially the sexual ones – as the virus carriers." In turn, the imperative to minimise the risk of HIV and reduce rates of HIV transmission came to be seen as both a health and moral issue, a signifier of the good and responsible sexual citizen (Ávila 2015; Weeks 1995). Immediately prior to the onset of HIV/AIDS at the beginning of the 1980s, sex between men was considered particularly

transgressive. Through the response to HIV/AIDS and the widespread adoption of condoms, however, sex between men was "refashioned into a model for good citizenship: tamed, responsible, and governed by a safe sex ethic" (Adam, 2005, p.334).[24] The non-use of condoms, particularly when deliberate and in seeming disregard for the risk of HIV, was therefore constructed as antithetical to the sexual values of the broader gay community. Aidan Varney et al. (2012, p.191) argue that the stigma of

> *barebacking has always been that, for those in a high-risk category, sex in which one exposes oneself to any significant possibility of contracting the virus [HIV] amounts to self-harming or suicidal behaviour, a view that persists even despite the availability of the drugs.*

Moreover, they claim that barebacking

> *dares us to see sexuality as jut that, a form of intimacy, rather than allow it to be defined by a disease it might lead to, and thus relegate it to an exercise in epidemiological risk management (Varney et al. 2012, p.192).*

In this way, those engaging in bareback sex are characterised as going against the moral and physical health norms of the broader gay community. It was this context into which PrEP first emerged.

Stigma as constantly 'in process', as evolving

Acknowledging the usefulness of Douglas' theorisation of risk, Lupton (2013, p.75) argues that her "approach does tend to be somewhat static … There is little explanation provided for how things might change in Douglas' accounts of risk, purity and danger." Although HIV stigma remains a significant issue for those living with the virus, throughout my fieldwork it was reported that this stigma was declining in both the frequency with which it was experienced and its severity[25]. This decline was put down to advances in HIV treatments, the emergence of PrEP, and the work done by HIV advocates and anti-stigma campaigns. A useful conceptualisation of the ways through which stigma attaches itself to certain identities and behaviours is Gayle Rubin's (2011c) theorisation of a 'sex hierarchy' that she outlines in her essay, *Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality*. According to Rubin, at the centre of this hierarchy is the "charmed circle" which includes the "'good,'

[24] It is worth noting that, when condom-based HIV prevention strategies were adopted, they were seen as a temporary measure that would only last until an effective cure or vaccine was found. As I describe further in Chapter 7, they were not considered by many as a permanent change to gay men's sexual cultures.
[25] Importantly, these reports came predominantly from those who were HIV-negative. While participants living with HIV believed their experiences of HIV stigma were reducing, they also believed there remained significant work to address stigma.

'normal,' and 'natural'" sexualities (ibid. p.151). That is, sexualities that are heterosexual, monogamous, procreative and private. Positioned in the centre, these expressions of sexuality represent the most idealised forms and, in turn, are afforded the highest levels of access to cultural capital and are not subject to social scrutiny or surveillance. At the outer limits of the circle are those expressions which are "'bad,' 'abnormal,' or 'unnatural'" (ibid. p.151) that either do not, or refuse to, conform to those idealised expressions in the centre. Individuals who are categorised as belonging to this outer circle are socially isolated, kept on the margins, and attract a significant degree of social stigma.

Rubin's (2011c) sex hierarchy provides a more nuanced understanding of the ways in which stigma attaches itself to specific identities and sexualities. Importantly, Rubin posits that this hierarchy is never static and that there is always the potential for those sexualities in the outer circle to move toward the centre. For example, in 1984 when *Thinking Sex* was originally published, same sex relationships were positioned in the outer margins of her hierarchy in both Australia and the United States. At the time of writing this thesis in 2020, however, both countries had legally recognised marriage between two people of the same sex, providing the possibility of same sex relationships to move from Rubin's outer position of "sin" to the inner circle of "married".

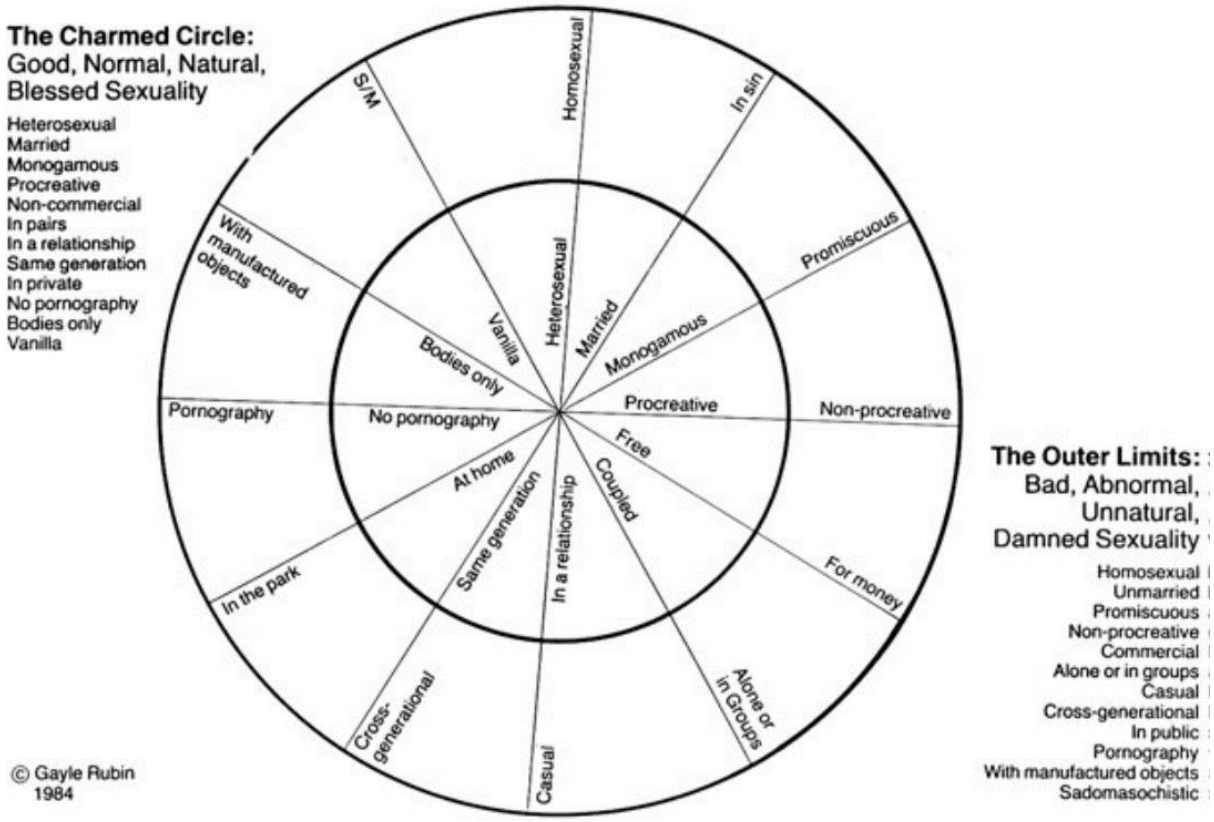

Figure 3: Rubin's Charmed Circle

While same sex attraction *per se* has shifted toward the centre of Rubin's sex hierarchy, promiscuous, multi-partnered and non-private expressions of sexuality have remained firmly at the outer limits. It was only through conforming to heteronormative expressions of sexuality, relationships, and family structures that same sex relationships have been able to move toward the centre. Coining the term "homonormativity," Lisa Duggan (2003, p.50) describes the politics surrounding same sex marriage as "a politics that does not contest dominant heteronormative assumptions and institutions, but upholds and sustains them."

The legal recognition of same sex marriage in Australia was certainly hard-fought and an important moment for the greater acceptance and inclusion of same sex attracted people. However, it is important to recognise that this campaign did not challenge assumptions of ideal family structures that are based on heterosexual and monogamous couplings. As Callum Stewart (2017, p.244) notes, "[s]ame-sex marriage may enable the homosexual to gain in heterosexualness" such that new hierarchies are formed and the "deviant homosexual

continues to be excluded because they do not or cannot gain in heterosexualness through marriage." Just as some same sex attracted individuals have been able to move into the inner circle through idealised expressions of sexuality, those who cannot or do not conform to these expressions remain in the outer.

While condomless anal sex has been considered a particularly deviant act when occurring with casual partners, it is largely framed as unproblematic within long-term romantic relationships (Lee 2013). In the 1990s, Australian researchers proposed the concept of "negotiated safety," a safer sex strategy whereby condomless anal sex occurring within one's primary partnership could be considered as low risk (Kippax 2002; Kippax et al. 1993). Key factors underpinning the effectiveness of negotiated safety have been: 1) an ongoing relationship; 2) that both partners are of the same HIV sero-status and aware of each other's HIV status; 3) a clear agreement on sex outside the relationship which includes the use of condoms with all other partners, and; 4) that the agreement is not broken (Kippax 2002, p.2). Negotiated safety became recognised as an effective HIV prevention strategy in Australia (Jin *et al.*, 2009) and, when fieldwork began in 2017, the notion of forgoing condoms within ongoing romantic relationships was largely taken for granted and unremarkable.

PrEP Stigma

The stigma of bareback sex and conceptualisations of it as a particularly deviant act has underpinned much of the stigma associated with PrEP. In 2014, HIV/AIDS activist Larry Kramer stated,

> *Anybody who voluntarily takes an antiviral every day has got to have rocks in their heads. There's something to me cowardly about taking Truvada instead of using a condom. You're taking a drug that is poison to you, and it has lessened your energy to fight, to get involved, to do anything (qtd Healy 2014)*[26].

Significantly, Kramer here describes PrEP users as cowardly, suggesting a moral claim whereby PrEP users are acting in their own self-interest and as lacking the strength to maintain the discipline required to ensure condoms are used in every casual sexual encounter. Moreover, it implies those using PrEP are prioritising their own self-pleasure, disregarding the work done throughout the HIV/AIDS epidemic to encourage the use of condoms and

[26] In 2015, Kramer's opposition to PrEP shifted and, along with other AIDS activists, Kramer characterised PrEP as an important tool in the response to HIV (Duffy 2015).

reduce rates of HIV transmission. Given the effectiveness of PrEP at preventing HIV, Kramer's comments highlight the moral attachment associated with the use of condoms among gay men. More than a failure to employ HIV prevention strategies, the non-use of condoms here is framed as a failure to conform to the moral standards by which gay men have been measured. Race (2016, p.17) argues that despite the potential benefits of PrEP, its "promise is so threatening or confronting to enduring habits of getting by in this world that it provokes aversion, avoidance – even condemnation and moralism."

Kramer's comment above also emphasises an important critique of using PrEP to prevent HIV. That is, the ongoing use of medication by those perceived as otherwise healthy for the prevention of illness or disease. Described as cowardly above, PrEP users are portrayed as lacking the strength, ability, and/or desire to adopt behavioural prevention strategies such as condom use. While critiques such as Kramer's imply a moral lack among PrEP users, concerns over the ongoing use of medication remain among some MSM. Holt *et al.* (2019), for example, found that a significant proportion of gay and bisexual men expressed concerns over the potential for side effect associated with PrEP medication.

As PrEP was emerging, the stigma associated with bareback sex was identified as a significant barrier to PrEP uptake (Biello et al. 2017; Cahill et al. 2017; Cairns et al. 2016; Calabrese and Underhill 2015; Herron 2016; Peng et al. 2018; Race 2016; Spieldenner 2016). Underpinning this barrier was an acknowledgement of potential risk, whereby potential PrEP users were required to acknowledge their increased risk of contracting HIV or, at least, a desire to engage in the stigmatised act of condomless sex (Race 2016). Indeed, such was the stigma associated with PrEP that despite some MSM acknowledging their occasional engagement in bareback sex, they did not consider PrEP as a suitable sexual health strategy (Biello et al. 2017; Spieldenner 2016). As they only occasionally participated in condomless sex, these individuals did not consider themselves as belonging to an at-risk population. Given this, PrEP was seen a strategy primarily suitable for those who regularly engaged in condomless anal sex.

Conclusion

The controversy and stigma surrounding PrEP as it emerged cannot be separated from broader discourses of condom use as a moral imperative among gay men. As HIV/AIDS first impacted gay communities in the early 1980s, it was framed by some conservative commentators as a form of punishment for sexual deviancy and values that were considered antithetical to those of the broader community (France 2017; Treichler 1987). Against this, condoms became more than just a harm minimisation strategy. They were also considered a symbol of gay men's responsibility and disciplining of their own bodies to protect themselves and the communities in which the lived. It was against this backdrop that PrEP emerged and, importantly, displaced the role of condoms as the primary HIV prevention strategy among gay men.

As I have argued in this chapter, for some, the figure of the barebacker presented a threat to efforts within gay communities to minimise the impact of HIV and reduce rates of new HIV infections. It is noteworthy, then, that even despite the efficacy of PrEP at preventing HIV, its potential negative impact on condom use has underpinned much of the stigma associated with it. Certainly, much of the stigma of PrEP was associated with perceptions of PrEP users engaging in so-called risk behaviours: that is, condomless sex. As I discuss further in the following chapter, however, the framing of bareback sex in-and-of-itself as high risk ignores other aspects of PrEP use such as, for example, the HIV and STI screening required to access it in Australia.

During the HIV/AIDS epidemic and prior to PrEP bareback sex could be thought of as "matter out of place" (Douglas 1966), an expression of sexuality considered as antithetical to the safer sex ethic and broader values of gay communities. Through their participation in such behaviours, individuals are stigmatised as embodying "spoiled identities" (Goffman 1963) and therefore associated with particular types of person (Link and Phelan 2001; Parker and Aggleton 2003). The stigma of bareback sex and associations of those engaging it as recklessly prioritising the pursuit of bodily pleasure over and above the imperative to maintain one's health were mapped onto the bodies of those using PrEP. Even as PrEP users engaged in regular sexual health screening and disciplined their bodies through the routine taking of medication to reduce their risk of contracting HIV, they too were portrayed as

irresponsible and engaging in high risk sexual behaviours. As evident in Kramer's characterisation of PrEP users as cowardly, PrEP stigma was underpinned by more than just a concern over STIs and was as much motivated by PrEP's challenge to existing moral and cultural attachments to condoms.

Chapter 3 – Risk, PrEP, and Condomless Anal Sex: PrEP users' Critiques of Risk Compensation Language

Introduction

Throughout my fieldwork, one of the most common concerns raised by those sceptical of PrEP was its potential impact on condom use and rates of STI transmission. These concerns were underpinned by a belief that, due to its high efficacy at preventing HIV, PrEP users might be less likely to use condoms thereby increasing rates of other STIs (Blumenthal and Haubrich 2014; Underhill 2013). Such an increase, it was said, might ultimately contradict any potential benefit of PrEP in reducing rates of new HIV infections. These concerns were expressed so often that, after only two months in the field I had developed an almost automatic response based on digital observations and conversations with PrEP advocates: "STIs were a concern, however other factors associated with PrEP also needed to be considered such as the multiple modes of STI transmission and the requirement for STI testing in order to access PrEP."

Careful monitoring of behavioural change associated with the use of any new health intervention is important. As discussed in the previous chapter, however, the concern over PrEP's impact on condom use was largely underpinned by a social and moral attachment to condoms (Race 2016). When Michael Weinstein characterised PrEP as a "party drug" in 2014 (see Cohen 2014), there was limited evidence to suggest there was an association between PrEP and declining rates of condom use (see Herron 2016). What research that did explore this phenomenon largely emerged from two contexts: PrEP clinical trials (Grant et al. 2010; Molina et al. 2015) and *anticipated* changes in condom use among *potential* PrEP users (Calabrese et al. 2017b; Grov et al. 2015; Holt et al. 2012; Peng et al. 2018; Spinner et al. 2016). Double-blind clinical trial data, for example, found no association between PrEP uptake and changes in rates of condom use (Calabrese et al. 2017b; Grant et al. 2010; Liu et al. 2013; Marcus et al. 2013; Peng et al. 2018). However, the double-blind nature of these trials meant participants could not be sure they were receiving the study drug or a placebo (Spinner et al. 2016). In contrast to these trials, the open-label *PROUD* study did find an association between PrEP uptake and a decline in condom use. In research exploring anticipated changes in condom use, participants generally reported a likelihood to maintain consistent condom use (Calabrese et al., 2017b; Grov et al. 2015; Peng et al. 2018; Spinner et

al. 2016). However, later research investigating the *real world* use of PrEP did find an association between PrEP use and a reported increase in rates of condomless anal sex among MSM (Holt et al. 2018).

Condom (non-)use in the context of PrEP has received significant attention in research addressing the use of PrEP, with some researchers and public health professionals describing it through the lens of risk compensation (Blumenthal and Haubrich 2014; Calabrese et al. 2017a, Grov et al. 2015; Traeger et al. 2018). Traditionally, risk compensation has been used as an analytical tool to describe a phenomenon whereby, a decrease in risk due to the introduction of an intervention might encourage individuals to engage in behaviours that increase that same risk (Blumenthal and Haubrich 2014; Hogben and Liddon 2008). As a conceptual tool risk compensation has been used to explore behavioural changes associated with interventions such as mandatory seat belt laws (Evans and Graham 1991), bicycle helmets (Phillips et al. 2011), and the use of sports safety equipment (Thomson and Carlson 2015). However, this definition contrasts with how risk compensation has been employed in research addressing exploring the interactions between PrEP, condom use, and STIs. In this context, the concept of risk compensation has been used to describe how by reducing the risk of HIV, PrEP might encourage users to engage in behaviours such as condomless sex, potentially increasing the *different* risk of STIs. Daniela Rojas Castro et al. (2019 p.53) claim that within these fields, the potential for risk compensation "remains a frequent argument to justify moral judgements against the availability and provision of prevention methods for vulnerable populations who already experience stigma and discrimination." As I demonstrate throughout this chapter, this was precisely the how the framing of risk and risk compensation was experiences by some PrEP users.

Drawing on data from social media and interviews, this chapter explores the responses of PrEP users to the framing of condomless anal sex while using PrEP as risky. Claims that PrEP might lead to increased rates of condomless anal sex were largely undisputed by PrEP users. However, PrEP users generally felt that describing condomless sex while using PrEP as "risk compensation" lacked the nuance to adequately describe varying degrees of risk. This chapter discusses four main critiques made by PrEP users of using risk as a framing device. Firstly, it was argued that describing condomless sex while using PrEP as risky failed

to account for other factors associated with PrEP such as routine HIV and STI screening. Secondly, even as they engaged in forms of sexual expression that have been considered high risk (i.e. condomless anal sex), PrEP users are not a bounded, discrete sexual group. Rather, their sexual interactions also occurred with those who were not using PrEP, some of whom might not be engaged in a regular cycle of STI and HIV screening. Thirdly, discussions around PrEP and risk compensation within the public health literature often conflated sex and, in turn sexual risk, with anal-penile penetration. This conflation was felt to overlook and/or minimise other avenues of STI transmission such as oral sex. Finally, PrEP users expressed significantly different levels of anxiety surrounding HIV when compared with other STIs. In contrast to an HIV diagnosis which was considered a particularly significant life event, other STIs were viewed as less consequential.

While the use of risk within public health literature has been framed as a neutral and value-free observation, any use of the term carries with it the potential of being interpreted as a moral judgement (see Lupton 2013). Such usage threatens to negatively influence those who might most benefit from the use of PrEP (Race, 2012; Calabrese and Underhill, 2015; Spieldenner, 2016; Young, Flowers and McDaid, 2016) and potentially alienate PrEP users from public health professionals seeking to implement it as a harm-reduction strategy.

Risk Compensation & Sexual Health Interventions

Moralising debates surrounding PrEP and its impact on condom use are part of a long history of concern over the potential for sexual health interventions to affect behaviour change (Rojas Castro et al. 2019). Notable examples include debates over the cure for syphilis (Dayan and Ooi 2005), the female contraceptive pill (Black and Sykes 1971; Cohen 1970) and the vaccination of (particularly female) school-aged children against the human papillomavirus (Forster et al. 2010; Guichon et al. 2013; Kasting et al. 2016). Arguments against interventions such as these frequently draw on ideologically based claims which are not always supported by evidence. For example, much of the sentiment against vaccinating children against the human papillomavirus has been based on a fear that it will encourage sexual activity among young children (Kasting et al. 2016). This is despite no evidence of such behaviour associated with the vaccine.

Even within the field of HIV prevention, the promotion of condoms to prevent the virus has received criticism. A notable example of this was the Catholic church's opposition to the promotion of condoms as a prevention strategy. Among those in favour of the Vatican's anti-condom stance, concerns were frequently raised over the promotion of condoms *alone* as a harm reduction strategy (Kalbian 2014, p.68-69). Proponents of this stance argued that in addition to condoms, it was also necessary to promote abstinence and/or monogamy. Aline Kalbian (p.70) notes that strict supporters of this stance argued that the promotion of condoms was analogous to encouraging promiscuity, and "that people who feel safe when using condoms increase their sexual activity, making them more vulnerable to infection."

The concerns raised over condom non-use described above foreshadowed later criticisms that surrounded PrEP. However, despite early research indicating PrEP was unlikely to impact on rates of condom use among MSM (Calabrese et al. 2017a; Grov et al. 2015; Peng et al. 2018; Spinner et al. 2016), an association was found between the real-world use of PrEP and declining rates of condom use (Holt et al. 2018; Kelen and Cresswell 2017; McCormack et al. 2016; Traeger et al. 2018). This association was rarely refuted by PrEP users and, as one participant Darren (PrEP advocate and user, 50s) commented, "that a person takes their PrEP and takes it for a test-drive is a perfectly natural thing to do." While a decline in condom use associated with PrEP was rarely disputed, PrEP users overwhelmingly took issue with depictions of engaging in condomless sex as risky. It is these criticisms that will be the focus of this chapter.

Current STI trends – Victoria

Before proceeding further, I will first outline STI trends in Victoria at the time of fieldwork to give a sense of the context within which PrEP emerged. According to surveillance data from the Victorian Department of Health and Human Services (DHHS 2019), 2017 saw record numbers of chlamydia, gonorrhoea, and infectious syphilis reported. These numbers followed a broader trend observed since 2008 whereby cases of all three STIs had been steadily increasing at a population level. Of the gonorrhoea notifications 81% were observed in men, of whom 70% identified as MSM (ibid., p.4). In 18% of the gonorrhoea

notifications, it was reported that PrEP was being used at the time of infection. Similarly, 88% of syphilis notifications were reported by men, with 74% of those identifying as MSM (ibid., p.6). No data were reported to indicate whether PrEP was being used at the time of infection.

PrEP users' Critiques of Risk

In social media discussions on the interactions between PrEP, STIs, and condomless anal sex, PrEP users were regularly reminded that PrEP only offers protection against HIV and that condom use remained necessary to prevent other STIs. Jared[27], a member of *PrEP'd for Change*, stated:

> I think it needs to really be hammered home. PrEP won't save anyone from an STI. You might feel a little more bullet proof, but it's not going to stop you from pissing razor blades if you stick [your dick] in someone who's an undiagnosed carrier of [an STI]. In my experience the amount of guys I've come across who think [PrEP] is a license to bareback someone is a little scary.

Metaphors of "bullet proof" were regularly invoked to characterise PrEP users as either ignorant of STIs or as having a blatant disregard for them. Such is Jared's belief of this that he feels the need to both "hammer home" and remind PrEP users that it will not "save" them from contracting an STI through sex with a "undiagnosed carrier." In Jared's account here, there is no suggestion of a shared responsibility to prevent the forward transmission of STIs between both partners in this hypothetical sexual encounter. Rather, the responsibility of STI prevention is projected on to the PrEP user themselves.

Such portrayals were often refuted by those using PrEP, particularly as they implied PrEP users were ill-informed about issues of sexual health. Responding to the comment above, Cameron claimed,

> I have never met anyone who thinks PrEP prevents STIs. I have met a lot of guys who choose to bareback because PrEP provides very close to perfect protection from HIV if taken daily. They have weighed up factors like, condoms "reduce risk" of STIs but are not a "protection," that pleasure is important and STIs are inconvenient but not life destroying … There's some house keeping to do and, mostly, that means three-monthly testing. If they have the information and they make the decision to go wet, wild and raw then that's absolutely their choice.

[27] It is unclear whether this group member was using PrEP or not. While comments such as these were more common among non-users, some PrEP users on social media did indicate their preference to use condoms during anal sex in conjunction with PrEP to reduce their perceived risk of STIs.

Responses such as these functioned as an important reminder that PrEP users were not ignorant of the potential for STI transmission when making their decision to use PrEP and forgo the use of condoms. Rather, they were usually fully cognisant of the potential for STI transmission and had made their decision to use PrEP and engage in bareback sex fully aware of all potential risks and health consequences.

In describing the potential for behavioural change and a decline in condom use associated with PrEP, individuals and health workers alike regularly employed the term risk. Reporting on a 2018 systematic review exploring the relationship between PrEP, condom use, and STI rates, Lucas, an HIV science journalist shared an article to *PrEP'd for Change* that reported on increased rates of STIs among PrEP users. The news article reported on a systematic review conducted by Michael Traeger et al. (2018) which reported a decrease in condom use and subsequent increase in rates of STIs among PrEP users. As in the original review, Lucas described an association between PrEP and so-called risky sex, defining risk in this context as

> the risk of contracting STIs. It's a catch-all term that can include having more partners, engaging in more types of sex that are riskier (i.e. receptive anal intercourse without a condom), using condoms less frequently etc.

According to his definition here, risk was used as a term to describe multiple factors that might contribute to the likelihood of contracting an STI. Later in the discussion his article provoked, Lucas went on to state that risk "is a widely used term in the public health research community" as a "way of saying someone, based on factor A, has an X-fold greater likelihood of outcome B."

In his use of the term risk above, Lucas's focus is primarily on factors that *increase* the risk of STIs and effectively ignores other factors associated with PrEP use that might ultimately minimise the risk and/or consequences of STIs (see Rojas Castro et al. 2019). This was captured by Oliver who stated in response to Lucas:

> Sure, there is potentially an increased risk of contracting an STI, but with increased testing there is also an increased risk of treating it in a timeframe which prevents future transmission to other partners. [On] the inclusion of more partners and receptive anal intercourse without condoms: how are those risky and what does that mean when you are using biomedical prevention? You're at risk of falling off a tightrope. But if that tightrope is two inches off the ground, we need to reassess what risk actually refers to.

I return to the distinction between HIV and other STIs later in this chapter. Here, Oliver highlights the increased STI screening associated with PrEP and the potential for early

detection and treatment. At the time fieldwork was conducted, Australian prescribing guidelines required PrEP users undergo HIV and STI screening every three months in order to obtain a PrEP prescription (ASHM 2019). Deploying risk in an interpretation which denotes any outcome whether positive or negative (see Douglas 1992; Lupton 2013), Oliver highlights that while any reduction in condom use associated with PrEP might increase the risk of STIs, there is also an associated "risk" of that STI being detected and treated early.

Lucas' definition of the term risk was echoed in an interview with James (PrEP researcher and user, 20s) who, when asked about the use of risk in medical research stated,

> The term risk is a very deeply ingrained epidemiological concept. All the studies, that's how you define the portion that get their outcomes.

According to both Lucas and James, risk is characterised as a firmly entrenched and value free measurement[28]. However, while they might consider their use of risk as both descriptive and value free, it is necessary to consider how such descriptions are interpreted by those outside medical and public health institutions. This consideration was capture by Julian, who highlighted the negative connotations and potential stigma associated with describing particular behaviours as risky. Julian commented that

> The lexicon naturally makes people reach for the word 'risk' as the opposite of self-protection or [as a] fearful behaviour. It doesn't actually take into account the reasonable assessment … of historical behaviours in the face of alternative measures, such as PrEP or regular testing.

As discussed in Chapter 2, risk is widely considered something to be avoided and, as Lupton (2013) notes, it cannot be disentangled from normative conceptualisations of moral citizenship. Therefore, even as risk can be considered a categorisation free of judgement in some contexts, it also functions as a standard by which desirable and undesirable behaviours and individuals are measured.

[28] In our interview, James did acknowledge that a shift was occurring among researchers whereby risk compensation was increasingly avoided to describe condomless anal sex while using PrEP:
"We don't really like to call it risk compensation anymore … because you're not really increasing your risk of HIV, so you're not compensating risk of HIV. It's risk of STIs, which is different."

Routine HIV & STI Screening

Overwhelmingly, responses to researchers' usage of risk to describe condomless anal sex among PrEP users were critical of the imprecision with which the term was used[29]. As suggested by Julian above, such usage effectively ignored the removal of HIV as a potential risk and failed to account for the routinisation of HIV and STI screening that was associated with PrEP. Oliver, for example, stated,

> I don't have a problem with the term risk where there is increased risk of acquiring *either* HIV or other STIs. I have a problem with the term "PrEP is associated with increased sexual risk taking," and "gay men taking greater sexual risk." Are they? If they are preventing HIV, first and foremost, and engaged with [STI] testing – sure they are more "at risk" of acquiring certain STIs but, as I stated, the outcome of that potential risk is being treated for those STIs (emphasis added).

The potential of PrEP to engage MSM in regular HIV and STI screening was praised by advocates and some health professionals as one of its unintended benefits. This benefit was noted by Seamus (PrEP user, 20s). Of all interview participants using PrEP, Seamus was the only one who had maintained consistent condom use and was also somewhat uneasy over what he considered a decline in condom use associated with PrEP. Despite this, however, Seamus contended,

> The flip side of [PrEP] is people are getting tested and getting treated. Because, every three months people have to [be tested] in order to get PrEP. Especially now that it's in Australia and you can get it from your GP. It's a very regular system – for anyone who wants it, [they] get tested. So, there's probably going to be a peak now in diagnoses around this time of STIs. But they'll also be treated more and less in the community. Therefore, that's a potential benefit of it as well – it's giving people the control or realisation that they have to go to the STI clinics regularly.

As for many participants, the benefits of regular testing outweighed the risks of increased condomless anal sex was a central theme for Seamus.

At the time of writing, the impact of PrEP on STI rates has not been established. However, PrEP users largely agreed that the required HIV and STI testing needed to access PrEP was an additional benefit. John (PrEP user, 50s) stated,

> [PrEP] also forces me to go for my test every three months, which is good. I always did that (John pauses): maybe not every three months, every four months or every six months. Now, I say I have to do it every three months. I've got a reminder and it's good … [PrEP] makes me want to do my tests more on time. Before [PrEP] it [was] like: I'll be fine, I'll be fine. But now it's like: I should for my own health. It's a good reminder. I think it's better for me. I discipline myself.

[29] Fengyi Jin *et al.* (2015) argue that historically, condomless anal sex among MSM has been the primary measure of HIV risk among MSM. As understandings of HIV transmission have advanced, coupled with pharmaceutical HIV prevention, they argue that the broad measure of "any condomless anal sex" is too imprecise a measure of risk.

Although John was engaged in a regular cycle of HIV and STI checks prior to initiating PrEP, he had not maintained the three-monthly testing cycle recommended under Australian guidelines (STIGMA 2019). John describes PrEP as a disciplinary technology, with the requirement to undergo 3-monthly HIV and STI screening considered as both an appropriate and acceptable condition for his utilisation of PrEP.

As I discuss in the following chapter, the required STI testing associated with PrEP has not been without criticism. Some scholars have argued that PrEP and the associated increased medical surveillance potentially re-medicalises the bodies of MSM (Giami and Perrey, 2012; Brisson and Nguyen, 2017). These critiques are particularly important when discussing the potential for medical surveillance over a population who have historically been marginalised by medical institutions (Bayer 1981; Drescher 2010).

Concerns over increased medical surveillance were generally not shared by participants, most of whom did not consider three-monthly HIV and STI screening to be particularly invasive. Indeed, this heightened medical surveillance was often used to counter constructions of PrEP users as sexually irresponsible and reckless (Holt 2015; 2019). PrEP users were often contrasted with an imagined gay man who, whether they used condoms or not, rarely if ever underwent STI screening. Through their frequent STI screening, PrEP users could protect themselves and, more significantly, potentially contribute to an overall decline in community STI rates through early detection and treatment. While participants did not express concerns over their own medicalisation through using PrEP, new hierarchies of responsible sexual citizenship were nonetheless forming around its use.

PrEP users as a neatly bounded group

Just as researchers' use of risk was criticised as failing to account for increased STI screening, it was also claimed that it portrayed PrEP users as a neatly bound sexual group. Responding to Lucas' definition of sexual risk on social media, Liam stated,

> Your major mistake, Lucas, is assuming that your risk does not decrease based on the actions of others as well. Having condomless sex with someone on PrEP is a lot less 'risky' than the same [action] with someone who has never been tested. Based on testing and treatment regimes, as a PrEP user I have actively reduced my risk *to* others … Herd management dictates that as a PrEP population, everyone's personal risk-*to*-others has dropped. Therefore, any activity that was deemed 'risky' in non-PrEP

> populations has significantly less total risk than for those in PrEP groups … Condomless anal sex with someone on TasP, who has an undetectable viral load, and has been tested in the last two weeks is far less risky than a blowjob from someone who's never been tested.

Liam makes the point here that research exploring the non-use of condoms and STI rates among PrEP users constructs those using PrEP as a discrete category of person distinct from those not using PrEP. While in terms of their chosen sexual health strategy this is true, it assumes that PrEP users only engage sexually with other PrEP users. Liam's comment also highlights a tension between the risk PrEP users pose *to* others and the risk posed *by* sexual partners not using PrEP. Similarly, Glenn commented,

> It's difficult to estimate the sexual risk and STI rates of MSM who neither get tested nor take PrEP, right? So, these stats only reflect the changing behaviours of highly health cognizant MSM. It only compares PrEP users with their health behaviours prior to PrEP and isn't a comment on the whole community.

Neither Liam nor Glenn disputed the importance of research that examined how new sexual health interventions might affect behaviour change and rates of STIs among PrEP users. However, both make the important point that sexually, PrEP users are not necessarily only interacting sexually with other PrEP users[30]. As argued in the previous section, comments such as these were frequently made to contrast the PrEP users as more responsible than a hypothetical non-user who rarely underwent sexual health screening. Importantly, the PrEP user here is framed as "highly health cognizant", as somehow more aware of issues around sexual health than those not using PrEP. Through this, the PrEP user is characterised as taking on a greater responsibility for not only their own health, but the health of their broader community.

As infections that are spread primarily through sexual contact, STIs necessitate some form of social interaction to be transmitted. Given the social nature of STI transmission, "theories of risk behavior which conceptualise risk behaviour as a volitional and individual act are inappropriate where risk behavior involves two parties" (Bloor 1995, p.20). In their critique of epidemiological categories, Parker et al. (2016, p.820) argue that while categories do provide necessary and useful data, their use in public health avoids dealing with "the complicated social, cultural and behavioural realities such categories mask – obscuring the porous margins of these classifications, the important diversities that exist within categories,

[30] During fieldwork, a small number of individuals did indicate a strong preference to only engage sexually with other PrEP users or PLHIV who had an undetectable viral load. While this was in-part due to a desire for condomless sex, it was also underpinned by an attitude of biomedical HIV prevention as a superior sexual health strategy to condoms. This is discussed further in Chapter 7.

and the intersections between them." In many contexts, HIV epidemics have been driven by a "core group" who frequently engage in sex without using any form of prevention strategy (Parker 2003). Importantly, individuals belonging to this group might also interact with individuals considered low risk of HIV infection, causing the HIV epidemics to be influenced by "the nature and extent of sexual mixing between this active minority and the less active majority" (Parker 2003, p.182). Similarly Flowers (2001, pp.61-62) argues that to properly assess degrees of risk, researchers must

> *inquire about the length of a relationship, the timing of mutual HIV testing, knowledge of own and partners' HIV antibody status, knowledge of negative seroconcordance and the existence of an agreement regarding the safety of sex outwith the primary relationship.*

Such inquiries are not conducive to neat constructions of particular risk categories. While the arguments of both Parker and Flowers are in the context of HIV prior to PrEP, they nonetheless highlight the limitations of classifying specific risk subjectivities according to PrEP use or other harm minimisation strategies.

The necessity of considering STI transmission within broader social and sexual contexts is particularly important when considering changes to condom use at a population level beyond PrEP users. Drawing on data from the Sydney and Melbourne Gay Community Periodic Surveys[31] between 2013 and 2017, Holt et al. (2018) found that while PrEP users were engaging in higher rates of condomless anal sex, rates of consistent condom use were also decreasing among those not using PrEP. Given the community level risk of HIV was also decreasing as more individuals used PrEP, it was argued that those not using PrEP might perceive the risk of HIV to be diminished. Holt et al. (2018, p.7) characterised this as a form of "indirect protection" whereby the HIV risk of those not using PrEP was lowered as a result of a large proportion of the population using PrEP.

From the perspective of HIV, the falling number of those engaging in condomless sex without any form of personal protection is cause for concern. However, given the indirect protection proposed by Holt et al. (2018), even as PrEP lowers individual risk, so too does it have the potential to decrease HIV risk at the community level. In his comment above, Liam

[31] The gay periodic surveys were established to provide information on drug use, sexual behaviour and HIV/STI testing habits among MSM (Lee et al. 2018).

mentions the idea of "herd management" associated with PrEP. Commonly known as "herd immunity," this concept is underpinned by the notion that removing enough individuals susceptible to a particular infection would render the risk of that infection as almost negligible (Fine 1993). This concept was frequently mentioned on social media, with one PrEP user describing it as "remov[ing] enough available warm bodies so that the virus can't expand." With enough MSM protected against HIV through using PrEP, the overall risk of HIV infection across the broader community was said to have diminished, ultimately making individual instances of condomless anal sex while not using PrEP less of a concern.

On social media and in interviews, PrEP users demonstrated active engagement with epidemiological research on PrEP and HIV. Their confidence in understanding this research was such that they were able to critically engage with researchers working in these fields. This engagement reflects a long history throughout the HIV/AIDS epidemic of PLHIV playing a central role in conducting HIV research (Epstein 1996). Rather than being passive subjects, PLHIV and gay men affected by HIV have been active contributors to the design and implementation of HIV research studies. Similarly, in Melbourne, PrEP advocates and many PrEP users were active contributors in shaping public discussions of PrEP, blurring the lines between expert scientific and non-expert communities.

One of the challenges in monitoring STIs at a community level is measuring rates of STIs among those who do not present for testing. Holt et al. (2018, p.e7) suggest that as PrEP rollout continues, "jurisdictions should monitor the behavioural effect of PrEP at a community or population level (not only in PrEP users)." Andy (PrEP advocate and user, 40s) commented,

> When you have syphilis, you can't get syphilis … and once you're cured, you can get it again. Once you're cured of gonorrhoea or chlamydia or syphilis, then you can go back into the community and get it again. Versus, if no one is treating you and no one is testing you, you could have it for years and not even know it. So, you're still giving it to people, you're still transmitting it, you're still part of a community that has high levels of STIs.

Situating the category of the PrEP user within the broader population acknowledges that even as those using PrEP might be more likely to contract an STI, they have contracted that STI from another partner who may or may not be using PrEP. This shift in focus is particularly important given the potential for reinfection after being treated for STIs.

STIs not only spread through anal sex

In his genealogy of the category MSM, Tom Boellstorff (2011, p.291) argues that the category of MSM first emerged to acknowledge that not all men engaging in sex with other men identified as gay; as a means to separate identity from behaviours that increase HIV risk. Critiquing this formulation, Boellstorff (ibid., p.294) claims that while it does "treat identity as a social construction, [it] reifies 'men' and 'sex' as prediscursive, conflating sex with penetration (above all, anal-penile intercourse) and maleness with biology." This conflation of sex with anal-penile penetration was evident in concerns over PrEP, its impact on condom use, and any potential for an increase in STIs. While STI transmission can occur through all forms of person-to-person sex, it was only when condoms were not used during anal sex that concerns over STIs were raised.

One of the earliest iterations of safer sex guidelines to prevent HIV[32] infection, *How to Have Sex in an Epidemic*, suggested that the exchange of semen through both anal and oral sex was high risk of HIV transmission (Callen and Berkowitz 1983). As knowledge of HIV transmission routes increased, it became evident that the risk of HIV through oral sex was low risk even when condoms were not used (Loutfy et al. 2014). This risk could increase, however, with factors such as the presence of other STIs or if the receptive partner had cuts or ulcers in their mouth. Despite these risks, the risk of HIV transmission through oral sex has been promoted as "very low risk" by community health organisations (Australian Federation of AIDS Organisations 2020).

Despite the multiple STI transmission avenues, it was widely reported throughout my fieldwork that condoms were almost never used for this sexual act. In an interview with Thomas (PrEP user, 40s), he and I reflected on our own experiences of forgoing condom use during oral sex:

> T: I did meet the odd person over time that did want to [use a condom during oral sex] and that was just weird.
>
> NW: Yeah. I've had one experience where somebody wanted to put a condom on for oral sex.

[32] In their original guidelines, Callen and Berkowitz (1983) referred specifically to the prevention of AIDS. As HIV is known to be the etiological agent causing AIDS, I refer here specifically to HIV.

T: What's the point?

NW: It also wasn't very nice.

T: No, it's not very nice. It tastes like rubber.

NW: Yeah (laughs).

T: (laughs). It's really, really odd.

In our interaction, both Thomas and I share the common experience of condom use during oral sex as physically unpleasant, with Thomas noting the objectionable taste of rubber. More significant, however, is Thomas' description of condom use as "just weird" in this context, a practice he considers "really, really odd." Engaging in sex did not form part of my fieldwork. However, my own sexual experiences prior to fieldwork reflected those of Thomas, with the non-use of condoms during oral sex a sexual norm. While not completely unheard of, their use during oral sex was considered by many in my field as an anomaly such that condomless oral sex was a taken-for-granted part of the sexual encounter.

In an essay discussing research on HIV/AIDS in the first decade of the epidemic, Ralph Bolton (1990, p.438) criticises sexual health researchers for "[a]verting their gaze from sex itself, with its messiness, complications, and research difficulties." One of the difficulties in assessing rates of HIV transmission through oral sex is that sexual encounters between MSM often include both oral and anal sex. Bolton's critique is also pertinent to research exploring the interactions between PrEP, condomless anal sex and STIs, particularly given the implicit conflation of sex with anal-penile penetration. This narrow focus on anal-penile penetration effectively ignores the multiple and varied sexual practices which can occur in a single sexual encounter, all of which offer the potential for STI transmission. Despite the potential for STI transmission through condomless oral sex, it was not met with the same level of anxiety or condemnation when compared with condomless anal sex.

Risk homeostasis

Studies addressing behavioural changes associated with PrEP framed through the concept of risk compensation have largely failed to account for how risk is perceived by individual PrEP users (Holt and Murphy 2017). Moreover, they often fail to account for attitudes among some gay men whereby STIs are considered an acceptable sexual risk when compared with HIV (Holt *et al.* 2010). Given the extent to which concerns over condom non-use and STIs

appeared in the research literature and discussions on social media surrounding PrEP, I was curious as to how interview participants responded to concerns over a potential increase in bareback sex. With only one exception, informants reported an overall decline in condom use as a result of using PrEP. Given the efficacy of PrEP in reducing HIV risk, it was widely felt by participants that a decline in condom use was both unsurprising and unproblematic. For many, it seemed almost obvious and unremarkable that, as individuals were able to experience condomless sex without the associated HIV risk, they would actively seek out sexual partners specifically to engage in bareback sex. This was the experience of Matt (PrEP advocate and user, 30s) who, upon beginning PrEP in 2015, described a period of multiple and frequent sex partners whereby he effectively "made the most" of his PrEP use. Matt's behaviour was motivated by a sense of new-found freedom and liberation from an overarching fear of potential HIV infection[33]. At the time of his interview in 2018, however, Matt's attitude toward sex had shifted whereby he valued a deeper connection with sexual partners[34]. As some MSM stated in their digital profiles, Matt expressed a preference for "quality over quantity."

When asked directly whether they were concerned over the potential for STI transmission through condomless anal sex, participants commonly stated that their use of condoms was primarily motivated by a desire to reduce the risk of HIV and not of other STIs. Thomas, for example, commented,

> I guess that when I was using condoms, I never worried about [STIs] either. So, I would only use condoms for anal sex, I wouldn't use them for oral sex. And, of course, you could get gonorrhoea or chlamydia or whatever it happens to be through oral sex. I never worried about it … So, I haven't [worried] and I've never really worried about [STIs] … I'm not going to stop myself from having pleasure doing those things because I'm concerned about getting gonorrhoea which, as I said, I can go to the doctor and take a couple of pills and it's gone. Whether this super-gonorrhoea finds its way to Australia and becomes common, or something else comes up, I don't really know. But equally, I'm not so worried about it that I'm going to downgrade my sexual pleasure for it.

Thomas' willingness to maximise sexual pleasure despite the potential for STIs can be usefully thought through what Gerald Wilde (1998) has described as risk homeostasis. In developing this theory, Wilde (p.89-90) argues

[33] This sense of liberation and freedom is discussed further in Chapter 5.
[34] Matt did not see this shift as necessarily moving from one set of values to a higher and more moral set of values. Indeed, on the condition it was consensual, Matt celebrated and encouraged every individual's right to express their sexuality and engage with their sexual fantasies regardless of how many sexual partners this entailed.

> *that people at any moment of time compare the amount of risk they perceive with their target level of risk and will adjust their behaviour in an attempt to eliminate any discrepancies between the two.*

Rather than individuals seeking to mitigate risk completely, Wilde argues instead that individuals seek to optimise risk. That is, defining a "target level" at which a certain degree of risk becomes acceptable in order to maximise other benefits of a particular behaviour or activity.

In the context of HIV and STI prevention, complete elimination of risk would necessitate refraining from all sexual contact with any other individual. However, this strategy would potentially produce other risks such as a lack of intimacy with sexual and romantic partners. Prior to his use of PrEP, Thomas had always used condoms for anal sex and, while his preference was for condomless sex, he had not experienced negotiating consistent condom use as particularly problematic. For Thomas, then, HIV can be described as outside the "target level" of acceptable risk such that the risks associated with condomless anal sex made it an unacceptable form of sexual behaviour. In contrast, the negligible risk of HIV through oral sex (Edwards and Carne 1998) made it a sexual act for which he was willing to forgo condoms despite the possibility of STI transmission. In removing the risk of HIV through PrEP, Thomas has reached a target level whereby the potential of contracting STIs is deemed an acceptable risk in order to maximise his sexual pleasure.

While STIs were considered by many to be an acceptable risk making the forgoing of condoms acceptable, the potential for drug resistant STIs was a significant concern that was consistently raised throughout my fieldwork. In 2018, an opinion piece titled *We Shouldn't let PrEP Fuel another Sexual Health Disaster* (Carter 2018) was shared to the Facebook page of *PrEP'd for Change*. In his commentary, Carter argues that condom use should be promoted alongside PrEP to minimise the risk of increasing drug resistance in some STIs. Significantly, at the time of fieldwork, drug resistant gonorrhoea had not emerged in Australia as a significant public health concern (Holt *et al.* 2019). While there had been two cases reported on in the media during this time, these were both among heterosexual men who had contracted it abroad. Despite this, the spectre of drug resistant gonorrhoea was regularly invoked as a potential disaster waiting to happen, one that PrEP would likely contribute to. As with other PrEP users, Thomas acknowledged drug resistance as a

potentially significant public health concern. However, this was considered a distant possibility and somewhat removed from his day-to-day reality.

Conducting research with intravenous drug users between 1993 and 1994, Tim Rhodes (1997) demonstrates the importance of considering contextual factors such as proximity to risk and how these factors might also influence attitudes to so-called risk behaviours. Rhodes found that even as participants acknowledged the risk of HIV associated with sharing needles, the risk of overdose was considered much more immediate. Moreover, Rhodes (ibid.) argued that the sharing of injecting equipment held important social signification for many intravenous drug users (see also Bourgois and Schonberg 2009). While HIV/AIDS was of concern, its potential fatality was significantly removed from the more proximate potential of death through injecting drugs themselves. Similarly, the potential of drug resistant STIs or, even, a potentially new and fatal virus akin to HIV, was considered far removed among my own participants such that these risks fell within the "target level" of acceptable risk taking.

As with Thomas, Harry (PrEP user, 40s) also expressed different levels of concern over HIV compared with other STIs:

> Well, my response is I did [use condoms] and I have got some [STIs] myself. And they have been far less trouble that the common cold. I've had chlamydia twice and gonorrhoea once … It was a bit of a nuisance but it wasn't excruciatingly painful or anything like that. I went to the clinic Monday morning, said "I've got gonorrhoea" and they said, "we'll look into that." And they saw me down there [referring to his penis] and decided I did have it. I was duly issued with the treatment, which was two pills to be taken, and that was it. You're off. And the same with chlamydia which I didn't even know I had! There are no symptoms at all … Now, that was far less trouble than the common cold which might have me in bed and miserable and dragging myself around like a dead man for three days. And, luckily, I've never had syphilis which is a bit more of a problem. But, if that's the worst that STIs can do to me well, I'll quite happily take risks.

Harry points out both the relative ease with which gonorrhoea and chlamydia can be treated, as well as his history of STIs even prior to initiating PrEP. More significantly, Harry highlights the difference in symptoms between those STIs and the more mundane, unremarkable condition of the common cold. Whereas gonorrhoea and chlamydia were experienced as "a bit of a nuisance," Harry experienced the common cold as "miserable" and of feeling "like a dead man for three days."

In highlighting the different physical experiences of STIs and the common cold, Harry draws attention to how different anxieties form around certain medical conditions in ways that do not necessarily reflect how such conditions are experienced. Despite the prolonged and negative impact on his day-to-day life, the common cold is a health condition which has been considered largely unremarkable and stigma-free[35]. Given their transmission through sexual contact, however, STIs provoke a heightened sense of anxiety and moralism among the broader public (Brandt, 1988). Such was the difference in their impacts that Harry found both gonorrhoea and chlamydia preferable to other health concerns that were considered more mundane[36]. Among participants, STIs were overwhelmingly portrayed as something ideally avoided, although their consequences were not so great that they provoked panic or anxiety. This is in contrast to a belief among some on social media that, for many MSM, STIs represented a "badge of honour" and almost a rite of passage. This was commented on by Alex (PrEP advocate and researcher, not using PrEP) who stated,

> From what I understand, [for] a gay man STIs are a badge of honour – like yeah, I'm prepared to cop this for the cause.

There are almost certainly individuals who consider an STI diagnosis as a source of pride. However, participants tended to view STIs as an adverse and almost inevitable part of being sexually active, much like any other aspect of life such as contracting the common cold.

Harry went on to describe a shift in his own attitudes toward, and anxieties around, HIV:

> Now that I'm almost 50 and that there is at least good treatment, at long last, it wouldn't phase me too much if I did get [HIV] from somebody who was undetectable. I'd just have to keep on taking one pill a day as before. So, you know, it wouldn't bother me all that much … Also, because I'm getting older as well, if PrEP failed and I got [HIV] it would be less of a disaster now. When I was 22 and I had my first test, I remember them saying to me "you still have a few good years left." That was in 1991 when I turned 22. And in the meantime, I'm almost 30 years older and treatments have improved. And, accordingly, if I got it today it wouldn't necessarily take much life expectancy away from me.

These shifts had begun prior to Harry's uptake of PrEP. He went on to inform me that even prior to beginning PrEP, he was increasingly engaging in condomless sex regardless of his partners' HIV status. Meunier et al. (2019) argue that while many HIV researchers are now exploring the potential for so-called risk compensation on PrEP, few engage with how risk is actually perceived by their study participants. "Compensation," they argue,

[35] This observation was made prior to the 2020 global COVID-19 pandemic. This saw heightened anxieties and policing over seemingly mundane conditions such as the common cold and the symptoms associated with it.
[36] This is not to dismiss the harmful impact gonorrhoea and chlamydia can have when left untreated, which can include infertility and possibly increase the risk of HIV infection (CDC 2020).

> *assumes replacing one risk by another as if the new risk was of the same gravity, but we do not know if gay men even perceive STI risk as appreciable risk or, rather, as a negligible cost they accept for the rewards they get from sex (p.54).*

Whereas for Thomas earlier, risk homeostasis was underpinned by the removal of HIV risk, Harry's stage in life, and the advancements made in HIV treatments, made HIV itself an acceptable risk to maximise sexual pleasure. This was made even more so with PrEP as Harry could effectively maintain the daily regimen of taking antiretroviral medication in order to manage his HIV status.

While some participants highlighted the different physical risks posed by HIV and other STIs, a small number of participants highlighted the social and cultural anxieties surrounding the virus. Matt, for example, contended,

> HIV is incurable, still. And nothing, *nothing* strikes fear into the hearts of people like those three letters do. There is nothing else that I can think of. It's awful of me to make comparison, certainly, but in terms of prevalence awareness, cancer is a much, much bigger problem. In the cohorts that I speak to, there's more of an emotional concern about HIV than there is about cancer.

Matt's claims of the fear surrounding HIV highlights his proximity to HIV as a sexually active gay man in his 30s. His assertion of a greater emotional concern over HIV than cancer reflects the significant degree of stigma that has attached itself to the virus since it first garnered public attention in the 1980s (see Patton 1985; Treichler 1987). Matt's comment above highlights broader social significations of HIV where, as argued in Chapter 2, HIV marks individuals as both a physical and moral threat to their own health and the health of their broader communities.

Statements which implicitly framed HIV risk and STI risk as effectively the same were critiqued by HIV advocate Ethan (HIV advocate and PLHIV, 30s) who claimed,

> That old thing? Well firstly, HIV is not like any of the STIs. Full stop. A debilitating epidemic that has taken the lives of 36 or 37 million people is not a jab in your bum for gonorrhoea. *Is not.* Full stop. You cannot conflate the two … You can't go off for 35 years and construct this whole kind of global health crisis around HIV/AIDS and, in doing so, you make HIV/AIDS the sun and all the other STIs are the planets that orbit it. Now that the sun's gone, you can't tell me that the problem is the same.

Characterising sexual health as a solar system, Ethan points out that for many MSM, sexual health has centred around the prevention of HIV with the management of STIs an almost secondary consideration. Prior to the first reports of HIV/AIDS in the United States, safer sex among gay men was largely conceived of as the potential of engaging in sex free from

violence or the intrusion of state authorities (Blair 2017). Even amid high rates of STIs at this time, including hepatitis B virus which was incurable, recommendations for gay men to use condoms went largely ignored (ibid.). In the first iterations of HIV/AIDS prevention guidelines, the reduction of STI transmission through condom use was framed as a secondary benefit (Callen and Berkowitz 1983).

Commenting on the moralising discourses surrounding potential challenges to the "condom ethic," Race (2003, p.374) argues that

> *Such indictments forget that gay men undertook the extraordinary level of behavior change observed in the first decades of the epidemic in order to prevent the experience of a substantially shortened lifespan and a painful death from AIDS for themselves and their sex partners, and not, for example, to resist a sexually transmitted infection."*

Written prior to PrEP, Race's comment here emphasises the central role HIV has had in the widespread uptake and use of condoms among MSM. Even as PrEP has disrupting the hegemony of condoms as a sexual health strategy, the centring of HIV prevention as having broader benefits for STI monitoring and prevention was present in discourses surrounding PrEP. As outlined earlier, one of the proposed benefits of PrEP as an HIV prevention strategy was the requirement for STI screening. While PrEP's challenge to condoms might seem antithetical to existing harm reduction strategies, so too are its broader benefits on STI prevention tied to its potential for preventing HIV.

Towards reframing of risk

In their discussion on unintended consequences associated with new health technologies, Hogben and Liddon (2008, p.1010) argue that

> *Instead of treating unintended consequences such as risk compensation as purely negative, one could reframe the events as opportunities for further and more complete intervention. For instance, if people are indeed rethinking their risks or their motives, perhaps that is precisely the time to communicate positive health messages.*

Such a reframing of risk has the potential to open more nuanced discussions around the sexual health of those using PrEP within which PrEP can be considered as having both positive and negative consequences. While research into the consequences of PrEP is important, it is also necessary that discussions of risk include factors that might contribute to a reduction and/or even offset the potential for STI risk.

A reframing of risk becomes particularly urgent when considering risk compensation in the context of debates outlined in Chapter 2, where those engaging in behaviours perceived as high risk and as holding values antithetical to those of the broader community (see Douglas 1992; Lupton 2013; Weeks 1995). For gay men in the context of HIV/AIDS, the use of condoms came to stand in as a signifier of an appropriately disciplined sexuality (Adam 2005; Race 2016; Weeks 1995). Against these discourses was the figure of the barebacker who, by virtue of not using condoms represented a threat to their own health as well as the physical and moral health of the broader gay community (Adam 2005; Dean 2015; Mowlabocus et al. 2014; Race 2016). These associations have underpinned much of the resistance to discussions of risk compensation, particularly as many PrEP users saw themselves as actively taking responsibility for their own health and contributing to an overall decline in rates of new HIV infections.

The stigma of describing condomless anal sex as risk compensation was highlighted by PrEP and sexual health educator Andy, who commented:

> I think it's inherently stigmatising to talk about sexuality as a risk. I tell the researchers: "my body is not a risk compensation. It is a celebration." And it's really offensive to call my pleasure a compensation of some sort … Are condoms being used less or are people just being a lot more honest about it now, and proud about it now, than they've ever been? I think it's probably yes to both questions … Why stigmatise people this way? Why label people this way? How does this help our conversation? How does that help our understanding of how to help people, and how does that help us end the epidemic by labelling that way?

Here, Andy highlights the potential stigmatisation associated with describing forms of sexuality and sexual behaviour as risky, a framing at odds with how he considers his own sexual behaviours. As Andy states, his sexual expression is "a celebration." It is unlikely that researchers exploring risk compensation among PrEP users have sought to actively stigmatise those on PrEP and engaging in condomless sex. Indeed, many of those researching behaviour change among PrEP users have been actively working to increase rates of PrEP uptake[37]. Despite their intention, however, it is crucial for researchers to consider how the language used might be interpreted by the populations they describe. This is made

[37] One notable example is Martin Holt whose work has been crucial in the implementation of PrEP in Australia. In 2018, Holt et al. (2018) published their findings on behavioural changes associated with PrEP. Despite Holt's significant contribution to PrEP research and uptake in Australia, even this report was criticised on Facebook for what was interpreted as a negative portrayal of PrEP users.

even more urgent when conducting research among already marginalised populations who have at times had problematic relationships with medical institutions.

Just as Hogben and Liddon (2008) have suggested a reframing of risk compensation that focuses on the potential benefits of sexual health interventions, so too did Andy suggest an alternative way of describing condomless anal sex in the context of PrEP:

> I call it natural pleasure or barrier-less intimacy. Or latex-less or barrier-less connection and intimacy that people can share. And when you use that language, that's about affirming the emotional, sexual, [and] spiritual parts of connecting bodies. Then, like I said before, you're normalising sexuality. And then it's so much easier to build relationships with patients and community members and get them into the clinic and get tested for STIs on a regular basis.

Andy went on to describe his work as a sexual health educator in the United States where some individuals refused to disclose experiences of bareback sex due to the stigma associated with it. Shifting the focus of condomless anal sex from that of a problematic behaviour to focusing on the potential benefits associated with it was felt by Andy to more adequately account for "the emotional, sexual, [and] spiritual" aspects of sexuality. In doing so, condomless sex *per se* need not be a problem in and of itself but, rather, one factor in a broader range of sexual health concerns.

While not his intention, Andy's claim of "natural" and "barrier-less intimacy" risk setting up new hierarchies of sexual citizenship, whereby the sexual intimacy experienced by those choosing to use condoms is somehow lesser. Statements such as these have effectively reframed condomless anal sex from a problematic sexual act to one with significant and important meaning for many MSM. In doing so, however, they risk implying that those who continue to use condoms do not fully experience sexual intimacy or pleasure. Recalling Rubin's (2011b) theorisation of sexual hierarchies, it is important that as PrEP becomes a more normalised and everyday part of HIV prevention, efforts to destigmatise PrEP do not end in the stigmatisation of condoms. In the field of HIV prevention, it is necessary for educators to promote a broad range of prevention options so that individuals are empowered to adopt the most suitable for them.

Conclusion

Given PrEP's status as an emerging technology during fieldwork between 2017 and 2018, its overall impact on the overall STI rates and condom use in Victoria has yet to be determined. This was made even more complex when, in 2020, the global COVID-19 pandemic impacted Australia and for the first time HIV/AIDS organisations discouraged casual sex among MSM[38]. It is certain, however that at population level PrEP was associated with a significant decline in condom use. Given PrEP entered a context of already increasing STIs, it was unclear the extent to which PrEP was contributing to these rates. Among PrEP users, there was a general consensus that research exploring behavioural changes associated with emerging sexual health technologies was necessary. However, it was also thought that much of the existing research into declining rates of condom use failed to account for how participants' interacted sexually.

Research that framed declining rates of condom use associated with PrEP as "risk compensation" was widely criticised by PrEP users. These critiques centred on a lack of nuance with the concept itself which was felt to be too narrow to adequately account for the lived experience of PrEP users. Even as PrEP users might be likely to forgo the use of condoms, they also engaged in a regular routine of HIV and STI screening. Thus, even as PrEP users might be more likely to contract STIs, so too was it said that such infections might be detected and treated in a timely manner. Similarly, research characterising PrEP users as a distinct sexual group was criticised as it failed to fully account for the sexual networks of PrEP users. These networks were not exclusively made up of PrEP users and included PrEP non-users, some of whom might not be engaged in a cycle of sexual health care.

Concerns over condomless anal sex associated with PrEP reflects an overarching conflation within sexual health research of sex with anal sex. Given the prioritisation of HIV research, this is perhaps unsurprising. However, this conflation ignores other STI transmission avenues such as oral sex. Given the almost negligible risk of HIV transmission, it was widely reported throughout my fieldwork that the use of condoms during oral sex was almost unheard of. This is despite the potential for STI transmission. While participants generally

[38] The impact of COVID-19 is discussed in the Afterword to this thesis.

believed STIs were something they preferred to avoid, they also felt that the consequences of such infections were not as significant when compared to the consequences of HIV. This was not a glib disregard for STIs but, rather, an attitude that these could be more easily dealt with. Given the recent history of HIV/AIDS as a fatal condition, alongside its association with an already marginalised population, the increased anxiety over HIV is unsurprising. For participants of this project, the risk of STIs was considered an acceptable risk to take in order to maximise sexual pleasure.

As risk is often associated with notions of irresponsibility and deviance (Douglas 1992; Lupton 2013), it is essential that researchers consider how the language they use might be interpreted by those they describe. Just as "risk" was felt to lack nuance, so to was it interpreted by many as inherently stigmatising. The experience of such language as stigmatising was evident in responses on social media to research which associated condomless anal sex with risk compensation. This is likely not the intent of HIV and PrEP researchers, many of whom have been strong PrEP advocates and some of whom would be categorised as MSM themselves. Despite this, the language of risk is not neutral and, importantly, has the potential to further alienate those communities that research is designed to help. Given this potential, it is necessary for researchers, particularly those conducting research with already-marginalised communities, to take care in how they use, define, and describe the terms with which they describe their communities of research.

Chapter 4 – Beyond HIV and STI prevention: PrEP users' interpretations of sexual health

Introduction

As outlined in the previous chapter, concerns over the potential for risk compensation among PrEP users was a prominent theme in discussions over PrEP use. These concerns were underpinned by a cultural and moral attachment to condoms (Auerbach and Hoppe 2015). At the same time, they reflect an overarching conflation of biomedical approaches to sexual health with disease prevention (see Edwards and Coleman 2004). This approach neglects and minimisations other aspects that are important to sexual health that go beyond the prevention of disease, illness, and dysfunction. These include the potential for sexual pleasure, intimacy with one's partners, as well as a sense of agency and control over one's sexuality. A biomedical approach was particularly prominent in research exploring an association between risk compensation and PrEP. This research generally failed to account for how notions of sexual safety, sexual health and sexual risk were imagined by PrEP users. It is these concerns that I discuss in this chapter.

Throughout my fieldwork, it was evident that PrEP was causing a shift in how sexual risk was understood and, as described in the previous chapter, PrEP users refuted characterisations of condomless sex while using PrEP as inherently risky. These critiques centred on the language of risk as lacking the nuance to adequately reflect participants' own experiences of their social and sexual worlds. Similarly, participants own understandings of sexual health and safer sex extended beyond a narrow, epidemiological approach focused on disease prevention. After providing a brief description of some shifting definitions of sexual health, I outline PrEP users' own understandings of sexual health, safety, and risk. This chapter begins by discussing participants' attitudes to an increased engagement with healthcare services, and then highlights the increased sense of control and empowerment that, for some PrEP users, was considered a benefit of PrEP use. I conclude this chapter by outlining how the concept of risky sex was defined. As I will demonstrate, participants widely conceived of sexual health as encompassing physical and mental health, as well as one's relationships to others.

Sexual Health Definitions

Charting the evolution of sexuality as a public health concern from the mid-19th century, Alain Giami (2002, p.2) argues that such concerns have been "historically based on political choices and strategies." Giami argues that in the mid-19th century, sexuality was largely understood as "oriented toward procreation" (p.2). Given this, public health approaches to sexuality "were to preserve the best conditions for procreation in the context of marriage, expressed both as a biological function and a moral value for society." At this time, those whose sexuality was considered as aligning with these concerns were largely left alone and were free of social surveillance (Foucault 1990). At the same time, however, those whose sexuality was considered antithetical to the potential for procreation, such as same sex attracted individuals, were considered as legitimate targets for punitive action (ibid.). At first, such individuals were subjected to heightened surveillance and punitive action by state authorities; however, the heightened surveillance was later carried out under the guise of medical intervention (Bayer 1981).

In the *History of Sexuality*, Foucault (1990) argues that prior to the 18th century, sodomy was classed as belonging to a "category of forbidden acts; their perpetrator was nothing more than the juridical subject of them." That is, sodomy itself was not considered an innate part of the individual but, rather, a deviant act which justified juridical intervention and punishment. As the authority of religious institutions waned and that of scientific and medical institutions increased, however, discourses surrounding same-sex attraction shifted. While understandings of homosexuality as a moral failing remained, it was also defined in pathological and psychiatric terms (Herdt 1997, p.27). No longer framed solely as a criminal act, homosexuality came to be considered a condition that, with the appropriate medical intervention, could be cured. One result of such an understanding was the inclusion of same sex attraction in the American Psychiatric Association's *Diagnostic and Statistical manual, Mental Disorders (DSM-1)* where it remained until 1973 (Bayer 1981).

Within medically framed definitions of sexual health, there is a strong emphasis on aspects such as sexual function and dysfunction, STIs, and concerns over reproduction (Edwards and Coleman 2004). These associations emphasise sexual health as primarily concerned with problems such as ideal bodily functioning, the absence of disease and illness, and control

over one's reproductive capacity which are said to best be dealt with through medical institutions (Giami 2002; Starrs and Anderson 2016). In an analysis of the historical evolution of sexual health, Edwards and Coleman (2004) found a significant lack of research addressing sexual health that was conducted outside the dominant, Western medical model. Rather, the overwhelming focus of this research was on aspects described above, effectively ignoring other aspects such as mental health, interpersonal relationships, satisfaction with one's experience of sex, and a need for intimacy and human connection (ibid.).

One of the most widely cited definitions of sexual health is that of the WHO's working definition. According to the WHO (WHO 2006, p.5), sexual health

> *is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.*

In this working definition, sexuality is understood as

> *a central aspect of being human throughout life and [it] encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. (WHO 2006, p.5).*

While this definition acknowledges the role of physical aspects related to health such as disease and illness, it takes a more holistic approach to sexual health. Included in this definition are other aspects which are often overlooked when sexual health is considered from a purely epidemiological perspective: sexual pleasure, autonomy, and the potential to experience positive sexual relationships. Importantly, the WHO define sexual health *in relation to* sexuality which, they state, is "a central aspect of being human." In this way, sexual health can be considered as more than simply related to the prevention of illness and one's reproductive capacity. Rather, sexual health is considered a core aspect of how individuals get by in the world.

To achieve ideal levels of sexual health, it is crucial that a positive approach be taken. According to the WHO,

> *Sexual and reproductive health and well-being are essential if people are to have responsible, safe, and satisfying sexual lives. Sexual health requires a positive approach to human sexuality and an understanding of the complex factors that shape human sexual behaviour. These factors affect whether the expression of sexuality leads to sexual health and well-being or to sexual behaviours that put people*

> *at risk or make them vulnerable to sexual and reproductive ill-health. Health programme managers, policy-makers and care providers need to understand and promote the potentially positive role sexuality can play in people's lives and to build health services that can promote sexually healthy societies (WHO 2006, p.1).*

This approach becomes particularly urgent for health programmes and services directed to individuals who are categorised as belonging to already marginalised populations such as MSM, some of whom might have historically troubled relationships with medical institutions. As demonstrated in the previous chapter, the use of risk in research describing condomless anal sex among PrEP users was considered particularly stigmatising. This was despite many of those researchers having a long history of working with MSM populations in Australia. The history of a negative approach taken by medical institutions toward MSM was one that has continued to be felt throughout the implementation of PrEP.

Emphasising the interactions between individuals and their communities, Beatrice Robinson et al. (2002, p.45) claim that

> *Sexual health involves an ability to be intimate with a partner, to communicate explicitly about sexual needs and desires, to be sexually functional (to have desire, become aroused, and obtain sexual fulfillment), to act intentionally and responsibly, and to set appropriate sexual boundaries. Sexual health has a communal aspect, reflecting not only self-acceptance and respect, but also respect and appreciation for individual differences and diversity, as well as a feeling of belonging to and involvement in one's sexual culture(s). Sexual health includes a sense of self-esteem, personal attractiveness and competence, as well as freedom from sexual dysfunction, sexually transmitted diseases, and sexual assault and coercion. Sexual health affirms sexuality as a positive force, enhancing other dimensions of one's life.*

Robinson et al. highlight the necessity for approaches to sexual health promotion to not only focus on the prevention of illness but, crucially, to foster a sense of self-esteem and positive attitudes toward sex and sexuality. The fostering of positive attitudes toward sex and sexuality have important mental health implications. In addition, sex positive attitudes among health workers has been shown to enhance engagement with the health care system among MSM, leading to an increased likelihood of engagement with STI prevention strategies (see Forda et al. 2019).

The approaches described so far provide important considerations for researchers and health professionals when designing sexual health programs and promotional campaigns. However, caution must also be taken that these approaches are not universalised. Understanding and acknowledgement of social, cultural, and political contexts in which they are implemented is also crucial. While organisations such as the WHO have attempted to provide an overarching

definition of sexual health, it "is [always] embedded in politics and in the health systems of different countries" (Giami 2002, p.32). Definitions of sexual health, then, will always be interpreted within specific social, cultural, and political contexts. This presents significant challenges in addressing the sexual health needs of already marginalised and/or criminalised population groups. For example, Starrs and Anderson (2016, p.10) argue that

> *To identify and address key aspects of sexual health in a formal, systemic manner would be seen as accepting, or possibly even condoning, sexual behavior outside of traditional heterosexual marital purposes and for relationships other than reproduction - a step that a number of governments, as well as conservative elements of civil society, have been loath [sic] to do.*

Even within epidemiological constructions such as MSM, for example, a broad range of attitudes toward sexual health exist. As I have already described, while some hailed PrEP for its potential to reduce anxiety over HIV, others characterised it as effectively giving permission for MSM to engage in condomless anal sex outside of monogamous, romantic relationships.

Dominant understandings of sexual health remain firmly grounded in medical and epidemiological approaches to harm reduction and the prevention of STIs. This is despite the conceptualisations of sexual health described above, which point to the necessity of approaches to sexual health promotion as more than simply the absence of disease, illness, and dysfunction (Forda et al. 2019). Tim Rhodes (1997, p.213) argues that

> *most HIV prevention responses, be these syringe exchanges or safer sex campaigns, are based on theories of health behaviour which view risk perception and behaviour change to be the product of individual cognitive decision-making.*

Such an approach masks the various meanings individuals attach to their actions, and how these meanings manifest in individual and group behaviours (ibid., p.222). It is critical that those involved in the development of sexual health interventions not only understand meanings attributed to so-called risk behaviours, but also how risk and safety are conceptualised by the populations they seek to address.

PrEP and shifting definitions of safe and unsafe sex

Given PrEP's efficacy at preventing HIV, the United States' CDC ceased using "unsafe" and "unprotected" to describe condomless sex among PrEP users. This shift in language was also reflected in Australian research. In their paper exploring changes in sexual practices among gay and bisexual men, for example, Holt et al. (Holt et al. 2018, p.e459) defined four

categories considered as safer sex: 1) No anal intercourse with any casual partners; 2) consistent condom use with all casual partners; 3) condomless anal sex with PLHIV on effective treatment and with an undetectable viral load, and; 4) condomless anal sex by HIV-negative men using PrEP. In contrast, "risky [behaviours] for HIV transmission or infection" (ibid., p.e459) were defined as: 1) any condomless anal sex by HIV-positive men who were not on treatment or not virally suppressed or; 2) any condomless anal sex (insertive or receptive) by HIV-negative or untested MSM not using PrEP.

The shift in language defining unsafe and/or unprotected sex is significant, particularly given that condomless sex itself was no longer defined *a priori* as unsafe or unprotected. This has important implications for how individuals engage with healthcare systems. For example, anticipated stigma from healthcare workers has been demonstrated as negatively influencing the likelihood of those living with a chronic illness accessing necessary healthcare (Datta et al. 2018; Earnshaw and Quinn 2011). Similarly, anticipated or actual experiences of stigma have been shown to result in a delay among some MSM in seeking sexual health care (Wolitski and Fenton 2011). Given the potential for stigma that is associated with behaviours considered unsafe or risky, this shift in language has the potential to bring significant benefits to the relationships between PrEP users and their healthcare providers.

Central role of STI prevention in sexual healthcare

Reflecting dominant biomedical conceptualisations of sexual health, participants commonly emphasised the link between sexual health and STIs. Seamus (PrEP user, 20s), for example, stated,

> I think that [versions of] safe sex do not say, "am I going to get HIV at the end of it?" Safe sex is, "am I going to get *any* infection?" I think that's what, for me, the "safe" thing is. I think if they're [just] saying "to prevent HIV", then yes PrEP is effective. But I think if you're sleeping with lots of different people then you have to reset what your safe is. Because you don't want to pick up anything. You don't want to get syphilis or anything else. It's not the desired outcome of having sex … I think that's what, for me, safe sex is.

Among interview participants using PrEP, Seamus' attitudes and sexual activities stood out as an anomaly. While others described a noticeable and significant decline in their condom use associated with PrEP, Seamus maintained regular and frequent condom use as part of his overall sexual health strategy. Seamus did not consider PrEP his primary sexual health

strategy but, rather, a contingency plan should there be situations in which condoms were not used or somehow failed. As he put it:

> You can recognise that you are human … I'm not perfect. And I have and probably will make more mistakes.

Despite the possibility of experiencing condomless sex with a significantly reduced risk of HIV, the minimisation of other STIs remained an important aspect of Seamus' conceptualisation of sexual health. Even though condoms were not 100% effective, they provided him with a feeling of enough protection against STI transmission that maintaining a commitment to their use was worthwhile.

While Seamus' focus was largely centred on the prevention of HIV and other STIs, seemingly reinforcing biomedical understandings of sexual health, his use of condoms fit within a broader ethic according to which Seamus navigated his world. He described his commitment to condoms as a "value", stating "just because [I'm] on PrEP doesn't mean [I] have to abandon [my] other values." Indeed, Seamus considered the declining rates associated with PrEP use as disrespectful of much of the work around safer sex done by gay men who had lived through the crisis years of the HIV/AIDS epidemic:

> You are kind of just ignoring the lessons that we've learned, I think personally. And it's almost a disservice to people who have gone through it and lost their lives from HIV to say, "oh well. We've got through it now. Nothing like that will happen again." But you haven't. It's sad and depressing.

Statements such as these would have likely been hotly disputed by other PrEP users. Many early adopters considered their own use of PrEP as not only an HIV prevention strategy but, more importantly, part of the larger HIV/AIDS advocacy landscape. Seamus identified STI prevention as underpinning definitions of safer sex, this was aligned with his broader worldview.

As with Seamus, John (PrEP user, 50s) recognised the use of condoms for the prevention of STIs as underpinning approaches to safer sex:

> J: Safe sex is condoms. Still condoms of course. Well, not having sex is safe but it's a very boring life. Life is about taking measured risks.
>
> NW: Sex without a condom on PrEP – do you consider that safe?
>
> J: Yes, 100%. 100% agree, not 100% safer.
>
> NW: What for you is risky sex?

J: Not on PrEP and barebacking.

Here, John notes that just as condoms are a form of safer sex, so too is abstinence albeit, as he states, "a very boring" sexual health strategy. Understood as forgoing any form of sexual contact, abstinence carries with it almost no risk of STI transmission. From the sole perspective of preventing STIs, then, abstinence could be considered a highly efficacious sexual health strategy. However, while this might be a desirable strategy for some, abstinence does not fulfil the WHO definition of sexual health as "a state of physical, emotional, mental and social well-being in relation to sexuality" (WHO 2006). For those who do gain satisfaction from sexual contact, suggestions of abstinence to prevent STIs would likely deny individuals of an aspect of life that is beneficial and meaningful.

Having defined safer sex as the use of condoms, John went on to acknowledge that sex without condoms while using PrEP can also be considered a form of safer sex. In contrast, he defined risky sex as engaging in bareback sex while not using PrEP. Whereas the prevention of *all* STIs was central to Seamus' understanding of safer sex, it was specifically around HIV prevention that John centred his conceptualisation of safer and risky sex. Importantly, John pointed out that he does not consider PrEP as necessarily safer than condoms, reflecting the potential for STI transmission through forgoing condoms. Reflecting Wilde's (1998) theorisation of risk homeostasis discussed in the previous chapter, John stated "life is about taking measured risks." Thus, the significantly reduced risk of HIV through PrEP makes the potential of STI transmission through condomless sex an acceptable "risk" for John.

As with the previous two comments, Ben (PrEP user, 30s) also acknowledged the central role that both condom use and STI prevention have had in how safer sex has been constructed:

> My opinion of safe sex is not doing it with some crazy person who wants to kill you [Ben laughs]. Safe sex varies from person to person. There will always be that section of society that says that [only] condoms are safe sex. In a way, I guess they're somewhat right because, as I said earlier, PrEP doesn't stop transmission of the other stuff – you know, all those other nasties you can get. However, to me [PrEP] is safe sex because I am protected from HIV. And as far as the other issue goes, with other STIs, the science has shown that the best course of action against those is actually regular testing and treatment. Every three months. Which is a requirement of getting a prescription for PrEP.

As with all interview participants using PrEP, Ben was highly cognisant that in and of itself, PrEP did not offer any protection against STIs other than HIV. However, he did believe that the quarterly STI and HIV screening associated with PrEP offset any increase in the

likelihood of contracting STIs. Even as STI prevention was central to how Ben thought of safer sex, however, Ben believed that condoms were not the only strategy to prevent STIs, with strategies such as regular screening also playing an important role. In addition to the prevention of STIs, Ben also claimed that safer sex is avoiding violence and/or murder, highlighting the broader nature of how safety in relation to sex and sexuality can be defined. Despite his claim here being somewhat tongue-in-cheek, there is a long history of gay men being the targets of (sometimes lethal) violence precisely because of their same sex desire (Thomsen 1993).

Taken together, the three examples above highlight the role that both condoms and the prevention of STIs have played in how safer sex and sexual health have been conceptualised. However, even as all three participants centre STIs, they nonetheless situate this aspect within broader contexts. For Seamus, condom use forms part of the broader ethics through which he navigates his sexual worlds while for John, the consequences of STIs were not so great that he considered the use of condoms necessary. While the prevention of STIs was considered important by Ben, he nonetheless felt that routine testing was an adequate way to minimise their impact.

Increased engagement with healthcare services

As suggested by Ben above, one of the benefits of PrEP was the required HIV and STI testing that was built into PrEP prescribing guidelines. This routine engagement with health services was said to have benefits beyond the sexual health of individuals. Alex (PrEP advocate and researcher, not using PrEP) claimed,

> It's bloody hard to get young men to see a doctor … and suddenly, you've got them there four times a year. What happens as a result of that? We've also had several PrEP clinics here pick up abnormal liver function tests, people's abnormal kidney function. All of these sorts of things suddenly pop up [which is] great, let's deal with this, high lipids, high cholesterol, depression.

As a population group, men's engagement with primary healthcare services is lower than that of women (Department of Health & Human Services 2015). As Alex notes, however, the increased engagement with health services through PrEP has led to increased opportunities for screening and other preventative health measures.

The potential benefits of regular engagement with healthcare services was commented on by Freddy[39] (PLHIV, 50s), who expressed a sense of feeling healthier than the broader HIV-negative population because of his HIV-positive status. Through his use of antiretroviral therapies and management of HIV, Freddy believed that he had established good relationships with health professionals through his routine contact with them. This is not to diminish the impact of his diagnosis which had originally come as a shock to Freddy and required a period of adjustment. However, the subsequent relationships he had developed with healthcare professionals reinforces Alex's arguments about increased opportunities for engagement with the health system.

PrEP, increased surveillance and the re-medicalisation of MSM

The emergence of PrEP has raised concerns among some scholars over a potential re-medicalisation of the bodies of MSM (Brisson and Nguyen 2017; Giami and Perrey 2012). The medicalisation of everyday life has been a key concern among scholars of health and illness and describes the processes through which non-medical conditions come to be understood in medical terms (Armstrong 1995; Conrad 1992; Giami and Perrey 2012; Lupton 1997; Tiefer 1996; Zola 1976). Medicalisation can be broadly understood as "defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using medical interventions to 'treat' it" (Conrad 1992, p.211). Lupton (1997) draws attention to what she terms the "orthodox medical critique" that emerged alongside the social movements of the 1960s and 1970s. Premised on "the notion that individuals should not have their autonomy constrained by more powerful others" (ibid., p.190), proponents of this critique took issue with what they saw as the growing dominance of medical institutions, particularly over individuals belonging to traditionally marginalised population groups. Critiques of medicalisation have drawn attention to the ways in which medical institutions increasingly function as sites of social control and regulation once occupied by more traditional institutions such as those of religion and law (Lupton 1997; Zola 1976). Ivan Illich (1974, p.918) claims that by "transforming pain, illness, and death from a personal challenge into a technical problem, medical practice expropriates the potential of people to deal with their human condition in an autonomous way." According to this critique, the human condition itself and its various states – defined

[39] Freddy asked that our interview not be audio recorded and so direct long quotes are not used here.

medically as either healthy or unhealthy – become legitimate sites to be managed by medical institutions.

While critiques of medicalisation have played an important role in drawing attention to the regulatory potential of powerful institutions, particularly over potentially vulnerable populations, Lupton (1997) argues that these critiques can present an overly deterministic analysis. In their portrayal of doctors and health professionals "as intent on increasing their power over their patients," she argues, individual patients themselves become "disempowered, their agency crushed beneath the might of the medical professions" (Lupton 1997, pp.192-193). Concerns raised over the potential for the re-medicalisation of MSM through PrEP are legitimate. However, as Lupton has argued, such critiques "neglect examination of the ways that hegemonic medical discourses and practices are variously taken up, negotiated or transformed by members of the lay population in their quest to maximise their health status and avoid physical distress and pain" (Lupton 1997, p.188). As such, the medicalisation critique of PrEP does not necessarily reflect how PrEP is experienced by those who use it.

Concerns over PrEP's potential to (re-)medicalise MSM are important, particularly given the complex relationships that have existed historically between medical institutions and same sex attracted people. However, participants generally saw their increased engagement with medical institutions as a beneficial aspect of PrEP. Although Seamus was concerned over the decline in condom use associated with PrEP, he did acknowledge the benefits associated with increased testing:

> The flip side of it is more people are getting tested and getting treated. Because every three months people have to in order to get PrEP. Especially now that it's in Australia and you can get it from your GP. It's a very regular system – for anyone who wants it, gets tested. So, there's probably going to be a peak now in diagnoses around this time of STIs. But they'll also be more treated and less in the community. Therefore, that's a potential benefit of it as well. It's giving people the control or realisation that they have to go to the STI clinics regularly.

As with most other participants, Seamus did not consider regular HIV and STI testing to be a particularly onerous task, particularly given his belief that MSM should be engaged in a

routine cycle of sexual healthcare regardless of their PrEP use. For Seamus, PrEP functioned as an important reminder to users of the need for STI screening[40].

Simon Williams et al. (2011, p.711) contend that "both medicalisation and pharmaceuticalisation should ideally be treated as value-neutral descriptive terms and may include both gains and losses to society." Far from being viewed solely as a process through which medical institutions exert regulatory power over individuals, this reframing of the medicalisation critique opens the possibility for medicalisation to be considered an "interactive process" (Conrad 1992, p.219). Within the medicalisation literature, significant attention has been paid to the way in which "individuals internalize society's norms; how normality and abnormality are defined, and by whom; [and] how and why particular social groups and individuals are sanctioned for being different from the norm" (Loe 2004). Stefan Ecks (2005, p.245) argues that there has been a great deal of work in "the anthropologies of science, technology and medicine … to illustrate the argument that the separation between authentic/human and inauthentic/non-human domains can be misleading." In other words, this work has highlighted the capacity of new technologies such as advancement in pharmaceutical therapies to actively affect and change embodied subjectivities.

Drawing on the example of antidepressant use to manage anxiety and depression, Stefan Ecks (2005) argues that pharmaceutical interventions have the potential to de-marginalise individuals from otherwise marginalised identities or conditions. Ecks (ibid., p.242) claims that the promotion of antidepressants often relies on promises of returning individuals to a "normal" sense of self, whereby

> *[b]eing oneself again means, above all, to overcome the isolating effects of depression and to be able to reintegrate oneself into society. More than other medicines, antidepressants hold the promise of a quick and effective demarginalization*

Ecks (ibid.) notes that the promises of an end to marginalisation through purely pharmacological interventions are generally met with distrust among social scientists, many of whom, he claims, argue that this is a "quick fix at best, and a new form of exploitation by pharmaceutical companies at worst" (p.244). According to this critique, he argues, antidepressants are framed as a "fetishized commodity" (p.244) that risk ignoring the social

[40] This is discussed in more detail in Chapter 3.

factors that might potentially contribute to depression and anxiety. He ultimately argues, however that "we have to find a way to think about mental health that neither reduces it to the proper distribution of medicines, nor simply rejects medicines as fetishized commodities" (ibid., p.245).

Drawing on Ecks' argument, Asha Persson (2016) demonstrates the way in which the use of HIV medications also has the potential to provide PLHIV with a sense of liberation from an otherwise marginalised identity. Within the context of sero-discordant couples, Persson found that the knowledge of the effectiveness of Treatment as Prevention reframed how their relationships were imagined. Where previously sero-discordant couples had been thought of as high risk for HIV transmission, HIV treatments effectively removed the association of risk from their relationships. In doing so, Persson found that this knowledge also removed a sense of self-stigmatisation for some partners living with HIV. This not only opened the possibility for those partners to experience their bodies differently but, also, provided those couples with a different way of experiencing their relationships.

PrEP, increased control and empowerment

For many respondents, PrEP offered participants a greater sense of control and agency over their sexual health, an aspect of PrEP that was considered particularly important for those who took a receptive role during sex. Darren (PrEP advocate and user, 50s) spoke of his decision to begin using PrEP:

> I decided to have a mid-life crisis and change my sexual behaviours and interests and stuff. So, in that process I also needed to change from the idea of condoms. Because in some settings … I couldn't rely on that for my protection. As a bottom[41] particularly. I never did strategic positioning[42] because that just doesn't work for me.

As he preferred to adopt a receptive role during sex, Darren felt that he could not always rely on the use of condoms to protect him against contracting HIV. It was not the efficacy of condoms *per se* that Darren doubted, although on social media I frequently observed as he reminded others that condoms were not a panacea for HIV prevention. Rather, it was he needed to rely on his sexual partners for the continued use of condoms during sex. While

[41] A "bottom" refers to the receptive partner in same-sex penetrative anal sex.
[42] Strategic positioning is an HIV prevention strategy whereby the HIV negative partner takes on the insertive role while the HIV positive partner is the receptive partner, reducing the risk of HIV infection.

Darren might be able to visually see whether condoms were being used prior to penetration, the knowledge of their continued use throughout the sexual encounter was somewhat more problematic. On the one hand, Darren could simply trust that his partners were correctly using condoms. On the other hand, Darren could employ a strategy of maintaining constant vigilance throughout sex to regularly confirm that condoms were still be used or had not broken. As I argue further in Chapter 6, this strategy firmly situates HIV as part of the sexual experience.

Through using PrEP, Darren felt a degree of certainty that he was protected against HIV whether his partners wanted to use condoms or not:

> PrEP gives me the assurance that I'm protected from HIV … so I don't have a concern about [condoms]. That's my HIV prevention strategy.

Importantly, Darren viewed PrEP as more than a pharmaceutical technology to prevent HIV describing it as

> a strategy, not just a tablet, that empowers a user to have control of their wellbeing. Particularly, but not limited to, sexual health. PrEP can remove a huge unspoken of anxiety around sexual expression, the result of 35 years of "sex is inherently unsafe" type messages.

More than simply a sexual health intervention, PrEP was defined by Darren as a "strategy" that allows a heightened sense of control over a users' wellbeing more broadly. The removal of anxieties around HIV through PrEP had broadened Darren's approach to, and understandings of, safer sex:

> My idea now of safer sex … is broader. It's about STIs [and] it's about checking my HIV status – which I know is going to be alright. I think it's also about mental health stuff too, in a way. I guess if anything, PrEP's kind of broadened my approach to sexual health rather than it being very limited. I don't know that that's the same with everyone, but I can't help but think if you're going off to the doctor every three months, and you're having the STI suite and bloods and all of that stuff … I think it's a good thing. I think it's a good thing that PrEP has, for me, broadened my approach to sexual health.

Darren's broadened understanding of sexual health reflects the approach taken by the WHO definition, whereby sexual health is defined more holistically than simply the prevention of HIV and other STIs. As Darren noted, the heightened sense of control and agency, coupled with reduced anxieties over HIV, also had significant mental health implications for him.

Immediately prior to and during my fieldwork, the phenomenon of "stealthing" became the subject of significant media attention. In its simplest definition, stealthing describes the phenomenon whereby one sexual partner, most commonly the penetrative partner,

deliberately and non-consensually removes the condom during sex without their partners' knowledge (Brennan 2017)[43]. It was precisely the experience of being "stealthed" that was the catalyst for Robert (PrEP user, 20s) in deciding to begin using PrEP. Robert told me of one particular night when he attended a large, male-only leather and fetish party at the Laird Hotel. As is typical of these events, a section of the venue was sectioned off with black plastic sheeting forming a small, makeshift darkroom[44]. After meeting someone in a different part of the venue, he and Robert decided to go to the darkroom to have sex. Prior to entering this space, they had negotiated that Robert would be the receptive partner and that, as he was not on PrEP, condoms needed to be used. Upon their sexual encounter ending, however, Robert could feel that his casual partner had ejaculated inside of him. Robert confronted his partner and, after initially denying it, his partner admitted to removing the condom soon after penetration. Immediately after this experience, Robert initiated a month-long course of post-exposure prophylaxis, a month during which he also experienced a significant amount of anxiety over his potential HIV seroconversion.

While Robert's experience stands out for the lack of consent given around the non-use of condoms, it echoes the experiences of other participants in their decisions to begin PrEP. The encounter described above was not the sole factor influencing Robert's decision to begin PrEP, but it was the catalyst for him ultimately deciding to begin using PrEP. Similarly, other participants described experiences of using post-exposure prophylaxis after condom failure or condom non-use as playing a role their decisions to begin PrEP. Regardless of participants' intentions to continue using condoms or not after beginning PrEP, it offered them a sense of control over their sexual health and a degree of certainty as to their protection against HIV. Even in circumstances such as taking the receptive role during sex where they might have less control over ensuring ongoing protection of HIV through condom use.

Echoing Darren and Robert, Andy (PrEP advocate and user, 40s) also described a heightened sense of control and agency through using PrEP:

[43] Joseph Brennan (2017) makes the point that although the potential for HIV transmission is part of the stealthing experience, it is not always the explicit intent of those who engage in stealthing.
[44] Darkrooms are a common feature of sex on premises venues and some bars. They are usually a separate room or defined section of a venue with very low or no lighting where patrons can engage in sex.

> I finally decide. I get to be in control of whether I become HIV positive or not. Whereas before, even when I was strict about condoms – which a was in the 90s – even back then I was still dependent on another person to keep me safe. It was still dependent on the top to wear the condom, to make sure it didn't break or fall off or fall in or disappear or whatever. It was always contingent on another person [for me] to stay HIV negative, as a bottom. Now, I make that decision every day when I take that pill.

Reflecting Darren and Robert, Andy too felt an increased sense of control and of no longer needing to rely on his sexual partners to ensure he was protected against HIV. Where Darren and Robert framed their use almost exclusively as no longer relying on another person, Andy's comment here portrays a heightened sense of agency. In addition to his initial decision to begin using PrEP, Andy also considered his daily taking of PrEP as a "decision" to remain HIV negative.

While the greater sense of control conferred by PrEP was celebrated by Darren, Robert, and Andy, it does have the capacity to erode norms around negotiating safer sex (Kippax and Stephenson 2016). These norms have been an important aspect of the response throughout the HIV/AIDS epidemic and became an entrenched part of gay men's sexual culture. Where all partners are using PrEP or have an undetectable viral load, this is arguably not a concern given the almost zero chance of HIV transmission. However, there is cause for concern should the negotiation of safer sex strategies becomes considered as antithetical to experiences of sexual pleasure and intimacy. This is particularly important for those who continue to rely on condoms, a sexual health strategy that relies on a degree of negotiation within the sexual encounter.

In contrast to the criticisms of PrEP outlined earlier, where PrEP is portrayed as facilitating increased control and surveillance by medical institutions, Andy described a sense of empowerment through using PrEP. The quarterly testing associated with PrEP was not considered particularly onerous for Andy. Rather, he felt the increased contact with the health system, coupled with a more open and honest dialogue with health professionals, had opened the opportunity for him to receive a higher standard of healthcare:

> I never actually got an anal swab until I was 41 years old. It just wasn't what people did; it wasn't something that doctors would typically offer to you. They just, you know, said I wasn't at risk because I told them I was using condoms … So now, you're getting all these folks, positive and negative, feeling good about their bodies. Feeling good about their sexuality. Which means, they're seeing their doctors more often. And getting tested and treated more often for STIs … PrEP has been the bridge by which so many people are now connected to healthcare for the very first time.

Despite engaging in condomless sex with casual partners prior to PrEP, Andy used to regularly inform his doctors that he had been consistently using condoms, leading to doctors' perceptions of him being at no risk of anal STIs. As Andy is based in the US, his experiences of healthcare do not necessarily reflect the Australian health context. However, it is important to note that it was his hesitance and lack of openness in disclosing his *actual* use of condoms that had led to him receiving inappropriate levels of healthcare.

Andy's claim of always using condoms was not a deliberate attempt to deceive his healthcare provider. Rather, these claims need to be considered within the context of the anticipated stigma of disclosing what has been described as an unhealthy or deviant behaviour (Wolitski and Fenton 2011). The anticipation of stigma or potential lecturing from healthcare workers has been documented as a significant barrier to HIV and STI testing (Datta et al. 2018), as well as the disclosure of behaviour that accurately reflects an individual's sexual experiences (Wolitski and Fenton, 2011). Similarly, the stigma associated with PrEP when it was first emerging as a prevention strategy proved to be a barrier to access, even when some individuals acknowledged engaging in condomless sex (Calabrese and Underhill 2015). This was particularly heightened for Andy who, compared to participants living in Australia, reported a more severe experience of PrEP stigma. Importantly for Andy, PrEP had facilitated the possibility of discussing bareback sex with healthcare professions without his feeling potentially judged. This led not only to more positive feelings about his own sexual health but also to him receiving higher levels of healthcare.

Unsafe sex as "ignorant" sex

As with definitions of safer sex and sexual health outlined so far, participants took an approach to sexual risk that was broader than HIV and STI prevention. Emphasising the importance of a sense of empowerment and agency, as well as an individual's relationship to their own sexuality, Josh (HIV advocate and PLHIV, 40s) stated,

> Risky sex to me is something that is ill-informed, unempowered, and safe sex is knowing sex. In that space, everything else kind of fits in … [It] is about being mature enough to understand where you're at, at any one time … Those that don't own their sexuality and embrace it and celebrate it are the ones that fear it and hide it and keep it in the shadows and make mistakes. I really think it's about being okay with yourself and in that space, you're free to go and find things out, and explore things, and do new things, and enjoy things. Without this dark shadow overlaying everything that you do and then afterward beating yourself up about it into a pulp and the mental fuck that goes with all of that.

Here, Josh considers risky sex as sex that is both "ill-informed" and "unempowered." In contrast, safer sex is defined as sex that is "knowing." While the sense of knowing that Josh refers to does incorporate an understanding of STIs and their transmission routes, his primary focus is on the importance of individuals being able to both embrace and celebrate their sexuality free of shame. As with Andy earlier, where positive experiences of one's sexuality were said to foster better relationships with healthcare providers, Josh too claims that such experiences underpin good sexual health.

Josh's claim around the importance of not just accepting, but also celebrating one's sexuality reflects the WHO definition of sexual health as underpinned by "physical, emotional, mental and social well-being" (WHO 2006, p.5). For Josh, risk is not necessarily about specific acts. Indeed, he actively promotes sexual experimentation as a fundamental component of sexual health. However, for him it is important that such experimentation be undertaken with a sense of agency and purpose, and without shame. Crucially for Josh, fostering an environment where people can celebrate and be proud of their sexuality lies at the heart of that experimentation and of good sexual health.

As a sexual health advocate and someone who had actively been working in the field of gay men's sexual health promotion, Josh's emphasis on being able to "celebrate" various expressions of sex and sexuality are unsurprising. While the removal of shame around sex is an important part of sexual health, care needs to be taken that such approaches do not prescribe a specific definition of sexual health whereby "owning" and "celebrating" sexuality become synonymous with overt and public displays of sex and sexuality. This is particularly important for those who might choose to not disclose their sexuality and who, because of this, might easily be classified as "hiding it" and "keeping it in the shadows". Just as fostering a sense of being proud of one's sex and sexuality is important, it nonetheless risks forming new hierarchies where only those loudly celebrating sex and sexuality are considered as embodying sexual health.

As with Josh, Brendan (PLHIV, 40s) also highlighted lack of agency as potentially leading to unsafe and risky forms of sex:

> I look at it as a more deep thing. Unsafe sex to me would be putting yourself in any situation where you're not comfortable, where there's no benefit to you. And I think a lot of people who are positive have done that to themselves … they've put themselves in situations and done things because they're not comfortable with or happy with [themselves], and there's no benefit to them. That's unsafe sex.

Here, Brendan takes an approach to unsafe sex that, while not excluding the prevention of HIV and STIs, emphasises a sense of agency and purpose, as well as engaging in sexual relationships in which there is some benefit to the individuals. Brendan's understanding of unsafe sex was drawn directly from his experiences in previous sexual and romantic relationships. In our interview, he described previous relationships with HIV-negative men in which, because of his own HIV-positive status, he felt somehow "less than" his partners. In these relationships, Brendan described doing

> everything possible in situations that I was uncomfortable, and not 100% willing to be in, to please [my partners] … I suppose by doing that, it meant that I could have somebody to love. Some closeness if I put myself at a lower level.

Brendan felt a heightened degree of responsibility to ensure his partners were protected against contracting HIV, such that he would only

> accept being a bottom for all those years, because that was the safer position for them – if they were a top.

Like many others living with HIV, Brendan experienced a heightened burden of responsibility in ensuring HIV partners were protected against HIV (Wolitski et al. 2003). This ultimately saw Brendan adopting the receptive role during sex as it posed less of a risk to his partners, in spite of that not always being his preferred role.

In addition to experiencing a heightened sense of responsibility for his partners' sexual health, Brendan had also internalised much of the stigma directed at those living with HIV:

> How was I supposed to not see myself as less as they were. And that was something I did to myself, or society did to me or stigma did to me or I'm not sure exactly. It took a lot of years for me to start to realise that no, it's not actually true and I was putting myself in bad relationships because that's the level I put myself in.

For Brendan, the internationalisation of this stigma lead to him finding himself in situations that he was not comfortable with. In these situations, it was not necessarily a potential increase for STI transmission. Rather, the internalisation of stigma and Brendan's low self-esteem had caused him to be in relationships that were detrimental to his mental health. While Brendan's experience had not necessarily increased risk from an epidemiological perspective, internalised stigma and low self-esteem do contribute to individual behaviours that can increase the risk of HIV and other STIs (see Bayer 1996). This emphasises the

importance of approaches to sexual health that not only encourage harm minimisation practices but, crucially, empower individuals to be able to make informed and conscious decisions around their sexual health.

Brendan's experiences were reflected in comments made by Mark (PrEP user, 30s) whose sense of low self-esteem had influenced decisions around sex and relationships that had put them[45] in potentially unsafe or dangerous situations:

> Up until four years ago I couldn't even say the word "deserve" in relation to and in the context of myself. I had been, up until then, pretty self-loathing and gotten myself into situations including risky bareback sex, violent intimate relationships, and abusive relationships with people. Because I was self-loathing. I saw myself to be, I guess, as part of the bottom of the barrel. That I didn't have a right to choose whatever was on offer to me … so that put me in situations where I'd compromise my values and what I really, really would want to do … It goes again to that relationship of trying to be more appeasing to other people – is that I think I am more attractive and have better luck in gaining sexual partners if I do whatever everyone else is doing, and doing what people want me to do. Which is to have bareback sex. I resent that, I don't like that, it makes me very sad.

Echoing Brendan, Mark described a sense of self-loathing and undeservedness that significantly impacted their own sense of agency in terms of their own sexual health. Because of this, Mark described compromising their own values and of finding themselves making decisions based on the desires of their partners and not their own. As Mark stated, this put them in potentially harmful situations, including bareback sex while not using PrEP, as well as physically violent and abusive relationships.

In contrast to other PrEP users, Mark had not experienced the same sense of empowerment through using PrEP. Before using PrEP, Mark described their non-use of condoms as being a significant issue of concern when engaging with healthcare workers. This would often result in a strong encouragement from healthcare workers that Mark address the reasons they did not use condoms. Importantly, while PrEP was a way for other users to experience condomless sex, Mark had hoped PrEP might provide some protection against HIV while they addressed their own relationship to, and use of, condoms. However, Mark found that having begun using PrEP, healthcare workers were largely unconcerned by their ongoing non-use of condoms. This was despite PrEP being promoted at the time as a strategy to be used *in conjunction* to condoms.

[45] Mark used the pronouns they/them.

On one level, it could be argued that the removal of HIV risk from Mark's experience of sex also removed medical understandings of their non-use of condoms as medically problematic. In doing so, however, the opportunity for health workers to engage more broadly with Mark's sexual health were potentially lost. As Mark expressed a desire to maintain or even increase their use of condoms, this lack of engagement by healthcare professionals over condom use can be considered as Mark not receiving the most appropriate health care. A more holistic approach to sexual health that goes beyond epidemiological concerns of disease prevention might be better suited to ensuring more appropriate levels of sexual health care. This approach would not only include a focus on the prevention of STIs, but also a focus on Mark's experience of sex itself.

A more holistic understanding of sexual health was acknowledged by PrEP and HIV researcher Alex who earlier in this chapter highlighted the benefit of PrEP as acting as a conduit for engaging young men with medical institutions. Reflecting on definitions of sexual health, she stated,

> Sexual health starts with your own attitudes to your body and your sexual needs. Without shame. Really coming to terms with your sexual fantasies and not being ashamed of them – that's not easy for many people. And then being – and this is not saying that I can live this way, this is just an ideal way – your sexual health sits very comfortably, very much in the centre of you with other key parts of your life: your general health. The fact that you're going to eat every day and you'll get fluids and food, a place to sleep. It is part of your core sense of identity. It doesn't mean that you have to be sexually active, but it is a sense of being unashamed of the sexual you, organically. So, your genitals … we have genitals and breasts and everything so, ideally, you're comfortable with them and have self-love … Sexual health means being able to be available to others … When we fall in love with somebody it's about discovery. So, sexual health, you should allow yourself to be discovered and be open to discovering others. And then there's the more, you can argue, plodding nature of it. Which, the plodding nature is being aware of maintaining the physical health – pap smears, sexual health checks if you need them.

Alex's conceptualisation of sexual health encompassed many of the points highlighted throughout this chapter. While the importance of physical health was acknowledged by Alex, sexual health could not be separated from one's overall health – both physical and mental. As imagined by Alex, this not only includes the attitudes and relationships toward oneself but, importantly, relationships with others. These relationships need not necessarily be sexual, as Alex noted. Rather, sexual health was premised on embracing and feeling comfortable with one's own body and sexuality such that, individuals have the confidence to choose to fully engage in discovering sexual relationships between themselves and their partners.

Conclusion

The prevention of STIs underpins dominant epidemiological understandings of, and approaches to, sexual healthcare. However, I argue that it is necessary for sexual health to be understood in broader terms. While PrEP offers a significant reduction in the potential for HIV transmission, some participants experienced it as more than simply a pill to prevent HIV. Rather, PrEP was said to provide a sense of empowerment, fostering healthy attitudes towards ones experience of sex and sexuality which, in turn, facilitated good relationships with healthcare systems. As noted throughout this chapter, the prevention of STIs is an important aspect of sexual health. However, participants also framed the fostering of positive attitudes toward sex and sexuality as an equally important aspect of sexual health.

Fostering approaches to sexual health in their broadest terms is essential and, while an epidemiological perspective is necessary, it is only one part. Within HIV prevention discourses, there has been a tendency to focus on potential negative outcomes and deficits such as the non-use of condoms (Herrick et al. 2011). As I have argued throughout this chapter, such approaches risk further alienating an already marginalised population, leading to a hesitance among some to seek out sexual healthcare (Wolitski and Fenton 2011). Herrick et al. (2011) argue that for the implementation of new sexual health strategies, a focus on positive aspects such as "resilience rather than deficits could improve both acceptability and efficacy." A shift in focus away from so-called risky sexual behaviours as sites of medical intervention might empower individuals to make more beneficial decisions around their own sexual health.

As I have demonstrated in this chapter, even as participants acknowledged the importance of preventing STIs, sexual health was conceived of as also including the potential to experience sexual pleasure and intimacy, a positive relationship to one's body and the bodies of sexual partners, interactions with healthcare providers that were free of judgement, and a sense of control and agency over one's own health. In contrast, a lack of these was believed to be detrimental to one's health and potentially lead to individuals making decisions which might see them in potentially harmful situations. This is not to suggest any one single approach

would work in all contexts – as the example of Mark and their problematic relationship to condoms demonstrated. Rather, it is about an approach whereby health workers can be sensitive to the beliefs, values, and desires of patients and, at the same time, foster relationships so that these can be expressed free of judgement.

Chapter 5 – Risk, Stigma, and Health: Shifting Discourses Surrounding PrEP

When I began fieldwork in 2017, PrEP was a relatively new and emerging HIV prevention strategy and discourses surrounding it were rapidly shifting and moving. At this time, PrEP was an exceptional object that was imbued with the potential to disrupt the role of condoms as the primary strategy to prevent HIV (Race 2016). Framed through discourses of risk, the emergence of PrEP carried with it the possibility of increasing STIs at both an individual and community level. This provoked a significant degree of concern among public health professionals and the broader public alike. At the same time, through the protection it offered against HIV, PrEP bore the prospect of significantly reducing anxieties surrounding HIV (Calabrese and Underhill 2015; Race 2016). Through this, it was suggested that PrEP could offer new possibilities for experiencing sex including increased sexual pleasure, heightened intimacy, and connection between partners. Simultaneously, PrEP advocates argued that PrEP could play an important role in addressing and eliminating HIV stigma.

As fieldwork was concluding in 2018, discourses around PrEP had shifted significantly and PrEP was increasingly becoming a rather *un*exceptional object. While PrEP's impact on the sexual landscape remained in a process of becoming, there had been a significant shift whereby PrEP was an increasingly accepted part of the sexual culture among gay men in Melbourne. PrEP had gone from a disruptive object to one that was an almost unthought of part of the sexual landscape. This was captured in an interaction I had with Rick (PrEP advocate and user, 50s) where I reflected on my own experiences beginning PrEP just after my fieldwork concluded. I commented to Rick that having experienced PrEP, I had gained a greater appreciation of my informants' experiences of sex while using PrEP. Rick responded, "it's been a few years for me on PrEP, but your enthusiasm brings back memories … You remind me why it's important to keep going with the PrEP rollout." Even with Rick's continued involvement in the promotion of and advocacy for PrEP, it had become an embedded part of his daily experience such that it went by almost unnoticed.

This chapter explores the shifting discourses surrounding PrEP and is divided into two distinct sections. In the first section, I explore the promise of PrEP to end HIV stigma. In

particular, I explore the ways in which PrEP was described as both raising an awareness of HIV stigma among PrEP users, as well as providing the space in which PrEP users could challenge their own negative attitudes toward HIV and PLHIV. Confronting HIV stigma was an important element of early PrEP advocacy. However, it was argued that this became less of a priority for later adopters of PrEP. The second part of this chapter explores a shift whereby PrEP was framed as a strategy to be used in conjunction with condoms to being characterised as a superior HIV prevention strategy. I highlight the emergence of so-called condom stigma, whereby the use of condoms was framed as somehow an inferior sexual health strategies to PrEP. These shifting discourses highlight the ongoing need to engage with how sexual health technologies are in a constant state of shaping and reshaping sexual cultures.

PrEP on Ending HIV Stigma

PrEP was commonly framed as having the potential to significantly reduce, or even eliminate, HIV stigma. Given PrEP's efficacy at preventing HIV and its potential to minimise HIV anxiety, PrEP was described as rendering the HIV status of sexual partners effectively irrelevant[46]. Rick, for example, stated "PrEP users forget about other people's HIV status … It's no longer relevant. It's a null stigma." At an address given to VAC in December 2016, chief investigator of the early *VicPrEP* and subsequent *PrEPx* study, Edwina Wright, alluded to the potential of PrEP to reduce HIV stigma:

> *One of the most remarkable things that we may see, and I think there is some early evidence of it now coming out anecdotally and also out of work from the* VicPrEP *study, is that through the widespread knowledge and use of PrEP, that we are seeing a decline in stigma from HIV negative MSM towards MSM living with HIV … So, we might be in a position to say that there is a pill for stigma (Wright 2016).*

The anecdotal evidence referred to by Wright was echoed in the experiences of Ethan (HIV advocate and PLHIV, 30s). Ethan reflected on his own experiences with his partner who was HIV-negative and using PrEP:

> We're definitely seeing [a decline in stigma happen]. This is purely anecdotal of my personal experience, but my partner is neg. He's on PrEP. All of his friends – most of them are all HIV-negative – they're all on PrEP. And their process in the last two years has been remarkable. My partner's really honest with me. He probably would have thought twice about jumping into bed with me. It would have at least made him stop and think for a moment and consider something. But that second thought barrier is now removed, so there isn't that kind of consideration. And it was only a few years ago that another ex-boyfriend of mine freaked out when I told him I borrowed his toothbrush, you know what I mean? There has been, in the last five years, a *massive* leap. So much to celebrate, so much to talk about.

[46] A more in-depth discussion of this appears in Chapter 6.

Ethan credited PrEP with removing any anxieties his partner might have had about having sex with Ethan because of their different HIV statuses. Through the removing of that hesitation, PrEP was said to make HIV almost irrelevant to Ethan's sexual and romantic relationship.

For some participants, use of PrEP was partly motivated by a desire to ameliorate their own negative attitudes and anxieties around HIV. Matt (PrEP advocate and user, 30s), commented:

> I'd already recognized that my behaviour was changing, and I'd already had the experience of engaging more with people that were living with HIV that were open about their status. Recognising my own fear around [HIV], my own lack of knowledge around that. My own internalised stigma about that as well. Little things like checking out a guy's profile on Scruff[47], going "oh you're hot," reading the details, finding out his status – HIV positive – and choosing just a swipe [left][48] … Things of that nature that came to my attention that, actually, that's not who I want to be. So, I'd already made the decision to change who I wanted to be at the time that PrEP was then suddenly in front of me. You can actually utilize this to manifest your behaviour change, and stay HIV negative, and remain true to your values and be compassionate towards people living with HIV.

For Matt, PrEP was more than simply a strategy through which he could prevent HIV infection. It also enabled Matt to rethink and re-evaluate his own attitudes toward HIV as well as those living with the virus. Immediately prior to beginning PrEP, Matt identified his own underlying prejudice against PLHIV as an attitude he wanted to change. Through taking PrEP, Matt was afforded a heightened sense of protection against HIV such that the HIV status of his sexual partners was no longer a concern.

Beginning PrEP in 2015, Matt was one of the so-called "early adopters" and "first wave" of PrEP users in Australia. This was a group whose use of PrEP was characterised as driven by a desire to reduce the risk of HIV infection while at the same time actively work toward eliminating HIV stigma. Reflecting on the work of this group of PrEP users, Ethan suggested that

> The first wave of PrEP activists, people really driving it … were, and remain, incredibly conscious of their part in the 35-year history of HIV/AIDS … and acknowledge the potential of PrEP to help bridge the sero-divide – with U=U[49].

[47] A geolocation dating and hook-up platform for MSM
[48] "Swipe left" is a slang phrase used to indicate romantic or sexual disinterest in a potential partner. It emerged through various dating and hook up smartphone applications, where users can swipe right or left to indicate their interest or disinterest in other users.
[49] Undetectable = Untransmissible.

PrEP and HIV advocates routinely described PrEP as one part of a broader project of HIV/AIDS activism. As a prevention technology used by HIV-negative MSM, PrEP was characterised as working alongside other advances in HIV prevention, such as Treatment as Prevention, to bridge the so-called "sero-divide". That is, these technologies were actively involved in closing a perceived gap between those who were HIV-negative and those where were HIV-positive.

Bridging the sero-divide (Persson *et al.* 2016) described above extended beyond the experience of sex itself, and the use of PrEP gave its users some insight into the broader experience of PLHIV, particularly around the experience of stigma and navigating health systems around HIV. In 2015 when Matt began using PrEP, there was a significant degree of stigma associated with PrEP use. There are significant differences in the experience of HIV stigma when compared with that of PrEP. For example, PrEP users can elect to stop taking medication, an effective cure for HIV remains elusive. While PrEP users have the opportunity to distance themselves from that stigma through their ceasing medication, PLHIV are unable to remove HIV from their experience of the world and interactions with others. Despite this, it was frequently suggested that PrEP users were given some understanding of the stigma PLHIV deal with on a day-to-day basis. Speaking about this Ethan stated,

> PrEP users talk about being shamed online for being on PrEP … [and] being discriminated against because they're on PrEP. Because they're being judged for being sexually promiscuous or something like that. It's like, "aww, tell me more. Tell me more about how they weren't nice to you on Scruff because you're on PrEP. That must be really difficult for you."

Given the tongue-in-cheek nature of the last part of Ethan's statement, and his own lived experience of HIV stigma, I asked him whether he felt a sense of satisfaction in hearing PrEP users' experiences of stigma. Laughing, he responded,

> Look, there is and there isn't. But it is great because it does balance things out, and we are seeing it happen. We're definitely seeing it happen.

Mirroring Ethan's comments were that of an attendee at a PrEP information event. Living with HIV himself, he commented that he perceived the stigma faced by PrEP users to be a positive aspect of PrEP. Importantly, neither of these statements were made out of a sense of bitterness or malice towards those using PrEP. Rather, these comments were said with the belief that, through these shared experiences of stigma, PrEP users might have a greater sense of empathy and understanding of the ways in which PLHIV navigate their worlds.

Through their use of antiretroviral therapies, PrEP users gained some understanding of the challenges associated with the daily use of HIV medications. As with PLHIV, this included routine engagement with healthcare systems and, in some instances, the potential challenges of travelling abroad with HIV medications. Commenting further on the shared experiences of PrEP users and PLHIV, Ethan stated,

> Here are these people that aren't afraid anymore. They know they're protected which does absolutely reduce fear and stigma of HIV because they've nothing to be afraid of. They also go through same-same but different experiences now. So, like us they've got to go to the doctor every few months. They've got to remember to take a pill every day. When they're going overseas travelling, they need to consider what they're doing and all that sort of stuff.

A concern regularly raised on social media was that of international travel, particularly given the complexity and changing nature of restrictions some countries place on the entry of HIV-positive travellers. Similarly, PrEP users were required to maintain a regular routine of HIV and STI screening, potentially placing their sex and sexuality under increased medical scrutiny.

While there were similarities between the experiences of PrEP users and PLHIV, Ethan was quick to highlight a significant difference between the two uses of antiretroviral therapies. Describing the context surround PrEP as "Disneyland", he contrasted it with HIV as a "socialist state." In this comparison, Ethan highlights the sense of fun and excitement associated with PrEP, of being able to engage sexually with significantly reduced anxiety over HIV. In contrast, the use of antiretrovirals to treat HIV is necessary to ensure the virus does not progress to the development of AIDS-defining conditions. In contrast to PrEP users who, in this project described their daily pill as a reminder of their sexual freedom, PLHIV have described their use of medications as a daily reminder of HIV (Race 2001).

Some participants had noticed a shift at a broader community level whereby HIV was becoming less of a concern. Thomas (PrEP user, 40s), for example, stated,

> [PrEP's] just made [HIV] more of a non-issue. Not only for me in the regard we talked about before. It's nice for it to be more of a non-issue in the community. Amongst my friends it just makes the atmosphere, I guess, nicer. To see that people aren't being worried about HIV anymore. In fact, I think it's a fair statement that I don't know anyone who is worried about HIV anymore while people used to be. So that's quite nice.

Thomas' primary partner was living with HIV and, importantly, he had never previously discriminated against sexual partners based on their HIV status. While Thomas had not

discriminated against PLHIV himself, he did notice a change in the social landscape whereby anxieties around HIV were decreasing. This shifting environment coincided with the emergence of PrEP. As Thomas noted, the effect of PrEP on stigma and anxiety around HIV was such that, where previously there were those in his social circles worried about HIV, that concern had largely evaporated.

When I began fieldwork, I was somewhat sceptical of PrEP's potential to deliver on the promise of ending HIV stigma, wondering instead if it might act as more of a temporary solution which failed to address many of the issues underpinning that stigma. I questioned, if PrEP were to stop working or a PrEP-resistant strain of HIV emerged, whether there might be a resurgence of HIV stigma. My concern reflected medicalisation critiques outlined in the previous chapter (Ecks 2005) as to the full extent to which a pill could act as a stigma-reducing strategy. I raised these concerns with Alex (PrEP advocate and researcher, not using PrEP) who responded,

> I think that stigma, it's like watching kids playing video games. And there's these sort of evil demon monster masters that keep growing a new limb and a new head and the kids have to earn or find a way to get all of these different sort of tools to kill it off. It could be a dagger, or a sword, or a ray gun, or hand to hand combat. And I think stigma is kind of like that. That you have to throw a lot at it. A lot of different things because it absolutely rejuvenates itself with every opportunity. And so, I guess, I think you're right, and it's right to be careful about how could a pill make a difference. I think it's not so much the pill in a sense, it's how many people are using it in a population, for how long are they using [it] … So, you've hundreds and hundreds of people – perhaps thousands – for several years on [PrEP] … and many opportunities during that time to rethink and reexperience. Rethink, reexperience and make changes in your behaviour about HIV and stigma … So, I think that it's not so much the pill. It's the use and durability of the pill. That's where the answer is.

Alex characterises PrEP as another tool in a battle against HIV stigma, a tool that offers HIV-negative individuals a sense of security while they are able to work through, rethink and reimagine their own relationships with, and concerns over, HIV. Moreover, Alex highlights the persistent nature of stigma that, without constant vigilance and attention, has the potential to re-emerge in new and various forms. Importantly for Alex, it is not solely the use of PrEP itself but, importantly, removing even a small element of anxiety that might then provide some space for individuals to, over time, explore their own attitudes to HIV and PLHIV.

Ethan emphasised the potential of PrEP to mask HIV stigma if PrEP users did not also go through a laborious process of addressing their own internalised HIV stigma and negative attitudes toward PLHIV:

> PrEP easily masks or even encourages a sero-phobic PrEP user who is so terrified of HIV and, by virtue of that HIV-positive people, that PrEP for them is a way to further enable that sero-phobia instead of dismantling it. It's a bit like saying you're doing radical self-care by having a bubble bath: if during that bubble bath you're not taking that moment to reflect on all the intersectional reasons why you require this bubble bath in the first place … it's just a fucking bubble bath. In that same way PrEP is not a form of radical self-care … *if* PrEP users aren't using it to dismantle their fear of HIV and AIDS.

The potential of PrEP to have little or no impact on HIV stigma was highlighted by Holt *et al.* (2018) who found that, despite the protection PrEP offered against HIV, some PrEP users remained reluctant or refused to have sexual relationships with PLHIV. Ethan went on to describe what he considered the "full experience" of PrEP. By this, he referred precisely to the process of reflection and dismantling of anxieties described here, whereby PrEP users are given the opportunity and space to rethink the significant impact of HIV on their own lives. This remains an important part of dismantling HIV stigma, much of which has been built up over more than 30 years and, as a result, is unlikely to be dismantled simply by introducing a new prevention technology.

Different PrEP Generations and Continuing HIV Stigma

Despite the protection offered by PrEP, some PrEP users remained cautious about engaging in sex with PLHIV. While it was not common, during my fieldwork I observed some dating profiles of PrEP users that specifically excluded PLHIV. Commenting on this, Tristan (PrEP advocate and user, 50s) stated,

> I attended the ASHM [Australian Society for HIV Medicine] Conference … and one or two other people presented information of responses from both negative guys on PrEP and the positive guys about questions relating to U=U. Asking negative guys, would you sleep with someone if you didn't know their status? Would you sleep with someone if you knew they were positive but undetectable? And all these questions. The answers were horrific. Ugh. It was mind-boggling that, you kind of think if someone's on a trial they'd sort of be enlightened. They'd know about these things. My heart sank.

Despite the best efforts of early PrEP advocates, there was a sub-group of PrEP users whose anxiety over HIV led them to actively exclude PLHIV as potential sex partners (Keen et al. 2017). This was reflected in the attitudes of John (PrEP user, 50s) who, when asked if PrEP had made him more or less likely to have sex with someone who was HIV-positive, responded,

> If I know that person has HIV would I sleep with him? Gosh. I know it's bad, I [would] still say probably not. But I'd think carefully because there's undetectable – it's actually safe. But I won't do bareback even though I'm on PrEP. I don't know why, it's stupid … I think if they're hot enough that's probably one factor. If they're hot enough and I'm desperate enough, I will sleep with him with a condom.

For PrEP advocates such as Tristan, John's comment here would likely have been disheartening, particularly his suggestion that he would only have sex with someone who was

HIV-positive if they were "hot enough" and he were "desperate enough." The potential impact of statements like these on PLHIV cannot not be minimised. At the same time, it is important to recognise that John understands the science behind both PrEP and U=U and that both do offer protection against HIV and can be considered "safe". The example of John here highlights the limits of PrEP in-and-of-itself as a strategy that might end HIV stigma. As Ethan notes above, PrEP use accompanied by a reflection on one's own attitudes, relationships, and internalised stigma around HIV and those living with the virus creates opportunities for stigma reduction.

As PrEP use became more mainstream and more MSM began using PrEP, the role of HIV activism became less central to the PrEP experience. Matt described a conflict he observed on social media between a small group of early PrEP adopters and others who began using PrEP at a later stage:

> I started noticing that the innovators and the early adopters who were very gung-ho about, "this is personal responsibility and I'm taking a stand on [stigma] and doing super activism type stuff." Some of those guys were then a little uncomfortable when the later groups came on board and the later groups were going, "yeah, I just want to do it. I want to fuck bareback." And that was then [interesting] because the earlier groups – the innovators and early adopters – said … "You shouldn't be doing PrEP because that's not the right reason. My reasons are virtuous and true and pure and, aren't I amazing. Whereas your reasons are outrageous and not okay. So, therefore, that's not appropriate for you to do that." So, we have two groups of people, both taking PrEP for different reasons, criticizing each other.

Among those sceptical of and/or against PrEP, there were some circumstances in which they considered PrEP use acceptable. For example, some argued PrEP was an important tool for sero-discordant, monogamous couples to be able to forgo the use of condoms more safely and, through doing so, experience heightened sexual intimacy. In this way, appropriate use of PrEP was underpinned by a specific moral and ideological position. Similarly, as described by Matt, there were certain contexts in which PrEP use was deemed unacceptable even among PrEP users themselves (see also Holt *et al.* 2019). Where PrEP use was primarily motivated by seemingly individualistic and selfish reasons, such as a desire for bareback sex, it was deemed inappropriate. In contrast, the use of PrEP to contribute to an overall project of HIV/AIDS activism was considered as an acceptable reason to use it. Thus, even among PrEP users themselves, there was a degree of surveillance over sexual behaviours such that the "good" and "bad" PrEP user were constructed.

Matt was quick to establish his view that an individual's motivation for using PrEP, whether to engage in HIV advocacy or simply to have condomless sex, was largely irrelevant. He argued,

> Do you know what? It doesn't fucking matter. None of this matters. You're all the same, none of you are special ... You're both taking PrEP, you're both not getting HIV. It doesn't matter what moralistic arguments you want to put around why and what for, and why that's an amazing fit for each of you. It doesn't matter, you're both the same.

What was most important for Matt was that, through using PrEP, the risk of HIV transmission was reduced at both the individual and community levels. This is not to suggest that Matt would have preferred that all those taking PrEP would also engage in activism around ending HIV stigma. However, Matt's greater goal was to facilitate access to PrEP for all those who might benefit from it.

Countering constructions of the PrEP user as irresponsible

Condom Stigma

Throughout my fieldwork, I became increasingly aware of a growing cohort of PrEP users who exclusively sought bareback sex and, at the same time, rejected sexual partners whose preference was to use condoms. This first came to my attention through several short conversations with users of digital hook-up platforms. Having seen my profile and research interests, these users shared their own stories of what they described as "condom stigma". They suggested that as anxieties over contracting HIV were declining among PrEP users, there was an associated increase in the desire for, and expectation of, bareback sex. As my time in the field progressed, and with an awareness of this phenomenon, I continued to hear anecdotes of individuals being rejected sexually due to their preference for condoms. Among a subset of this group, some individuals claimed that they had felt pressured into engaging in bareback sex.

Commenting on the extent to which PrEP users pressured or coerced others into bareback sex is beyond the scope of this project. Importantly, the accounts of those who described experiencing condom stigma are at odds with the public representation put forward by PrEP users on social media. In these spaces, there was an overarching attitude of needing to respect an individual's chosen approach to sexual health, whether that be condoms, PrEP, or Treatment as Prevention. In interviews, however, PrEP users regularly described having a

strong preference for condomless anal sex. Without prompting, Matt commented on this phenomenon in an interview:

> From a behaviours point of view, one of the things that I do see that I am concerned with is the pressure and culture now of condomless sex. Which [is] great, fantastic. We've got a community with significantly reducing anxiety. But one of the shifts that I've seen is almost this pressuring of "well I'm so disinterested in condoms now I'm not going to have sex with somebody who chooses to use condoms." Sure, great – limit your options if you want to. However, that's then concerning for somebody else who does want to use condoms but isn't comfortable negotiating or advocating for themselves to do so, because then they're in a situation of risk.

The reduced anxiety over HIV was, for Matt, an aspect of increased PrEP usage that ought to be celebrated. At the same time, however, he was highly cognisant of the potential power imbalances that can influence the negotiation of sexual health strategies including PrEP (Braksmajer et al. 2019). From an epidemiological perspective, condomless anal sex where one partner is using PrEP can be considered as low risk of HIV transmission. However, as I argued in the previous chapter, this ignores the importance of empowering individuals to be able to make decisions around their sexual health free of coercion.

Among participants, it was routinely stated that if a partner wished to use condoms during sex, that decision would be respected and condoms would be used. Indeed, it was widely felt that relying on another individual's stated PrEP use was not an effective prevention strategy as a user's adherence could never be guaranteed. Where most participants indicated that they would use condoms if requested, PrEP user Rick stood out as a notable exception:

> You know, condoms suck. I mean, they're uncomfortable to use. If someone asks me to use one, I'll go, "let's do something else. Let's do other fun."

From Rick's comment, it can be extrapolated that a request for condoms did not necessarily result in an end to the sexual encounter itself and Rick might engage in other forms of sexual activity with his partners. Rick did not consider his refusal to use condoms as a form of stigma against those using condoms. Rather he saw it as a personal preference for a particular experience of sex. Nonetheless, this raises important questions around the extent to which, within a limited pool of sexual partners, this might result in feeling a degree of pressure to begin using PrEP.

While there was an overarching attitude among PrEP advocates of the need to respect individual choice regarding safer sex strategies, some believed that a growing social pressure

to use PrEP was not necessarily a negative aspect of widespread PrEP use. Conscious of the growing number of MSM exclusively seeking bareback sex, I asked Josh (HIV advocate and PLHIV, 40s) whether PrEP might replace condoms in terms of the social and moral expectation that all MSM use it. He responded,

> God, I hope so. Because all of those that say they don't need it are most likely the ones that need it urgently … For every person that I've ever met that has said, "oh, there is no way I would need something like that", six, twelve, eighteen months later? Turns out they would have benefited from that.

Here, Josh highlights the importance of destigmatising PrEP as an HIV prevention strategy, particularly given this stigma can and does act as a significant barrier to PrEP uptake (Biello et al. 2017; Cahill et al. 2017; Calabrese and Underhill 2015; Golub et al. 2013). This stigma has led some MSM to conclude that for them, PrEP is an unsuitable HIV prevention strategy despite their sometimes engaging in condomless anal sex (Biello et al. 2017; Spieldenner 2016). It is this potential that underpins Josh's belief and desire that discourses around PrEP shift so that its non-use becomes the exception.

PrEP: Better than a condom

In August 2019, a guerrilla poster campaign by activist group *See it Clearly 2020* appeared in Melbourne's inner city and, in large bold font across the poster's top was written, "PrEP: Better than a condom". Using data from the CDC, the poster compared PrEP and condoms as HIV prevention strategies, claiming that where PrEP offers a 99% HIV risk reduction, condoms only provide 72-91%. While the poster did not cause nearly the same levels of controversy as the 2015 Fuck Raw posters discussed in Chapter 2, they did attract pointed criticism from members of the PrEP advocacy groups. Some criticised the posters for falsely representing the statistics, stating that the CDC point out the statistics on condoms are based on self-reported use. Given this, it was said that the *effectiveness* of condoms was likely to be much higher. Similarly, others pointed out that the CDC also included statistics on treatment as prevention in their comparison of HIV prevention strategies, a prevention strategy that the poster did not include.

The most significant criticism of the posters was over what was perceived as putting condoms and PrEP in direct competition. Given the statement "better than a condom", this was not an unfair conclusion. In defending the posters, however, it was stated that they were merely presenting information and, based on that, individuals could draw their own conclusions. The

following interaction between two group members, one critiquing and one defending the posters, highlights these stances:

> P1: I would prefer you (a) not use an incorrect statistics about condom efficacy and (b) not dishonestly present this as an either/or question. You can promote PrEP without discouraging the most effective method of preventing other STIs.
>
> P2: You mean hide the fact from people. That data comes from the CDC page … People can still use condoms if they wish. This data is just making that choice an informed one …
>
> … P1: You can just say that PrEP is 99% effective and simple and easy and cheap and the message will be just as powerful. There is no need to combine it with messaging to discourage condom use.

While for some the posters were interpreted as discouraging condom use, others argued that they were merely presenting scientific data to aid others in their decision making. On the one hand, P1 is correct in their assertion that the posters make a claim as to PrEP being a superior form of HIV prevention than condoms. This was made explicit in the contrasting of PrEP as "better than" a condom. On the other hand, P1 also describes condoms as the "most effective method" in the prevention of STIs, a similarly comparative statement. As discussed in the Chapter 3, claims such as these fail to account for the complex social and sexual contexts in which individuals interact. That is, while such claims might hold true in ideal clinical trial conditions, they fail to reflect how interventions are experienced outside of trial contexts.

Claims of PrEP as a scientifically superior HIV prevention strategy conflate efficacy with effectiveness. While efficacy describes the effect of a specific intervention in ideal settings, effectiveness describes the extent to which an intervention works in real-world settings. As Susan Kippax and Niamh Stephenson (2016) argue, it does not necessarily follow that the efficacy of an intervention will result in its effectiveness outside of clinical trials. Significantly, the figures quoted above compare PrEP's efficacy, based on randomised control trials, with the effectiveness of condoms as based on self-reported use in real-world settings. Moreover, the data presented demonstrating PrEP's efficacy is drawn from trial participants with detectable drug levels, ignoring those who might not adhere to a daily drug regimen. While the landmark *iPrEx* trial found PrEP to provide a relative risk reduction of 92% for those with detectable drug levels, the overall risk reduction, including those not adhering to the daily regime, was only 46% (Grant et al. 2010).

The statistics from the poster discussed above were cited repeatedly throughout my fieldwork. In social media discussions, interviews, and at various information sessions,

advocates for PrEP often claimed that where condoms were only 70% effective, PrEP was up to 92% effective. This comparison was distilled in the comments of PrEP researcher Alex who, addressing criticisms of a potential decline in condom use associated with PrEP stated,

> I think arguments [and] counter-arguments to comments like that, you just try and go use the science as much as you can. If you look at the science, in prospective studies in America in men who have sex with men, who are at very high risk of acquiring HIV, and who reported consistent condom use, in their hands, consistent condom use only reduced HIV transmission 70% … So where's the argument? Use both if you want to, if you're super nervous or just feel safer – and a lot of people do use condoms and PrEP. But sorry, your argument's flawed … I think people are genuinely surprised when they find condoms just don't pass muster if you compare it to PrEP.

As PrEP was emerging, statistics such as these were particularly important for PrEP advocates as there was considerable doubt within the broader community over the efficacy and effectiveness of PrEP as an HIV prevention strategy. Alex later reflected on the authority of more positivist approaches to science asserting,

> To be fair, science cuts through that by turning up and going, "hey sorry. Bad luck. Treatment as Prevention works, PrEP works." Whether you're white, wealthy, whatever. Doesn't matter what you think because here are the facts … I guess that's the beauty of something like science. That it can just demand attention. It gives communities power to say "look at all this research. Start putting it out there. Start telling people".

With an apparent grounding in so-called objective fact, positivist science does have the potential to be a useful tool with which communities can, and do, demand attention from powerful institutions such as those of government and medicine. It is important to note, however, that the figures used in the posters and by Alex were based on data that have since been superseded. For example, Johnson *et al.* (2018) later found condoms to be 91% effective at preventing HIV. The figures used by Alex, however, suggest condoms as being less effective at preventing HIV when compared with PrEP. While the use of the 70% effectiveness has been a useful strategy to promote PrEP, it does rely on data that has since been superseded. Moreover, it sets up a polarised competition in between PrEP and condoms, a competition in which condoms are characterised as an inferior HIV prevention strategy. While this might be an effective strategy to promote the use of PrEP, it risks doing precisely what many HIV and PrEP advocates have fought against. That is, disempowering and/or delegitimising the sexual health decisions of individuals.

In the context of PrEP use in Australia, advocates utilised scientific data to argue the efficacy of PrEP, claiming that regardless of social, economic, or political context, PrEP can be a powerful HIV prevention tool. While this claim is correct according to the studies, it remains necessary for social analysis of how new interventions are received by communities. Even at

the end of my fieldwork, PrEP was primarily used by MSM closely connected to gay male communities. PrEP use among Indigenous and culturally and linguistically diverse populations, who might also benefit from it, remained low. Therefore, positivist scientific approaches to new and emerging health interventions must also be accompanied by research exploring the social, economic, and/or political contexts, all of which might present barriers to PrEP effectiveness (Kippax and Stephenson 2016).

HIV technologies

As a new application of a medical technology, PrEP is an active agent that has shaped and reshaped the social worlds through which individuals move and, as it does so, produces new forms of personhood. Throughout the HIV/AIDS epidemic, new technologies have emerged to test and treat the virus, generating new subjectivities (Hughes et al. 2018; Lloyd 2018; Race 2016, 2001). In the earliest years of the HIV/AIDS epidemic in the United States, risk was associated with particular categories of person as opposed to specific behaviours and/or medical needs. As such, groups such as gay men, intravenous drug users, haemophiliacs and certain cultural and ethnic groups were considered at risk (Patton 1990; Treichler 1987). Paul Flowers (2001) argues that the advent of the HIV antibody test in 1984 saw the formation of new identities based around HIV serostatus. Where once gay men *as a collective* were considered at risk by virtue of their sexual identity, the antibody test divided this group into individuals who were either HIV-negative or HIV-positive. In doing so, MSM were stratified into those *at risk* and those who *posed a risk*. Similarly, albeit some decades later, Jonathan Banda (2015) considers the impact of rapid home-testing for HIV in the formation of new experiences of personhood, suggesting that while MSM have been epidemiologically identified as a risk group,

> *the most 'risky' bodies now are those who have not been tested, those who have not fulfilled their duties as biological citizens in actively monitoring their status. These subjects comprise a specific category of biocitizens: the 'untested bodies' (p.35).*

Importantly, Banda highlights the social and moral expectations that are associated with biological citizenship (see also Clarke et al., 2003). That is, within MSM communities, HIV testing has come to be seen as an important part of individual healthcare and an obligation one holds to the broader community. This was certainly so among those I observed, where the three-monthly obligatory testing associated with PrEP was considered an important and useful way to engage MSM in regular HIV and STI testing.

Just as scholars have demonstrated the potential for HIV testing to produce new forms of subjectivity around sero-status, others have argued that the use of antiretrovirals by those living with HIV functions in a similar way. Karen Lloyd (2018, p.488) argues,

> *The transformation of the self through the consumption of antiretrovirals in order to achieve a particular biomedical state, 'virally suppressed', is productive not only of emergent identities and social categories, but also new expectations for the performances of biomedical engagement, the very modes of subjectification, that bring into being those identities.*

Here, antiretrovirals work within the body to suppress HIV to potentially undetectable levels. In doing so, PLHIV are offered protection against the development of HIV into AIDS, and also embody the identity of the undetectable HIV-positive body. Given the scientific consensus surrounding Treatment as Prevention, attaining an undetectable viral load was seen by many living with HIV as particularly desirable. Not only does this provide an indication of their own health but, more significantly, an undetectable viral load has the potential to reframe the HIV-positive body. Where an HIV-positive status once signified a potential threat, it can now be argued *scientifically* that it is not a threat.

Asha Persson et al. (2016) argue that just as new HIV treatment technologies have the potential to reduce the stigma of some bodies, they might also function to further stigmatise others. That is, while an undetectable status might reduce the stigma associated with an HIV-positive serostatus, there is a risk of the further stigmatisation of those who refuse or delay treatment (Lloyd 2018; Persson 2016). Prior to the scientific consensus over Treatment as Prevention, the use of antiretrovirals was largely seen as a moral obligation one had to one's own health (Race 2001). With the dramatic shift in how HIV risk is understood with Treatment as Prevention, however, the use of antiretrovirals to obtain an undetectable viral load is reframed as *both* an important measure of self-care, as well as a moral obligation toward the broader community. Race (2001, p.168) argues medical truths have the potential

> *to generate highly moralistic emotions, imbued with notions of responsibility and blame, and bearing the potential to mark or single out particular actors as loci of responsibility.*

Just as biomedical technologies have the potential to produce new forms of personhood and, in doing so, reduce the stigma previously associated with certain bodies, it is necessary to be aware of how these same technologies might function to further marginalise others.

The use of medical technologies such as antiretrovirals are not neutral and establish new sexual hierarchies underpinned by one's compliance with medical regimes. While this burden was not experienced by participants, as demonstrated in the previous chapter PrEP users did claim a position of sexual responsibility through their use of PrEP and submitting to medical surveillance through HIV and STI screening. Recalling Rubin's (2011c) theorising of sexual hierarchies[50], rather than ending stigma biomedical technologies such as PrEP might instead displace it onto other bodies. In being considered a superior prevention technology to condoms, the PrEP user who engages in condomless sex might become viewed as taking better care of their sexual health and, in turn, considered a morally superior sexual citizen.

Conclusion

Just as prior technologies have produced new subjectivities in relation to HIV, PrEP too has been accompanied by the production of what Matinez-Lacabe (2019) describes as "the non-positive antiretroviral gay body." That is, the production of HIV-negative individuals who, like those living with HIV, use antiretroviral medications to manage their own HIV status. As PrEP was first emerging, it was often said that the use of PrEP provided HIV-negative individuals some insight into the lived experience of those living with HIV. In addition to adhering to a daily regime of antiretroviral medication, PrEP users also experienced moral judgements made about what was perceived as their inability or unwillingness to use condoms. This was exemplified in the term "Truvada Whore", a term used disparagingly to portray PrEP users as promiscuous (Calabrese and Underhill 2015; Race 2016). Despite this, PrEP advocates embraced this term, reclaiming it in an act of reappropriation reminiscent of earlier reclamations of 'queer' by queer activists.

The production of new HIV subjectivities has been accompanied by new forms of social and moral obligation and, as demonstrated in the case studies above, PrEP too has been framed as a superior form of HIV prevention. Whether intentionally attempting to discourage the use of condoms over PrEP or not, the "Better than a Condom" poster campaign explicitly states that PrEP is better than condoms. Importantly, claims of PrEP's superiority are grounded in so-

[50] This is discussed in more detail in Chapter 2.

called scientific fact and data from highly influential medical institutions such as the CDC. With its grounding in positivistic thought, this data gives the impression of an underlying, objective truth and, in doing so, holds a significant degree of authority. Through this authority, scientific thought has the potential to not only produce various categories of person, but also generate the moral and social landscapes in which these categories are positioned.

The CDC data used by PrEP advocates to compare the efficacy of PrEP versus condoms makes a comparison between the optimal use of PrEP in clinical trial settings with the self-reported use of condoms. Based on this and given the potential for self-reporting to misrepresent actual use, the CDC claim that the efficacy of condoms is likely to be significantly higher. Through their use of scientific data, PrEP advocates are engaging in a form of truth-making, where PrEP is represented as *the* superior form of HIV prevention. Given the timing of my fieldwork, a period in which PrEP use was first emerging in Australia and had yet to become mainstream, the landscape sketched above must be read as part of an ongoing process of the biomedicalisation of HIV management. The broader impact of PrEP among MSM in Melbourne had not settled throughout my time in the field and, as newer HIV technologies emerge, it is likely the sexual landscape in this context will remain in a state of constant flux. Given this, it remains necessary that research engages not only with those who take up these technologies, but also focus on what these technologies *do* at the broader social level.

The case studies presented above suggest that, as with other HIV testing and treatment technologies, PrEP is re-shaping the sexual landscapes through which MSM move. As discussed throughout this thesis, the emergence of PrEP was accompanied by a significant degree of stigma, predicated on the potential of PrEP to increase incidences of bareback sex. Moreover, as early research on attitudes toward PrEP has shown, PrEP users faced potential sexual rejection upon disclosure of their PrEP use (Biello et al. 2017). However, a notable shift occurred in the sexual landscape whereby those who preferred condoms began to face rejection due to their sexual health strategy. As PrEP use becomes increasingly widespread and condomless anal sex a standard, unremarkable aspect of the sexual landscape among

MSM, it will be necessary for PrEP research to broaden its focus to include the impact of PrEP on those *not* using it.

Chapter 6 – Liberation from HIV: Displacing HIV from the Experience of Sex

Introduction

PrEP was regularly characterised by advocates as having the potential to liberate gay men from an almost ever-present, overarching fear of HIV. While the concern of HIV was present in sexual relations through the use of condoms, these concerns were also said to permeate into everyday life. This was a backdrop against which MSM navigated their social worlds, an ever-present threat that had to be guarded against (Dowsett 2009). The fear of HIV was said to exist regardless of whether condoms where consistently used or not. Given the efficacy of PrEP at preventing HIV, advocates claimed that PrEP could offer users a sense of freedom from anxiety that they had not previously experienced due to the potential threat of HIV.

This chapter begins by discussing the impact of HIV on the lives of research participants. Drawing on the notion of *habitus* (Bourdieu 1977; Crossley 2013; Mauss 1973), I argue that HIV can be thought of as shaping the behavioural norms of individuals and communities, particularly norms around condom-based safer sex strategies. In addition to influencing these norms, I suggest that even as new treatments have made HIV a potentially long-term and manageable condition, the association of HIV as a potentially fatal virus continues to be felt. From the first reports of HIV/AIDS, there has been a strong association between the virus and gay men in countries such as Australia (Patton 1990). While the focus on MSM as a target population has been necessary and important, it has also been a backdrop against which both sexuality and sociality have been experienced. I argue that HIV has been present as potential risk within the sexual encounter, has played an important role in gay community organisation, and exists in the form of safer sex messaging in the social spaces MSM gather.

While PrEP advocates routinely framed PrEP as liberating, PrEP does not fully remove HIV from an individual's broader experience of the world. As Mark (PrEP user, 30s) reminded me, the use of PrEP is predicated on an acknowledgement of one's HIV risk or, at the very least, a desire to participate in expressions of sexuality that increase that risk (see also Race 2016). I argue, however, that PrEP displaces the act of HIV prevention and, therefore risk

from the sexual encounter itself. Through the daily use of PrEP, HIV is instead incorporated into one's daily routine. In doing so, associations between sex and HIV are disrupted offering new possibilities of experiencing sex and sexuality.

Just as PrEP shifts the act of prevention itself from the sexual experience, so too did participants describe PrEP as removing the relevance of their partners' HIV status. Aware of their own PrEP use, participants reported feeling confident as to their being protected against HIV. This effectively eliminated the need for any discussion around HIV status and the negotiation of safer sex strategies. While this did not necessarily foreclose these discussions, these conversations were generally only had if instigated by sexual partners. Through this, associations of one's partner as sites of potential risk were disrupted, offering new opportunities for sexual connection and intimacy.

HIV and habitus

Andy (PrEP advocate and user, 40s) spoke about his own experiences of growing up in the United States during the HIV/AIDS crisis and of his coming to terms with his sexuality. Having worked in sexual health promotion and HIV advocacy, Andy was well connected to gay communities and had spent a considerable number of years promoting condom-based HIV prevention. At the time of his 40th birthday in the early years of the 2010s, he ended a long-term relationship and found himself once again enjoying sex with casual partners. Despite his previous work in HIV prevention and sexual health, Andy was not using condoms in every sexual encounter and, in the absence of PrEP, described himself as

> having a lot of what in therapy [is called] cognitive dissonance. About the fact that I was enjoying [condomless sex] so much but was so terrified of [HIV]. And saying to myself, "come on, you know better!" And I thought, "I'm 40 years old. My entire life has been dominated by AIDS and HIV. Will there ever be a day of my life where it's not dominated by AIDS and HIV?" And I thought, "well, yeah, once you become positive you don't have to worry about getting HIV anymore." And I was like, wow … That's probably the only way I'm ever going to have the kind of sex I want to have, and not be afraid afterward.

Despite not living with HIV himself, Andy describes it as having dominated his life. Such was the extent to which his concern over HIV dominated his life that he considered becoming HIV-positive as the only way to alleviate his fear of contracting the virus. While contracting HIV would certainly bring with it significant challenges, it would also provide Andy with a degree of certainty over his status (see also Gauthier and Forsyth 1999). Through contracting

HIV, Andy would no longer need to protect and guard his HIV-negative status, a status always at risk, and could instead manage his HIV-positive status.

Andy later went on to speak about the impact of HIV on his life more broadly:

> I became aware, or conscious, of my attraction to men in 1984 or 85. Right when AIDS was hitting the media and Rock Hudson – an actor in the US – was being exploited by the media. I understand more now about development, and your brain starts to function a certain way. That [becomes] deeply embedded. So, my brain automatically associated sexual desire with tragic, painful death at a very early age. That dominated my life for so long.

Andy describes becoming aware of his attraction to other men in his early teens, a time that coincided with the death of actor Rock Hudson. Hudson's death was said have catapulted HIV/AIDS into the mainstream consciousness of the United States (France 2017; Treichler 1987). In media reporting at this time, there was a strong emphasis on HIV/AIDS as associated with what were considered unnatural and deviant lifestyles, particularly homosexuality and injecting drug use (Patton 1990; Treichler 1999). While some commentators were more neutral in their reports of MSM as an affected group, others employed rhetoric framing the then-painful death associated with HIV/AIDS as a form of divine retribution, a form of punishment for living what were considered deviant lifestyles (Treichler 1987). For example, homosexuality was described by some in the United States as a "manifestation of a depraved nature" (France 2017, p.319) and homosexuals were blamed for "inflicting AIDS not only on one another but on 'innocent victims' as well" (ibid. p.319). It was against this backdrop that Andy's awareness of his own sexuality emerged, and his sexual identity was formed. Andy's experience in the United States is also reflected in early discourses surrounding HIV/AIDS in Australia. In response to concerns over the potential for HIV-positive blood to appear in Australian blood banks, then-Queensland Premier Joh Bjelke-Petersen characterised gay men as "insulting evil animals" (Robinson 2010, p.37).

Andy's association of sexual desire with HIV/AIDS and a tragic, painful death can be usefully thought of in terms of Bourdieu's (1977, pp.78-79) conceptualisation of *habitus*. For Bourdieu, *habitus* is an almost unreflected on and automatic practice, the history of which is so forgotten and taken for granted that it is seen as natural. Bourdieu (p.79) claims that "habitus is the universalizing mediation which causes an individual agent's practices, without either explicit reason or signifying intent, to be none the less 'sensible' and 'reasonable'"

(ibid. p.79). Similarly, Mauss (1973) describes *habitus* as aspects of culture that are expressed through the everyday and mundane daily habits and actions, actions often thought of as taken-for granted and of "going without saying." As Nick Crossley (2013, p.139) argues, however, this "in no way precludes intelligence, understanding, strategy or knowledge on the part of the actor." Rather, *habitus* can be thought of as a set of skills that, once learnt become so ingrained that they are almost instinctively employed and taken-for-granted.

The uptake of condom-based HIV harm reduction among gay men has been described as "a process of sexual reskilling" (Scott and Freeman 1995, p.161). When Andy became aware of his attraction to men in the mid-1980s, a time in which effective treatments for HIV remained elusive, a diagnosis of HIV/AIDS was almost akin to that of a terminal illness. Given this, prevention through the use of condoms became a strategy whereby MSM could continue to have sexual relationships while, at the same time, prevent an often-fatal condition (Race 2001). Such was the extent to which condoms became part of the sexual culture among gay men that they were an almost taken-for-granted part of the sexual experience. This is not to say that they were so taken-for-granted that their use in every sexual encounter – casual, anonymous, or otherwise – was guaranteed. For self-described sexual health "educator", the promotion of condoms was a key part of Andy's professional role such that, as he states, he knew better than to *not* use condoms during sex. In contrast to his professional role, however, Andy did not always use condoms, even during casual sex which might otherwise be epidemiologically defined as high risk. For Andy, this was experienced as "cognitive dissonance" and of "knowing better". In this way, the incorporation of condoms into an already-existing culture became so complete that it was their *non*-use, as opposed to their use, that came to be interpreted as exceptional.

Drawing on Bourdieu, Adam Green (2014 p.12) proposes a theory of "sexual fields" in which "field, capital and habitus are brought together to frame action as a form of 'practice.'" Green (ibid. p.12) argues that "a field is a socially structured arena composed of situated agents, institutionalized practices, and an overarching logic or regulative principle." Andy's awareness of his own sexual desire can be described as developing within a field whereby, due to the risk of HIV/AIDS, condom use had become an institutionalised practice. This saw

the use of condoms go beyond public health concerns and condom use was a measure by which an individual's social and moral standing was measured (Auerbach and Hoppe 2015; Mowlabocus et al. 2014; Weeks 1995).

Given Andy developed an awareness of his sexuality as HIV/AIDS was devastating many gay communities, it is unsurprising that he associated sex between men with a potentially life-threatening condition. It is noteworthy, however, that even as advances in HIV treatments have rendered HIV a manageable (albeit lifelong) condition for those with access to effective treatment, the virus has continued to be imbued with a significant degree of stigma (Race 2012). Despite the markedly different health outcomes for those with access to treatment when compared to the earliest years of the known HIV epidemic, the social and moral imperative to continue using condoms remained (Race 2016). In his articulation of habitus, Crossley (2001, p.83) states,

> *an agent's habitus [is] an active residue or sediment of his [sic] past that functions within his present, shaping his perception, thought, and action and thereby molding [sic] social practice in a regular way. It consists in dispositions, schemas, forms of know-how and competence, all of which function below the threshold of consciousness.*

Even as advances in treatment and prevention strategies have been made, the recent history of HIV/AIDS, and its association with "tragic, painful death" continued to be felt by Andy in the present prior to his using PrEP.

The Legacy of the Grim Reaper

The Australian Grim Reaper HIV awareness campaign was continually commented on in interviews, on social media, and at numerous community events. Airing on Australian television in 1987, this campaign was the first large-scale campaign in Australian raising awareness of HIV/AIDS, as well as the first to suggest heterosexuals might also be at risk (Vitellone, 2001; Power, 2011). The minute-long advertisement began with 10 men, women, and children representing bowling pins being lowered into a bowling alley. The camera cuts to a close-up of the face of the Grim Reaper who breathes heavily as if they were a ferocious beast about to kill their prey. In an urgent tone meant to elicit panic, a voiceover states,

> *At first only gays and IV drug users were being killed by AIDS. But now we know every one of us could be devastated by it. The fact is, over 50,000 men, women, and children now carry the AIDS virus. That in three years nearly 2,000 of us will be dead. And if not stopped, it could kill more Australians than*

> *World War II. But AIDS can be stopped, and you can help stop it. If you have sex, have just one safe partner. Or always use condoms. Always (Power 2012).*

As the voiceover speaks, the Grim Reaper bowls a ball symbolising HIV/AIDS toward the ten human pins indiscriminately knocking all within its path down. This continues until all individuals are lying on the ground dead.

The Grim Reaper campaign "ignited a flurry of media and public hysteria" and was ultimately taken off the air after only three weeks (Power 2011, p.69). Despite this short run, the campaign could be vividly remembered 30 years later. Thomas, (PrEP user, 40s), for example, recalled,

> I was chatting with some mates not that long ago about when the Grim Reaper ads came out … [and] someone said, "do you realise that those ads were only around for a week or a month?" I can remember seeing it on TV. I can literally remember seeing it on TV … I can't remember anything from my childhood.

At the time of the campaign Thomas was approximately 10 years old and, despite his claim of remembering almost nothing from his childhood, the memory of the Grim Reaper advertisement remains vivid some 30 years later. This narrative was repeated throughout my fieldwork and, often regardless of gender or sexuality, individuals would distinctly remember the first time seeing the campaign and the fear it instilled within them.

In her work on HIV corporeality, Asha Persson (2013, p.1070) describes "the embodied vestige left by the infamous Grim Reaper campaign" felt by some of her participants, one of whom described the campaign as "hard-wired into the brain" (p.1071). This was reflected by Brendan (PLHIV, 40s). At 16 years old, Brendan was diagnosed with HIV after being sexually assaulted in what was thought to be a gay hate crime. Brendan's assault and subsequent positive diagnosis occurred at almost the same time as the Grim Reaper campaign and in an era when HIV/AIDS was effectively terminal. Reflecting on the campaign, Brendan stated,

> How many generations are we going to have to go through before AIDS is forgotten about? Or even that old-fashioned mentality of the Grim Reaper with the sickle? It's like the bowling alley ads. They were around when I was fucking recently diagnosed! It was hard to see this fucking death – and it was death. And *The Simpsons*, or *Family Guy*, does it now – the guy has the little character in there and it is actually death. He comes out in the Grim Reaper outfit with the sickle. And every time I see him, I remember back to the AIDS [and] HIV ads: "Don't let it get you." He was bowling a fucking bowling ball down the lane, and you see people's faces. It's like, how many decades do we have to go through?

Here, Brendan refers to the character of Death, represented as the Grim Reaper, in the adult cartoon series *Family Guy* and *The Simpsons*. In *Family Guy* in particular, Death is portrayed as character who, despite their traditionally fearsome reputation, is meek, timid, and continues to reside with their mother. This is a stark contrast to the figure of the 1987 campaign, where the Grim Reaper is represented as a potential threat to the heterosexual family. It is notable, then, that even the cartoon figure of the Grim Reaper, employed in *Family Guy* to subvert traditional understandings of the Grim Reaper as an ominous and threatening menace, reminds Brendan of his earlier diagnosis and, significantly, the association of that diagnosis with, as Brendan states, death.

Produced without input from state-based AIDS councils, the Grim Reaper campaign was criticised by some for what was considered as a negative portrayal of gay men (Power 2011). Some feared that viewers might interpret the Grim Reaper as representing gay men deliberately seeking to infect the broader heterosexual population (Vitellone 2001). Others such as former Victorian AIDS Council president Phil Carswell (qtd Power 2011), however, saw the campaign as an opportunity to raise widespread public awareness of HIV/AIDS. He commented,

> *I don't regret what the ad provided for us in terms of an open door to every school in the country, and [an] open door into every bowls club and social organisation and Rotary [club] in the country, every doctor, GP and health professional who tried to ignore it in the past now couldn't (qtd Power 2011, p.69)*

This ambivalent response was echoed by Josh (HIV advocate and PLHIV, 40s), who recognised the demonisation of MSM while also acknowledged the campaign's potential role in reducing new HIV infections:

> I have no doubt that the stigma the Grim Reaper campaign delivered to our community we are still reeling from. But I honestly believe that [the] campaign saved thousands – if not millions – of lives … I remember the day it played. The first day it played.

Josh went on to comment,

> Where are the national campaigns that are telling our mums and dads that we're okay? You know, because they're still living in fear. They don't understand the new paradigm and the general public doesn't understand the new paradigm. Why isn't there an anti-Grim Reaper campaign, that is a national campaign, to inform the general public that there's a new world out there and it's okay … There's an anti-stigma, anti-Grim Reaper campaign that could take place tomorrow and it's all about U=U[51].

[51] U=U is the abbreviation of Undetectable equals Untransmittable.

The full extent to which a widespread educational campaign around Treatment as Prevention and PrEP would reduce the stigma of HIV had not been determined at the time of my fieldwork. However, such a campaign would sit in stark contrast to the 1987 Grim Reaper campaign which, by its very design, reinforced characterisations of HIV – and therefore PLHIV – as both dangerous and to be feared.

The legacy of the Grim Reaper can be thought of as *habitus*, as an aspect of the past that continues to be felt in the present (Crossley 2013). For Brendan, even cartoon depictions of the Grim Reaper elicited often painful memories of the 1987 campaign. While Josh credited the campaign for raising awareness of HIV/AIDS and potentially saving many lives, he also felt it had been done at the cost of creating a lasting association between HIV and death and stigmatisation of those living with the virus.[52] Importantly, this was an association that Josh believed had continued despite the advances in treatments which had ultimately made HIV akin to a chronic condition.

Physical Presence of HIV

More than simply a virus that can be transmitted sexually, HIV has been a prominent feature in the social and sexual worlds of many MSM. Even as the HIV/AIDS epidemic devastated gay communities, it tapped into a latent sense of community, mobilising many gay men who had previously regarded gay and queer identity politics as irrelevant (Altman 1988; Epstein 1996; Power 2011). Race (2009) contends that in the early years of the HIV/AIDS epidemic, large-scale dance parties served not only as a form of much needed entertainment in the face of devastation, but also as fundraisers for HIV/AIDS organisations and services. At bars, clubs, and sex on premises venues[53] I visited during my fieldwork, health campaigns promoting PrEP and HIV prevention were commonly sighted. In Australia, these venues became important sites for the communication of health information to MSM and an effective way for state and federal governments to provide targeted, culturally appropriate messaging

[52] It is worth noting that the *Grim Reaper* campaign was not solely responsible for creating an association between HIV and death. As discussed in the following section, HIV/AIDS devastated gay communities throughout the 1980s and early-1990s. The memories of this devastation remain strong for many people today, some of whom lost friends, family, and loved ones during this time.

[53] While fieldwork was not conducted in sex on premises venues, one participant asked to be interviewed at a men's only cruise club in Melbourne. During the interview, I was taken on a tour by my informant to observe the sexual health information posted throughout the club.

around HIV and HIV prevention (Power 2011). And where some bars might traditionally have had peanuts for their patrons to snack on, my field site of the Laird had bowls of condoms distributed throughout the venue.

Sexual health messaging was also a prominent feature of digital dating and hook-up apps. In addition to allowing users to choose from a range of pre-determined HIV statuses and preferred sexual health strategies, these apps also frequently displayed advertisements promoting PrEP. In some instances, these advertisements had been organised by the two PrEP advocacy groups that were observed throughout my fieldwork. While these served an important function in the promotion of harm minimisation strategies, this messaging firmly embedded HIV as part of the broader social milieu within which gay men moved and interacted (see also Ávila 2015). The virus was therefore an ever-present aspect that formed the social and sexual assemblages through which gay men have moved.

HIV-negative as Liminal

Walt Odets (1995) argued that much of the early work on HIV focused on those living with the virus, often ignoring the impact of the epidemic on those who are HIV-negative. Odets (ibid., p.15) argued, however, that just as living with HIV is a condition that must be managed, so too is "being gay and uninfected … a condition, not the absence of one." That is, despite *not* living with the virus, those who are HIV-negative must also engage in processes of disciplining their bodies, of modifying their behaviours to avoid contracting HIV. Moreover, gay men are encouraged to subject themselves to heightened medical surveillance, of incorporating a routine cycle of screening and testing for HIV antibodies. Given the potential for HIV to develop into a fatal condition in the absence of treatment, the consequences of *not* engaging in a routine of sexual health care are potentially severe. It is important to note that just as living with HIV forms (bio-)medicalised subjectivities (Persson 2013), so too do forms of medicalised subjectivity coalesce around the maintenance of an HIV-negative stats.

Speaking on the impact of HIV and, more specifically, HIV prevention, Alex (PrEP advocate and research, not using PrEP) commented,

> I'll never forget the person … who said, people have no idea how much effort goes into staying HIV-negative. It's a huge hidden effort and we don't applaud people enough for having done that … [The] shame and fear straight after [sex], 24 hours after an episode where a condom broke or wasn't used. Fear and doubt and misery. Fuck that! It's dreadful … It's so much energy and so many head-miles.

As argued in Chapter 2, the imperative to minimise HIV risk has been framed as both a moral and social obligation, with the failure to protect oneself explained as either deviance or as pathological (Dean 2015; Flowers et al. 1997; Green 2016; Gretemen 2018; Hoppe 2011; Moskowitz and Roloff 2007; Tomso 2004; Varney et al. 2012). In this way, it is the lack of behaviour change itself that becomes exceptional. In contrast, the adoption of prevention strategies is a social norm and standard against which individuals are measured. What this obscures, as Alex argues, is the work and effort that goes into behavioural hypervigilance around actions such as condom use.

Gary Dowsett (2009, p.219) characterises the state of *not* living with HIV as occupying a liminal space, "liminal because being HIV-positive is irreversible and definitive, whereas being HIV-negative always contains the *possibility* of being infected" (emphasis added). The status of being HIV-negative is one that exists in uncertainty, a status that, as Alex notes above, requires extra "energy and so many head-miles" to maintain. While the use of condoms does allow MSM to experience sex while reducing HIV, they also require individuals to be cognisant of potential HIV risk during sex.

Given the extent to which PrEP was described reshaping participants' experiences of concern over HIV, I began to wonder how my own experiences of sex and relationships might have differed had I used PrEP in my past. I expressed this to Ethan (HIV advocate and PLHIV, 30s) who responded,

> Isn't that such a fascinating thing, what PrEP has unlocked for guys who haven't been given the gift of the sexual liberation that comes with a positive diagnosis? … That journey towards sexually adventurous practices for gay men used to be in your kind of late 20s, early 30s, when that blooming would happen. And this is all in a post-AIDS world we're talking about, in the context of HIV … And what I'm seeing now, in this new wave of late-millennial kids who are jumping on PrEP at 21, 22, they are fast-tracking that sexual freedom and sexual experimentation phase which is so exciting to see … If anyone wants to deny anyone that pleasure and that process, they are so hurt by HIV – whether they've got it or not – that it's very sad for them.

Here, Ethan's description of "the gift" of a positive diagnosis echoes characterisations of HIV-negativity as a liminal space (Dowsett 2009). Importantly, Ethan is not suggesting that an HIV diagnosis is without its own challenges, nor that it is always a welcome event.

Rather, Ethan makes the point that once HIV is contracted, individuals are no longer *at risk* of HIV. This, coupled with the knowledge that an undetectable viral load makes the risk of HIV transmission effectively negligible, ironically may afford PLHIV the possibility to experience sex where HIV is not necessarily part of the experience.

Numerous factors could be said to have facilitated what Ethan described as a fast-tracking of sexual freedom and experimentation. For example, the tireless work of LGBTIQ activists, a greater visibility of sexually and gender diverse people and a relaxation of social norms around sex outside of marriage have certainly made a significant contribution. However, Ethan specifically attributes PrEP with offering HIV-negative MSM the potential of sexual liberation. With the potential of contracting HIV a constant possibility, (Odets, 1995; Dowsett, 2009), gay men were encouraged to adopt behavioural changes minimise this threat. While condoms were promoted as the gold standard of HIV prevention, so too negotiated safety was put forward as another strategy to minimise the risk of HIV transmission (Kippax 2002). These strategies position HIV and HIV risk as part of the sexual assemblage. PrEP, on the other hand, displaces that risk from the experience and instead shifts HIV prevention into the more mundane routine of everyday practice.

PrEP as liberation

The narrative of PrEP's potential to liberate MSM from a constant fear of HIV was particularly strong among PrEP advocates. This same narrative was also reflected in PrEP users' personal accounts of their own experiences of using PrEP. Some participants described how until using PrEP, anxiety of potential HIV infection had nearly always overshadowed the sexual experience. Seamus (PrEP user, 20s), who had almost always used condoms, stated,

> I think [PrEP] definitely means I can enjoy it a bit more. If I'm drunk or if I have taken drugs or something and then have sex, [HIV] is not on the forefront of my mind. But I think if I have sober sex it's always something I think of. I think about, what is the risk I'm taking here? And [PrEP] has allowed me to enjoy it more because it's not kind of the there afterwards – that thought [of HIV] where it previously would have been after. I think that's because all my life it was taught: gay sex [equals] HIV.

Despite his use of condoms, concern of HIV was a central aspect to the experience of sex for Seamus. While the use of alcohol or other drugs diminished this concern, it nonetheless remained present. Seamus attributed this overarching concern with having grown up in a

culture whereby sex between men was closely associated with HIV risk and danger. Thought of as *habitus*, Seamus' experience of enculturation whereby "gay sex" is almost synonymous with HIV had become an almost habitual and automatic part of the sexual experience. This becomes even more significant when considering Seamus had almost always used condoms with sexual partners. Despite the minimisation of HIV risk, condoms had not alleviated Seamus' anxiety over HIV, both during and after the sexual encounter. Such was the extent to which HIV had become part of Seamus' everyday world that even this harm minimisation strategy could not disentangle the link between sex and risk.

Seamus' experience of PrEP in minimising anxieties over HIV was echoed by other participants. John (PrEP user, 50s) stated,

> Well, [HIV] has made me very anxious in the past about sex. Nervous, worried afterwards. I think that took away from the pleasure of sex quite a bit – anxiety about it. And I think a lot of that [anxiety] has been taken away now by using PrEP. Didn't have to worry about [HIV]. Still, a tiny little bit in the back of the head, but most of it is gone. And if there's any anxiety it's about other sexually transmitted diseases now.

Here, John describes feeling anxious, nervous, and worried about the potential of HIV prior to his use of PrEP. Even despite the sense of protection offered through PrEP, those anxieties had not been completely eradicated although, as he states, much of those concerns now centred around other STIs. John's comment functions as a reminder that anxiety around HIV is not the only concern or risk around sex that individuals might have. In addition to STIs, there are also potential concerns around consent, sexual violence or, even, a risk of having unsatisfactory sex. Even as John did have some concern over STIs, however, these were not so great to stop him engaging in condomless anal sex.

Other participants reflected Ethan's earlier comment and described PrEP as unlocking a phase of sexual experimentation that they associated with adolescence. After outlining the broader impact of HIV on his life whereby HIV was an almost constant fear, Andy described his experience of starting PrEP,

> Oooooohhhhhh, my, god. I told you I was 40 when I started this, and I feel like my life began. Or, at least, I am still going through an adolescent phase that I never actually got to have as an adolescent. And I'm not the only one either – a lot of people I know in their 40s and 50s … talk about this. Feeling like now, we're finally getting the youth that we never got to have when we were growing up.

Here, PrEP is characterised as fostering a sense of life beginning for Andy as well as many of his peers close to his age. The HIV/AIDS epidemic had not stopped Andy from being sexually active but, rather, had imbued the experience with sense of anxiety and fear. As Andy's awareness of his sexuality had developed just as HIV/AIDS was at its peak, he had never experienced sex without this concern. With this concern lifted through PrEP, Andy felt able to embark on a journey of sexual experimentation and discovery that he associated with youth.

Reflecting the ongoing impact of becoming a sexually active gay man as HIV/AIDS was impacting gay communities was also the experience of Ben's (PrEP user, 30s) partner Edward. In his 50s, Edward lived through the peak of the HIV/AIDS crisis and, like many other gay men at the time, had lost many friends to AIDS. Ben described Edward's experience of beginning PrEP, stating,

> My partner's older than me and he lived through the AIDS epidemic. And, in his words, he went to a funeral once a week which was very heartbreaking to hear … We went to Melbourne Queer Film Festival and saw [the documentary] *Remembering the Man* … and it actually included footage of AIDS patients who were dying … and that's what he lived through. So, after the first seven days when he had taken his PrEP, he just let out a big sigh and said, "I'm free."

Ben went on to describe his own experiences beginning PrEP:

> It's just amazing. Not only in the way you conduct yourself during sex, but it's amazing to see how other people conduct themselves as well. And the attitudes that are changing and the freedom that comes with it … It's been an amazing journey to be perfectly honest, just based on one little blue pill.

In both instances described by Ben, PrEP was associated with a sense of freedom, of offering the possibility to experience sex in a way not mediated by HIV. This was particularly notable for his partner who had lived through the peak of the HIV/AIDS crisis.

Challenging the Liberation Narrative

While a sense of liberation through adopting PrEP was reflected in the comments of nearly all participants, it was not shared to the same degree for all. Speaking on the impact HIV had on his experiences of sex, Thomas stated,

> Another thing that I hear a lot is, and one of the big arguments of PrEP advocates is that it gets rid of the fear of sex. I can't personally relate. I've never been scared about having sex. I was on PEP [post-exposure prophylaxis] maybe three times, and I think that you worry about it, right? You worry about getting the results, but it wasn't enough to stop me from going out and having sex again.

While Thomas had not experienced the same degree of fear or anxiety over HIV, he did go on to comment,

> I think [HIV] is just something you're used to thinking about. As I said before, I didn't worry about sex or wasn't scared about sex. But it was certainly something you thought about.

Despite not being afraid of having sex, HIV was something that Thomas was aware of. Indeed, he describes it as "just something" he was "used" to thinking about, a description suggesting HIV had become an almost unquestions of part of his experience of the world.

Mark was sceptical of the narrative of liberation surrounding PrEP implementation:

> Are you actually free when you're taking PrEP? Because you're still subjecting yourself to medicalisation [and] you're still agreeing that you are at risk … You're also not sexually liberated because you're only taking PrEP because you're afraid of HIV … How free are you? How freeing is it? Is this really more a matter of a collective sigh of a community in their psyche, going: "fuck, breathing space [after] 30 years of stigma and HIV trauma"? And I can totally appreciate that, but that is different. Reprieve is different from freedom, and I think that's kind of more what people have been experiencing. That's what I experienced – that it actually isn't freedom or freeing. But, of course, when you compare that to the high anxiety levels that people have felt being afraid, and just that anticipation of you're waiting for your [HIV] results for a fucking week? Yeah, you come across PrEP and, when you compare those two extremes, it does seem like freedom and [that] a massive burden's been lifted.

Mark points out that an individual's decision to initiate PrEP is not only contingent on an individual's acknowledgement of HIV risk, but also being categorised medically as high risk. At the time of fieldwork, Australian prescribing guidelines categorised individuals as "PrEP eligible," with eligibility assessed according to a range of risk factors including engaging in condomless anal sex and/or injecting drug use[54] (ASHM 2019).

While PrEP requires individuals to assess their own risk in relation to HIV, Mark also argued that PrEP use is predicated on a desire to be protected from HIV and/or engage in condomless sex while avoiding HIV infection. A broad spectrum of concern over HIV was expressed by participants. Regardless of their concern over HIV, however, all participants expressed a desire to remain HIV-negative as underpinning their decisions to initiate PrEP. Given the need for the ongoing use of PrEP and engagement in HIV and STI screening, HIV remained part of the broader experience of PrEP users' worlds.

[54] The language was changed in 2019 to "PrEP suitable".

Displacing HIV

Displacement of HIV prevention from sex

One of the proposed benefits of PrEP was that it effectively decouples HIV prevention from the act of sex itself. It was frequently suggested that one of the problems with condoms as a sexual health strategy was that to be effective, condoms had to be used during sex. This required individuals to be cognisant of any potential risk during sex and at a time, it was argued, when one's judgement could be clouded through heightened emotions, drugs and/or alcohol, power imbalances between partners, or simply a desire for increased intimacy and pleasure. Analogous to the contraceptive pill and in contrast to condoms, PrEP could be taken separately to sexual encounters. Advocates of PrEP claimed that this was a time when individuals were more likely to have a greater sense of control over their actions.

The displacement of HIV prevention has significant public health implications, particularly for those who might not always use condoms. When PrEP was first emerging as a prevention technology, the focus on PrEP reaching those already vulnerable to HIV was an important framing device in justifying PrEP use (Holt 2015). Indeed, it was precisely because they were already engaging in condomless anal sex that motivated the decision of some participants to begin using PrEP. Within public health circles, PrEP was considered a way that these individuals could protect themselves and future partners from HIV, engage in a routine cycle of sexual health care, and have an opportunity to receive counselling around condom use (ibid., p.436). Despite the potential for counselling over the use of condoms, participants widely reported that their use of PrEP largely made the non-use of condoms unproblematic from the perspective of their health providers.

While displacing prevention from sex has important public health implications, PrEP also has the potential to divorce the association of sex between men with HIV risk and danger, an association that has been particularly strong throughout the HIV/AIDS epidemic (Treichler 1999). Race (2016) argues that where condoms function as a visual reminder of one's protection against HIV, a tangible barrier preventing fluid exchange, they also function as a physical manifestation of HIV risk. Condom use also requires individuals to be cognisant of their potential HIV risk during sexual encounters and therefore at least once in these

encounters, individuals must consider some form of harm minimisation. Given these aspects of condom use, I argue that condoms firmly position HIV as a part of the sexual experience.

At the time fieldwork was conducted, the only PrEP dosing strategy publicly recommended in Australia was daily use. To facilitate their adherence to medication, PrEP users were actively encouraged to incorporate PrEP into an already-existing daily routine. A common post appearing on social media was from individuals concerned after forgetting to take their medication for one or two days. These comments were usually met with sympathy and concern, with some group members also offering advice on their own strategies to remember taking their medication:

> I find it's easier to remember to take it if you take it with a main meal. I.e. I always take mine with dinner, and now after several months I don't even need to think about it. It's just part of my routine.

After several months of taking PrEP with dinner, PrEP and HIV prevention had become firmly entrenched as part this PrEP user's daily routine. Such is the extent to which PrEP had been routinised, this individual no longer needed to think about HIV prevention. Unlike condoms which require a degree of awareness of HIV risk during sex, the routinisation of HIV prevention associated with PrEP makes it an almost unthought of act, a habit that is almost unconsciously acted out.

While PrEP does not completely eradicate HIV from an individual's broader experience of the world, it does offer the possibility of experiencing condomless sex while, at the same time, reducing the sexual transmission of HIV. Describing his own experience of PrEP, Rick (PrEP advocate and user, 50s) commented:

> I love my pill a day. It's the best time of my day. I go to my bathroom cabinet and go, freedom. Freedom that I can put in my mouth, excellent. And that's the job done. Now, for the rest of the day, I'm not thinking about anything [other] than just being the…rooting[55] animal I am.

For Rick, PrEP effectively separates the act of HIV prevention and therefore risk from the sexual experience. HIV prevention is now simply a "pill a day" that, for him, represents sexual freedom[56]. Importantly, PrEP is freedom that Rick can put in his mouth and not, as with a condom, on his penis during sex. The use of condoms had previously required Rick to

[55] Australian slang for 'sex'.
[56] Analogies between PrEP and the contraceptive Pill often come up in discussions around socio-cultural aspects of PrEP. While these comparisons are fascinating, they are beyond the scope of this thesis.

momentarily pause during sex, to put a condom on and thereby bringing HIV into the experience. Through his use of PrEP, HIV prevention had become part of his daily routine. Once taken, PrEP removed any concern or thought of HIV, even in situations where Rick might previously have been at risk. While PrEP has not necessarily removed HIV risk completely from Rick's broader experience of the world, that risk now manifests itself at his bathroom cabinet and not during the experience of sex.

Displacing the "HIV Talk"

In addition to removing the *physical* act of HIV prevention from the sexual encounter, some participants described PrEP as removing the need for what was described as the "HIV talk." Several participants described how prior to beginning PrEP, they would regularly have awkward conversations with sexual partners where, in addition to condom negotiation, there was the added expectation of disclosing their HIV status. The experiences they described were immediately recognisable to me and had also formed a significant part of my own past sexual experiences.

In relation to more casual partners, the HIV talk was framed as being overly intrusive, of inappropriately asking detailed and personal health information of relatively unknown people. As Darren (PrEP advocate and user, 50s) described it:

> It's like negotiating a home loan before you've even dropped your pants.

Darren's experience of negotiating sexual health strategies was echoed by Matt (PrEP advocate and user, 30s), who reflected on his own experiences after first using PrEP:

> The disclosure thing was huge … How do I tell them? What am I supposed to do? And that [negotiation] often presented itself … just before you're getting down to business: "Hey, by the way I'm on this really cool thing. It's called PrEP and means I don't get HIV." You blurt this kind of thing out which is the most un-sexiest of conversations to have … I quickly learned that doing that right before the moment you were about to fuck is not conducive to a really good, chilled, sexual experience.

Both Darren and Matt describe the negotiation of safer sex strategies as negatively impacting the sexual experience. For Darren particularly, these conversations introduce an element of business-like negotiation. Reflecting Darren's experience, Matt describes it as one of "the most un-sexiest conversations", an experience which does not set the foundations for an enjoyable sexual experience.

Importantly, just as PrEP does not remove HIV from the broader experience of PrEP users, I do not suggest here that PrEP necessarily removes negotiation itself from the sexual encounter. As an experience between two or more individuals, consensual sex will always involve some form of negotiation regardless of sexual orientation and/or gender. As Thomas commented:

> Look, at the end of the day if you're going to have sex with someone there's generally negotiation or discussion of some sort. Even if you're asking whether they want to [have sex]. But it's removed [HIV] from the equation so there's one less thing for people to be worried about, I guess. And it's more fun to talk about *what* it is that you're negotiating to do rather than whether one or both of you want to use a condom or not. There's nothing sexy about – maybe some people have a fetish for condoms – but there's nothing sexy about a condom. There's something sexy talking about the rest. I think that's changed.

As Thomas stated, sex almost always requires some form of negotiation, even if it is simply the gaining of consent. However, where the negotiation of safer sex strategies such as condoms was seen as unsexy, an onerous and business-like task, the negotiation of what might occur during sex and how partners might engage with each other was considered by Thomas as more enjoyable.

While some participants saw the growing irrelevance of the HIV talk as a positive aspect of PrEP, it has raised concerns among some health professionals and HIV researchers. Kippax and Stephenson (2016, p.136) suggest that one of the risks of the widespread uptake of pharmaceutically based HIV prevention technologies is their potential "to further privatise HIV, making it (whether we are talking about treatment or prevention) a matter for individuals or couples, and not for broad public discussion, debate and action." Rather than HIV/AIDS being a concern dealt with in close consultation with affected communities, such critiques frame it instead as an issue to be solved on an individual level in close consultation with medical experts and institutions (Dowsett 2017; Kippax and Stephenson 2016).

As noted in the Chapter 1, the emergence of PrEP in Australia provoked a significant response from advocates working at the grassroots community level. These advocates were very publicly involved in discussions and debates around PrEP, including issues of access, uptake, and its potential for positively impact the sexual experiences of PrEP users. While researchers and health workers were often part of these conversations, early PrEP advocacy was largely a community-led phenomenon. Analyses such as those offered by Kippax and Stephenson (2016) raise important questions as to the broader impact of new sexual health

technologies and their potential to shift norms around the negotiation of safer sex strategies. However, they do not necessarily reflect the broader Australian context into which PrEP emerged, a context in which there was much community debate and discussion around PrEP.

Displacing HIV risk from sexual partners

PrEP's rendering of the "HIV talk" as irrelevant was considered one of the additional benefits of PrEP use. More than simply removing this discussion from the sexual experience itself, it also introduced the possibility of removing the potential of one's partner being seen as a threat and site of danger to one's own health. The framing of one's sexual partners as such has been one of the consequences of many HIV/AIDS prevention campaigns (Gamarel and Golub 2015). These campaigns have encouraged individuals to consider any new partner as potentially living with HIV and potential health risk. Hence, condoms should be used with every sexual encounter. Take, for example, the Australian *How Many* awareness campaign, airing on Australian television in the late 1980s[57]. The approximately 45 second advertisement opens with a close-up of a heterosexual couple lying in bed kissing, set to the sounds of a lush string orchestra. Over this, a male voiceover states,

> *next time you go to bed with someone ask yourself, "do you know how many people they've been to bed with?"*

The music abruptly finishes, and the camera begins to pan away from the couple. As it does so, more and more heterosexual couples come into the screen until a seemingly infinite number of couples lying in bed and kissing fills the screen. The voiceover continues,

> *because it's quite possible they've had several partners. And it's just as likely that these partners have had several partners too. And they've had partners and so-on.* And any of them could have been infected with the AIDS virus and passed it on. But you don't know. *That's why you should always use a condom because* you can never be sure just how many people you're really going to bed with *(*emphasis my own*).*

The overarching message behind this advertisement is that, even when having sex with just one other person, one can never be completely certain as to the risk of HIV resulting from any of their previous partners. Given this, condoms should be used in every sexual encounter. The more implicit messaging contained in this advertisement, however, is that

[57] A copy of this advertisement was accessed on YouTube <https://www.youtube.com/watch?v=DGv63hFdWlw>, accessed 02 June, 2018

one's sexual partners might always pose a danger to one's health and, therefore, a level of caution and distrust should be maintained[58].

Despite the potential for fostering a sense of distrust of all sexual partners, it is necessary to situate campaigns such as the *How Many* campaign within the broader social and political climate in which they were produced. The *How Many* campaign was launched in the 1980s, a time when there were no effective treatments for HIV and an HIV diagnosis could potentially be terminal. Moreover, HIV testing technology was relatively new and, given the absence of effective treatment and potential for discrimination, testing was actively discouraged by some Australian state-based AIDS organisation (Power 2011). It is also necessary emphasise that in contrast to HIV prevention campaigns in other countries, the *How Many* campaign did not shy away from a portrayal of potentially casual and/or sex outside of marriage. There is almost no doubt that campaigns such as the *How Many* campaign played a significant role in not only raising awareness of HIV/AIDS, but also in encouraging the use of condoms as an HIV prevention strategy. However, it is also important to recognise the potential unintended consequences of this and subsequent campaigns in how sexual partners were imagined. In representing all individuals as sites of potential risk, sex and sexual partners become something to approach with caution.

Commenting on the importance of sexual relationships, whether ongoing and longer-term relationships or those that were more casual, Darren stated:

> I have a need to connect. I'm single and I find that I can connect with men in a sexual way. More comfortably, more easily for me than sitting down and having a conversation. And so for me, if I didn't have that, I guess I'd have to find something else. But I don't really want to join a philately club[59] … There's a social aspect to it [and] there's an intimacy aspect to it. My self-esteem – all that sort of stuff I'm getting from sexual experiences. And with those experiences, mainly they're with friends who are also sexually active, as well as with some casual people thrown in.

Sex with both ongoing and casual partners here is more than simply the pursuit of hedonistic pleasure and is an important form of physical and social connection for Darren. Writing of

[58] The public health strategy of assuming that everyone is potentially infected with a disease aims to reduce both disease transmission and stigma (Pulerwitz *et al.*, 2010). As is evident in the experiences of participants, the reduction of stigma was not universally experienced.
[59] A stamp collecting club.

The Catacombs[60], a San Franciscan sex club popular with the sadomasochism, leather, fisting and kink community, Rubin (2011b) argues that the connection and intimacy built during sexual encounters there would often extend outside the club. She writes,

> *The Catacombs facilitated the formation of important friendships and lasting networks of support. Many of the men who frequented the Catacombs found relationships there that have sustained them through time, nurtured them with affection, cared for them in sickness, and buried them in sorrow (p.240).*

Situated outside of hegemonic relationship norms, however, these forms of intimacy and relationships are in the outer circle of Rubin's (2011c) sex hierarchy discussed in Chapter 2. Instead, these bonds are easily dismissed and rejected, reframed instead as frivolous, callous, or even deviant.

As with condoms, PrEP is also an HIV prevention strategy that could be interpreted as a marker of distrust of sexual partners. However, PrEP differs from condoms in that it is taken outside of the sex, thereby removing that distrust from the sexual experience. Tristan (PrEP advocate and user, 50s) commented:

> [PrEP] changed a lot of things. It made me aware of the amount of [HIV] stigma that there is because I hadn't really considered how bad stigma may have been. Personally, I hadn't discriminated sexually [against PLHIV] myself. But I'd certainly made sure that I was as careful as possible. In 2014, U=U was unheard of. It certainly wasn't something that entered my mind. But the fact that all of a sudden I could have sex with anybody and just not care? [HIV] made no difference? I didn't have to ask them [and] there didn't need to be conversations? Oh, it was truly amazing. Really amazing.

Tristan's comments were echoed by Darren, who earlier described the negotiation of safer sex as like negotiating a home loan:

> I used to always have a conversation around HIV ... I'd make decisions around what strategies I was going to use or not use or whatever around that conversation … And now, I don't have any conversation about it at all. Doesn't come into the mix. I'm not concerned about somebody's status. I'm not concerned about whether they want to use condoms or not. It's just, it's not there. Which is the way we're meant to have sex … The other thing about connection I was talking about. You get to a point … I can talk about more ongoing relationships I guess – but not very long ongoing relationships. But in a casual relationship, that connectedness is a focus rather than the 'let's have the HIV talk around this and that' and all of that stuff, you know … and so, in that sense as well, [PrEP] changes connectedness.

Both Tristan and Darren claimed to have never discriminated against sexual partners based on their HIV status. However, both did consider the status of their partner both prior to and during sex. For Tristan, this meant taking the highest levels of precaution possible while for Darren, the harm minimisation strategies he would use were predicated on the HIV status of

[60] The Catacombs operated between 1975 and 1981 before closing down and reopening again between 1982 and 1984. Although ultimately closing as a result of the AIDS epidemic, Rubin argues that the Catacombs' approach to HIV/AIDS prevention and education was "exemplary".

his partners. For both, PrEP shifted this and in doing so, changed the experience of sex itself and how Tristan and Darren were able to relate to their partners.

In a later conversation with Darren, he told me of an experience he had not long after beginning PrEP in 2015, a situation in which he did negotiate sex with a new partner:

> One of the most beautiful things, a friend and I were negotiating having sex for the first time, about two years ago. He declared his testing positive for HIV … and his viral load being undetectable (before U=U but to those informed, knowing he couldn't pass on the virus). I declared I was negative on PrEP, and therefore neither of us had to worry, undetectable and PrEP. It changed the encounter. Neither of us had to be concerned about the other. My HIV positive friend no longer had to be concerned about the sense of responsibility [for] keeping me negative. We could just relate. As we were discussing it after the sex, he said that my PrEP had removed that pressure.

Given Darren's previous lack of discriminating against those living with HIV, it is unlikely the disclosure of his partner's HIV-positive status would have been met with rejection. Nonetheless, it is apparent that Darren's own use of PrEP, coupled with his partner's undetectable status, meant that HIV had effectively become irrelevant to their sexual experience. While the impact of an undetectable viral load on the sense of safety cannot be underestimated, it is noteworthy that Darren here specifically credits PrEP as removing any sense of pressure or concern over the potential for HIV transmission.

Significantly, Darren described PrEP as altering the experience for his partner living with HIV. As Darren states, PrEP removed the additional pressure felt by his partner in ensuring Darren's protection against HIV infection. This reflects the heightened burden of responsibility for HIV prevention often felt by PLHIV (Wolitski et al. 2003). During my fieldwork, PrEP was often described as a form of levelling the playing field in terms of responsibility. Particularly in the context of U=U, PrEP and Treatment and Prevention were considered by both PLHIV and PrEP users alike as closely related strategies to prevent the potential transmission of HIV. That is, a pill a day to prevent HIV. Darren later addressed the impact of his PrEP use on his partner, stating,

> [C]ertainly from people who are living with HIV, I think generally they see it as being, as I talked about before, a shared responsibility.

In the situation described above, both PrEP and Treatment as Prevention opened the possibility of Darren and his partner relating to each other in a way that was not mediated by any potential HIV risk.

Darren credited PrEP specifically with opening the space to relate to sexual partners not as potential sites of risk but, importantly, as people:

> PrEP removes those awful aspects of judgement, of labels, of status. Such that we can relate as people, not [HIV] status.

More than simply a strategy to protect himself from HIV infection, PrEP fundamentally shifted how Darren was able to relate to others. While participants described PrEP as potentially changing how they were able to relate to their partners, it also has the potential to shift how PLHIV might relate sexually and emotionally to their HIV-negative partners. This is particularly significant given Brendan's comments in Chapter 4, whereby he had experienced himself as "less than" his HIV-negative partners because of the risk he perceived he posed.

Challenging HIV as Irrelevant

To this point I have focused primarily on PrEP's potential to displace HIV from the sexual experience, through both shifting the act of prevention itself as well as rendering the HIV talk as seemingly irrelevant. While this is certainly significant, it is necessary to note that the experiences outlined so far are from the perspective of PrEP use. It does not necessarily follow that these same experiences would be had by PLHIV. This was particularly so for Brendan. Living with HIV for approximately 30 years, HIV continued to shape his experiences of the world and sexual relationships with others. While the legal requirement to disclose his HIV status to sexual partners was no longer in place in Victoria, it had formed part of his experience in negotiating sex and relationships previously. Moreover, there remained an expectation from some HIV-negative men that PLHIV disclose their HIV-positive status even, in some cases, when they were using PrEP. Having also experienced significant degrees of stigma and sexual rejection due to his positive status, Brendan had developed a strategy to inform new partners of his HIV status. In their earliest interactions, Brendan would disclose his HIV status to sexual partners and then immediately ask, "does that make a difference? It is okay if it does." Explaining why he took this approach, Brendan stated:

> I had to tell them. Because if I didn't tell them either I would fall [in love or] my emotions would become involved and I would fall for them and then I would have to tell them anyway. So, it saved a lot of pain in the long run when I learnt very quickly to tell them upfront before we did anything sexual. Because

> then I could say, hey, we haven't actually touched each other. We haven't had sex. We haven't even got undressed yet. You're not at any risk here.

He justified this approach as making it easier for his partner to reject him and, despite the hurt this caused him personally, he believed it made the encounter less awkward. Importantly, this was a strategy Brendan employed to make it less awkward for future partners to reject him and not to prioritise his own feelings and emotions.

Having lived with HIV for almost 30 years, Brendan's strategy of disclosure can also be thought of through the lens of *habitus* (Bourdieu 1977; Crossley 2013), an almost ingrained aspect of how Brendan negotiated sexual encounters. PrEP had not changed how he approached these encounters and, even when Brendan was aware of a partner's use of PrEP, it was a disclosure strategy he continued to use. Regardless of whether PrEP users experienced HIV as irrelevant or not, Brendan's almost 30 years of living with HIV had firmly positioned HIV as part of his sexual experiences. Even as PrEP might reduce or eradicate any concern over HIV for those who use it, it is necessary to remain cognisant of how HIV and the experience of it continues to affect and shape the experiences of those living with the virus.

Conclusion

As demonstrated in this chapter, PrEP has provided new opportunities for experiencing sex. As participants such as Andy stated, the use of PrEP instigated a period of sexual experimentation usually associated with adolescence, a period that he felt he had been denied of due to the impact of HIV/AIDS. Moreover, PrEP had effectively removed the association of sex and, in his words, "tragic, painful death," an association that had dominated his life almost without his knowledge. For Mark, however, the extent to which PrEP can fully liberate MSM from the experience of HIV is limited. While it has provided an increased sense of protection against HIV infection compared with condoms, PrEP is an HIV prevention strategy. As such, it requires a *different* engagement with HIV harm reduction. It should be noted that, even if a cure for HIV were found, it does not follow that HIV would automatically be eradicated. Rather, the potential for contracting HIV would remain and, even if this potential were substantially lowered, it would nonetheless require individuals to maintain sexual health screening. While the *consequences* of an HIV diagnosis might be

diminished with a cure, true liberation from the virus could only occur through its total eradication.

HIV as *habitus* has fundamentally shaped behavioural norms among MSM as well as the social and sexual standards against which individuals are measured. As a technology that displaces HIV prevention from the act of sex, PrEP alters the assemblages through which sex is experienced. In displacing HIV prevention and, therefore, HIV risk, PrEP disrupts associations between sex, risk, and danger. Rather than sex being experienced through discourses of risk and danger, sex can instead be experienced through discourses of pleasure, intimacy, and connection.

Chapter 7 – PrEP: Unlocking the Potential for New Experiences of Pleasure and Intimacy

Introduction

In this thesis, I have discussed the various ways in which PrEP has interacted with condom-based harm reduction discourses, understandings of risk and safety, and experiences of reduced HIV anxieties. In particular, I have highlighted the potential of PrEP to disrupt existing sexual assemblages and how, through this disruption, new possibilities for experiencing sex have emerged. When I began fieldwork in 2017, there was a paucity of literature exploring the association of PrEP with increased sexual pleasure. At this time, the dominant focus of research tended to be framed through public health perspectives, highlighting concerns such as: early clinical trials (Grant et al. 2010; McCormack et al. 2016; Molina et al. 2015), barriers and facilitators to PrEP uptake (Arnold et al. 2017; Brooks et al. 2012; DiStefano and Takedo 2017; Gilmore et al. 2013; Golub et al. 2013; Grov et al. 2015; Hannaford et al. 2018; Khanna et al. 2017; Peng et al. 2018; Rolle et al. 2017; Spieldenner 2016; Young et al. 2016; Zablotska et al. 2016), risk compensation (Blumenthal and Haubrich 2014; Cassell et al. 2006; Holt and Murphy 2017; Koester et al. 2017; Lal et al. 2017; Marcus et al. 2013; Oldenburg et al. 2018; Rojas Castro et al. 2019; Traeger et al. 2018) and stigma (Arnold et al. 2017; Biello et al. 2017; Cahill et al. 2017; Calabrese et al. 2017; Calabrese and Underhill 2015; Herron 2016; Spieldenner 2016), as discussed in earlier chapters. At this time, research exploring how PrEP might facilitate heightened sexual pleasure was limited.

As the use of PrEP became more widespread, research exploring its impact on the experience of sex began to emerge, a notable example being that of Collins et al. (2017) who explored the lived experiences of PrEP users. Specifically, they sought to understand the "impact of HIV pre-exposure prophylaxis (PrEP) use on the *sexual health* of men who have sex with men" (ibid., p.55 emphasis added). Finding that PrEP positively impacted the experience of sex, Collins et al (ibid.) argued that experiencing sexual pleasure was a key aspect of sexual health. Reflecting the discussions of Chapter 4, they framed sexual health as more than the prevention of disease and infection, claiming that the potential to experience pleasure and intimacy was a central aspect of sexual health.

As I have discussed widely throughout this thesis, the uptake and use of condoms by MSM in causal sexual encounters has been an enduring legacy of the HIV epidemic and, until the emergence of PrEP, has been an almost taken-for-granted part of gay men's sexual culture. The role of condoms in lessening the impact of HIV/AIDS cannot be minimised. As HIV/AIDS devastated gay communities, and in the absence of effective treatments, condoms were a prevention strategy that built "on the characteristic pleasure and styles of embodiment found among gay men" (Race 2003, p.5). By disrupting the exchange of semen during sex, condoms allowed gay men to continue engaging in casual sexual relationships while reducing their risk of HIV infection. At the same time, condoms have also been considered antithetical to sexual pleasure and intimacy, acting as both a physical and mental barrier between sexual partners (Gamarel and Golub 2015; Purcell et al. 2014). The condom can thus be thought of as an ambivalent object through which sexual pleasure and intimacy is both enabled and inhibited.

In this chapter, I discuss the experience of sex for participants using PrEP and focus on the interrelated aspects of sexual pleasure, intimacy, and condomless anal sex. Importantly, it is not my suggestion here that PrEP alone is responsible for, or necessarily gave individuals permission to engage in, condomless sex. As Andy's (PrEP advocate and user, 40s) experience described in Chapter 6 highlights, condomless anal sex was something he not only engaged in prior to PrEP but, more significantly, gained enjoyment from. However, this experience was instilled with a sense of knowing better", of engaging in an expression of his sexuality that was somehow wrong. While PrEP might not have necessarily been the catalyst for condomless sex, I argue in this chapter that it does have the potential to enable individuals to celebrate sexual expressions that have previously been stigmatised and devalued.

This chapter begins with a short discussion of the emergence of condom-based safer sex guidelines, particularly those developed by New York-based HIV/AIDS activists Michael Callen and Richard Berkowitz. My aim here is not to provide a detailed historical analysis, but rather to highlight how from the earliest iterations of HIV prevention guidelines, semen has been coded as dangerous. While condoms do prevent the exchange of bodily fluids and the transmission of HIV, they were also experienced as disruptive to the sexual encounter. In

the second section of this chapter I explore participants' experiences of condom use, arguing that condoms present both a physical and psychological barrier between sexual partners.

By significantly reducing the risk of HIV, PrEP offers the potential for MSM to experience condomless sex while at the same time reducing anxieties over the HIV (Keen et al. 2020). While this allows MSM to experience heightened physical sensation, it also offers the possibility of transforming the experience of semen exchange from a potentially dangerous act (Long, 2015, p.115) to one that facilitates a deeper sense of connection between sexual partners. From a public health perspective, the exchange of semen has been considered something to be prevented, an act that carries with it the potential of the transmission of HIV and other STIs. I argue, however, that the act of semen exchange is also an act that held deep significance for some participants, a significance that outweighed any potential risk of infection.

Semen as Danger

How to have Sex in an Epidemic: One Approach

From the earliest iterations of safer sex guidelines aimed at preventing HIV/AIDS, the exchange of bodily fluids has occupied a central position. Influenced by the multifactorial theory, whereby HIV/AIDS[61] was said to be the result of continued exposure to cytomegalovirus, Callen and Berkowitz (1983) developed one of the first sets of HIV/AIDS prevention guidelines, *How to Have Sex in an Epidemic*. It is now widely known that AIDS is not caused by repeated exposure to cytomegalovirus (CMV). However, the presence of CMV in semen and other bodily fluids led Callen and Berkowitz (ibid.) to propose the disruption of such fluids as a strategy that could significantly reduce the risk of HIV transmission. Callen and Berkowitz outlined several strategies aimed specifically at gay men to reduce their exposure to cytomegalovirus. During oral sex, they suggested that "swallowing a load of come[62] can be a massive inoculation of CMV" and that if "your partner 'accidentally' comes in your mouth, … spitting it out will probably reduce your risk for

[61] As HIV had not been identified at the time *How to Have Sex in an Epidemic* was published, Callen and Berkowitz's guidelines refer specifically to AIDS. Given HIV is now known to be the causative agent of AIDS, I refer to both HIV and AIDS throughout this section.
[62] Slang for semen.

CMV" (ibid. p.18). Similarly, they claimed that "[g]etting fucked poses a great risk to you if your partner … comes inside you when he's not wearing a rubber," emphasising that "[t]he risk isn't of getting fucked; the risk is getting exposed to CMV and the sperm of many different partners" (ibid. p.21). As with oral sex, they suggested that the best way to prevent exposure to CMV was the use of condoms or, if condoms were not used, that individuals should avoid having their partners ejaculate inside them (ibid., pp.20-22).

Understandings of HIV/AIDS transmission routes have developed significantly since the Callen and Berkowitz's publication of *How to Have Sex in an Epidemic*. However, the focus on disrupting the exchange of semen during sex has, at least until the emergence of PrEP, continued to underpin HIV prevention and safer sex campaigns. VAC, for example, described HIV as a virus "primarily transmitted in *blood, semen,* and *vaginal* fluids via condomless sex or sharing injecting equipment" (Thorne Harbour Health 2020) As with Callen and Berkowitz (1983), their emphasis was on bodily fluids as sites of potential contagion, with the exchange of blood, semen and vaginal fluids considered as particularly high risk. It is important to stress here that in describing bodily fluids as sites of potential HIV risk, neither Callen and Berkowitz nor VAC were attempting to minimise the importance of these fluids during sex. However, given the avenues through which HIV is transmitted, it would be irresponsible for those working in HIV/AIDS advocacy to *not* provide specific and detailed information as to the potential risks associated with certain fluids and behaviours. It was the virus itself, however, that imbued some bodily fluids and specific sexual acts with a sense of danger and, in the early years of the epidemic, even death. Writing in 1988, physician Harvey Fineberg (p.128) stated "HIV is insidious. It corrupts vital body fluids, turning blood and semen from sources of life into instruments of death." Coded as dangerous, the once life-giving substances of semen and blood are transformed into abject fluids, ones that were best avoided and guarded against (Fineberg 1988; Guss 2010).

From a public health perspective that emphasises harm minimisation, engaging in bareback sex and placing oneself at risk of HIV might seem an irrational practice (Odets 1995). Within these discourses and throughout the HIV/AIDS epidemic more generally, semen has been widely

> *conceptualized as an abject material and the embodiment of sexual risk. With no way of detecting HIV outside of the clinician's office or the medical laboratory, semen stood in for the unseen virus – the signifier of a potential infection (Mowlabocus et al. 2014, p.1474).*

Such a perspective, however, largely fails to account for the value and meaning that bareback sex and semen have to those who engage in the practice (Holmes and Warner 2018, p.101). Odets (1995) argues that many campaigns emphasising the importance of condoms essentially ignored the importance that semen exchange holds for some gay men. "What AIDS education has come to call the 'exchange of body fluids' was once acknowledged as an important aspect of intimacy for many men" (ibid. p.9). While condoms do provide a barrier against the transmission of HIV, they also prohibit the transfer of semen from one partner to another. Underwood (2003, p.15-16) argues,

> *[a]lthough most have adopted safer sex … as an intrinsic aspect of their sexualities, there's no doubt that it represents a significant loss for gay men. Condoms are regarded as a hindrance to bodily pleasure and to emotional closeness. AIDS has altered the negotiations around anal sex (or any sex) and has brought on additional layers of meaning. Caution and distrust around sex and potential partners have become a daily routine. We live in a state of tension between a desire to remain healthy and a genuine need to experience intimacy and physical pleasure.*

In preventing this exchange, condoms also represent a barrier to the building of intimacy and connection between sexual partners (see Green 2016). Such was the importance of semen exchange during sex that for some, the symbolic meaning of this act has been a more powerful driver than the potential risk of HIV (Patton, 1990; Flowers, 2001). Writing just prior to the development of effective HIV treatments, Eric Rofes (1996) claimed that even despite the association between semen, HIV, and risk, semen continued to have important meanings for many gay men. Patton (1990, p.100) contends that

> *[t]o introduce condoms or eliminate such acts makes men feel as if they are being callous or unkind toward sexual partners. Ironically, the use of condoms to promote safety on the biological level cancels the feeling of "caring" on the level of human interaction and brotherhood.*

In other words, the introduction of condoms introduces an element of clinical disease prevention to the experience of sex, reducing or even erasing the important bonds formed through the exchange of bodily fluids.

Condoms as Disruptive

The association of condomless anal sex and intimacy has been the subject of some attention, particularly in the setting of ongoing, primary romantic relationships (Gamarel and Golub 2015). Early HIV prevention campaigns promoted the message that, particularly with new or casual partners, the risk of HIV infection could be present in every sexual encounter

(Gamarel and Golub 2015). A pertinent example is the Australian *How Many* campaign where it was explicitly stated "you should always use a condom because you can never be sure just how many people you're really going to bed with" (ABC 2010). While these campaigns were effective at promoting the use of condoms and reducing new HIV infections, they also fostered a sense of distrust in all sexual partners. A consequence of this was that *not* using condoms came to be the ultimate sign of trust within relationships (Gamarel and Golub 2015; Purcell et al. 2014). David Purcell et al. (2014) found an association between changes in relationship dynamics and condom use, whereby a shift from casual to primary partners was associated with a decline in condom use because of a desire for greater intimacy. The forgoing of condoms within regular, sero-concordant relationships was first promoted by Australian researchers in 1993 (Kippax et al. 1993). Termed "negotiated safety," this was a strategy whereby two partners who were both HIV-negative could forgo the use of condoms, provided they had undergone testing. If there was a relationship agreement allowing for sex outside the primary partnership, it was necessary that condoms always be used for secondary sexual partners.

Where bareback sex between casual partners has been discussed, particularly from a public health perspective, it has generally been considered a form of behaviour to be discouraged. Given the significant impact of HIV and the associated risk of infection through sex with casual partners, this viewpoint is understandable[63]. Darren (PrEP advocate and user, 50s) spoke about how condoms affected the experience of sex:

> I also am acutely aware of, for some people, how disruptive [condoms] are in their sexual expression … I've always found them to be disruptive and also, physically irritating sometimes. I've also found them just a plain passion killer and in my relationships in the past, what's the first thing we've wanted to do? Throw away the condoms as I'm sure many, many other couples do as well … And so, I think to be able to throw them away when you don't need them is a good thing. Not a bad thing.

In disrupting the flow of his sexual encounters, where Darren would have to stop momentarily while he or his partner fumbled around as they found a condom and put it on, condoms broke the sense of passion and connection Darren felt with his partner. The opportunity to be able to do away with condoms and, in turn, experience a connection that was uninterrupted was considered by Darren to be a positive and beneficial aspect to PrEP. It is noteworthy that just as the use of PrEP was criticised for a potential decline in condom use

[63] It is worth noting, however, that in the United States, a significant number of new infections occur within the early stages of monogamous primary relationships where the non-use of condoms occurs despite an absence of HIV testing.

in casual encounters, those same critics would frequently describe it as beneficial for those in monogamous, sero-discordant relationships. In reducing the risk of HIV transmission in these contexts, it was claimed, sero-discordant partners were afforded the opportunity to experience condomless sex.

Reflecting Darren's description of increased intimacy through the forgoing of condoms, James (PrEP researcher and user, 20s) described a deeper psychological connection through the non-use of condoms:

> It's not necessarily about the sensation or the feeling. It [does] feel better. I describe it to people as: wearing a condom is like sex without kissing. It's a little bit impersonal. It just has an aspect that isn't the full part of sex if you're wearing a condom. I just feel closer to someone. It's like, it's more hot without a condom rather than it feels better when they're not – or I'm not – wearing a condom. Do you know what I mean? Some guys it's much more the practicality of it – it just feels comfortable, or [helps] maintaining an erection or stuff like that. But for me, it's just the idea of condomless sex you feel closer.

Here, James acknowledges increased physical sensation associated with sex as well as the more "practical" aspects such comfort and the maintenance of erections. However, these were not the primary drivers for his desire to engage in condomless sex. In describing wearing a condom as like sex without kissing, I was immediately reminded of the 1990 film *Pretty Woman* (Marshall 1990). In the film, Julia Roberts plays the role of Los Angeles-based sex worker Vivian Ward who meets, and goes home with, the wealthy businessman Edward Lewis played by Richard Gere. As they are negotiating their first sexual encounter, Ward states "I don't kiss on the mouth" as "it's too personal." Kissing was considered a level of intimacy that went beyond the more transactional nature of sex between a sex worker and their client, an act that could break through the emotional barrier erected by Ward to maintain some distance between her and her clients. In his comment above, James draws a direct comparison between not kissing during sex and using condoms, whereby condoms similarly create a physical and emotional barrier between him and his partners.

The sense of intimacy and connection through engaging in condomless sex was also described by Mark (PrEP user, 30s):

> There's the intimacy as well that I kind of generally crave in my life. And that's one way of me having that intimacy with another person, through the nakedness of sex, the rawness of sex. The "way sex is meant to be."

I return to Mark's portrayal of "the way sex is meant to be" below. Mark described a sense of "intimacy" that was felt through the "nakedness" and "rawness" of sex that condoms detract from. It is worth noting that colloquially, condomless anal sex is also known as "raw" sex, a term which implies both a pure, natural state as well as an intense and primal expression of sexuality. The heightened intimacy Mark associated with condomless sex was widely acknowledged as one of the benefits of PrEP.

The lack of a barrier between partners was also associated with a transference of energy, as a member of the hook-up platform *Bareback Real Time Sex* (*BBRTS*) noted:

> This is "my not so valuable" input for your PhD study!! I believe that when the cock of the top guy I have sexual chemistry with is inside my arse fucking it, it feels like I am receiving his primal sexual instinct and sacred intangible energy. And therefore, my arse, body, mind and spirit react to his cock in my arse. And through my arse I also send my bottom primal sexual instinct to his body, mind and spirit via his cock. In which it takes us both to a "union state" between the top and the bottom!!

In this member's profile, he stated that he was primarily searching for sexual partners which, given the focus of the platform itself was not at all unusual. In our short conversation that followed his initial message, he divulged experiences of being treated by others as "just a toy hole for their cock." While this user did engage in bareback sex purely for the physical pleasure, he also associated it with spiritual connection:

> The bottom line is that you can still be having a wild, hardcore fuck session to give pleasure to your body and sexual organ. But at the same time, you can also feel/gain the intangible pleasure or ecstasy in our soul … [the] soul is not made of flesh and bone … [the] soul is a divine energy.

These experiences of bareback sex do not necessarily counter dominant framings whereby barebacking is associated with the hedonistic pursuit of bodily pleasure. Indeed, he explicitly highlights the "wild" and "hardcore" aspects of sex which provide bodily pleasure. These aspects of sex are not antithetical to intimacy but, rather, are an important aspect to it. While condoms can prevent the transmission of some STIs during sex, their use would prevent the transference of "primal sexual instinct and sacred intangible energy." Just as James associated condoms with an incomplete experience of sex, so too do they remove an important aspect of the sexual experience here for.

Condomless Sex, Pleasure, and Sexual Health

PrEP advocates learned from the experiences of PrEP advocates and educators in the United States, where the stigma surrounding PrEP was said to influence low levels of PrEP uptake

(Herron 2016). For Australian PrEP advocates, the emphasis on sexual pleasure as an important aspect of PrEP use had important health implications. Speaking on the role pleasure played in promoting PrEP, Andy commented,

> You also have these grassroots community members that are talking in a really open, honest, affirmative way about sexual pleasure in a way that I have never, ever seen done before. I've never seen it. I think in the 70s maybe people did that more. But I came out in the 80s. I've never seen people talk about condomless sex in such a healthy way before. So, we're changing the *culture* of sexuality. And of course, the more people change their minds and the culture and normalise sexuality, the more likely it is they're going to make healthier decisions about what they do with their bodies, and who they do it with.

I return to Andy's hinting at a return to the sexual culture of the 1970s shortly. As discussed in the previous chapter, Andy's coming out as gay and becoming sexually active coincided with the onset of HIV/AIDS in the United States. At this time, condomless sex was considered particularly dangerous and a sexual act that should be discouraged. PrEP facilitated a shift in Andy's attitude, however, where discussions of condomless anal sex could be openly celebrated.

The importance of fostering of an environment whereby individuals are more likely to be honest about their sexual behaviour is highlighted in the work of anthropologist Ralph Bolton (1990). Prior to the development of effective HIV treatments in the mid-1990s, Bolton conducted ethnographic fieldwork exploring safer sex practices among MSM in Belgium. Actively participating in the social and sexual worlds of Belgium's MSM, Bolton's findings contradicted survey data of AIDS councils in which the majority of MSM were reported as consistently using condoms. While Bolton did not engage in condomless sex himself, he observed that his sexual partners were often willing to engage in condomless anal sex and that it was only at his insistence that condoms used. Through his research, Bolton argued for the necessity of examining the lived experiences of research participants, particularly as self-reported sexual behaviour often did not reflect the varieties of sexual expression MSM engaged in.

Bolton's research was reflected by Andy, who questioned the extent to which PrEP was directly responsible for a seeming rise in rates of condomless anal sex:

> Are condoms being used less? Or are people just being a lot more honest about it now, and [more] proud about it now than they've ever been? I think it's probably yes to both questions. Definitely, there are people who have not used condoms for 20 years that have been afraid to talk about it and, now they can talk about it because there's scientific validity behind [PrEP].

Andy does not refute the potential of PrEP making it more likely that MSM forgo the use of condoms. However, he does introduce the importance of also considering the degree to which destigmatising condomless anal sex might influence the likelihood of MSM accurately reflecting their own engagement in this practice. Given PrEP's demonstrated effectiveness at preventing HIV, Andy suggests that PrEP users are now able to claim condomless anal sex while using PrEP as a form of safer sex. Given the stigma of condomless anal sex that has existed within gay communities, a stigma underpinned by the potential for HIV transmission, the removal of HIV risk opens the opportunity for that stigma to be reduced. Implied in Andy's comment here is how, through fostering spaces in which to discuss sexuality in judgement-free ways, analyses of human behaviour might more accurately represent the lived experiences of those they seek to represent.

Pleasure and Intimacy

The potential of PrEP to increase sexual pleasure was seen by Rick (PrEP advocate and user, 50s) as an effective marketing tool. Rick had a long history of working in gay community organisations and had been involved with state-based HIV/AIDS organisations since their inceptions in Australia. He described his experiences of promoting condoms in the earliest years of Australia's HIV/AIDS epidemic:

> I came out in 1982, and in about 1984 it was all about educating with condoms. I was running around beats handing out condoms to people telling them how to use them and trying to introduce this alien concept to them saying "this is a temporary, extraordinary measure just to save our lives at the moment."

Rick's characterisation of condoms as a "temporary" and "extraordinary measure" to mitigate against death frames the uptake of condoms in the early 1980s as a short-term behavioural measure.

There can be no doubt that although condoms are not a 100% effective HIV prevention strategy, their promotion has been an important part of the response to the HIV/AIDS epidemic. As a strategy that relies on behavioural change during the act of sex, however, the adoption of condoms has relied on shifting and changing sexual behaviour itself. In contrast, PrEP can be taken outside of sex. While both strategies do rely on behaviour change, PrEP need not necessarily impact *sexual* behaviour and can instead be incorporated into one's daily routine. Contrasting condoms to PrEP, Rick described PrEP as

> A downhill run. Condoms were an uphill run. [With condoms] we were telling people to reduce their pleasure, to do something unnatural, to think about it in the heat of the moment. So, while you're screwing [you need to] think about whether the condom's broken or not. All this maintenance stuff … We were brow beating people into using condoms. Now we should just be going meh, take the condom off. It's fine. Have you taken your pill? It's a much easier sell.

Here, Rick points out a significant difference in how these two different prevention strategies are promoted. Taken outside of sex itself, PrEP allows individuals to minimise the risk of HIV while, at the same time, maximising the potential for sexual pleasure.

Overwhelmingly, participants described condomless sex as significantly more pleasurable than the experience of sex while using condoms. For some, sex on PrEP was associated with a sense of liberation from HIV. For others, such as Thomas (PrEP user, 40s), PrEP was experienced in less revolutionary terms. At the time of our interview, Thomas had been in a long term, non-monogamous relationship for more than 10 years. During their relationship, Thomas' partner had contracted HIV as a result of condom failure. Speaking of his motivation for using PrEP, Thomas explained that he was primarily motivated by a desire for increased physical pleasure:

> I thought that [PrEP] would be a better way of sexually protecting [myself] than using condoms. Better meaning more pleasurable … it feels a lot better and it's less complicated. You don't have to stop and put one on, it's simple.

Unlike some participants for whom HIV had been an almost constant and overarching concern, Thomas had never experienced any fear of HIV. Before using PrEP, Thomas had consistently used condoms and, on three occasions where condoms failed and left him vulnerable HIV, he went onto a month-long course of post-exposure prophylaxis. However, Thomas only used condoms to prevent HIV and, despite using them consistently, they were not an object he enjoyed using. In contrast to condoms, PrEP provided an opportunity for Thomas to both protect himself against HIV while also engaging in forms of sex he preferred.

Echoing both Rick's and Thomas' motivations for using PrEP was Harry (PrEP user, 40s). When asked why he initially began using PrEP, Harry stated,

> Oh, I wanted to have better sex (*laughs*). I had to use condoms for virtually my whole [sexual] life. Almost 30 years. 30 years accompanied by a chorus of songs in the background along the lines of "we have almost developed a vaccine. We are nearly there." Which, of course, was a lie. I was fed up with this problem and fed up with constantly having to worry about, you know, is the condom going to break. Also, [I'm] getting older so the machinery doesn't work quite as well as it used to. I mean it's still in good working order but nevertheless, it doesn't respond quite as readily to stimuli as it used to do. And, obviously, condoms get in the way of that.

Harry's use of PrEP was not associated with the sense of liberation from HIV described in Chapter 6. Rather, he described a sense of frustration that HIV prevention strategies had not seemed to evolve since the introduction and widespread uptake of condoms. As with Rick, Harry had considered condoms as a temporary strategy that would eventually be superseded through the development of a vaccine. While condoms had enabled Harry to continue having sex while reducing his risk of HIV infection, they required him to maintain a degree of vigilance during sex. Moreover, Harry described increased difficulties in becoming aroused which were further compounded by reduced physical sensation through using condoms.

The issue of condoms, their impact on maintaining an erection, and their disruption to the sexual encounter were the subject of some discussion on social media:

> P1: I have to wonder if it's "condom fatigue" or just that many guys really do struggle with [condoms]. I [know people] who find the process of putting on the condom jarring. It breaks the intimacy and for many, this leads to loss of erections and frustration. This is for both the straight and gay population, so I wonder why we often fail to acknowledge this observation.
>
> P2: Good point. I've talked to some guys who just can't get hard if a condom is involved. I think it's a combination of factors and all of the above. Anxiety about performance is a boner killer and it only takes one episode of losing it while fiddling with getting a pesky condom on to start a cycle of dread. I think long-term erosion of your will to keep doing the "right" thing in the face of some very strong opposing desires is real too.

Condom fatigue was a popular hypothesis which attempted to explain decreasing rates of condom use among MSM (Adam et al. 2005). According to this narrative, the development of protease inhibitors and highly effective HIV treatments in 1996 had led to so-called AIDS optimism and a perception of HIV as a chronic yet manageable condition. As the consequences of an HIV diagnosis diminished, it was argued that there was less of an imperative for MSM to continue using condoms. While the interaction above acknowledges the potential for condom fatigue, it also highlights multiple reasons as to why MSM might choose to forgo the use of condoms, including intimacy, the disruption caused to sex, and the maintaining of an erection. P2 notes the negative effect of condoms on maintaining an erection can be more than simply a lessening of physical sensation, and the very act of putting a condom on itself can potentially cause the loss of an erection. According to P2, the occurrence of this even once has the potential to cause future anxieties around condom use and maintaining an erection.

The examples provided thus far highlight the various motivations for, and experiences of, using PrEP. Through the disruption of sexual assemblages that had previously included condoms, PrEP facilitated experiences of sex with heightened physical sensation, that were less complicated, and did not have a sense of disruption. Importantly, these assemblages differed across PrEP users and, while for some the new experiences PrEP enabled were revolutionary, others were less enthusiastic as to its impact. For these individuals, PrEP simply facilitated experiences of sex that were better than when condoms were used, however, this did not impact their day-to-day experiences of the world outside of sex.

Semen as Building Connection

For some participants, sexual pleasure and intimacy were built through the exchange of semen, a substance that across cultures has been imbued with various meanings. This was stated by Andy who reminded me of the history of semen as a sometimes-fetishized subject:

> Like ancient Greece and boys swallowing semen because it would increase them as warriors. When we talk about PrEP and condomless sex and oh my god the sky is falling. I wish people had more of that historical, anthropological perspective that we're talking about rites of passage, and pleasure, that seem to be pretty consistent over humanity.

Gilbert Herdt (1987) reported that for the Sambia of Papua New Guinea, semen was considered vital to "the creation of biological maleness and the maintenance of masculinity" (p.2). Such was the importance of semen that, from as young as seven, boys would ingest the semen of older youths as an important part of their development from boys to men. Similarly, anxieties exist cross-culturally over the loss of semen and, in turn, a loss of male power, strength and energy (Bottéro 1991). At the same time, semen represents both the source of life (Aydemir 2007) and, since the beginning of the HIV/AIDS epidemic, potential disease and death (Mowlabocus et al. 2014).

Exploring the narratives of HIV-negative MSM who predominantly adopt the role of the receptive partner during sex, Trevor Hoppe (2011, p.204) highlights "seminal fluid exchange as an important symbolic exchange of pleasure from top to bottom." Hoppe argues that for many receptive partners, their own sexual pleasure was experienced through the pleasure they were able to give to their partners. As a fluid derived through orgasm, semen represented "pure, embodied pleasure" with the experience of it entering one's own body, "both a literal and metaphorical exchange" (ibid., p.204). Given the importance many MSM placed on this

experience, Hoppe (ibid., p.205) concludes that the erotic meanings associated with the exchange of semen has significant implications for sexual health messaging.

The exchange of semen during sex held deep significance for Freddy (PLHIV, 50s)[64], who also believed that the desire for semen exchange during sex was a barrier to condom use among MSM. Freddy also described condoms as disruptive to the sexual encounter, reducing physical sensation while at the same time causing him physical irritation. Just as he described the physical disruption, Freddy also commented that his first experience of bareback sex had left him somewhat disappointed:

> [I expected] to feel the guy cum inside me. To feel the heat of the cum just as you do if someone cums on your balls.

Despite his initial disappointment at not feeling his partner ejaculate inside, Freddy described a feeling of deep psychological satisfaction in knowing he had received his partner's semen. More than the physical sensation itself, the exchange of semen built an emotional connection between him and his partner. For Freddy, the forgoing of condoms not only removed the physical barrier between him and his partners, allowing for the sensation of skin-on-skin contact, but also allowed for a building of intimacy and connection through the exchange of bodily fluids. Given the significance of this exchange, Freddy believed that safer sex campaigns premised on semen as potentially dangerous were set to "fail" as, he stated, "no amount of scare campaigning would turn people off."

Freddy highlights the necessity of understanding the various meanings that individuals attribute to different expressions of sexuality. In Chapter 3 I highlighted the necessity of more nuanced conceptualisations of risk while, in Chapter 4 I argued that sexual health goes beyond the narrow public health lens of disease prevention. Taken together, these arguments allow us to move toward a weighing up of two related but different risks: the risk of sexually transmitted infections versus the risk of losing a potentially important aspect of human sexuality. In considering sexual health as beyond solely the prevention of disease and infection, the possibility of viewing semen exchange as healthy, despite the potential for STI transmission, becomes possible. Darren stated:

[64] As stated earlier, Freddy's interview was not recorded at his request.

> There is something about having a man cum in you that is different to a man cumming in you wearing a condom. And you can try and minimise that all you like for safer-sex condom messages in the community. But the reality is people prefer not to use condoms. That's the reality of it.

As with Freddy, Darren too spoke of an increased intimacy and connection through his partners ejaculating inside him. Mowlabocus et al. (2014, p.1474) describe semen as "an ambivalent and unstable signifier within gay male subculture, attracting a diverse range of meanings and understandings." Exploring the significance of semen among the United Kingdom's barebacking community, Mowlabocus (2010) identifies semen as a transcendental substance, with the act of internal ejaculation touted by some as offering "an opportunity to reconnect gay men with their own bodies" (p.315).

Of all my interview participants, none were so emphatic about the significance of semen exchange as Andy. An early adopter of PrEP in the United States, Andy had also been a strong PrEP advocate and, reflecting on his own PrEP advocacy stated,

> we're talking very openly and celebratory about condomless anal sex. About the emotional, sexual, spiritual pleasure of exchanging semen with somebody else. Also, kind of the glory and joy that comes with that.

As in the previous two comments, the exchange of semen is about more than sexual pleasure as if it were a trivial aspect of sex and sexual health. Rather, pleasure also encompasses both emotional and spiritual aspects of sexuality:

> What has [PrEP] done? Okay. Sexually, I love having sex now. And multiple partners, total strangers. Getting fucked, getting cum up my arse, feels wonderful. Every part of that feels good. Physically, sensationally and spiritually. I'm a very spiritual person too. It feels like, it's, it's just one of the most incredible things to have a man's semen inside your body. And that's very powerful. You're an anthropologist so you know different cultures over history have had fetishized and prioritised semen for different reasons and different ways and for different rituals. Well, I never got to have that experience until I was 40. And it feels amazing, it feels incredible.

More than simply the physical experience of bareback sex, Andy also associated the exchange of semen with a spiritual experience, echoing the exchange on *Bareback Real Time Sex* discussed in the previous chapter.

The emergence of PrEP has been accompanied by the deterritorialization of sexual assemblages in which semen was considered a dangerous and potentially lethal substance. As a substance that carried with it the potential for HIV infection, the semen of other partners was something to be avoided or, if exchanged willingly through bareback sex, something deviant. However, as Andy's experience reveals, the overlay of danger mapped onto semen

does not necessarily remove the pleasure associated with its exchange and, in Chapter 6 Andy described how prior to PrEP he enjoyed semen exchange despite being aware of its risk. Through disrupting the association of semen with danger, new sexual assemblages emerge through which semen can be exchanged without the risk of HIV. These assemblages allow for the exchange of semen to be celebrated. Through this, PrEP unlocks the potential for new ways of experiencing sex, pleasure, and intimacy between partners.

Bug Chasing and Gift Giving

The potential for semen as substance that established bonds and kinship between individuals is highlighted through the subculture of "bug chasing" and "gift giving."[65] Held as one of the most extreme and deviant subcultures among gay men (Dean 2009), these phenomena refer to those actively seek contracting HIV (bug chasers) and those willing to infect those who are HIV-negative (gift givers). Awareness of bug chasing and gift giving has been closely linked with the rise of the internet (Dean 2009; Gauthier and Forsyth 1999) and a number of digital platforms exist to facilitate connection between those engaging in this subculture.

Gauthier and Forsyth (1999) suggest for some, the fear of HIV limited their behaviour so much that "their perceived quality of life had diminished to unacceptably low levels" (p.93). They argue that for these individuals, HIV infection was "inevitable" and therefore "they wish to merely quicken the inevitable so that they can get on with the business of living out their lives in a more uninhibited fashion" (ibid., p.93). According to this explanation, bug chasing and contracting HIV is viewed as a way in which individuals can gain a sense of control over their own health. As suggested in Chapter 6, a negative HIV status always exists in a state of uncertainty (Dowsett 2009) with HIV a potentiality that must always be guarded against. Once an HIV-positive diagnosis is received, however, individuals may be afforded a sense of relief from that uncertainty and are able to go on with the processes of managing that diagnosis. Importantly, this relief from uncertainty is only experienced by a small number of people and, for many, an HIV diagnosis is experienced as a profound and often distressing event (Bilardi *et al.* 2019). However, we might recall here Ethan's (HIV advocate and

[65] Research exploring these phenomena has primarily been conducted in the United States with little evidence of a similar subculture in Australia. Existing literature into bugchasing and gift giving primarily relies on analyses of digital dating profiles. Given this, the extent to which these profiles reflect an actual desire or merely fantasy is uncertain.

PLHIV, 30s) description of "the gift of sexual liberation that comes with a positive diagnosis" and Andy who prior to PrEP felt that the only way he might be relieved of the uncertainty of HIV would be to contract the virus. While an HIV diagnosis was not necessarily desired, it was nonetheless a way to establish a sense of control over one's health while also engaging in forms of sexual expression that might put an individual at risk of HIV.

Gauthier and Forsyth (1999) offer important insights into what has otherwise been considered a particularly deviant subgroup of gay men. Other scholars, however, have argued that part of the appeal of bug chasing and gift giving is the supposed social connection and bonds it creates between individuals. Drawing on the work of anthropologist Marcel Mauss (1989), some have suggested that HIV acts as a gift which, in passing from one individual to another, forms social bonds between HIV-positive and HIV-negative individuals (Dean 2009; Escoffier 2011; Reynolds 2007). Ellie Reynolds (2007), for example, argues that although bug chasing is portrayed as one of the most extreme forms of sexuality, it nonetheless mirrors normative representations of semen and sperm. That is, whether HIV-negative or -positive, semen has transformative potential and is able to change and reshape the bodies of those it enters. Just as semen has the potential to transform bodies through pregnancy, so too does it have the possibility of altering HIV-negative bodies through HIV seroconversion. Reynolds (2007) suggests that this can be understood in terms of kinship, whereby the DNA of one (HIV-positive) individual mixes, through HIV infection, with the DNA of another (HIV-negative) individual.

I had not set out to explore in any detail the phenomenon of bug chasing and gift giving beyond merely a curiosity as to what impact PrEP might have on this subculture. Beyond the rare profile on *Bareback Real Time Sex*, there was little evidence of people within my field engaging in the practice. Brendan (PLHIV, 40s), however, did describe experiences of some individuals who wanted to contract HIV through him, something which he had difficulty understanding:

> How could you be willing to sleep with somebody who's positive to catch this? On purpose!? Now they call it breeding and seeding. "Breed me, make me yours" … What the fuck? So what, now instead of donating my sperm to impregnate [women] or lesbians, I can donate it to people who want to become poz? … That's weird. I still can't get my head around that. And some are really – they think it's going to make them closer to you or make them yours for the rest of their life. How the fuck do you get to think like that?

Josh (HIV advocate and PLHIV, 40s) had similar experiences and was equally disturbed by them:

> Ugh … there is no greater – what's the opposite of aphrodisiac? – Turn-off for me the minute someone uses that sort of language … The fetishization of cum in that space, of that sort of part-fetishization, has been a construct of the porn industry that I still to this day struggle to deal with … I've even had people say to me, "would you go off your medication so that you could infect me?" Now, that sort of thing just, nothing could be a greater turn off. Not only are you asking me to put my own health into question … but you're asking me to actively endanger a third party at the cost of my own health. Fuck off. Fuck. Off.

What is clear in both these comments is the contempt both Josh and Brendan have for those wanting to contract HIV through them. It is in Brendan's comment particularly that notions of kinship and bonding through the virus are seen. In becoming HIV-positive through Brendan and in contracting his specific strain of the virus, some of those who contacted him believed they would be "his," bonded to him for the rest of their lives.

While I did not explore the phenomenon in great detail during my fieldwork, bug chasing provides a useful way to understand the potential for semen exchange to form strong bonds between individuals. As highlighted here, this literature serves as a useful counterpoint to constructions of semen and HIV as necessarily dangerous. Through the exchange of fluids, and the DNA of one individual entering another, a connection is established that, in bug chasing discourses, has been described in terms of kinship.

Hedonism

To this point, I have discussed the way in which some participants experienced the exchange of semen as deeply significant, an act that bonded sexual partners. Framed in this way, the exchange of semen between partners shifts from a particularly transgressive act associated with risk and danger to an act which can be understood in terms of intimacy and connection regardless of whether between casual or ongoing partners. Described as such, condomless sex and the exchange of sexual fluids becomes a valued and celebrated aspect of sexuality. The potential of PrEP to facilitate this experience is certainly one of its significant benefits.

At the same time, it is necessary to recognise the potential of individuals engaging in sexual expressions that run counter to constructions of semen exchange as a form of sexual

connection and intimacy. Mark, for example, described an element of hedonistic pleasure associated with the exchange of semen:

> Sometimes, I just want to feel like a slut – and it's interesting to note that the feeling of slut and the meaning [of it] means barebacking … So yeah, sometimes I'll just [think] "you know what? I'm going to make damn good fucking use of my PrEP today." And I'll go to a sauna or a beat and I'll just seek out loads. [I'll] go up to a glory hole and get as much as I possibly can, and it satisfies me for that day.

In these encounters, Mark describes making "good use" of their PrEP, of seeking out as much semen from as many partners as possible. Mark went on to describe a gendered aspect to the experience of bareback sex and semen:

> There's a femininity to it that also I like engaging with – as the receiver of [semen]. And this kind of also goes with my difficult relationship with condoms. I perceive masculinity and one of the aspects of masculinity to be uninterrupted and unobstructed penetration in a range of ways, including sex. So, fisting I find quite masculine and powerful, dangerous, risky. You can kill someone. But it's also very raw because when I do fisting, I don't do that with gloves. So I feel the anatomy of a person's inside and there being no obstruction between my skin and there being no obstruction between my skin and their skin. Feeling that is incredible and it adds to the feeling of masculinity and power … But then when on the receiving end of bareback sex, that unobstructed penetration, I interpret that as a femininity (with my narrow gender binary stereotypes).

Just as Mark described a hedonistic element to the experience of bareback sex, whereby they sought the feeling of being a "slut", so too was there a gendered aspect to the experience of semen exchange and condomless sex. Mark acknowledges their conceptualisations of gender as operating within a narrow binary of gender stereotypes, a discussion of which is beyond the scope of this section. It is worth noting, however, that previous literature has suggested the heightened HIV risk of barebacking had led to associations of bareback sex as a particularly masculine sexual act, regardless of whether individuals were the top or bottom during sex (Dean 2009; Dowsett et al. 2008; Holmes et al. 2008). Notably, Mark specifically described the *unobstructed* skin-to-skin contact as adding to heightened feelings of masculinity and femininity. While there was a sense of hedonistic pleasure associated with semen exchange for Mark, it also allowed for an element of experimentation and play with gender. This was significant for Mark who, at the time of our interview, identified as both pan-sexual and gender non-binary.

A return to how "people naturally have sex"

Through its potential to enable gay men to forgo the use of condoms, PrEP was considered by some as facilitating a return to what Jeffrey Escoffier (2011, p.129) has described as "a golden age of sexual freedom." Coinciding with the sexual revolutions of the 1960s and 1970s, this was a period "that not only opened up the possibility of openly acknowledging

one's homosexuality and fostering a sense of identity and community, it also initiated a period of radical sexual experimentation" (Escoffier 2011, p.129; see also Altman 2013). With gay liberationists emphasising an imperative to be open about one's sexuality (Altman 2012; Escoffier 2011), the celebration of sex was more than an exercise in physical pleasure and was also a considerable political act. While this characterisation of the two decades prior to the emergence of HIV/AIDS has become common, it is important to note that this was the experience of a small subset of gay men. At this time, gay men and gay communities were subjected to physical and state sanctioned violence, the potential loss of housing and employment, as well as ostracization from one's communities and families (Rofes 1998, 1996; Reynolds 2002). Because of this, many gay men in this period actively avoided this movement.

The emergence of HIV/AIDS within gay communities in the 1980s was said to cause a seismic shift in the sexual cultures among gay men, particularly in cities with large gay communities. Such was the early impact of HIV/AIDS on these cultures that, in the 1980s, self-described "sluts" Callen and Berkowitz authored an essay in the *New York Native* titled "We Know who we Are." In it, they implored gay men to stop engaging in casual sex, writing,

> *This isn't a game. People are dying – very real, horrible, and unnecessary deaths … Sure, the baths are fun, but the risks have simply become too great … What ten years ago was viewed as a healthy reaction to a sex-negative culture now threatens to destroy the very fabric of urban gay male life (qtd France 2017, pp. 61-63).*

Both HIV-positive themselves, Callen and Berkowitz had been active participants the New York gay scene. Having high numbers of sexual partners themselves, they were both fully aware of the important place sex, in particular casual sex, had in the sexual culture among gay men. Escoffier (2011, p.129) describes the emergence of HIV/AIDS as an "historical trauma" that "shattered the experience of sexual freedom and disrupted new patterns of identity and community." HIV/AIDS transformed a highly valued and important aspect of gay sexuality – anal sex – into an act of potential danger and death (Bersani, 1987; Escoffier, 2011).

As noted extensively throughout this thesis, the development of condom-based safer sex strategies has been an enduring legacy of the HIV/AIDS epidemic. While they did enable sex

with reduced risk of HIV transmission, their use was also thought to inhibit physical pleasure and forms of intimacy built through skin-to-skin contact and the exchange of semen. In this way, HIV was considered a virus that had taken an important aspect of gay sexual experience away, limiting the possibilities for sexual expression. Darren stated:

> I grew up before HIV. Or, I didn't grow up, I was sexually active before HIV. So, I remember what sex was like without a condom. I am acutely aware of how disruptive they are in [people's] sexual expression. The idea of raw sex, or bareback sex or, to use the sociological condomless anal sex' … Yes of course [condoms] have got their place. Yes of course there are times where they're really useful for people. But in relatedness and relationships I don't think they're such a good idea.

Here, condoms are characterised as an unwelcome intrusion into the experience of sex and the building of connection between individuals. Condoms were framed by Darren as an intrusion that only occurred in conjunction with HIV such that, he describes being sexually active prior to HIV as synonyms with condomless sex. Through the removal of HIV risk by using PrEP, Darren was therefore afforded the opportunity to return to this period and re-experience sex without the presence of condoms or HIV.

Reflecting portrayals of condoms as an unwelcome part of the sexual experience was the characterisation of condomless sex as "the way sex is meant to be." Rick, for example, described PrEP as

> Basically reinforcing the natural urges. This is how people naturally have sex and if you give them permission, they will take a pill a day.

Natural sex was conceptualised as sex without a condom, a natural urge which with permission, people will take pharmaceutical medication to experience. Dean (2015) critiques the notion of natural sex, claiming that the "idea of sex as raw, unmediated contact with another body or being is nothing more than a fantasy – albeit a powerful one – that responds to the intensively mediated conditions of modern existence" (p.224). For Dean, all sexual experiences are thoroughly mediated by normative understandings of what sex should or should not be. Similarly, for participants such as Rick, "natural" sex was constructed as an expression of sexuality in which HIV risk and prevention were removed from the experience, position PrEP-enabled sex as more natural than sex in which condoms were present.

As described in this chapter, participants' experiences of natural sex have only been enabled through the replacement of condoms with a pharmaceutical prevention technology. The feeling of sex that was more natural, then, can be said to have only been enabled using a

pharmaceutical technology to change the chemical composition of the body. While PrEP does mediate the experience of sex in this sense, it also displaces the act of HIV prevention itself from the experience. In doing so, the act of sex can be experienced without the introduction of seemingly artificial prophylactic devices.

Conclusion

Throughout the HIV/AIDS epidemic in Australia, condoms have been a safer sex strategy that has enabled MSM to maintain various sexual relationships while, at the same time, protecting themselves against HIV infection. Despite offering the possibility for MSM to engage more safely in sexual relationships, they were also experienced as disruptive to sexual pleasure and intimacy. For participants such as Harry, condoms inhibited physical pleasure which had further implications for his ability to maintain an erection. Similarly, Thomas considered PrEP a better prevention strategy over condoms, with Thomas equating better with more pleasurable. For other participants such as Darren and Andy, it was the exchange of semen itself that established an important and intimate bond between sexual partners, reflecting a broad body of literature exploring bug chasing as a way of forming bonds of kinship among MSM.

As a prevention strategy inseparable from sex, condoms form a sexual assemblage in which semen is considered a potentially dangerous substance that must be guarded against. For participants discussed in this chapter, this foreclosed the celebration of semen exchange. While from an epidemiological perspective the exchange of semen has been considered a sexual behaviour to be prevented, it has been a core part of the sexual experience for many gay men (Escoffier 2011).. As a strategy that is both taken outside of the sexual context and works at the microbiological level, PrEP can disrupt the association of semen with risk. This offers MSM the opportunity to experience and celebrate semen exchange in a way that has not been possible through much of the HIV/AIDS epidemic.

As a sexual health technology, PrEP carries with it the potential for offering its users new ways of experiencing sexual pleasure and intimacy that the use of condoms did not enable. That is, an experience of sex without the physical and psychological barrier that condoms

represent. Significantly, PrEP was thought of as offering a return to a perceived golden age of sexual expression and experimentation among gay men, a period that had effectively ended with the emergence of HIV/AIDS in 1981 (Altman 2013, 2012; Escoffier 2011). Through the chemical enhancement of their bodies, PrEP users were portrayed as being able to experience more natural forms of sex and sexuality, experiences that had been denied them throughout almost four decades of the HIV/AIDS epidemic.

Conclusion

PrEP has significantly shifted how notions of sexual risk and safety are imagined among MSM. Highly effective, PrEP enables MSM to experience condomless sex while, at the same time, significantly reduces their risk of HIV. The emergence of PrEP has been accompanied by a promise of both reducing HIV anxiety and liberating MSM from an almost constant, overarching fear of HIV. More than just an HIV prevention strategy, PrEP is a technology that has challenged, disrupted, shaped, and re-shaped many of the discourses that have formed through and around the HIV/AIDS epidemic.

Throughout the HIV/AIDS epidemic, gay men have experienced sex through assemblages that have included: individual bodies, HIV and its potential risk, condoms, and the social and moral discourses surrounding harm minimisation. In addition to condoms acting as a physical barrier to prevent the exchange of semen, they also acted as psychological barrier that inhibited sexual pleasure and intimacy. Condom use required that individuals be cognisant of the potential HIV risk posed by their sexual partners, firmly positioning HIV as part of the sexual encounter. Moreover, by preventing the exchange of semen, condoms also removed an important aspect of the sexual encounter. For some, semen exchange was an important sexual act that established a sense of connection and intimacy between partners.

Through providing heightened protection against HIV and reshaping how sexual risk is experienced, PrEP de-territorialises sexual assemblages through which a sense of risk and danger were a part of the sexual experience. As an HIV prevention strategy used outside of the sexual experience, PrEP displaces condoms and HIV prevention from the act of sex itself. Hence, PrEP shifts HIV prevention into the more mundane realm of everyday routine, enabling the formation of new sexual assemblages in which HIV risk can be considered irrelevant. In doing so, PrEP offers the possibility of experiencing sex through assemblages that foreground pleasure and not, importantly, through assemblages that include risk and danger.

PrEP advocates described HIV as an almost constant and overarching fear against which gay men have navigated their sexual and social worlds. To be HIV-negative was to exist in a

liminal state (Dowsett 2009), a status that required constant guarding against the risk of infection. This required individuals to be cognisant of their potential for HIV infection and consideration of their sexual partners as potential sites of risk and danger. I have demonstrated in this thesis that concern over HIV was experienced differently by each participant. While some experienced HIV as an almost constant fear which overshadowed their lives, others experienced it as a health condition that could be easily prevented by always using condoms. Regardless of the differing degrees of HIV anxiety (or not), however, the virus had negatively impacted the experience of sex for all participants.

Grassroots community advocacy has been central to the emergence and implementation of PrEP in Australia. Building on a long history of HIV/AIDS activism (Epstein 1996), groups such as *PrEP'd for Change* and *PAN* established working relationships with PrEP researchers and community health organisations. Chapter 1 highlighted the importance of these reciprocal relationships, whereby researchers gained insight into PrEP beyond being solely a tool to prevent HIV, becoming aware of PrEP use as a strategy that could significantly reshape people's experience of sex. At the same time, the relationships *PrEP'd for Change* and *PAN* had with PrEP researchers meant they received the most up-to-date information about the implementation of PrEP in Australia, including information on state-based clinical trials. Through their social media networks, these groups were able to quickly disseminate information to a wide audience, in-part contributing to the fast uptake of PrEP in Australia.

The advocacy of *PrEP'd for Change* and *PAN* was underpinned by an ethos of sex positivity. This was particularly important given the stigma that has been associated with condomless anal sex (Ávila 2015; Dean 2009; Mowlabocus et al. 2014), a stigma that was also attached to PrEP. In Chapter 2, I demonstrated that the stigma of condomless anal sex and PrEP has been underpinned by conceptualisations of individuals as unnecessarily engaging in high-risk behaviours. Those deliberately forgoing the use of condoms have been characterised as prioritising bodily pleasure over their own safety, values that are considered antithetical to those of the broader community. Imagined as "matter out of place" (Douglas 1966), those who disrupt existing sexual norms threaten more than just the physical health of community members. They also represent a threat to the social and moral values of a group and, importantly, how that group might be seen by others. This is particularly significant for

historically marginalised groups such as gay men who, throughout the HIV/AIDS epidemic, have been invested in presenting their sexuality as appropriately disciplined and responsible (see Weeks 1995). PrEP's challenge to condoms goes beyond their use to prevent HIV and threatens the cultural and moral attachment gay communities have had to this HIV prevention strategy.

The potential of PrEP to negatively impact rates of condom use has been an influential concern associated with PrEP use. Concerns were raised that PrEP might encourage a widespread abandonment of condoms and subsequent increase in rates of STI transmission. As demonstrated in Chapter 3, the notion that PrEP users would be likely to abandon condoms was almost never refuted. Indeed, it was suggested that this should be an expected outcome of PrEP use. However, PrEP users critiqued concerns that characterised these concerns as risk compensation. It was widely argued that framing the potential for increased STIs while use PrEP as "risk" failed to account for the complex ways in which MSM navigate their sexual worlds. These included increased testing associated with PrEP, the potential STI risk posed by sexual partners, and the multiple avenues of STI transmission. In defending themselves against engaging in so-called high risk sexual behaviour, PrEP users here positioned themselves as both disciplined and responsible (Weeks 1995). This is the very position gay men have been expected and sought to occupy in relation to HIV. Different levels of anxiety around STIs when compared with HIV were also reported, such that the potential of STIs was considered an acceptable risk to take to maximise one's pleasure. This chapter builds on existing literature that describes condomless sex among PrEP users through the lens of risk (Brooks et al. 2012; Grov et al. 2015; Traeger et al. 2018), and argues that such language has the potential to further alienate PrEP users. Given the interrelationship between risk and stigma, and the history gay men being marginalised by medical institutions, it is important that researchers critically consider the language used to describe the populations they describe.

Chapter 4 outlined participants' own understandings of sexual health, safety, and risk. These understandings extended dominant epidemiological definitions of sexual health which have focussed primarily on the prevention of disease, illness and disfunction. Participants took a more holistic approach to sexual health and emphasised aspects such as the relationship to

one's body, feelings of empowerment and control, a potential for experiencing pleasure and intimacy, and the fostering of open and frank dialogues around sex, sexuality, and sexual expression. The sex positive approach taken by PrEP advocates was about more than simply encouraging the pursuit of bodily pleasure. Rather, this approach was considered essential to fostering good quality sexual health care. As some participants suggested, feelings of shame and stigma around sex and sexuality created a significant barrier to accessing healthcare and increased the likelihood of individuals engaging in unsafe behaviours. By normalising condomless sex, removing much of the associated shame and stigma, PrEP advocates have contributed to a shift whereby more honest and candid communication has been opened.

In Chapter 5, I highlighted the way in which PrEP was characterised as having the potential to make a significant contribution to a decline in HIV stigma. This promise was underpinned by the belief that PrEP's efficacy, coupled with a heightened sense of protection against HIV, would make the virus almost irrelevant to PrEP users. By removing the fear of HIV, it was claimed that PrEP could also remove the fear of people living with the virus. This potential was an exciting and hopeful prospect. However, PrEP has so far not proven to be a panacea for this stigma. Despite most participants reporting they did not sexually discriminate based on HIV status, two participants remained hesitant to interact sexually with PLHIV. Moreover, the conflation of HIV anxiety among PrEP users with a decline in stigma does not account for the impact of being subjected to HIV stigma. As shown in Chapter 6 through the experiences of Brendan (PLHIV, 40s), the many years of living with HIV and the stigma associated with it continued to shape his interactions with others. Just as PrEP brings with it a promise to reduce HIV stigma, it is essential that work continues to address and health the ongoing effects of that stigma.

Just as it remains necessary to centre people living with HIV (PLHIV) in research addressing the effect of PrEP on HIV stigma, so too is it necessary to examine how PrEP is experienced by those who continue to rely on condoms as their chosen HIV prevention strategy. Chapter 5 also outlined the shifting discourses around PrEP and sexual responsibility, whereby PrEP came to be framed by some users as a superior HIV prevention technology when compared with condoms. During fieldwork, some PrEP non-users reported that as more PrEP users exclusively sought condomless sex, they found it increasingly difficult to find sexual

partners. Some also described situations whereby they had been pressured to forgo the use of condoms as their partner was using PrEP. These situations contrasted with an overarching narrative among PrEP users of needing to respect individuals' own sexual health preferences. As PrEP uptake increases, it will be necessary for research to explore the experience of PrEP among users and non-users alike.

Chapters 6 and 7 described how through displacing risk from sex and into the world of everyday routine, PrEP opens new possibilities for MSM to experience sex and sexuality. There is no doubt that MSM were engaging in condomless sex prior to PrEP and, for some participants in this project, their engagement in condomless anal sex functioned as motivation for beginning PrEP. As described by Andy (PrEP advocate and user, 40s), however, this was associated with a form of cognitive dissonance, of condomless anal sex being experienced as pleasurable while also experienced with a sense of self-reproach. The use of PrEP has disrupted these assemblages through which sex was experienced as cognitive dissonance and formed new sexual assemblages whereby condomless anal sex can be experienced as both safe and pleasurable. In these chapters, I argue that it is by displacing risk from the experience of sex that PrEP enables new experiences of sex and relationships to emerge.

Previous research has explored the interrelationships between PrEP, sexual pleasure, and intimacy (Gamarel and Golub 2015; Mabire et al. 2019). Chapter 7 builds on this literature and highlights the significant role of semen exchange itself in building kinship, and intimacy between some MSM. A substantial body literature has explored this in the context of so-called "bug chasing" (Moskowitz and Roloff 2007; Reynolds 2007; Tomso 2004), arguing that HIV and the semen of HIV-positive individuals is framed as building a form of kinship between partner. This chapter adds to both bodies of research, going beyond the use of pleasure in an abstract sense and highlights the different meanings attributed to particular sexual experiences.

Fieldwork for this thesis was conducted at a time when PrEP was first emerging in Australia and, as such, my informants were uncertain about the extent to which it would reshape community norms. Discourses surrounding PrEP in Australia were quickly shifting

throughout the 10 months that fieldwork was conducted. Where at the beginning of fieldwork PrEP had been a source of concern and anxiety, by the time I concluded my fieldwork it had become an almost every day and taken-for-granted part of the sexual landscape. The speed with which this occurred can be credited to the work of Australian PrEP advocates who worked closely with researchers to shape the implementation of PrEP in a culturally sensitive and appropriate manner. This thesis supports the arguments of Rosengarten and Michael (2009), demonstrating that multiple PrEP assemblages have, and will continue to, emerge.

As PrEP becomes an increasingly unexceptional part of the sexual landscape, it will be necessary to explore its impact at the broader community level. For example, will the widespread uptake of PrEP and increased desire for condomless anal sex result in an expectation that those not using PrEP forgo the use of condoms? How might perceptions of PrEP as a superior sexual health technology create new forms of sexual citizenship whereby condom use becomes stigmatised as "risky" sex? What will be the overall impact of PrEP on STIs and how best can these be managed? Or, will PrEP even remain useful as new technologies to manage HIV emerge?

PrEP is unlikely to be the end of the road in how HIV is prevented, managed, and treated. It is my sincerest hope that one day, sooner rather than later, an effective cure for HIV is discovered and PrEP becomes effectively irrelevant. However, even as new strategies emerge to reduce or even eliminate HIV, the concerns raised in this thesis will remain relevant. Medical technologies, risk, stigma, and social and cultural norms all interact in assemblages through which sex is experienced. In turn, how sex is experienced through these assemblages influences the uptake of such technologies. A great strength of social science approaches to research that explores the implementation of medical interventions is a recognition of the various aspects that influence individual and community sexual health.

In this project, I have explored the implementation of the prevention strategy PrEP among MSM in Melbourne, Australia. My participants had relatively high levels of social, cultural, economic, and political capital when compared with many other HIV-affected communities

globally. The individual experiences presented in this thesis therefore cannot be extrapolated to represent a global experience of PrEP. However, the anthropological approaches I have taken in this project highlight the importance of situating individual experience within the broader social, cultural, economic, and political milieu's in which they occur. A greater sensitivity to these will bring important insights to HIV research and policy making.

Afterword

As I entered the final year of this project, news began to emerge from the Chinese city of Wuhan of a new respiratory condition. This condition was identified as a novel coronavirus and quickly became known simply as "coronavirus" and "COVID-19". As the virus spread through Wuhan and then to other parts of China, the city and country were placed under strict lockdown and people's movements were severely curtailed. By March 2020, it was evident that the virus was spreading to other parts of the world and some countries, including Australia, began to close their international borders. Australian state and federal governments began campaigns encouraging good hand hygiene practices and cough etiquette, as well as encouraging social distancing. In March 2020 and as the virus began to spread in Australia, cities went into various levels of lockdown. Many businesses were forced to close, workers were made to work from home if they could, and a strict set of reasons for leaving one's home were enforced. As I finalise this thesis in November 2020, almost 12 months to the day since COVID-19 was first reported, Melbourne was only just beginning to come out of a second lockdown due to a severe "second wave."

The COVID-19 pandemic affected all my fieldsites, both physical and digital. As physical fieldsites such as the Laird closed their doors, the discussions on social media shifted in focus. In both *PrEP'd for Change* and *PAN*, concerns were raised over how COVID-19 might affect PLHIV as well as the global supply of HIV medications including PrEP. At the same time, there was a significant increase in questions around the protocols of either stopping PrEP completely or moving to an on-demand protocol. Similarly, digital dating and hook-up platforms began to encourage their users to engage in sex mediated through digital platforms.

A particularly significant moment came when state-based HIV/AIDS organisations began to discourage their communities from engaging in casual sex, a position that appeared almost antithetical to their ethos of sex positivity. Unlike HIV which could be prevented by using condoms, PrEP, or Treatment as Prevention, COVID-19 was spread through respiratory droplets. Given the close contact usually associated with sex, this made sexual contact particularly problematic. While casual sex was discouraged, these organisations also took a harm reduction approach and provided advice on ways to continue engaging in sex while

reducing the potential for COVID-19 transmission. These included strategies such as sexual positions that reduced face-to-face contact, the wearing of masks, and the use of barriers such as gloryholes[66]. While not perfect, these reflect a history within queer communities of adapting to various challenges in order to maintain sexual and intimate relationships.

It was widely acknowledged by many in this sector that the messaging around COVID-19 and sex would need to be particularly sensitive given the history of stigma against the LGBTIQ population. This became evident in discussions on social media, where some claimed that it was only the LGBTIQ population being told to limit their sex and that similar messaging was not being targeted to heterosexuals. These claims were not entirely accurate. In the first weeks of Victoria's first lockdown, initial restrictions did not allow for couples who lived separately to visit each other. This restriction was subsequently lifted after significant backlash. Despite the inaccuracy of claims of discrimination, they nonetheless reflect a history of marginalisation and stigma against LGBTIQ peoples such that they felt to be unfairly targeted by this messaging. This response reflects the necessity of health communication that, regardless of the target population, is both culturally appropriate and sensitive to their historical relationships with dominant institutions. Without this, health communication risks being considered irrelevant, ignored or, in the case here, might further alienate those who health professionals seek to help.

[66] A hole in a thin wall or partition used to facilitate anonymous sex.

References

ABC (2010) ‘Safe sex advertisements in the 1980s’. Available at: https://education.abc.net.au/home#!/media/29196/safe-sex-advertisements-in-the-1980s (Accessed: 3 July 2020).

Abu-Lughod, L. (2013) *Do Muslim Women Need Saving?* Cambridge, Massachusetts: Harvard University Press.

Adam, B. D. *et al.* (2005) ‘AIDS Optimism, Condom Fatigue, or Self-Esteem? Explaining Unsafe Sex among Gay and Bisexual Men’, *The Journal of Sex Research*, 42(3), pp. 238–248.

Adam, B. D. (2005) ‘Constructing the Neoliberal Sexual Actor: Responsibility and Care of the Self in the Discourse of Barebackers’, *Culture, Health & Sexuality*, 7(4), pp. 333–346.

Alldred, P. and Fox, N., J. (2015) ‘The sexuality assemblages of young men: A new materialist analysis’, *Sexualities*, 18(8), pp. 905–920.

Allen, L. and Carmody, M. (2012) ‘Pleasure has no passport”: re-visiting the potential of pleasure in sexuality education’, *Sex Education*, 12(4), pp. 455–468.

Altman, D. (1988) ‘Legitimation through Disaster: AIDS and the Gay Movement’, in Fee, E. and Fox, D. M. (eds) *AIDS: The burdens of history*. Berkeley: University of California Press, pp. 301–314.

Altman, D. (1995) ‘Political Sexualities: Meanings and identities in the time of AIDS’, in Parker, R. and Gagnon, J. H. (eds) *Conceiving sexuality: Approaches to sex research in a post modern world*. London: Routledge, pp. 97–106.

Altman, D. (2012) *Homosexual : oppression & liberation*. St Lucia, Qld.: University of Queensland Press.

Altman, D. (2013) *The End of the Homosexual?* St Lucia, Qld.: University of Queensland Press.

Armstrong, D. (1995) ‘The rise of surveillance medicine’, *Sociology of Health & Illness*, 17(3), pp. 393–404.

Arnold, T. *et al.* (2017) ‘Social, structural, behavioral and clinical factors influencing retention in pre-exposure prophylaxis (PrEP) care in Mississippi’, *Plos One*, 12(2), pp. 1–10.

ASHM (2019) *PrEP guidelines update: Prevent HIV by prescribing PrEP*. Sydney: The Australian Society of HIV, Viral Hepatitis and Sexual Health Medicine (ASHM).

Auerbach, J. D. and Hoppe, T. A. (2015) ‘Beyond “‘getting drugs into bodies’”: social science perspectives on pre-exposure prophylaxis for HIV’, *Journal of the International AIDS Society*, 18.

Australian Federation of AIDS Organisations (2004) *Discussion Paper: HIV Pre-Exposure Prophylaxis*. Australian Federation of AIDS Organisations.

Australian Federation of AIDS Organisations (2020a) *HIV in Australia 2020*. Sydney: Australian Federation of AIDS Organisations. Available at: https://www.afao.org.au/wp-content/uploads/2019/11/2725_afao_infographic_9.pdf (Accessed: 6 February 2020).

Australian Federation of AIDS Organisations (2020b) 'Oral Sex and HIV Transmission'. Available at: https://www.afao.org.au/about-hiv/hiv-prevention/oral-sex-and-hiv-transmission/ (Accessed: 4 September 2020).

Ávila, R. (2015) 'Bareback sex: Breaking the rules of sexual health and the assumption of risks', *Sexualities*, 18(5–6), pp. 523–547.

Aydemir, M. (2007) *Images of Bliss Ejaculation, Masculinity, Meaning*. Minneapolis: University of Minnesota Press.

Baeten, J. M. *et al.* (2012) 'Antiretroviral prophylaxis for HIV prevention in heterosexual men and women', *The New England Journal of Medicine*, 367(5), pp. 399–410.

Banda, J. (2015) 'Rapid Home HIV Testing: Risk and the Moral Imperatives of Biological Citizenship', *Body & Society*, 21(4), pp. 24–47.

Bavinton, B. R. *et al.* (2018) 'Viral suppression and HIV transmission in serodicsordant male couples: An international, prospective, observational, cohort study', *The Lancet HIV*, 5(8), pp. e438-477.

Bayer, R. (1981) *Homosexuality and American Psychiatry: The Politics of Diagnosis*. New York: Basic Books.

Bayer, R. (1996) 'Sounding Board: AIDS Prevention - Sexual ethics and Responsibility', *The New England Journal of Medicine*, 334(23), pp. 1540–1542.

Beaulieu, A. (2004) 'Mediating ethnography: objectivity and the making of ethnographies of the internet', *Social Epistemology*, 18(2–3), pp. 139–163.

Beck, U. (1992) *Risk soceity: Towards a new modernity*. London: Sage.

Bilardi, J.E *et al.* (2019) 'The role of stigma in the acceptance and disclosure of HIV among recently diagnosed men who have sex with men in Australia: A qualitative study', *PlosOne*, 14(11)

Bersani, L. (1987) 'Is the Rectum a Grave?', *October*, 43, pp. 197–222.

Biello, K. B. *et al.* (2017) 'The "Safe Sex" Conundrum: Anticipated Stigma From Sexual Partners as a Barrier to PrEP Use Among Substance Using MSM Engaging in Transactional Sex', *AIDS and Behavior*, 21(1), pp. 300–306.

Black, S. and Sykes, M. (1971) 'Promiscuity and oral contraception: The relationship examined', *Social Science & Medicine*, 5(6), pp. 637–643.

Blair, T. R. (2017) 'Safe Sex in the 1970s: Community Practitioners on the Eve of AIDS', *American Journal of Public Health*, 107(6), pp. 872–879.

Bloor, M. (1995) 'A user's guide to contrasting theories of HIV-related risk behaviour', in Gabe, J. (ed.) *Medicine, health, and risk : sociological approaches*. Oxford: Blackwell, pp. 19–30.

Blumenthal, J. and Haubrich, R. (2014) 'Risk compensation in PrEP: An old debate emerges yet again', *Virtual Mentor*, 16, pp. 909–915.

Boellstorff, T. (2011) 'BUT DO NOT IDENTIFY AS GAY: A Proleptic Genealogy of the MSM Category', *Cultural Anthropology*, 26(2), pp. 287–312.

Bolton, R. (1990) 'Mapping Terra Incognita: Sex Research for AIDS Prevention – An Urgent Agenda for the 1990s', in Parker, R. and Aggleton, P. (eds) *Culture, Society and Sexuality: A Reader*. London: UCL Press, pp. 434–456.

Bottéro, A. (1991) 'Consumption by semen loss in India and elsewhere', *Culture, Medicine and Psychiatry*, 15(3), pp. 303–320.

Bourdieu, P. (1977) *Outline of a Theory of Practice*. Translated by R. Nice. Cambridge: Cambridge University Press.

Bourgois, P. and Schonberg, J. (2009) *Righteous Dopefiend*. Berkeley: University of California Press.

Boyce, P. *et al.* (2007) 'Putting sexuality (back) into HIV/AIDS: Issues, theory and practice', *Global Public Health*, 2(1), pp. 1–34.

Braksmajer, A., Zhang, C. and McMahon, J. (2019) 'Associations Between Relationship Power and Pre-Exposure Prophylaxis (PrEP) Use Among Men Who Have Sex With Men', *AIDS and Behavior*, 24(5), pp. 1358–1364.

Brandt, A. M. (1988) 'AIDS and Metaphor: Toward the Social Meaning of Epidemic Disease', *Social Research*, 55(3), pp. 413–432.

Branfman, J. and Ekberg Stiritz, S. (2012) 'Teaching Men's Anal Pleasure: Challenging Gender Norms with "Prostage" Education', *American Journal of Sexuality Education*, 7(4), pp. 404–428.

Brennan, J. (2017) 'Stealth breeding: bareback without consent', *Psychology & Sexuality*, 8(4), pp. 318–333.

Brisson, J. (2019) 'Reflections on the history of bareback sex through ethnography: the works of subjectivity and PrEP', *Anthropology & Medicine*, 26(3), pp. 345–359.

Brisson, J. and Nguyen, V.-K. (2017) 'Science, technology, power and sex: PrEP and HIV-positive gay men in Paris', *Culture, Health & Sexuality*, 19(10), pp. 1066–1077.

Brooks, R. A. *et al.* (2012) 'Sexual risk behaviors and acceptability of HIV pre-exposure prophylaxis among HIV-negative gay and bisexual men in serodiscordant relationships: A mixed methods study', *AIDS Patient Care and STDs*, 26(2), pp. 87–94.

Buckley, T. and Gottlieb, A. (1988) 'A Critical Appraisal of Theories of Menstrual Symbolism', in Buckley, T. and Gottlieb, A. (eds) *Blood Magic: An Anthropology of Menstruation*. Berkeley: University of California Press, pp. 1–53.

Butler, J. (1990) *Gender trouble : feminism and the subversion of identity*. 2nd edn. New York: Routledge.

Butler, J. (2004) *Precarious life : the powers of mourning and violence*. London: Verso.

Cahill, S. *et al.* (2017) 'Stigma, medical mistrust, and perceived racism may affect PrEP awareness and uptake in black compared to white gay and bisexual men in Jackson, Mississippi and Boston, Massachusetts', *AIDS Care*, 29(11), pp. 1351–1358.

Cairns, G. P., Race, K. and Giocochea, P. (2016) 'PrEP: controversy, agency and ownership', *Journal of the International AIDS Society*, 19(6), pp. 1–3.

Calabrese, S. K. *et al.* (2017) '"'Support Your Client at the Space That They're in'": HIV Pre-Exposure Prophylaxis (PrEP) Prescribers' Perspectives on PrEP-Related Risk Compensation', *AIDS Patient Care and STDs*, 31(4), pp. 196–204.

Calabrese, S. K. and Underhill, K. (2015) 'How stigma surrounding the use of HIV preexposure prophylaxis undermines prevention and pleasure: A call to destigmatize "Truvada Whores"', *American Journal of Public Health*, 105(10), pp. 1960–1964.

Calabrese, S. K., Underhill, K. and Mayer, K. H. (2017) 'HIV Preexposure Prophylaxis and Condomless Sex: Disentangling Personal Values From Public Health Priorities', *The American Journal of Public Health*, 107(10), pp. 1572–1576.

Callen, M. and Berkowitz, R. (1983) *How to have sex in an epidemic: One approach*. New York: News from the Front Publications.

Carballo-Diéguez, A. and Bauermeister, J. (2004) '"Barebacking": Intentional Condomless Anal Sex in HIV-Risk Contexts. Reasons for and Against It', *Journal of Homosexuality*, 47(1), pp. 1–16.

Carter, C. (2018) 'We shouldn't let PrEP fuel another sexual health disaster', *The Guardian*. Available at: https://www.theguardian.com/commentisfree/2018/apr/26/we-shouldnt-let-prep-fuel-another-sexual-health-disaster (Accessed: 28 April 2018).

Cassell, M. M. *et al.* (2006) 'Risk compensation: The Achilles' heel of innovations in HIV prevention', *BMJ*, 332(7541), pp. 605–607.

CDC (2020) *Sexually Transmitted Diseases (STDs)*. Atlanta: Centres for Disease Control. Available at: https://www.cdc.gov/std/default.htm (Accessed: 21 July 2020).

Chambers, D. L. (1993) 'Gay Men, AIDS, and the Code of the Condom', *Harvard Civil Rights - Civil Liberties Law Review*, 29(2), pp. 353–386.

Choopanya, K. *et al.* (2013) 'Antiretroviral prophylaxis for HIV infection in injecting drug users in Bangkok, Thailand (the Bangkok Tenofovir Study): A randomised, double-blind, placebo-controlled phase 3 trial', *The Lancet*, 381(9883), pp. 2083–2090.

Clarke, A. E. *et al.* (2003) 'Biomedicalization: technoscientific transformations of health, illness, and U.S. biomedicine', *American Sociological Review*, 68(2), pp. 161–194.

Cohen, H. (2014) 'PrEP pill: "party drug" or life saver?', *Background Briefing*. Available at: https://www.abc.net.au/radionational/programs/backgroundbriefing/5829648 (Accessed: 14 September 2017).

Cohen, L. (1970) ‘The “pill”, promiscuity, and venereal disease’, *The British Journal of Venereal Diseases*, 46(2), pp. 108–110.

Cohen, M.S *et al.* (2011) 'Prevention of HIV-1 infection with early antiretroviral therapy', *The New England Journal of Medicine*, 365(6), pp.493-505

Collins, S. P., McMahan, V. M. and Stekler, J. D. (2017) ‘The Impact of HIV Pre-exposure Prophylaxis (PrEP) Use on the Sexual Health of Men Who Have Sex with Men: A Qualitative Study in Seattle, WA’, *International Journal of Sexual Health*, 29(1), pp. 55–68.

Conrad, P. (1992) ‘Medicalization and social control’, *Annual Review of Sociology*, 18, pp. 209–232.

Cornelisse, V. J. *et al.* (2018) ‘Evaluation of preexposure (PrEP) eligibility criteria using sexually transmissible infections as markers of Human Immunodeficiency Virus (HIV) risk at enrollment in PrEPX, a large Australian HIV PrEP trial’, *Clinical Infectious Diseases*, 67(12), pp. 1847–1852.

Crimp, D. and Bersani, L. (1988) *AIDS: Cultural Analysis/Cultural Activism*. Cambridge, Massachusetts: MIT Press.

Crosby, R. A. (2017) ‘Dealing with pre-exposure prophylaxis-associated condom migration: Changing the paradigm for men who have sex with men’, *Sexual Health*, 14, pp. 106–110.

Crossley, N. (2001) ‘The Phenomenological Habitus and Its Construction’, *Theory and Society*, 30(1), pp. 81–120.

Crossley, N. (2013) ‘Habit and Habitus’, *Body & Society*, 19(2 & 3), pp. 136–161.

van Damme, L. *et al.* (2012) ‘Preexposure Prophylaxis for HIV Infection among African Women’, *The New England Journal of Medicine*, 367(5), pp. 411–422.

Datta, J. *et al.* (2018) ‘Places and people: the perceptions of men who have sex with men concerning STI testing: a qualitative study’, *Sexually Transmitted Infections*, 94, pp. 46–50.

Dayan, L. and Ooi, C. (2005) ‘Syphilis treatment: old and new’, *Expert Opinion on Pharmacotherapy*, 3(13), pp. 2271–2280.

Dean, T. (2009) *Unlimited intimacy : reflections on the subculture of barebacking*. Chicago: University of Chicago Press.

Dean, T. (2015) ‘Mediated intimacies: Raw sex, Truvada, and the biopolitics of chemoprophylaxis’, *Sexualities*, 18(1/2), pp. 224–246.

DeLanda, M. (2006) *A new philosophy of society: Assemblage theory and social complexity*. London: Continuum.

Department of Health & Human Services (2015) *Engaging men in healthcare: Information resource paper*. Melbourne: State Government Victoria.

DHHS (2019) *Surveillance of notifiable conditions in Victoria (as at 26 February 2019)*. Melbourne, Victoria: Department of Health and Human Services. Available at:

http://www.health.vic.gov.au/ideas/downloads/daily_reports/rptVS_SNIDSVictorianSummary_GR.pdf (Accessed: 27 October 2019).

DiStefano, A. S. and Takedo, M. (2017) 'HIV pre-exposure prophylaxis and postexposure prophylaxis in Japan: Context of use and directions for future research and action', *AIDS Patient Care and STDs*, 31(2), pp. 60–77.

Dolling, D. I. *et al.* (2016) 'An analysis of baseline data from the PROUD study: An open-label randomised trial of pre-exposure prophylaxis', *Trials*, 17, p. 163.

Douglas, M. (1966) *Purity and danger: An analysis of concepts of pollution and taboo*. London: Routledge.

Douglas, M. (1992) *Risk and blame : essays in cultural theory*. London, New York: Routledge.

Dowsett, G. (1998) 'Pink conspiracies: Australia's gay communities and national HIV/AIDS policies, 1983-96', in Yeatman, A. (ed.) *Activism and the policy process*. St Leonards: Allen & Unwin, pp. 171–193.

Dowsett, G. *et al.* (2008) '"Taking it Like a Man": Masculinity and Barebacking Online', *Sexualities*, 11(1/2), pp. 121–131.

Dowsett, G. (2009) 'Dangerous desires and post-queer HIV prevention: Rethinking community, incitement and intervention', *Social Theory & Health*, 7(3), pp. 218–240.

Dowsett, G. (2017) 'Abjection. Objection. Subjection: rethinking the history of AIDS in Australian gay men's futures', *Culture, Health & Sexuality*, 19(9), pp. 935–047.

Drescher, J. (2010) 'Queer diagnoses: Parallels and contrasts in the history of homosexuality, gender variance, and the Diagnostic and Statistical Manual', *Archives of Sexual Behavior*, 39(2), pp. 427–460.

Duvov, A. *et al.* (2018) 'Stigma and Shame Experiences by MSM who take PrEP for HIV Prevention: A Qualitative Study', *American Journal of Men's Health*, 12(6), pp. 1832-1843.

Duffy, N. (2015) 'AIDS activist Larry Kramer has changed his mind about HIV-preventing drugs', *Pink News*. Available at: https://www.pinknews.co.uk/2015/12/09/aids-activist-larry-kramer-has-changed-his-mind-about-hiv-preventing-drugs/ (Accessed: 29 August 2020).

Duggan, L. (2003) *The Twilight of Equality? Neoliberalism, Cultural Politics, and the Attack on Democracy*. Boston: Beacon Press.

Earnshaw, V. A. and Quinn, D. M. (2011) 'The Impact of Stigma in Healthcare on People Living with Chronic Illnesses', *Journal of Health Psychology*, 17(2), pp. 157–168.

Ecks, S. (2005) 'Pharmaceutical Citizenship: Antidepressant Marketing and the Promise of Demarginalization in India', *Anthropology & Medicine*, 12(3), pp. 239–254.

Edwards, S. and Carne, C. (1998) 'Oral sex and transmission of non-viral STIs', *Sexually Transmitted Infections*, 74(2), p. 95.

Edwards, W. M. and Coleman, E. (2004) 'Defining Sexual Health: A Descriptive Overview', *Archives of Sexual Behavior*, 33(3), pp. 189–195.

Epstein, S. (1996) *Impure science: AIDS, activism, and the politics of knowledge*. Berkeley: University of California Press.

Escoffier, J. (2011) 'Sex, Safety, and the Trauma of AIDS', *Women's Studies Quarterly*, 39(1/2), pp. 129–138.

Evans, W. N. and Graham, J. D. (1991) 'Risk Reduction or Risk Compensation? The Case of Mandatory Safety-Belt Use Laws', *Journal of Risk and Uncertainty*, 4(1), pp. 61–73.

Facebook (2017) 'Terms of Service', *Facebook Terms of Service*. Available at: https://www.facebook.com/terms.php (Accessed: 24 August 2017).

Falzon, M.-A. (2009) *Multi-sited ethnography : theory, praxis and locality in contemporary research*. Farnham: Ashgate.

Fine, P. E. M. (1993) 'Herd Immunity: History, Theory, Practice', *Epidemiologic Reviews*, 15(2), pp. 265–302.

Fineberg, H. V. (1988) 'The Social Dimensions of AIDS', *Scientific American*, 259(4), pp. 128–135.

Flowers, P. *et al.* (1997) 'Health and romance: Understanding unprotected sex in relationships between gay men', *British Journal of Health Psychology*, 2, pp. 73–86.

Flowers, P. (2001) 'Gay men and HIV/AIDS risk management', *Health*, 5(1), pp. 50–75.

Forda, J. V. *et al.* (2019) 'Why Pleasure Matters: Its Global Relevance for Sexual Health, Sexual Rights and Wellbeing', *International Journal of Sexual Health*, 31(3), pp. 217–230.

Forster, A. *et al.* (2010) 'Passport to promiscuity or lifesaver: Press coverage of HPV vaccination and risky sexual behavior', *Journal of Health Communication*, 15(2), pp. 205–217.

Foucault, M. (1990) *The history of sexuality Vol. 1: An Introduction*. New York: Vintage Books.

Fox, N., J. and Alldred, P. (2013) 'The sexuality-assemblage: Desire, affect, anti-humanism', *The Sociological Review*, 61(4), pp. 769–789.

Fox, N., J. and Alldred, P. (2015) 'New materialist social inquiry: Designs, methods and the research-assemblage', *International Journal of Social Research Methodology*, 18(4), pp. 399–414.

France, D. (2017) *How to Survive a Plague: The Story of How Activists and Scientists Tamed AIDS*. UK: Pan Macmillan.

Gamarel, K. E. and Golub, S. A. (2015) 'Intimacy motivations and pre-exposure prophylaxis (PrEP) adoption intentions among HIV-negative men who have sex with men (MSM) in romantic relationships', *Annals of Behavioral Medicine*, 49(2), pp. 177–186.

Gamson, J. (1989) 'Silence, Death, and the Invisible Enemy: AIDS Activism and Social Movement "Newness"', *Social Problems*, 36(4), pp. 351–367.

Gauthier, D. K. and Forsyth, C. J. (1999) 'bareback sex, bug chasers, and the gift of death', *Deviant Behavior*, 20(1), pp. 85–100.

Giami, A. (2002) 'Sexual Health: The Emergence, Development, and Diversity of a Concept', *Annual Review of Sex Research*, 13(1), pp. 1–35.

Giami, A. and Perrey, C. (2012) 'Transformations in the Medicalization of Sex: HIV Prevention between Discipline and Biopolitics', *The Journal of Sex Research*, 49(4), pp. 353–361.

Gilead (2016) 'Treatment for HIV'. Available at: http://truvada.com/treatment-for-HIV (Accessed: 11 July 2017).

Gilmore, H. J. *et al.* (2013) 'Participant experiences and facilitators and barriers to pill use among men who have sex with men in the iPrEx pre-exposure prophylaxis trial in San Francisco', *AIDS Patient Care and STDs*, 27(10), pp. 560–566.

Goffman, E. (1963) *Stigma : notes on the management of spoiled identity*. Englewood-Cliffs, N.J: Prentice Hall.

Golub, S. A. *et al.* (2013) 'From efficacy to effectiveness: Facilitators and barriers to PrEP acceptability and motivations for adherence among MSM and transgender women in New York City', *AIDS Patient Care and STDs*, 27(4), pp. 248–254.

Gottlieb, M. S. (2006) 'Pneumocystic pneumonia - Los Angeles', *American Journal of Public Health*, 96(6), pp. 980–981.

Grant, R. M. *et al.* (2010) 'Preexposure chemoprophylaxis for HIV prevention in men who have sex with men', *The New England Journal of Medicine*, 363(27), pp. 2587–2599.

Green, A. I. (2014) 'Introduction: Toward a Sociology of Collective Sexual Life', in *Sexual fields : toward a sociology of collective sexual life*. Chicago: University of Chicago Press, pp. 1–23.

Green, A. I. (2016) 'Keeping gay and bisexual men safe: The arena of HIV prevention science and praxis', *Social Studies of Science*, 46(2), pp. 210–235.

Gretemen, A. J. (2018) 'Viral Matters: Barebacking and PrEP', in *Sexualities and genders in education : towards queer thriving*. Cham, Switzerland: Palgrave MacMillan, pp. 145–167.

Grov, C. *et al.* (2015) 'Willingness to Take PrEP and Potential for Risk Compensation Among Highly Sexually Active Gay and Bisexual Men', *AIDS and Behavior*, 19(12), pp. 2234–2244.

Guichon, J. R. *et al.* (2013) 'Citizen intervention in a religious ban on in-school HPV vaccine administration in Calgary, Canada', *Preventive Medicine*, 57(5), pp. 409–413.

Guss, J. R. (2010) 'The Danger of Desire: Anal Sex and the Homo/Masculine Subject', *Studies in Gender and Sexuality*, 11(3), pp. 124–140.

Halperin, D. (2016) 'The biopolitics of HIV prevention discourse', in Cisney, V. W. and Morar, N. (eds) *Biopower : Foucault and beyond*. Chicago: University of Chicago Press, pp. 199–227.

Hammond, C., Holmes, D. and Mercier, M. (2016) 'Breeding new forms of life: a critical reflection on extreme variances of bareback sex', *Nursing Inquiry*, 23(3), pp. 267–277.

Han, C.-S. (2008) 'No Fats, femmes, or Asians: The utility of critical race theory in examining the role of gay stock stories in the marginalization of gay Asian men', *Contemporary Justice Review,* 11(1), pp. 11–22.

Han, C.-S. (2015) *Geisha of a different kind: Race and sexuality in Gaysian America*. New York: New York University Press.

Hannaford, A. *et al.* (2018) 'The Use of Online Posts to Identify Barriers to and Facilitators of HIV Pre-exposure Prophylaxis (PrEP) Among Men Who Have Sex with Men: A Comparison to a Systematic Review of the Peer-Reviewed Literature', *AIDS and Behavior*, 22(4), pp. 1080–1095.

Hannem, S. (2012) 'Theorizing Stigma and the Politics of Resistance: Symbolic and Structural Stigma in Everyday Life', in *Stigma Revisited: Implications of the Mark*. Ottowa: University of Ottowa Press, pp. 10–28.

Hannerz, U. (2012) 'Being there…and there…and there! Reflections on multi-site ethnography', in *Ethnographic fieldwork: An anthropological reader*. Malden: Blackwell Publishers.

Healy, P. (2014) 'A Lion Still Roars, With Gratitude', *The New York Times*. Available at: https://www.nytimes.com/2014/05/25/arts/television/larry-kramer-lives-to-see-his-normal-heart-filmed-for-tv.html (Accessed: 15 January 2019).

Herdt, G. (1987) *Guardians of the flutes : idioms of masculinity*. New York: Columbia University Press.

Herdt, G. (1997) 'Cultural Myths about Homosexuality', in *Same sex, different cultures exploring gay and lesbian lives*. Boulder: Westview Press, pp. 25–62.

Herrick, A. *et al.* (2011) 'Resilience as an Untapped Resource in Behavioral Intervention Design for Gay Men', *AIDS and Behavior,* 15(Supp 1), pp. 25–29.

Herron, P. D. (2016) 'Ethical Implications of Social Stigma Associated with the Promotion and Use of Pre-Exposure Prophylaxis for HIV Prevention', *LGBT Health*, 3(2), pp. 103–108.

Hine, C. (2000) *Virtual Ethnography*. London: Thousand Oaks.

Hine, C. (2008) 'Virtual Ethnography: Modes, Varieties, Affordances', in Fielding, N., Lee, R. M., and Blank, G. (eds) *The SAGE handbook of online research methods*. Los Angeles: Sage.

Hoff, C. C. *et al.* (2015) 'Attitudes Towards PrEP and Anticipated Condom Use Among Concordant HIV-Negative and HIV-Discordant Male Couples', *AIDS Patient Care and STDs,* 29(7), pp. 408–417.

Hogben, M. and Liddon, N. (2008) 'Disinhibition and Risk Compensation: Scope, Definitions, and Perspective', *Sexually Transmitted Diseases*, 35(12), pp. 1009–1010.

Holmes, D. *et al.* (2008) 'Bareback sex: a conflation of risk and masculinity', *International Journal of Men's Health,* 7(2), pp. 171–192.

Holmes, D. and Warner, D. (2018) ‘The anatomy of a forbidden desire: Men, penetration, and semen exchange’, in Holmes, D., Murray, S., J., and Foth, T. (eds) *Radical sex between men : assembling desiring-machines*. Obingdon, Oxon: Routledge, pp. 100–117.

Holt *et al.* (2010) 'Gay men's perceptions of sexually transmissible infections and their experiences of diagnosis', *Sexual Health*, 7(4), pp. 411-416.

Holt, M. *et al.* (2012) ‘Willingness to use HIV pre-exposure prophylaxis and the likelihood of decreased condom use are both associated with unprotected anal intercourse and the perceived likelihood of becoming HIV positive among Australian gay and bisexual men’, *Sexually Transmitted Infections*, 88(4), pp. 258–263.

Holt, M. (2015) ‘Configuring the users of new HIV-prevention technologies: the case of HIV pre-exposure prophylaxis’, *Culture, Health & Sexuality*, 17(4), pp. 428–439.

Holt, M. *et al.* (2018) ‘Community-level changes in condom use and uptake of HIV pre-exposure prophylaxis by gay and bisexual men in Melbourne and Sydney, Australia: results of repeated behavioural surveillance in 2013–17’, *Lancet HIV*, 4(6), pp. e448–e456.

Holt, M. *et al.* (2019) ‘HIV pre-exposure prophylaxis and the “problems” of reduced condom use and sexually transmitted infections in Australia: a critical analysis from an evidence-making intervention perspective’, *Sociology of Health & Illness*, 41(8), pp. 1535–1548.

Holt, M. *et al.* (2019a) 'Trends in attitudes to and the use of HIV pre-exposure prophylaxis by Australian gay and bisexual men, 2011–2017: implications for further implementation from a Diffusion of Innovations perspective', *AIDS and Behavior*, 23(7), pp. 1939-1950.

Holt, M. and Murphy, D. A. (2017) ‘Individual Versus Community-Level Risk Compensation Following Preexposure Prophylaxis of HIV’, *American Journal of Public Health*, 107(10), pp. 1568–1571.

Hoppe, T. A. (2011) ‘Circuits of power, circuits of pleasure: Sexual scripting in gay men’s bottom narratives’, *Sexualities*, 14(2), pp. 193–217.

Hughes, S. D. *et al.* (2018) ‘Body/selves and beyond: Men’s narratives of sexual behavior on PrEP’, *Medical Anthropology*, 37(5), pp. 387–400.

Illich, I. (1974) ‘Medical Nemesis’, *The Lancet*, 1(7863), pp. 918–921.

Indyk, D. and Rier, D. A. (1993) ‘Grassroots AIDS Knowledge: Implications for the Boundaries of Science and Collective Action’, *Knowledge: Creation, Diffusion, Utilization*, 15(1), pp. 3–43.

Jin, F *et al.* (2009), 'Unprotected anal intercourse, risk reduction behaviours, and subsequent HIV infection in a cohort of homosexual men', *AIDS*, 23(2), pp. 243-252.

Kalbian, A., H. (2014) ‘SEX: HIV/AIDS, Condoms, and Sexual Morality’, in *Sex, Violence, and Justice: Contraception and the Catholic Church*. Washington, DC: Georgetown University Press, pp. 60–94.

Kasting, M. L. *et al.* (2016) ‘Tempest in a teapot: A systematic review of HPV vaccination and risk compensation research’, *Human Vaccines and Immunotherapeutics*, 12(6), pp. 1435–1450.

Keen, P. *et al.* (2017) 'Are HIV-negative gay men who take PrEP more likely to have sex with HIV-positive men?', in. *The Australasian HIV & AIDS Conference*, Canberra.

Keen, P. *et al.* (2020) 'Use of HIV Pre-exposure Prophylaxis (PrEP) Associated With Lower HIV Anxiety Among Gay and Bisexual Men in Australia WhoAre at High Risk of HIV Infection: Results From the Flux Study', *Journal of Acquired Immune Deficiency Syndromes*, 83(2), pp. 119–125.

Kelen, M. and Cresswell, F. (2017) 'HIV pre-exposure prophylaxis (PrEP): effective but controversial', *Trends in Urology & Men's Health*, 8(1), pp. 9–12.

Khanna, A. S., Schumm, P. and Schneider, J. A. (2017) 'Facebook network structure and awareness of preexposure prophylaxis among young men who have sex with men', *Annals of Epidemiology*, 27(3), pp. 176–180.

Kippax, S. *et al.* (1993) 'Sustaining safe sex: a longitudinal study of a sample of homosexual men', *AIDS*, 7(2), pp. 257–264.

Kippax, S. (2002) 'Negotiated Safety Agreements Among Gay Men', in O'Leary, A. (ed.) *Beyond condoms: alternative approaches to HIV prevention*. New York: Kluwer Academic Publishers, pp. 1–15.

Kippax, S. and Race, K. (2003) 'Sustaining safe practice: twenty years on', *Social Science & Medicine*, 57(1), pp. 1–12.

Kippax, S. and Stephenson, N. (2016) *Socialising the Biomedical Turn in HIV prevention*. London, UK: Anthem Press.

Kippax *et al.* (2018) 'In memoriam: Professor David Cooper (1949 to 2018), *Journal of the International AIDS Society*, 21(6) p.e25152

Kirby Institute (2018) *HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2018*. Sydney: Kirby Institute, UNSW. Available at: https://kirby.unsw.edu.au/report/annual-surveillance-report-hiv-viral-hepatitis-and-stis-australia-2017 (Accessed: 27 November 2019).

Koester, K. *et al.* (2017) 'Risk, safety and sex among male PrEP users: time for a new understanding', *Culture, Health & Sexuality*, 19(12), pp. 1301–1313.

Lal, L. *et al.* (2017) 'Medication adherence, condom use and sexually transmitted infections in Australian preexposure prophylaxis users', *AIDS*, 31(12), pp. 1709–1714.

Lee, E. *et al.* (2018) *Gay Community Periodic Survey: Melbourne 2018*. Sydney: Centre for Social Research in Health.

Lee, N. (2013) 'Becoming Undetectable', *e-flux journal*, 44, pp. 1–9.

Link, B., G. and Phelan, J. C. (2001) 'Conceptualizing Stigma', *Annual Review of Sociology*, 27, pp. 363–385.

Liu, A. Y. *et al.* (2013) 'Sexual risk behavior among HIV-uninfected men who have sex with men (MSM) participating in a tenofovir pre-exposure prophylaxis (PrEP) randomized trial in the United States', *Journal of Acquired Immune Deficiency Syndrome*, 64(1), pp. 87–91.

Lloyd, K. (2018) 'Centring "being undetectable" as the new face of HIV: Transforming subjectivities via the discursive practices of HIV treatment as prevention', *BioSocieties*, 13(2), pp. 470–493.

Loe, M. (2004) *The rise of Viagra : how the little blue pill changed sex in America*. New York: New York University Press.

Long, D. (2015) *Dissolving the Solid Body: An Ethnography of Birthing in an Australian Public Hospital*. PhD (Sociology & Anthropology). University of Newcastle.

Loutfy, M. *et al.* (2014) 'Canadian consensus statement on HIV and its transmission in the context of criminal law', *The Canadian Journal of Infectious Diseases & Medical Microbiology*, 25(3), pp. 135–140.

Lupton, D. (1994) *Moral threats and dangerous desires: AIDS in the news media*. London: Taylor & Francis.

Lupton, D. (1997) 'Foucault and the medicalisation critique', in Petersen, A. and Bunton, R. (eds) *Foucault, Health and Medicine*. London; New York: Routledge, pp. 187–214.

Lupton, D. (2013) *Risk*. 2nd edn. New York: Routledge (Key Ideas).

Lupton, D. and Tulloch, J. (1996) '"Bringing home the reality of it": senior school students' responses to mass media portrayals of HIV/ AIDS', *Australian Journal of Communication*, 23(1), pp. 31–45.

Mabire, X. *et al.* (2019) 'Pleasure and PrEP: Pleasure-Seeking Plays a Role in Prevention Choices and Could Lead to PrEP Initiation', *American Journal of Men's Health*, 13(1), pp. 1–14.

Macapagal, K. *et al.* (2017) 'HIV prevention fatigue and HIV treatment optimism among young men who have sex with men', *AIDS Education and Prevention*, 29(4), pp. 289–301.

Mao, L. *et al.* (2016) *Annual Report of Trends in Behaviour 2016: HIV/AIDS, hepatitis and sexually transmissible infections in Australia*. Centre for Social Research in Health.

Marcus, G. E. (1998) *Ethnography through thick and thin*. Princeton N.J.: Princeton University Press.

Marcus, J. L. *et al.* (2013) 'No Evidence of Sexual Risk Compensation in the iPrEx Trial of Daily Oral HIV Preexposure Prophylaxis', *PLoS One*, 8(12).

Markham, A. N. (2013) 'Fieldwork in Social Media. What Would Malinowski Do?', *Qualitative Communication Research*, 2(4), pp. 434–446.

Marrazzo, J. M. *et al.* (2015) 'Tenofovir-Based Preexposure Prophylaxis for HIV Infection Among African Women', *The New England Journal of Medicine*, 372(6), pp. 509–518.

Marshall, G. (1990) *Pretty Woman*. Walt Disney Studios Motion Pictures.

Martin, E. (1994) *Flexible bodies: Tracking immunity in American culture from the days of polio to the age of AIDS*. Boston, Mass.: Beacon Press Books.

Mauss, M. (1973) 'Techniques of the body', *Economy & Society*, 2(1), pp. 70–88.

Mauss, M. (1989) *The gift : the form and reason for exchange in archaic societies*. London: Routledge.

Mayer, K. H. and Beyrer, C. (2016) 'Antiretroviral chemoprophylaxis: PROUD and pragmatism', *The Lancet*, 387(10013), pp. 6–7.

McCormack, S. *et al.* (2016) 'Pre-exposure prophylaxis to prevent the acquisition of HIV-1 infection (PROUD): effectiveness results from the pilot phase of a pragmatic open-label randomised trial', *The Lancet*, 387(10013), pp. 53–60.

Meunier, É., Escoffier, J. and Siegel, K. (2019) 'Rethinking Risks and Interventions Beyond HIV: The Importance of Contextualizing Collective Sex', *Archives of Sexual Behavior*, 48(1), pp. 51–56.

Miller, D. *et al.* (2016) *How the World Changed Social Media*. London: UCL Press.

Molina, J.-M. *et al.* (2015) 'On-Demand Preexposure Prophylaxis in Men at High Risk for HIV-1 Infection', *The New England Journal of Medicine*, 373(23), pp. 2237–2246.

Moskowitz, D. A. and Roloff, M. E. (2007) 'The existence of a bug chasing subculture', *Culture, Health & Sexuality*, 9(4), pp. 247–357.

Mowlabocus, S. (2010) *Gaydar culture : gay men, technology and embodiment in the digital age*. London: Routledge.

Mowlabocus, S., Justin, H. and Charlie, W. (2014) 'What we can't see? Understanding the representations and meanings of UAI, barebacking, and semen exchange in gay male pornography', *Journal of Homosexuality*, 61(10), pp. 1462–1480.

Murphy, D. *et al.* (2016) *Annual Report of Trends in Behaviour 2016: HIV/AIDS, hepatitis and sexually transmissible infections in Australia*. Centre for Social Research in Health Odets, W. (1995) *In the shadow of the epidemic: being HIV-negative in the age of AIDS*. Durham: Duke University Press.

Oldenburg, C. E. *et al.* (2018) 'Behavioral Changes Following Uptake of HIV Pre-exposure Prophylaxis Among Men Who Have Sex with Men in a Clinical Setting', *AIDS and Behavior*, 22(4), pp. 1075–1079.

O'Reilly, K. (2009) *Key Concepts in Ethnography*. Los Angeles: Sage.

Parker, M. (2003) 'Anthropological reflections on HIV prevention strategies: the case for targeting London's backrooms', in Ellison, G., Parker, M., and Campbell, C. (eds) *Learning from HIV/AIDS*. Cambridge: Cambridge University Press, pp. 179–209.

Parker, R. and Aggleton, P. (2003) 'HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action', *Social Science & Medicine*, 57(1), pp. 13–24.

Parker, R., Aggleton, P. and Perez-Brumer, A. G. (2016) ‘The trouble with “Categories”: Rethinking men who have sex with men, transgender and their equivalents in HIV prevention and health promotion’, *Global Public Health*, 11(7–8), pp. 819–823.

Patton, C. (1985) *Sex and Germs: The Politics of AIDS*. Boston: South End Press.

Patton, C. (1990) *Inventing AIDS*. New York: Routledge.

Patton, C. and Kim, H. J. (2012) ‘The Cost of Science: Knowledge and Ethics in the HIV Pre-Exposure Prophylaxis Trials’, *Journal of Bioethical Inquiry*, 9(3), pp. 295–310.

Peng, P. *et al.* (2018) ‘A Global Estimate of the Acceptability of Pre-exposure Prophylaxis for HIV Among Men Who have Sex with Men: A Systematic Review and Meta-analysis’, *AIDS and Behavior*, 22(4), pp. 1063–1074.

Persson, A. (2013) ‘Non-infectious corporealities: tensions in the biomedical era of “HIV normalisation”’, *Sociology of Health & Illness*, 35(7), pp. 1065–1079.

Persson, A. (2016) ‘“The world has changed”: pharmaceutical citizenship and the reimagining of serodiscordant sexuality among couples with mixed HIV status in Australia’, *Sociology of Health & Illness*, 38(3), pp. 380–395.

Persson, A., Ellard, J. and Newman, C.E. (2016) 'Bridging the HIV divide: stigma, stories, and serodiscordant sexuality in the biomedical age', *Sexuality & Culture*, 20(2), pp. 197-213

Persson, A., Race, K. and Wakeford, E. (2003) ‘HIV health in context: Negotiating medical technology and lived experience’, *Health*, 7(4), pp. 397–415.

Phillips, R. O., Fyhri, A. and Sagberg, F. (2011) ‘Risk Compensation and Bicycle Helmets’, *Risk Analysis*, 31(8), pp. 1187–1195.

Potts, A. (2004) ‘Deleuze on Viagra (Or, What Can a “Viagra-Body” Do?)’, *Body & Society*, 10(1), pp. 17–36.

Power, J. (2011) *Movement, knowledge, emotion : gay activism and HIV/AIDS in Australia*. Canberra: ANU Press.

Power, J. (2012) ‘The Grim Reaper died in the 80s – time for a new approach to HIV prevention’, *The Conversation*. Available at: https://theconversation.com/the-grim-reaper-died-in-the-80s-time-for-a-new-approach-to-hiv-prevention-9106 (Accessed: 13 December 2018).

Power, J. (2014) ‘Change through collaboration: Gay activism and HIV/AIDS in Australia’, in Blunden, A. (ed.) *Collaborative Projects : An Interdisciplinary Study*. Leiden: Brill, pp. 239–260.

Puar, J. (2013) ‘Queer Times, Queer Assemblages’, in Hall, D. E. et al. (eds) *The Routledge queer studies reader*. London; New York: Routledge, pp. 515–528.

Pulerwitz, J. *et al.* (2010) ‘Reducing HIV-Related Stigma: Lessons Learned from Horizons Research and Programs’, *Public Health Reports*, 125(2), pp. 272–281.

Purcell, D. W. *et al.* (2014) 'Incorporating Couples-Based Approaches into HIV Prevention for Gay and Bisexual Men: Opportunities and Challenges', *Archives of Sexual Behavior*, 43(1), pp. 35–46.

Race, K. (2001) 'The undetectable crisis: Changing technologies of risk', *Sexualities*, 4(2), pp. 167–189.

Race, K. (2003) 'Revaluation of risk among gay men', *AIDS Education and Prevention*, 15(4), pp. 369–381.

Race, K. (2008) 'The use of pleasure in harm reduction: Perspectives from the history of sexuality', *International Journal of Drug Policy*, 19(5), pp. 417–423.

Race, K. (2009) *Pleasure consuming medicine the queer politics of drugs*. Durham, NC: Duke University Press.

Race, K. (2012) 'Framing Responsibility: HIV, Biomedical Prevention, and the Performativity of the Law', *Journal of Bioethical Inquiry*, 9(3), pp. 327–338.

Race, K. (2016) 'Reluctant Objects: Sexual Pleasure as a Problem for HIV Biomedical Prevention', *GLQ: A Journal of Lesbian and Gay Studies*, 22(1), pp. 1–31.

Rasmussen, L. M. and Richey, L. A. (2012) 'The Lazarus Effect of AIDS Treatment: Lessons Learned and Lives Saved', *Journal of Progressive Human Services*, 23(3), pp. 187–207.

Refugio, O. N. *et al.* (2016) 'Sexually transmissible infection control programs for men who have sex with men – what will they look like in 2020?', *Sexual Health*, 14(1), pp. 126–132.

Reynolds, R.H 2002 *From camp to queer: Re-making the Australian homosexual*, Melbourne University Press, Carlton South

Reynolds, E. (2007) '"Pass the Cream, Hold the Butter": Meanings of HIV Positive Semen for Bugchasers and Giftgivers', *Anthropology & Medicine*, 14(3), pp. 259–266.

Rhodes, T. (1997) 'Risk theory in epidemic times: sex, drugs and the social organisation of "risk behaviour"', *Sociology of Health & Illness*, 19(2), pp. 208–227.

Robards, B. (2012) 'Leaving MySpace, joining Facebook: "Growing up" on social network sites', *Continuum: Mediated Youth Cultures*, 26(3), pp. 385–398.

Robinson, B. E. *et al.* (2002) 'The Sexual Health Model: application of a sexological approach to HIV prevention', *Health Education Research*, 17(1), pp. 43–57.

Robinson, S. (2010) 'Responding to Homophobia: HIV/AIDS, Homosexual Community Formation and Identity in Queensland, 1983–1990', *Australian Historical Studies*, 41(2), pp. 181–197.

Robinson, S. (2014) 'Beyond tombstones and grim reapers: the gay community's challenge to the official HIV/AIDS campaigns in 1980s Australian and Britain', in Featherstone, L., Jennings, R., and Reynolds, R. (eds) *Acts of Love and Lust: Sexuality in Australia from 1945-2010*. Newcastle upon Tyne: Cambridge Scholars Publishing, pp. 95–111.

Rodger, A. J. *et al.* (2016) 'Sexual activity without condoms and risk of HIV transmission in serodifferent couples when the HIV-positive partner is using suppressive antiretroviral therapy', *The Journal of the American Medical Association*, 316(2), pp. 171–181.

Rofes, E. (1996) *Reviving the tribe: Regenerating gay men's sexuality and culture in the ongoing epidemic*. Binghamton, NY: Harrington Park Press.

Rofes, E. (1998) *Dry bones breathe: Gay men creating post-AIDS identities and cultures*. New York & London: The Haworth Press.

Rojas Castro, D., Delabre, R. M. and Molina, J.-M. (2019) 'Give PrEP a chance: moving on from the "risk compensation" concept', *Journal of the International AIDS Society*, 22(S6), pp. 50–56.

Rolle, C.-P. *et al.* (2017) 'Willingness to use pre-exposure prophylaxis among Black and White men who have sex with men in Atlanta, Georgia', *International Journal of STD & AIDS*, 28(9), pp. 849–857.

Rosengarten, M. and Michael, M. (2009) 'The performative function of expectations in translating treatment to prevention: The case of HIV pre-exposure prophylaxis, or PrEP', *Social Science & Medicine*, 69(7), pp. 1049–1055.

Rubin, G. (2011a) 'The Catacombs: A temple of the butthole', in *Deviations: A Gayle Rubin Reader*. London: Duke University Press, pp. 224–240.

Rubin, G. (2011b) 'Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality', in *Deviations a Gayle Rubin reader*. Durham, NC: Duke University Press, pp. 137–181.

Scheper-Hughes, N. (1994) 'AIDS and the social body', *Social Science & Medicine*, 39(7), pp. 991–1003.

Scott, S. and Freeman, R. (1995) 'Prevention as a problem of modernity: the example of HIV and AIDS', in Gabe, J. (ed.) *Medicine, health, and risk : sociological approaches*. Oxford: Blackwell, pp. 151–170.

Seccombe, K., James, D. and Walters, K. B. (1988) '"They Think You Ain't Much of Nothing": The Social Construction of the Welfare Mother', *Journal of Marriage and Family*, 60(4), pp. 849–865.

Selemogo, M. (2008) 'HIV pre-exposure prophylaxis trials: socioeconomic and ethical perspectives for sub- Saharan Africa', *African Journal of AIDS Research*, 7(2), pp. 243–247.

Sendziuk, P. (2004) *Learning to Trust: Australian Responses to AIDS*. Sydney: UNSW Press.

Shernoff, M. (2006) *Without condoms: Unprotected sex, gay men and barebacking*. New York: Routledge.

Singh, J. A. and Mills, E. J. (2005) 'The Abandoned Trials of Pre-Exposure Prophylaxis for HIV: What Went Wrong?', *PLoS Medicine*, 2(9), p. e234.

Spieldenner, A. (2016) 'PrEP Whores and HIV Prevention: The Queer Communication of HIV Pre-Exposure Prophylaxis (PrEP)', *Journal of Homosexuality*, 63(12), pp. 1685–1697.

Spinner, C. D. *et al.* (2016) 'HIV pre-exposure prophylaxis (PrEP): a review of current knowledge of oral systemic HIV PrEP in humans', *Infection*, 44(2), pp. 151–158.

Stahlman, S. *et al.* (2016) 'HIV incidence among gay men and other men who have sex with men in 2020: where is the epidemic heading?', *Sexual Health*, 14(1), pp. 5–17.

Stardust, Z. *et al.* (2017) *Effective HIV Prevention and Health Promotion among Asian Gay and Homosexually Active Men in Sydney*. Sydney: ACON.

Starrs, A. M. and Anderson, R. (2016) 'Definitions and Debates: Sexual Health and Sexual Rights', *The Brown Journal of World Affairs*, 22(2), pp. 7–23.

Steinmetz, K. F. (2012) 'Message Received: Virtual Ethnography in Online Message Boards', *International Journal of Qualitative Methods*, 11(1), pp. 26–39.

Stewart, C. (2017) 'The sexuality bind: same-sex marriage and structures of homophobic violence', *Distinktion: Journal of Social Theory*, 18(2), pp. 236–254.

STIGMA (2019) *Australian sexually transmitted infection & HIV testing guidelines 2019: For asymptomatic men who have sex with men*. New South Wales: STIs in Gay Men Action Group.

The Laird (2018) 'The Laird Hotel - About Us'. Available at: http://www.lairdhotel.com/about_us.php (Accessed: 23 January 2018).

Thigpen, M. C. *et al.* (2012) 'Antiretroviral Preexposure Prophylaxis for Heterosexual HIV Transmission in Botswana', *The New England Journal of Medicine*, 367(5), pp. 423–434.

Thompson, M. and Stelter, B. (2018) 'Facebook's data crisis deepens as questions mount', *CNN*. Available at: https://money.cnn.com/2018/03/20/technology/facebook-data-scandal-deepens/index.html?iid=EL (Accessed: 13 April 2019).

Thomsen, S. (1993) 'The Political Contradictions of Policing and Countering Anti-Gay Violence in New South Wales', *Current Issues in Criminal Justice*, 5(2), pp. 209–215.

Thomson, C. J. and Carlson, S. R. (2015) 'Increased patterns of risky behaviours among helmet wearers in skiing and snowboarding', *Accident Analysis & Prevention*, 75, pp. 179–183.

Thorne Harbour Health (2020) 'What is HIV?' Available at: https://thorneharbour.org/hiv-aids/what-is-hiv/ (Accessed: 20 January 2020).

Tiefer, L. (1996) 'The medicalization of sexuality: Conceptual, normative, and professional issues', *Annual Review of Sex Research*, 7(1), pp. 252–282.

Tomso, G. (2004) 'Bug Chasing, Barebacking, and the Risks of Care', *Literature and Medicine*, 23(1), pp. 88–111.

Traeger, M. W. *et al.* (2018) 'Effects of Pre-exposure Prophylaxis for the Prevention of Human Immunodeficiency Virus Infection on Sexual Risk Behavior in Men Who Have Sex With Men: A Systematic Review and Meta-analysis', *Clinical Infectious Diseases*, 67(5), pp. 676–686.

Treichler, P. (1999) *How to have theory in an epidemic: Cultural chronicals of AIDS*. Durham and London: Duke University Press.

Treichler, P. A. (1987) 'AIDS, homophobia and biomedical discourse: An epidemic of signification', *Cultural Studies*, 1(3), pp. 263–305.

Tyler, I. and Slater, T. (2018) 'Rethinking the sociology of stigma', *The Sociological Review Monographs*, 66(4), pp. 721–743.

UNAIDS (2014) *90-90-90: An ambitious treatment target to help end the AIDS epidemic*. Geneva, Switzerland: UNAIDS.

UNAIDS (2019) *UNAIDS DATA 2019*. Geneva, Switzerland: UNAIDS.

Underhill, K. (2013) 'Study designs for identifying risk compensation behaviour among users of biomedical HIV prevention technologies: Balancing methodological rigor and research ethics', *Social Science & Medicine*, 94, pp. 115–123.

Underwood, S. G. (2003) 'Introduction: Is it a natural thing?', in *Gay Men and Anal Eroticism : Tops, Bottoms, and Versatiles*. New York: Harrington Park Press, pp. 3–18.

VAC (2015) 'Community organisations, researchers and activists in Victoria sign historic accord on PrEP'. VAC. Available at: https://cdn.thorneharbour.org/media/documents/2482aec3-20151207_prep-accord-at-pronto.pdf (Accessed: 31 January 2018).

Varney, A. T. A. *et al.* (2012) 'Queer Theory Does It Raw: The Sociopolitical (Un)intelligibility of Barebackers' Bodies', in *Queer futures reconsidering ethics, activism, and the political*. Burlington, VT: Ashgate, pp. 191–202.

Vernazza, P. L. (2009) 'The debate continues: Does "undetectable" mean "uninfectious"?', *HIV Therapy*, 3(2), pp. 113–116.

VicPrEP (2018) 'Vic-PrEP – Victorian Pre-Exposure Prophylaxis project'. Available at: https://vicprep.csrh.org (Accessed: 25 March 2018).

Vitellone, N. (2001) 'Watching AIDS, Condoms and Serial Killers in the Australian "Grim Reaper" TV Campaign', *Continuum*, 15(1), pp. 33–48.

Wade, M. (2015) 'Melbourne posters saying men can "F*** RAW on PrEP follow report revealing record figures of condomless sex', *Star Observer*. Available at: https://www.starobserver.com.au/news/national-news/melbourne-posters-saying-gay-men-can-f-raw-on-prep-come-after-report-reveals-record-figures-of-unprotected-sex/140834 (Accessed: 27 January 2018).

Walby, K. (2012) 'The Mark of Sexual Deviance: What Keeps Men Who Have Sex with Men Up at Night?', in *Stigma Revisited: Impmlications of the Mark*. Ottowa: University of Ottowa Press, pp. 79–94.

Ware, C. (2017) '"Time to Speak Out": The 1980s Australian Gay Press and Personal Accounts of Living with HIV', *Journal of Australian Studies*, 41(4), pp. 472–486.

Warin, M. (2010) *Abject Relations: Everyday Worlds of Anorexia*. London: Rutgers University Press.

Weeks, J. (1995) *Invented Moralities: Sexual Values in an Age of Uncertainty*. Cabridge: Polity Press.

Whitacre, R. (2012) 'Ethical and Efficacious Interventions: HIV Pre-Exposure Prophylaxis, Behavioral-Pharmaceutical Slippage and Biomarkers', *Kroeber Anthropological Society Papers*, 101, pp. 22–32.

WHO (2006) *Defining sexual health Report of a technical consultation on sexual health 28–31 January 2002, Geneva*. World Health Organisation.

WHO (2015) *WHO expands recommendation on oral preexposure prophylaxis of HIV infection (PrEP)*. Policy Brief. Geneva, Switzerland: World Health Organisation.

Wilde, G. J. S. (1998) 'Risk homeostasis theory: an overview', *Injury Prevention*, 4(2), pp. 89–91.

Williams, S. J., Martin, P. and Gabe, J. (2011) 'The pharmaceuticalisation of society? A framework for analysis', *Sociology of Health & Illness*, 33(5), pp. 710–725.

Wolitski, R. J. *et al.* (2003) 'Richard J. Wolitski,1,4 Caroline J. Bailey,1 Ann O' Leary,1 Cynthia A. Gomez, ´ 2 and Jeffrey T. Parsons', *AIDS and Behavior*, 7(4), pp. 363–372.

Wolitski, R. J. and Fenton, K. A. (2011) 'Sexual Health, HIV, and Sexually Transmitted Infections among Gay, Bisexual, and Other Men Who Have Sex with Men in the United States', *AIDS and Behavior*, 15(Supp 1), pp. 9–17.

Wright, E. (2016) '24th Annual Keith Harbour Address', *Thorne Harbour Health*. Available at: https://thorneharbour.org/news-events/news/24th-annual-keith-harbour-address/ (Accessed: 24 August 2017).

Wright, E. *et al.* (2018) 'Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine HIV pre-exposure prophylaxis: clinical guidelines. Update April 2018', *Journal of Virus Eradication*, 4(2), pp. 143–159.

Yang, L. H. *et al.* (2007) 'Culture and stigma: Adding moral experience to stigma theory', *Social Science & Medicine*, 64(7), pp. 1524–1535.

Young, I., Flowers, P. and McDaid, L. (2016) 'Can a pill prevent HIV? Negotiating the biomedicalisation of HIV prevention', *Sociology of Health & Illness*, 38(3), pp. 411–425.

Zablotska, I. *et al.* (2016) 'PrEP implementation in the Asia-Pacific region: opportunities, implementation and barriers', *Journal of the International AIDS Society*, 19((suppl 6)), pp. 1–9.

Zola, I. K. (1976) 'Medicine as an institution of social control', *Ekistics*, 41(245), pp. 210–214.

Zuniga, J. M. and Ghaziani, A. (2008) 'A world ravaged by a disease without HAART', in Zuniga, J. M. et al. (eds) *A decade of HAART: The development and global impact of highly active antiretroviral therapy*. Oxford: Oxford University Press.