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**Beyond Prevention:
Lived Experiences of Pre-Exposure Prophylaxis
in Aotearoa New Zealand**

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Doctor of Philosophy
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Abstract

The prevailing research perspectives surrounding the use of pre-exposure prophylaxis (PrEP) among men who have sex with men (MSM) revolve around public health aspects, offering less insights into the lived experiences of those who use it. This project aimed to expand this perspective and examine the experiences of PrEP users in Aotearoa New Zealand by contextualising them in the local social and cultural backgrounds.

Ten individuals (nine men and one non-binary person) who identified as gay were interviewed individually, each on two separate occasions. A method of interviewing that followed the interpretive Gadamerian hermeneutical approach was used to elicit the deeper meanings of PrEP for its users. The theoretical lens of analysis included Bourdieu's habitus theory and informed understanding of PrEP use and sexual behaviours as social practices.

During the interviews, participants shared how their connection with the gay community gave them an informed and empowered status as they actively sought PrEP access. Participants pointed to pervasive heteronormativity in healthcare as a source of difficulties, and they reflected on their methods to challenge it. Many participants demonstrated resilience and were active advocates for themselves and their communities. PrEP was not only seen as one of the methods of HIV prevention, but primarily as an agent of personal and sexual liberation. PrEP also served as an enabler of what was seen as *safe* condomless sex as a carrier of new or recovered symbolic meanings signifying intimacy, connection, and ecstasy, as contrasted with fear and contagion. Condomless sex constituted an important part of the gay habitus that entailed subversive notions of social resistance contradicting the homonormative ideas of mainstream social acceptability. The use of PrEP enabled interrogation of moralised HIV prevention discourses, where condom use served as proxy for homonormative judgments. Differences were noted in ways participants were reconstructing the notions

surrounding sexual liberation depending on their generational experiences of HIV/AIDS history.

The new methods of HIV prevention may enable transformation of established discourses that can now allow agentic practices and offer safe ways of embodying desire. The changing notions of sexual risk and safety in previously forbidden practices need to be considered when analysing the impacts of HIV prevention methods and designing public health interventions.

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Explanation of Acronyms

AIDS – Acquired Immune Deficiency Syndrome. The clinical condition that may develop following HIV infection. Effective treatments prevent clinical progression to AIDS in persons adherent to therapy.

ARV – Antiretroviral; also ART - Antiretroviral Therapy. Medicinal agents that work against the retrovirus (HIV) being the causative agent behind immune deficits in AIDS. They can be used to stop viral replication before it establishes presence in the body (used as prophylaxis), or to prevent active replication and destruction of target cells in established infection (used as treatment).

CAI – Condomless Anal Intercourse. Technical term describing anal sex without the use of condoms, used in behavioural and epidemiological studies.

CD4+ (cells) – Cluster of Differentiation 4-cells; main target cells of HIV; a group of T-helper cells critical for the functioning of immune system. Their depletion as a result of ongoing HIV infection is the fundamental mechanism of immune deficiency in AIDS.

HIV – Human Immunodeficiency Virus, causative agent of AIDS.

LGBTQ – Lesbian Gay Bisexual Transgender Queer. One of the commonly used acronyms denoting identities or communities of gender and sexual minorities. Other commonly used acronyms include LGBT+, LGBTQIA, and others that may also account for intersex, asexual, and other identities. More terms are in use, such as rainbow communities or SOGIESC-diverse persons (Sexual Orientation, Gender Identity and Expression, and Sex Characteristic). LGBTQ was chosen to be used in the present thesis for simplicity of use, reflecting relatively common practice.

MSM – Men Who Have Sex with Men. A term used in HIV and sexual health epidemiology; it emphasises sexual behaviours that may be associated with specific sexual risk profiles. This term is used to avoid referring to identity that may or may not be shared by different MSM.

PLHIV – People Living with HIV. An abbreviation common in HIV/AIDS-related literature to denote individuals who have acquired HIV.

PrEP – Pre-Exposure Prophylaxis. A drug-based method of prevention of HIV that requires taking antiretrovirals prior to possible exposure to HIV; explored in depth withing this thesis.

PEP – Post-Exposure Prophylaxis. A drug-based method of prevention of HIV that requires taking antiretrovirals shortly after possible exposure to HIV.

STI – Sexually Transmitted Infection. A general term for infections that are transmitted primarily through sexual routes.

TasP – Treatment as Prevention. The paradigm that treatment and subsequent viral suppression results in rendering PLHIV unable to transmit HIV sexually, therefore effectively stopping HIV chains of transmission.

TD*/FTC – Tenofovir Disoproxil (*salt) / Emtricitabine. A combination of ARVs used both as part of HIV treatment regimens and as prophylaxis. TD*/FTC is the combination of antiretrovirals currently used as PrEP in Aotearoa New Zealand.

UAI – Unprotected Anal Intercourse. See: CAI.

U=U – Undetectable equals Untransmittable. Statement promoted by Prevention Access Campaign and supported both globally and in Aotearoa New Zealand by numerous non-governmental organisations and scientific bodies. It summarises the evidence that PLHIV who have maintained viral suppression for 6 months or more cannot transmit HIV sexually to their partners.

PART ONE: BACKGROUND TO THESIS

Chapter One. Introduction

It is possible for me to regard the study of man's sexual behaviour with the interest of a scientist who observes almost absently the play of light on the flight of a wasp. Of course, human conduct can be the object of scientific study: it is then observed with no more humanity than if it were an insect's. (Bataille, 1986, p. 149)

Introduction

The ways humans engage with HIV prevention are numerous and diversely motivated. In this thesis, I explore the social and cultural shifts that accompanied the emergence of pre-exposure prophylaxis (PrEP) among the largest group disproportionately affected by HIV in Aotearoa New Zealand: gay and bisexual men. Through analysing the accounts of the study participants surrounding PrEP use, I find that PrEP use is entangled in complex and highly moralised discourses of history of HIV prevention, and the motivations to use it extend beyond solely reducing the risk of acquiring HIV but rather centre around reducing fear and shame. Enabled by PrEP use, the discourses that were earlier anchored around risk, morality, and disease can give way to intimacy, connectedness, and community cohesion.

In recent years, there has been a substantial change in the availability of new methods of HIV prevention. PrEP and Treatment as Prevention (TasP) have completely rearranged the landscape of effective methods to reduce or even eliminate the risk of HIV transmission between sexual partners. Condoms, pillar of sexual safety and heretofore the gold standard of HIV prevention, are no longer the only measure sexually active individuals at risk of HIV may take to stop its transmission. Considering that "HIV prevention" effectively meant "condoms" in Aotearoa New Zealand (Hughes & Saxton, 2015), there is no doubt this shift can be called revolutionary.

Recent years have also seen a rapidly changing picture of HIV epidemic in Aotearoa New Zealand. Following an unprecedentedly high numbers of new diagnoses among men who have sex with men (MSM) in 2015 and 2016, there were some sharp reductions in infections, in particular among those who acquired HIV locally (AIDS Epidemiology Group, 2020). At the outset of undertaking this project, PrEP use was uncommon in Aotearoa New Zealand. Access to HIV treatments for persons living with HIV was also restricted: criteria for accessing publicly funded antiretroviral treatments required either symptomatic infection or low CD4+ cell counts. In such a context, before the project began, the number of locally acquired HIV diagnoses concerningly rose for several consecutive years. At that time, national HIV prevention campaigns remained focused almost exclusively on promoting condom use. However, despite the strong preventive efforts made by public health agencies, over a quarter (27.2%) of MSM declared infrequent condom use (Hughes & Saxton, 2015).

New drug-based methods of HIV prevention have now become available worldwide and in Aotearoa New Zealand. One of them, PrEP, is the focus of this thesis. The current locally used regimen consists of combination of two active ingredients: tenofovir disoproxil (TD*) and emtricitabine (FTC), and this formulation is most often recommended as a daily-dosed single tablet.¹ The drug has been originally patented and marketed by Gilead Sciences under the brand name Truvada, however, during the present project roll-out, generics have become available; first, for private importation from overseas and, later, through ordinary local pharmaceutical distribution.

The uptake of PrEP, its funding and access criteria have been a subject of research and policy discussions (e.g., Saxton et al., 2018). PHARMAC² data suggests that by December 2019, the number of people who were using funded PrEP remained low, at

¹ Other dosing regimens are also recognised and recommended for cisgender MSM (ASHM, 2019; World Health Organization, 2019). Other populations should not use regimens other than daily PrEP due to insufficient evidence. This will be explained in more detail in further chapters.

² PHARMAC is the national agency tasked with management of procurement and distribution of medicines for the public health system in Aotearoa New Zealand.

around a quarter of estimated number of clinically eligible individuals (Macpherson et al., 2020). Suboptimal uptake has also been noted in Australia and PrEP provision has been further complicated by inequities in access (Hammoud et al., 2019). In response to these challenges, in Australia, the evolving approach resulted in a shift from restricting PrEP to high-risk individuals (Wright et al., 2018), to a more nuanced practice that emphasises individual perception of risk and recommends considering PrEP use in all persons at risk of HIV (ASHM, 2019).

The issues of HIV prevention have been rooted in community responses since the emergence of the virus (UNAIDS, 2011). In many developed countries, including Aotearoa New Zealand (Lindberg & McMorland, 1996), the overrepresentation of gay and bisexual men among PLHIV along with tardy state responses led to a need for the community to demonstrate leadership in keeping themselves safe. Among Aotearoa New Zealand gay and bisexual men, along with a culture of relatively high condom use among MSM, there is a strong community whakapapa of community responsibility over HIV prevention, which is entangled in pride history and gay rights activism (Parkinson, 2009).

There is tension between different perspectives on human sexual health (Bancroft, 2009). One approach is rooted in public health paradigms and aims at reducing the risks of sexually transmitted infections (STIs) and minimising the burden of sexual health disorders. A different perspective focuses on a human-oriented approach, aiming to expand our understanding of different forms of human sexuality, as they are enacted in social or cultural contexts. Both paradigms are productive in different contexts and together have allowed for building a generally effective and more inclusive culture in healthcare contexts, raising awareness around risks associated with sexual activity, and developing and adopting various preventive measures, with an aim to maximise the well-being of vulnerable communities and individuals. Before undertaking this study, most of my research activities were rooted in a biomedical model, as that was the context of my professional work. In the present study, I aim to

critique this approach, to recognise its limits, and draw more attention to lived experiences surrounding issues of HIV prevention in their cultural and historic contexts.

In particular, the prevailing perspectives on HIV prevention have been generally rooted in a deficit-oriented public health risk-reduction framework (LoVette et al., 2019) aiming at identifying the “harmful” behaviours and seeking to eliminate or modify them. Less is known about cultural contexts of PrEP and HIV prevention and all the diverse meanings it may entail for MSM, especially in Aotearoa New Zealand setting.

While the overarching goal of wider health sector efforts to widen access to PrEP is to reduce the risk of HIV infection on an individual level, and the incidence of HIV on a population level, it is not clear what motivations lead its users to access and continue using it. Research has recognised that individuals engage with pharmaceutical products in ways different than those intended by prescribers and drug manufacturers. Instead, “patients” may focus on benefits extending greatly beyond the clinically defined goals and the pharmacological pathways used to exert the given molecule’s desired biochemical effects (Whyte et al., 2003).

Existing studies of PrEP use tend to focus either on public health or risk-reduction frameworks while offering less insight into to the lived experiences of PrEP users. Detailed local studies are lacking that would enable capturing the real-life motivations to start using this form of prevention or engage in certain risky sexual practices. In the present study, I will attempt to address these gaps and try to understand what motivates MSM to use PrEP and to understand how it affects their lives.

Research Question

The central research question of this project is: *what meanings do gay men make of PrEP use in the diverse social, cultural, and historic contexts in which they access and continue (or discontinue) using it?*

A number of sub questions are further formulated in an attempt to guide the exploration of the important issues surrounding the lived experiences of PrEP:

- *Why do gay men in Aotearoa New Zealand use PrEP?*
- *How do they access PrEP and what expected benefits motivate them to use it? Do they gain what they anticipated from its use?*
- *How is engagement with PrEP informed by cultural or generational experiences of different eras of HIV prevention?*
- *How does PrEP impact on the ways in which participants navigate the intersections between desire and risk?*

Through undertaking this project, I want to understand the social and cultural contexts in which PrEP and HIV prevention discourses play out and interrogate how they can be placed within larger historic and social processes of gay rights advancement and evolving norms of sexual ethics. In other words, this project seeks to gain understanding of how gay men in Aotearoa New Zealand contextualise their PrEP use.

As the aim of the present study is to highlight the individual experience of PrEP, the study methodology sets to elevate the accounts of those who use it. The thesis is based on the understanding that HIV prevention discourses are more than simply sets of attitudes and beliefs, as well as actions undertaken by individual actors in intimate situations are more than simply health behaviours. These *behaviours* occur in social contexts, are informed by cultural norms, and result in both social and material consequences. In the present thesis, I will argue that HIV preventive practices, including using PrEP, are *social practices* in Bourdieusian understanding and contribute to, are informed by, and reflect the erotic *habitus* of desire: the embodied self-reproducing set of dispositions. I will further analyse how initiation of PrEP influences this habitus.

Critically, I hope that understanding the experiences of gay men with PrEP along with their contexts will contribute to answering larger scope questions about the relationship they have with HIV prevention, its discourses, and cultural roles.

Personal Motivation

It is important for social researchers, and in particular qualitative researchers, to understand their positionality in undertaking any study, as well as to make explicit the drivers that led them to investigating a particular matter (Maso, 2003). Such reflexivity contributes to research integrity (Watson & Girard, 2004) and helps to reconcile with positivist critique of qualitative interpretive studies as “unobjective.” The methodological underpinnings of this study are further explained in the upcoming chapters as well as issues pertaining to researcher subjectivity. However, it is important to signal here the initial motivations and reflections I had as a researcher at the outset of the project. The theoretical hermeneutical phenomenology lens I adopted for this project, as will be explored in more depth in Chapter Three, encourages careful interrogation of one’s presuppositions and realisation that the “data” created through research inquiry is a product of dialogical interaction between researchers and study participants.

Below, I present my initial personal motivation section of the introduction that I included in my original PhD proposal submitted for the confirmation event at Massey University. Except for minor corrections, I present it as it was written in 2017 to serve as a snapshot of the early stages of my personal reflection that was informing the shape of this project as I embarked on it.

I came to [Aotearoa] New Zealand specifically to pursue my doctoral studies. For several years, I worked with persons living with HIV in Poland. My work included research and providing psychological support to hospital patients of an Infectious Diseases Department in Warsaw. I was also an HIV testing counsellor in Warsaw. Shortly after coming to [Aotearoa] New Zealand, I started work with an Auckland-based charity organisation called Body Positive performing [a diverse set of tasks] – a support person, national outreach program developer and coordinator, and HIV testing counsellor.

As a gay man, as long as I can remember I have been aware of an elevated risk of HIV infection. I believe that this is a shared experience of gay men of my generation

in most countries of the world. ... Since I started working within the field my knowledge of routes of infection, risk reduction methods, and means of prophylaxis improved greatly, but my anxiety has remained. I have met many people living with HIV, some of them as clients and some of them as friends, and I know how difficult living with HIV still is. Regardless of spectacular advances in treatment, which can, in most cases, entirely halt progression to AIDS and allow for long and healthy life with minimal drug-related side effects, the stigma around HIV is still widespread, both in New Zealand, and in Poland. Living with HIV does impact on one's personal relationships, self-esteem, sexual life, legal situation, and everyday life. I have seen numerous such cases working at Body Positive and previously in Poland. ...

I come from a country where homophobia and anti-gay prejudice are experienced on an almost daily basis, and where, with a population of [almost] 38 million, there are only a handful of openly HIV-positive persons. Many men living with HIV do not speak up because of shame and fear of discrimination. I have heard all too many first-hand accounts of discriminatory practices. [I strongly oppose] isolating people already living with HIV by building an invisible wall – serosorting relationships, whether these are romantic, sexual, or strictly platonic. And I believe PrEP offers at least a partial solution to this isolation. At the moment of writing these words I am not using PrEP myself, although I have had personal experiences with it and, had it been more easily accessible I probably would have used it. Since I am engaged in this research project, I believe it is essential for me to disclose my personal attitude towards PrEP: I am confident it is an amazing advancement in HIV prevention and a revolutionary tool to reduce fear of HIV and build more inclusive culture for people already living with [HIV].

On a fundamental level, my understanding of the matters outlined above has not changed since the time of writing the confirmation proposal. I have not started using PrEP either, due to my personal circumstances. However, engaging in dialogue with the participants motivated me to interrogate my own assumptions about the role of PrEP and realise the diversity of motivations and experiences surrounding it. In Chapter

Three I will theorise further how researcher preunderstandings influence research outcomes, while in the concluding chapter of the thesis, Chapter Nine, I will summarise my reflections on how this doctoral project influenced me as a researcher and on a personal level.

Structure of the Thesis

The thesis is divided into two parts and nine chapters. Part One (Chapters One through Four) provides the background for the thesis, while Part Two (Chapters Five through Nine) focuses on the findings and their implications for research, practice, and policy.

Chapter One provides an introduction to the thesis, its basic rationale, along with presenting the research question and the study aims. It also offers initial reflection on researcher subjectivity along with a snapshot of my initial personal motivations at the outset of undertaking the study.

Chapter Two provides an overview of the literature relevant to the research questions and communities at the centre of the thesis. It presents the understandings that guided the project surrounding social and health implications of belonging to a sexual minority group. I also present the current state of knowledge about HIV prevention, and its policy implications, especially as they pertain to Aotearoa New Zealand. In the chapter, I also lay out the sexual health perspectives underpinning current understandings of sexual health, sexual risk, and condomless sex, and focus on select social and cultural theories of understanding gay sexualities. Finally, in Chapter Two, I review the local relevant literature surrounding lived experiences of men who use PrEP in Aotearoa New Zealand and identify some gaps in knowledge.

Chapter Three offers an insight into the theoretical underpinnings of the study. It presents an overview of the phenomenological approach to social studies, with focus on the Gadamerian hermeneutical paradigm. The chapter explains why this

methodological approach has been selected to answer the research question and discusses the various methodological dilemmas and how these are reflected and reconciled with in this project.

Chapter Four presents a description of the methods used in the study. It discusses participants recruitment, the interviewing and analysis process, and some of the ethical considerations of the project.

Chapter Five introduces the study participants and offers some reflection on the understanding of participants' identity construction and its implications for the study. I also present parts of the account of one of the participants as illustration of complexities in constructing and experiencing one's own identity.

Chapter Six presents the study findings in relation to PrEP initiation and accessing it through healthcare. It touches upon challenges surrounding PrEP access and heteronormativity in healthcare along with discussing participants' qualities that helped them overcome the difficulties. The chapter emphasises participants' resilience and demonstrates how intersectional challenges continue to be experienced by takatāpui. Here I explore the community ownership of PrEP and community-centred ethics of PrEP proliferation both among Māori and tauīwi participants.

Chapter Seven follows the account of the only participant who was identified within the AIDS Generation (Halkitis, 2019). This chapter aims to recognise the uniqueness of his generational experience and contextualise it within the history of AIDS crisis as well as analyse the arc of recovering an AIDS-free sexual experience.

Chapter Eight explores the experiences of the participants in relation to PrEP, but also offers insights into their understandings of intimacy, pleasure, and personal and sexual freedom. Within the chapter, I theorise on the transgressive role of intimacy within the gay habitus and reflect upon liberation, biomedicalisation of HIV prevention, and meanings of condomless sex.

Chapter Nine is the concluding section of the thesis. It summarises the findings and identifies their contribution to current knowledge. Within the chapter, I discuss some of the limitations of the study and reflect upon the impact of this project on myself as a researcher and on a personal level. Finally, the chapter offers some recommendations for practice and future research.

Conclusion

In this first chapter I presented the rationale for the thesis, research questions, and my motivations to undertake this study. I also provided an outline of the structure of this thesis. Overall, this research project is an attempt to study the experiences of individuals who use PrEP and position them within wider social and community contexts of HIV prevention in Aotearoa New Zealand. Next chapter, Chapter Two, provides a description of the social backgrounds of HIV prevention, including lived realities of gay men in Aotearoa New Zealand. This is also where I explore the evolution of methods used to reduce the risk of HIV infection and interrogate the notions at the centre of this thesis: sexual health, risk, practices, and embodying desire.

Chapter Two: Setting the Research Context

The aim of this chapter is to present the epidemiological, social, and cultural backgrounds of the project and outline the research context. I attempt to give an overview of contemporary methods of HIV prevention and situate them within Aotearoa New Zealand epidemiologic situation. Furthermore, I provide a description of socio-cultural conditions of the gay communities, and discuss stigma and discrimination, focusing on their impacts on sexual minorities' health. I set out my understanding of sexual "behaviours" as *practices* and how such paradigmatic orientation can link with the broader research on human sexuality and HIV prevention, including notions of risk and condom use and non-use. Within this chapter, I review the limited local literature pertaining to PrEP use and elaborate on the rationale for this study.

MSM constitute a population disproportionately affected by HIV; this is especially the case in developed nations (Beyrer et al., 2012). In Aotearoa New Zealand, while HIV prevalence in the general population remains low, MSM make up a majority of new diagnoses (AIDS Epidemiology Group, 2020). This fact makes it even more crucial for MSM to negotiate sexual safety and follow certain protocols to reduce the risk of acquiring HIV. It is this very moment of negotiation, whether expressed verbally in an open fashion or just by taking certain actions (e.g., putting on a condom, disclosing PrEP use or one's serostatus on a dating app), that is of key significance to reducing the number of new infections among key populations (Horvath et al., 2008; Serovich et al., 2009). In recent years, the array of preventive measures has been broadened by the addition of new biomedical methods of prevention, such as TasP and PrEP. Both methods are highly effective in reducing the number of new infections (Cohen et al., 2011; Dolling et al., 2016).

Use of new drug-based methods of prevention may have consequences to one's lifestyle, relationship formation, safe sex negotiation, and ultimately to the number of

new HIV diagnoses. In Aotearoa New Zealand, the relative impacts of these new methods of prevention have not yet been formally assessed on a large scale, but there are downward epidemiological trends (AIDS Epidemiology Group, 2020) coinciding with increased use of biomedical methods of HIV prevention, suggesting these methods may have contributed to decreased local acquisitions of HIV among MSM. Data from other countries support the interpretation that the wide adoption of biomedical measures contributes to decreasing the number of new infections. Modelling studies support PrEP as an effective method to reduce HIV incidence on a populational level across different settings (Elion et al., 2019; LeVasseur et al., 2018). New South Wales EPIC study outcomes provide evidence for real-world impacts of PrEP on reducing HIV incidence (Grulich et al., 2018). Furthermore, PrEP is likely not only to be cost-effective across diverse jurisdictions, but may also be cost-saving if delivered at scale to populations which may benefit the most (Cambiano et al., 2018; Choi et al., 2020; van de Vijver et al., 2019).

Contemporary HIV Prevention

This section outlines the currently accepted approaches to HIV prevention, along with best recommended international and local practices. It provides a brief overview of HIV prevention methods and their basic rationale.

An older global strategy for populational-level HIV prevention consisted of three pillars, abbreviated to ABC of HIV prevention. “A” stood for Abstinence, “B” for Be faithful, while “C” stood in for Condoms. However, promoting abstinence and fidelity, despite significant global endorsements and funding (e.g., through PEPFAR: the U.S. President’s Emergency Fund for AIDS Relief programme in Sub-Saharan Africa), has now been considered ineffective in reducing high-risk sexual practices (Lo et al., 2016). The ABC rationale is also highly moralised, and may easily become entangled in religious and political discourses (Parikh, 2007) equating traditional sexual ethics with health and moral good.

The contemporary internationally accepted paradigm of HIV prevention can be summarised as combination prevention approach (UNAIDS, 2010). Combination prevention programmes should be:

...rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions, prioritized to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections. Well-designed combination prevention programmes are carefully tailored to national and local needs and conditions; focus resources on the mix of programmatic and policy actions required to address both immediate risks and underlying vulnerability; and they are thoughtfully planned and managed to operate synergistically and consistently on multiple levels (e.g. individual, relationship, community, society) and over an adequate period of time. They mobilize community, private sector, government and global resources in a collective undertaking; require and benefit from enhanced partnership and coordination; and they incorporate mechanisms for learning, capacity building and flexibility to permit continual improvement and adaptation to the changing environment. (UNAIDS, 2010, p. 8)

In Aotearoa New Zealand, this approach has been widely supported by key stakeholders of the HIV and sexual health sector and this has been reflected in the Consensus Statement, endorsed by the National HIV/AIDS Forum (2017). The key actions recommended by the Forum to reduce sexual transmission of HIV are: (1) promotion of condoms; (2) increasing HIV testing; (3) rapid initiation of ARV among PLHIV and retention in care to maintain undetectable viral load; (4) PrEP accompanied by STI screening in high-risk populations; (5) STI vaccination, screening, and treatments; and (6) ongoing surveillance and research into HIV and STIs. Below, I will outline the components of this approach and explain how they apply to Aotearoa New Zealand context.

Since the identification of infectious aetiology and sexual route of transmission of AIDS, condoms have been the mainstay of reducing sexual HIV acquisition

worldwide, and the cornerstone of safe sex messaging in many settings, including in Aotearoa New Zealand (Hughes & Saxton, 2015). An intact condom provides a physical barrier that is impenetrable to HIV and many other infectious agents. When used consistently, they are effective at reducing the risk of HIV (Smith et al., 2015). Condoms may also lower the risk of acquiring other STIs (Holmes et al., 2004). However, even when used consistently and properly, a certain rate of condom failure remains, estimated at less than 1% per intercourse that can be further lowered by using condom-compatible lubricant (Siegler et al., 2019). Condoms in Aotearoa New Zealand are funded by PHARMAC on prescription and are available in many healthcare settings as well as through targeted distribution to MSM by New Zealand AIDS Foundation through postal order and in gay community venues.

There is broad consensus that PLHIV who have maintained undetectable viral load for 6 months or longer do not transmit HIV to their sexual partners, regardless of condom use or non-use (UNAIDS, 2018). This statement is commonly communicated with a slogan U=U (or u=u; undetectable equals untransmittable). It has been promoted globally by Prevention Access Campaign since 2016, and found the support of over 1000 organisations from 102 countries (Prevention Access Campaign, 2016). Two years later, the U=U statement was formally endorsed in Aotearoa New Zealand by National HIV/AIDS Forum (2018).

The individual health benefits of early HIV diagnosis and antiretroviral treatment initiation in PLHIV are commonly accepted. Starting treatment promptly, before CD4+ cell decline results in decreased serious AIDS-related and non-AIDS-related events and improved health outcomes (The INSIGHT START Study Group, 2015). The understanding that viral load suppression results in halting ongoing HIV transmission added necessary momentum to advocacy efforts emphasising the need for early diagnosis and treatment initiation. Encouraging frequent testing practices, aimed at early HIV detection and viral suppression before ongoing transmissions occur, is an important pillar of combination approach to HIV prevention. Antiretroviral treatment and HIV care are now available free of charge for all persons living with HIV in Aotearoa

New Zealand, regardless of their CD4+ cell counts and regardless of whether they are otherwise eligible for publicly funded healthcare (Kolodziej et al., 2020)

New drug-based methods of HIV prevention include PrEP and post-exposure prophylaxis (PEP). It is important to differentiate between the two terms. PrEP requires individuals to start taking medication *prior* to a risk event, while PEP involves taking antiretrovirals *after* a risk event. For PEP to be effective, it should be taken as soon as possible after the exposure, and no later than 72 hours (European AIDS Clinical Society, 2017); after 72 hours its use is considered ineffective. Recommended PEP regimes involve continuing using the medication for 28 days (Dominguez et al., 2016). Despite consensus that promptly initiated PEP reduces the risk of HIV acquisition, it is unknown how effective it is in different occupational (primarily in healthcare) and non-occupational (including sexual), exposures. There have been no randomised controlled trials of PEP conducted in humans, and they are unlikely to be performed for ethical reasons, so the bulk of supporting evidence comes from animal studies (Irvine et al., 2015). PEP is available in Aotearoa New Zealand, however access to it following non-occupational exposures is limited by lack of universal knowledge about it and costs, as it is only funded in narrowly defined circumstances (e.g., sexual assault or unprotected sex with a known HIV-positive person with detectable viral load).

PrEP, the prevention method at the centre of this thesis, involves taking antiretroviral medication prior to sexual HIV exposure, in order to reduce the risk of HIV acquisition. It is highly effective in stopping HIV transmission and has been described as nearly eliminating the risk of transmission (BPAC NZ, 2019). The cases of PrEP failures, defined as breakthrough infections in persons following the recommended dosing regimens, are considered rare (Molina, 2019).

Currently recommended PrEP agents in Aotearoa New Zealand are combinations of tenofovir disoproxil (TDF or TD*) with emtricitabine (FTC), however, globally, tenofovir alafenamide (TAF) with emtricitabine combinations have also been approved for certain populations ("New PrEP formulation approved... but only for some," 2019). Daily use of PrEP is recommended for all persons at high risk of HIV

infection. As an alternative, event-based dosing regimens are recommended for cisgender MSM who have infrequent sexual exposures; it is not recommended for other populations due to insufficient evidence. This alternative regimen is also called on-demand PrEP, or PrEP 2-1-1, and involves taking two tablets 2-24 hours before sexual exposure, followed by one tablet 24 hours later, and a final tablet another 24 hours later. This can be repeated for as long as sexual exposures continue, so long as two successive tablets are taken following the final exposure (World Health Organization, 2019). Importantly, during the interviewing stage of this study, the alternative regimen was recommended only in some jurisdictions around the world (e.g., Europe; European AIDS Clinical Society, 2017) and not in Aotearoa New Zealand.

Gay Identities: Terminology

Throughout this thesis, I discuss phenomena relating to sexual practices, sexual orientation, and sexual identity. In most cases, I refer to the sexual minority communities of MSM, many of whom identify as gay, but others identify as bisexual, takatāpui, queer, pansexual, straight, use other categories, or refuse to accept any labels. To emphasise the importance of sexual behaviours, and avoid discussing identity, the term MSM (as is often employed in this thesis), is commonly used in epidemiological studies (Boellstorff, 2011). This term not only sets aside considerations of identity, but also deliberately omits sexual orientation or other motivations for particular sexual practices. MSM, as a broad category indicating a common populational route of HIV transmission, may encompass, for example, male heterosexual sex workers who have sex with men driven by financial motives.

In Aotearoa New Zealand, many scholars researching HIV prevention (e.g., Hughes & Saxton, 2015) use the term *GBM*, to signify Gay, Bisexual, and other Men who have sex with men. This term highlights the common intersection of sexual orientation/identity and sexual practices. When discussing communities of same-sex attracted (exclusively or not) persons, other researchers (e.g., Neville & Henrickson,

2006) choose the term *LGB* – Lesbian, Gay, and Bisexual, consciously omitting T for Transgender, which term does not refer to sexual orientation, but gender identity.

The term *queer* was historically used pejoratively, but is now considered reclaimed as a valid, affirmative term to denote one's sexual or gender identity (Zosky & Alberts, 2016). The word is commonly used both in academic contexts, as exemplified by the discipline of queer studies, as well as by many members of LGBTQ communities to denote their own identities (e.g., Kolker et al., 2020). In a narrower sense, as used in some segments of critical theory, *queer* can signify the deconstructive potential or necessary antithesis to allow the construction of dehistoricised and normalised heterosexuality (Carroll, 2012). However, within this thesis, I will use the term *queer* in a broad sense, denoting simply non-heteronormative identities.

The use of any of these terms is not uncontroversial and further nuance emerges when we acknowledge the need for terminology that enables cultural self-determination of the Māori in Aotearoa New Zealand (Henrickson, 2006). *Takatāpui* is a term that denotes the intersection between Māori identity and non-heteronormative sexual orientation, and can signify homosexual or bisexual sexual identity, but also non-cisgender identities, such as whakawāhine, tangata ira tāne, and more (Kerekere, 2017). It appears to be increasingly commonly used by Māori lesbian, gay, and bisexual individuals, and its use is gaining more recognition in Aotearoa New Zealand, also by official government bodies (Stats NZ, 2020).

In this thesis, I attempt to consistently use a mixture of terms I introduced above taking into consideration their differential meanings. In essence, when I refer to epidemiology and emphasise sexual behaviour, I use the term *MSM*; when I talk about identity, I use terms such as *gay* or *bisexual*, and, lastly, when I discuss Māori identities, I use the term *takatāpui*, when such self-identification appears preferred (notably, not all gay Māori men use the term *takatāpui* to describe themselves). When I refer to other researchers' scholarly work, I use the terms as they appear in the source material, unless it risks making the context unclear.

Stigma and Discrimination

As was emphasised earlier, gay and bisexual men constitute a group that is overrepresented in the number of new HIV diagnoses and among PLHIV in Aotearoa New Zealand. Such vulnerability intersects with a set of challenges sexual minorities face during life.

The gradual introduction of new methods of prevention comes at a time when the social situation of gay and bisexual men is complex. Just a few decades after decriminalising homosexual practices through the Homosexual Law Reform Act of 1986, same-gender couples can now legally marry, jointly adopt children, and enjoy legal protections from various forms of discrimination in Aotearoa New Zealand. Despite all these beneficial regulatory changes, social prejudice and discrimination remain a significant challenge (Kushner et al., 2013). Even in highly regulated contexts, such as child adoption, same-gender couples continue to suffer from prejudice despite *de jure* full equality in rights (Scherman et al., 2020).

Non-heterosexual individuals are consistently reported to experience poorer outcomes in a number of areas, including self-rated health, drug use, smoking, and others, with the effects being even more pronounced in non-heterosexual men than non-heterosexual women (Bariola et al., 2016). In professional health settings gay and bisexual men experience both homophobia (prejudicial attitudes towards homosexuality) and heterosexism (assuming heterosexual orientation as default; Neville & Henrickson, 2006). In a local study, only half of gay and bisexual men believed their general practitioners were aware of their sexual orientation or practices (Ludlam et al., 2015). Considering knowledge about sexual practices is essential for providing appropriate sexual health screenings, prevention, and ongoing care, this is a deeply concerning result.

One of the accepted models explaining the poorer health outcomes in minority groups is the Minority Stress Model (Meyer & Frost, 2013). It posits that it is not only the experienced systemic or individual discrimination that contributes to poor health

outcomes; it is also the self-stigma and internalised homophobia experienced by living in a heteronormative culture that devalues any deviations from social norms (Enson, 2015; Walch et al., 2016; Williamson, 2000). Experiencing feelings of lower self-efficacy and self-worth, members of minority groups may lack motivation to take good care of their own well-being, which, when paired with chronic stress caused by prejudice and discrimination, significantly affects their health outcomes.

A notion useful in considering the processes that lead to social exclusion is the concept of abjection. Introduced by Douglas (1966) and further developed by Kristeva (1982) the concept of an *abject* can be understood as “what disturbs identity, system, order. What does not respect borders, positions, rules” (Kristeva, 1982, p. 4). The abjected groups are positioned as dirty, and as threats to the morally “pure” fabric of ideal society. Such social positioning allows for the increased surveillance and/or elimination of the abject from society as means of purification. The “dirt” (impurity) provokes strong emotions as both belonging to a given social category and, at the same time, being somehow different. The gravity of abjection can be interpreted as stemming from “the disintegration of the very ontological coordinates that enable me to locate an object into external reality out there” (Krecic & Zizek, 2016, p. 69). Abject is therefore constituting a threat to one’s very existence on an ontological level, by making the distinction between self and Other ambiguous. The abject crumbles the lines of distinction by at the same time belonging and not belonging to a social category. Practices transgressing social boundaries may provoke feelings of “horror” and therefore are prone to being subject of abjection.¹

According to some authors, the process of abjection is situated at the root of social exclusion and discrimination by viewing the Otherness as “dirty” elements in the “healthy” social organism (Douglas, 1966). By the processes of mainstreaming and

¹ Common psychoanalytical allegories of abjection often point to physiological roots of abjection: for example, a wound that reminds of the fragile boundaries of the body. The terror it involves is nauseating and therefore objects of abjection are often dehumanised and presented using a language that invokes the feelings of disgust (Krecic & Zizek, 2016).

normalisation of certain social phenomena (like HIV-positivity or homosexuality) abjection may be avoided, but that happens at the expense of uniformisation of difference. In his essay about living with HIV, Armendinger (2009) writes, “our [queer] lives have had some tacit acceptance from the mainstream, so long as we learned our lesson from AIDS and stopped being so queer in the first place” (pp. 173-174).

It is impossible to fully evade the negative sequelae of possessing the socially debilitating qualities. To better understand that phenomenon, within his classic theory, Goffman (1963/1990) introduces and describes the concept of *stigma*:

While the stranger is present before us, evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind—in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive; sometimes it is also called a failing, a shortcoming, a handicap. (p. 12)

Goffman proposes that possessing the burdening attribute constructs a spoiled or *stained* identity that separates the stigmatised from society. This occurs by damaging their social relationships, as it is in the space of social relationships that various attributes become stigmatising.

The term stigma, then, will be used to refer to an attribute that is deeply discrediting, but it should be seen that a language of relationships, not attributes, is really needed. An attribute that stigmatizes one type of possessor can confirm the usualness of another, and therefore is neither creditable nor discreditable as a thing in itself. (Goffman, 1963/1990, p. 13)

Social pressure is applied to individuals who possess certain characteristics that are devalued by wider society. Goffman (1963) called this process *stigmatisation*, and it is relevant to different attributes in marginalised groups; whether this is same-sex attraction, ethnicity, disability, HIV status, or any other stigmatised attribute.

However, by constructing a culture that appreciates (or reconstructs) the formerly stained identities and reassesses them as a highly valued point of difference, those queer identities allow those who internalise them to regain their sense of dignity (Galinsky et al., 2013). Without the burden of discrimination, by such reconstruction, the formerly stained minorities can make informed and independent decisions, including those regarding their health, and apply individualised strategies to protect themselves from hazards. The examples of this process in relation to HIV prevention will be discussed later in in this chapter.

Sexual Health Perspectives

This section seeks to position the understanding of sexual health in this thesis within the commonly employed theoretical approaches. To provide a background for my understanding of sexual health as a product of socially contextualised practices, I will outline some of the dominating paradigms surrounding sexual health as a component of human health.

In contextualising health, many researchers employ the framework offered by Dahlgren-Whitehead rainbow model of health (Dahlgren & Whitehead, 1991). This broad model emphasises the multifactorial nature of health determinants that range from constitutional factors, individual lifestyle factors, social, and community networks, to general socio-economic, cultural, and environmental conditions. This nexus of factors can be extended to researching sexual health to inform a broad understanding of populational and individual health challenges. The model emphasises that health outcomes are a product of the totality of human environments and living conditions and maximising health can only occur in conjunction with optimising other aspects of individual and community lives.

It is broadly accepted that for health promotion interventions to be effective they need to engage communities. Contemporary public health policies and interventions often draw on the principles of Ottawa Charter (World Health Organization, 1986),

which emphasises engaging communities as well as collaboration in health-maximising efforts by governments, communities, and individuals. The document underlines that physical and mental health is a product of social conditions, which include the entirety of human environment: both physical and social. To complement such holistic and contextualised understanding of public health, research should seek to position health practices within these complex contexts. At the centre of this thesis lies understanding that human behaviours do not occur in a social void, but within wider social contexts, where they become sanctioned as community norms or practices as they are allocated with collectively established meanings through social discourses.

Establishing community practices and collective meanings can be complex, and multi-layered. Feelings of belonging to a given (sub)community (e.g., BDSM² community, gay community, or wider queer community) can alter the behaviours of individuals. In other words, socially constructed identities influence the health outcomes by setting boundaries of what are acceptable and/or recommended practices (Jetten et al., 2011). These practices establish a new “normal” within communities where individual experiences are not only understood but validated.

It is worth noting here as a side note that some practices can also, in social reality, make a statement about belonging to a community. For example, belonging to the gay community may result in experiencing HIV stigma, even by those who are HIV-negative (Broady et al., 2020). Such association by proxy can prove very challenging for people who are unwilling to share the stigmatised status of stigmatised groups. On the other hand, among a population of PLHIV in Aotearoa New Zealand where MSM constitute a majority (Dickson et al., 2015), the fact of taking antiretroviral drugs by those who do not identify as gay may carry the burden of anti-gay discrimination and stigma. Almost thirty years ago, Susan Sontag (1991) wrote: “indeed, to get AIDS is precisely to be revealed ... as a member of a certain ‘risk group,’ a community of pariahs” (p. 110). The

² BDSM stands for Bondage, Discipline (or Domination), Sadism (or Submission), and Masochism (Vance, 2011). This is an umbrella term for various sexual practices related to sado-masochism and/ or domination and submission.

consequences of disclosure may be less pronounced for certain groups of men who identify with the gay community. The wider category of MSM however is very diverse and does not only include men who identify as gay, but all those individuals who share the same epidemiological risks. For those who do not identify as gay, belonging to the group of “pariahs” might create more stigma than they are willing to endure.

Health interventions are often based on models that emphasise individualised decision-taking and construct health-related practices as fundamentally rational. However, simply informing individuals about prevention options may not be enough to promote safer sexual practices (Albarracín et al., 2003). When focusing on modifiable lifestyle or behavioural factors, researching sexual health practices has been based chiefly on one of the two models: 1) the Health Belief Model (HBM; Janz & Becker, 1984), and 2) the Theory of Planned Behaviour (TPB; Ajzen, 2011). Both approaches (and their variations) are commonly employed in addressing sexual health promotion, despite some criticisms. They assume that human health-related behaviours are generally rational and follow the logic that intentions lead to behaviours. Such concept is often criticised as overly simplistic in that it ignores the influences of situational factors, socially constructed norms, and commonly accepted practices prevalent in a given population (Jetten et al., 2011). The link between intention and action is often weaker than could be expected, therefore the predictive value of the various factors of the models may be limited, especially in the long-term (Carpenter, 2010). Especially in the context of sexual practices, models that assume rational choices fail to predict behaviours, because of the intrinsically impulsive nature of human sexuality (Bancroft, 2009). HIV testing, using a condom and/or taking PrEP, or taking one’s antiretroviral drugs might not be a result of individually considered calculation of costs and benefits, but instead they may stem from complex interplay of social and cultural contexts occurring in a given historic space.

A note should be made about the applicability of models of behaviour change used by social and health practitioners. Arguably, one of the most commonly used models in behaviour change interventions is the Transtheoretical Model (TTM;

Prochaska & DiClemente, 2005). It was first developed as an empirical model to overcome the limits of narrow theoretical approaches in psychotherapy and draws on the commonalities in effective therapeutic interventions. It has been implemented in behaviour change across several domains, including smoking cessation, weight loss, substance use, and HIV prevention (Prochaska et al., 1994). TTM seeks to address the links mediating between knowledge or beliefs about healthy/unhealthy behaviours, and material behaviour change. Its authors emphasise recognising different stages of change (or readiness for change) and applying motivational techniques that are most appropriate for a given stage. It is implicit within the model, that the behaviour sought to be changed needs to be undesirable. As PrEP makes the distinction between safe and unsafe sexual behaviours challenging and highly contextualised, objectives of TTM-based interventions become blurred as well.

The commonly employed models in researching PrEP and, consequently, promoting its use rely on risk-reduction and knowledge-based frameworks (e.g. Collier et al., 2017). An example of one of the first campaigns that has offered a novel perspective and emphasised orientation towards intimacy and pleasure among people of various ethnic and sexuality characteristics was the 2016 Chicago campaign called PrEP4Love. The main message read: “Love is contractible. Lust is transmittable. Touch is contagious. Catch feelings, not HIV” (Chicago PrEP Line, 2016). It aimed to convey a positive, affirming message, addressing some of the emotional and sexual drivers to PrEP initiation. The campaign webpage followed in similar vein and stated:

Pleasure and sexual intimacy are important, whether it's with your long-term partner or with someone you've just met. They are important for everyone, whatever your gender identity or sexual orientation. ... Many people who take PrEP report they experience peace of mind while having sex. That peace of mind brings relief from the intense fear — and stigma — of HIV that has characterized our sexual lives for far too long. PrEP users also report feeling safer in their relationships and more in control regarding their sexual health and wellness. What's sexier than that?
(Chicago PrEP Line, 2016)

Chicago PrEP Line campaign was a pioneering large campaign that focused on health equity and sex-positivity in promoting PrEP worldwide. It reached a very wide audience and was well received (Dehlin et al., 2019).

An example of a more holistic research and practice models is the one suggested by Robinson (2015). The Sexual Health Model can be applied to all sexual health research, including HIV prevention research. It consists of 10 interrelated and equally important elements contributing to an overall sense of sexual well-being: (1) talking about sex; (2) cultural and sexual identity; (3) sexual anatomy functioning; (4) sexual health care and safer sex; (5) challenges; (6) body image; (7) masturbation and fantasy; (8) positive sexuality; (9) intimacy and relationships; and (10) spirituality (Robinson et al., 2002). Satisfying sexual health and well-being can be achieved only when all the elements are taken into consideration, which notion underpins this holistic approach. The authors note: “Too often, HIV prevention interventions have viewed sexual exploration only in terms of risk and disease” (Robinson et al., 2002, p. 50). This argumentation falls in line with the understanding that true motivators for sexual practices, unlike is implied by rationality-based models, are sexuality-based and are an expression of sexual needs and desires and are not “health choices” as they are often presented.

Both of the previously described rationalising models of health (HBM and TPB) and many of the behaviour change intervention models (e.g. TTM) are broadly based on a deficit-oriented model of human sexual health which assumes sexual health is the lack of disease or deficit (Bancroft, 2009). In reality, sexual health, similar to overall health, can be understood not merely as absence of disorder, but as an important factor contributing to well-being of individuals. This focus on well-being instead of deficits has not always been applied in HIV prevention research and interventions (Robinson et al., 2002). The World Health Organization (WHO), however, recognises holistic understanding of sexual health by proposing the following definition:

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. (World Health Organization, 2006, p. 5)

In this thesis, I will aim to construct an understanding of sexual health in such holistic way. I will try to embody the spirit of WHO definition, that emphasises positive outcomes of actualising one's sexuality, and not merely avoidance of disease. Now, I will further situate my understandings of the key notions of this thesis within a larger context of human sexuality.

Theory of (Sexual) Practice

The understanding of sexuality that informs this research project draws on Bourdieu's theory of practice (Bourdieu, 1977). In essence, Bourdieusian social theory provides lens for interrogation of how social structures of power are continuously reproduced, even though they may elude conscious intention. The key interest of the theory of practice is understanding the social stratification and injustices along with the systems that propagate and reproduce them.

Some of the key notions of Bourdieu's theory that are relevant to the study of practice of sexualities include habitus, field, doxa, and agency. *Habitus* can be defined as a set of subconscious "embodied dispositions" that govern making sense of the world and social practices of individuals and larger social units. On a social level, habitus represents the internalised and embodied values and expectations of society, but it is important to note that habitus can also be seen as specific to different social contexts. These differing social contexts are what Bourdieu calls *fields*; individuals normally participate in several fields which can be guided by distinct internal logics. As is relevant to this thesis and will be further explored within this research project, gay men may embody a specific habitus in relation to the field of their gay identities.

Typically, the habitus and practices are restricted by doxa. *Doxa* denotes a set of taken for granted, naturalised, and dehistoricised “truths” about social and material world, that make it appear self-evident. Bourdieu (1977) argues, “because the subjective necessity and self-evidence of the commonsense world are validated by the objective consensus on the sense of the world, what is essential **goes without saying because it comes without saying**” (p. 167).

Doxa needs to be distinguished from orthodoxy or heterodoxy (Bourdieu, 1977). The latter two present a possibility to be openly interrogated, and, if not, can be at least expressed or explicitly spelled out. Even though doxa is not normally consciously recognised, it establishes the limit of what can be said and thought; it sets the boundary of discourse(s).

Finally, an important aspect of Bourdieu’s work is agency. *Agency* can be understood as deliberate action aimed at transforming or moving beyond the existing structures of power where groups or individuals had been situated. One must note that Bourdieu’s theory has been critiqued as deterministic (Roth, 2014). Several authors, however, point to the potential for transformative agency and change allowed by the theory, provided that certain social conditions are met (Angus et al., 2005; Béhague et al., 2008; Fowler, 2020; Yang, 2014).

Bourdieu’s theory extended to issues of gender and sexuality (Bourdieu, 2001). Similar to earlier critical queer theorists such as Eve Kosofsky Sedgwick or Judith Butler, however with notable theoretical departures (Reeser & Seifert, 2003), he noted that structures of power that regulated class, were at play in underprivileging women. Bourdieu elaborated that, within social discourses of the West, the gender power differences were dehistoricised and eternalised. In other words, while it was in fact a historical process, establishing patriarchy started to seem natural, and female underprivilege became the accepted norm.

Effective agency to change the self-reproducing structures can only emerge when there is realisation of implicit mechanisms governing these structures (Yang, 2014). In

extending his theory to the gay and lesbian rights movement,³ Bourdieu (2001) signalled that gay identities can be subjected to similar forms of stigmatisation and “naturalisation” of inferior status, while their struggles for social recognition are being hindered by forced subjugation to the dominant discourses (heteronormativity).

It has been proposed that Bourdieusian frameworks may offer a way to provide an alternative to two traditional approaches of sexual desire inquiry: first, psychoanalysis, focused on highly individual development-regulated drivers, and, second, scripting theory, emphasising behaviourally trained “social scripts” (Green, 2008). Bourdieu emphasised somatisation of the habitus, which he understood as mirroring in the body (embodying) of stratified social structures and processes. The internal spheres of erotic fantasy, along with social interactions, sexual practice, and sexual object preference (including eroticisation or fetishisation) are embodied by (and inform) the erotic habitus of individuals and communities. This erotic habitus seeks to unconsciously reproduce a certain social order (or social orders). An example of such understanding is the analysis of racialised sexuality, extensively described as ubiquitous in the gay communities. Racialised sexual desire is informed by racialised and gendered social stratification of the West. Examples include the hypermasculinisation and hypersexualising of perceptions of African men (e.g., Wade & Harper, 2020) and feminising discourses surrounding Asian men (e.g., Han, 2008). Importantly, erotisation of stratified social order also characterises heterosexual discourses. Chodorow writes, “Those who are called or who consider themselves heterosexuals are, in all likelihood, tall-blond-Wasposexual, short-curly-haired zaftig-Jewishosexual, African-American-with-a-southern-accentosexual, erotically excited only by members of their own ethnic group or only by those outside that group” (as cited in Green, 2008, p. 613).

In this project I draw on Bourdieu’s theory of practice to inform my understanding of the participants’ sexual “behaviours” as social *practices*. I use this lens

³ Bourdieu, notably, removed the gay and lesbian issues from the main body of the text and delegates it to the appendix of his book dedicated to gender power structures, *Masculine Domination* (2001).

to understand what constitutes gay habitus, how HIV prevention discourses align (or misalign) with the participants' practices, and how understandings of HIV prevention may be transforming with the emergence of new methods of prevention.

Social Constructions of Condomless Sex in Cultural Context(s)

As stated earlier, there is significant tension between the public health approach and the lived experiences of men who engage in sexual relations with other men. Very often the public health approach representatives assume that MSM who do not adhere to safer sex recommendations lack knowledge about HIV prevention (Adam et al., 2009) or simply "forget" about condom use either due to substance use (Allen et al., 2015) or in the heat of the moment (Shuper & Fisher, 2008). In reality though, the very existence of barebacking subculture (Dean, 2009) and the tremendous popularity of bareback pornography (Jonas et al., 2014) may suggest that men *choose* not to use condoms deliberately, somehow hearing the messaging in the back of their heads and *choosing* not to listen. It appears that a connection between those two perspectives might be lacking, and a limited number of studies aim to address this gap, by examining the meanings of condom non-use among MSM.

To understand human practice as it occurs, it is important to consider its historic and cultural surroundings and discourses. Individualistic Western cultures have allowed the construction of social identities of gay men who self-identify as such (Flowers & Buston, 2001). They have, over time, established sets of exclusively gay practices and cultural phenomena that are sometimes being mainstreamed into the general culture (e.g., drag-queen culture, fetish apparel, and cruising venues). Within those clos(et)ed cultures a set of HIV-related practices also exists.

Subcultural norms play a role in informing health choices. One notable example that pertains to this thesis is *barebacking*, meaning a deliberate act of condom non-use (Tomso, 2008). The act of non-compliance with the promoted social norm of using condoms can be perceived as liberating and subversive. One may ask the question why

men decide to have bareback sex (and researchers often do ask that question), but it could also be reversed: why do individuals decide *not* to have bareback sex? The interrupted sexual act which is a real-life effect of using a condom can be seen as an intrusion of social norm: the biomedical intervention ruining the decorum of sexual spontaneity. A menacing reminder of the threats of biological and social reality may feel very unwelcome by individuals whose identities include notions of resistance and subversion.

Barebacking, rejected both by wider society and many of the gay-oriented HIV prevention agencies, is a practice construed as abnormal and immoral; deserving deepest condemnation. The popular media representations of barebacking gay men focus on their almost vampirical characteristics: the search for death (e.g., Freeman, 2003) along with other dark, sinister, and incomprehensible motivations. Akin to a moral panic (González, 2019), the representations of the concept of barebacking are often equated with pure evil and presented in a sensationalist tabloid style (Tomso, 2004).

The real-life reasons for both barebacking and bug chasing⁴ – the latter represented very marginally among MSM (Moskowitz & Roloff, 2007) – are potentially complex and it is likely that men who engage in such practices have significant psychological gains that motivate them to do it. The true meanings of barebacking to men who bareback are rarely analysed without prejudice; the underlying assumptions usually call for ritual condemnations of barebacking when writing about it. Tomso (2004) asks rhetorically, “Can we speak of bug chasing and barebacking at all without perpetuating some form of homophobic violence?”, and promptly responds: “no” (p. 92). It cannot happen, because both popular and scientific publications position themselves in a relationship of power; whether it is exerted by condemnation, terror, or “concern.” Tomso further claims (2004) that even typically neutral language of medical

⁴ *Bug chasing* is a term used to describe a practice of deliberately seeking to acquire HIV by HIV-negative individuals (Moskowitz & Roloff, 2007).

research reveals the emotions barebacking activates and quotes one of the articles in a nursing journal:

Many barebackers report a desire to either stay HIV negative or to protect partners from infection. What is more frightening is the reportedly small group of men actively seeking to become HIV infected ("bug chasers") or to infect others ("gift givers"). (Goodroad et al., 2000, p. 30)

The reaction of fear is hardly concealed and points not only to the condemnation of bug chasers who are even "more frightening" than "barebackers." In a world of risk-reduction and rationality barebacking may appear as not only a problem, but a disease. Parsons (2005) proposes a "treatment model for barebackers," not only implicitly placing barebacking in the category of illnesses as requiring treatment, but also by constructing an essentialised identity of a "barebacker." Pre-framing bareback sex as a dangerous disease or a deficit related to sexual or public health domains narrows our possibilities of understanding the phenomenon. In other words, such implicit prejudices effectively complicate uncovering the true meanings of condomless sex among those who engage in it.

Tomso (2008) introduces the term viral sex to talk about all the forms of deliberate condom non-use in a pre-PrEP era. He claims that in a neoliberal reality the act of transgressing the norms imposed by either state or "experts" may be the only means of re-establishing self-sovereignty. Without such revolt, the Foucauldian *biopower*, understood as the power over the human body, belongs to public health experts that deem what is rational and beneficial. With the advancements of mainstream LGBTQ political demands (such as marriage equality) men who bareback are considered an embarrassment to the LGBTQ movement (as used to be the case for the previously considered aesthetically problematic groups of fems or bears⁵) and therefore are

⁵ By *fems* I understand men who act and/or dress in a manner traditionally considered effeminate. *Bears* are men who belong to a specific gay subcommunity and typically have higher body mass and/or a lot of body hair.

invisibilised to the non-gay world. This concealment does not render them non-existent; and with a changing landscape of HIV prevention methods their place in the community may change. What had been considered either murderous or suicidal can shift in image.

Years of representations of ejaculate as poison are not likely to be erased from common memory, but the motivations to play with what used to be taboo may be reinforced. According to Tomso (2008) a similar process took place along with the introduction of protease inhibitors⁶ in the mid-1990s. With less perceived threat of HIV and the panic AIDS involved in the past, the pursuit of sensual pleasure became once again something thinkable and potentially liberating from the burden of years of terror and mourning. The idealised “lost paradise” and sexual freedom of pre-AIDS era was again on the horizon and the same could be the case with the introduction of PrEP, which has the potential to symbolically purify the toxic bodily fluids.

Holmes and Warner (2005) conducted a qualitative study using framework inspired by Lacan’s psychoanalytical theory and poststructuralist ideas of Deleuze and Guattari, and anchored their research in the notion of penetration and semen exchange. They conducted 18 interviews with men who declared they practice bareback sex in Canada, France, and Switzerland. The authors concluded that “semen exchange is not an accidental by-product of the practice of bareback sex, but in many ways is the very *raison d’être* of the activities. ... Men meet to share semen, and healthcare workers try to ‘stop’ the sharing” (Holmes & Warner, 2005, p. 12). There is concealed meaning in fluid exchange that goes beyond the physical pleasure of barrierless intercourse. One of the participants of the above international study noticed how MSM are “stripped” of the opportunity to experience fluid exchange in comparison to heterosexual couples:

Sperm has a very powerful symbolic function ... for men who have sex with men, it is the odor of masculinity, the ‘fluid’ that tastes like a gift ... AIDS prevention

⁶ The introduction of protease inhibitors (PI) as an adjunct to two nucleoside reverse transcriptase inhibitors (NRTI) is widely considered a breakthrough in effective HIV infection treatment. This three-drug therapy (Highly Active Anti-Retroviral Therapy; HAART) greatly improved survival rates of PLHIV and reduced AIDS-diagnoses wherever the new drugs were implemented (Moore & Chaisson, 1999).

command that we do not 'eroticize' this perilous secretion anymore. I do not know what girls think about it. My girlfriends all say that they love holding on to the sperm of their partner inside of them for a long time. (Holmes & Warner, 2005, p. 13)

The authors' interpretations of the meanings associated with bareback sex are two-fold. The first, following a Lacanian approach, interprets the behaviours as the need for recognition by the Other, which is a fundamental desire in the psychoanalytical theory. Semen is meant to fulfil the subject at an unconscious level and provide the feeling of true connectedness between partners, serving as a signifier⁷ for a completed self in relation to the Other. The second line of interpretation draws on Deleuze and Guattari's concepts of (de)territorialisation. The state and wider society impose power-related sanctions on human bodies and a subject's struggle for independence is fought on the surface of his own body ("Body without Organs"). The men who practice bareback sex are resisting the public health regime, by taking control of their own bodies and using them in ways that contradict the dominating commands of normative institutions. The two levels of analysis (level of desire, and level of resistance/transgression) proposed by the study authors are complementary and provide a promising alternative to the dominant public health orientation that often assumes that ignorance or "sex- and drug-induced frenzy" are the only reasons why MSM are not compliant with the prevailing safer sex discourse (Holmes & Warner, 2005, p. 18).

Engaging in "bareback sex" means more than just condom non-use. Using qualitative data, Mowlabocus, Harbottle and Witzel (2014) found that in the understanding of consumers of gay pornography "barebacking," as differentiated from other forms of condomless sex, is a distinct phenomenon with specific associated

⁷ Signified and signifier are central notions of Lacan's theory and are linked to its linguistic orientation (Johnston, 2018). *Signified* denotes a particular phenomenon in the unconscious mind, inaccessible to conscious analysis, while *signifier* is its symbolic representation.

meanings. While the term UAI (or CAI) means simply condomless anal sex, they argue that,

Bareback is used to signify the act of [unprotected] anal intercourse between men in a cultural context that has witnessed almost 30 years of HIV/AIDS awareness work, and in which gay and bisexual identifying men report high levels of knowledge around safer sexual practices. (Mowlabocus et al., 2014, p. 1465)

Interestingly, and somehow in line with the Lacanian understanding of desire to be recognised by the Other, the authors discovered that majority (68%) of bareback pornography included elements of power imbalance: for example, BDSM, intergenerational or interracial⁸ intercourse. Notably, 88% of interracial scenes included bareback sex and all of the analysed intergenerational scenes were filmed bareback. The participants of the study expressed preference for this genre of pornography and – however drawing one-to-one parallels between preferred type of pornography and actual behaviours may be problematic – the results reveal some “inappropriate” desires.

Research indicates that feelings of intimacy are experienced in more satisfying ways while having condomless sex (Golub et al., 2012). Overseas studies suggests that intimacy motivations can play central role in deciding to use PrEP among non-monogamous MSM who are in primary relationships (Gamarel & Golub, 2015). With societal pressures on individuals not to discuss condomless sex openly, along with broader expectations to fit same-sex desire into a traditional set of norms (such as committed, monogamous couple model), there are understandable reasons for gay man to censor themselves, also within the role of research participants. Allowing for an open discussion about sexuality, even if what we may hear is not socially acceptable, is of crucial importance to understanding the motivations to use PrEP. Many postmodern authors, such as Foucault (1978), argue there is a subversive emancipatory force in

⁸ Racialised power dynamics of sexual desire and representations fall outside of the scope of this thesis, however, significant literature on the subject is available globally (e.g., Wade & Harper, 2020), and emerging literature starts to appear in Aotearoa New Zealand (e.g., Lim, 2019).

embodying “the perverse.” The social positions of power may become less obvious and the intrapsychic experience of self-worth may arise. As Otto Fenichel (1946) famously wrote: “neurotics, who have repressed perverse longings, may envy the perverts who express the perverse longings openly” (p. 328).

The new social phenomena emphasising emancipation through transgression notably include the “Truvada whore” notion: a response to criticisms that taking PrEP encourages promiscuity in men who take it (Calabrese & Underhill, 2015). This subversive use of the term aims to reclaim the persona of a “whore” as an empowered self-determining individual in a way which is analogous to reclaiming other words by stigmatised communities. Examples may include the words such as “queer” in the Anglophone world or “Schwul” in German-speaking countries (Gaucher et al., 2015). A community response to “slut-shaming” may take the form of organising SlutWalks.⁹ Being given an identity of a “whore” in the traditional sense could result in individuals not considering using PrEP, whereas reclaiming the term in a new, subversive, and positively valued way can protect one from acquiring HIV by incentivising the use of new methods of prevention.

The notion of re-appropriation can be defined as taking possession of a formerly negatively charged social label by minority groups in order to regain control over one’s identity. It involves agency and as such has the potential to reclaim the power of self-defining (Galinsky et al., 2013). An appropriate response to the “whore” slur would be a dignified statement along the lines of: “You can call me Truvada whore all you want, and I am one, and I am proud of it!” Shifting the meanings of words formerly used as derogatory labels into positively charged manifestations of agency by owning and re-

⁹ SlutWalks have been organised all over the world as a response to *rape culture*, i.e., putting blame on the victim of rape or sexual harassment by focusing on the supposedly inappropriate behaviours that allegedly provoke male perpetrators to commit sexual crimes. The proponents of SlutWalks emphasise that women have the right to dress and act as they please and cannot be put at risk of sexual violence because of perceptions of “immodest conduct.” The use of the word “slut” here is aimed at reclaiming it from the oppressing patriarchal culture (Gaucher et al., 2015).

appropriating the words is a powerful tool of subversion that allows for self-determination.

Drug-Based Methods of HIV Prevention in Cultural Discourses

Research indicates that also within the gay community the stigma attached to HIV is significant (Smit et al., 2012). Stigmatising notions of “threat,” “danger,” “risk,” “dirty” (as contrasted with “safe” or “clean”) continue to be associated with being HIV-positive. Recourse to such associations may hamper community members in coming to terms with the diagnosis of HIV infection and may damage the sense of belonging to the broader community (Armendinger, 2009). In this context, TasP is revolutionary: it crumbles the divisive protective walls by introducing the scientifically proven (Cohen et al., 2011) idea of U=U. It can allow for the construction of HIV-positive identities that differ dramatically from those that existed before (Dowsett, 2017), and in that it provides an important incentive to adhering to medicinal regimes. It is worth noting that TasP is probably the most effective way of preventing new infections among sexually active individuals, which underscores how important it is in terms of public health (Cohen et al., 2011). From a different perspective, reducing the feelings of guilt associated with engaging in what would formerly (before the arrival of new methods of prevention) be considered high-risk behaviours allows for a fuller expression of individual sexual desires and preferences. Joining these two perspectives may potentially bring colossal changes to both community coherence and well-being, as well as populational reduction of number of new HIV infections.

PrEP has the potential to crumble the division between the “poz” and the “neg”¹⁰ in a similar way. Contemporary criticisms of PrEP often revolve around the concern that its adoption will contribute to sexual disinhibition and increase sexual risk-taking

¹⁰ The word *poz* originates from the word “positive” while *neg* from “negative” and are terms for HIV-positive and HIV-negative individuals, used commonly by gay and bisexual men or PLHIV communities. However colloquial, these terms are not typically considered offensive.

(Castel et al., 2015; Kolodziej et al., 2016; Tellalian et al., 2013). In Aotearoa New Zealand, where access to PrEP has only relatively recently started to widen, such concerns must be addressed by analysing international data. Conflicting evidence exists as to whether or not increases in number of sexual partners and/or frequency of CAI occur among PrEP users (Collins et al., 2017). There is, however, a clear reduction in the number of new HIV infections among its users both in clinical trials (Dolling et al., 2016) and in real-life settings in places where PrEP is used (Grulich et al., 2018; Lydal, 2017). Therefore, it appears that the roots of such concerns are moralistic in nature and stem from a position that is based on judgment that having multiple sexual partners and practicing sex without condoms is morally unacceptable. Is one of the reasons for this, that casual sex between men contradicts the heteronormatively established perception of what “a committed monogamous couple” should be?¹¹

Sexual Risk

Some of the international PrEP guidelines continue to recommend it only to individuals at “high risk” for HIV infection (Centers for Disease Control and Prevention, 2017). However, quantifying the risk often proves challenging: the notions of “low,” “moderate,” “high” or “very high” risk may be vague. Various guidelines attempt to overcome this ambiguity by introducing classifications of risk.

In Australia and Aotearoa New Zealand, the landmark study informing the quantification of risk, stratifying its levels from low through medium to high, was the Sydney-based HIM study (Poynten et al., 2010). Based on a cohort study involving structured face-to-face interviews about sexual behaviours followed by laboratory

¹¹ As a side note, it is sometimes argued that queer identities and ways of being invoke social terror because they contradict the figure of “a child,” central to the contemporary culture. The *reproductive futurism*, understood as the need for members of society to procreate and care for children first and foremost, positions the non-heterosexual desire in an anti-productive null and void social space (Edelman, 2004). Mainstreaming of queer identities therefore usually assumes the social construction of straight-like queer families.

testing, the authors constructed a model that identified the factors associated with increased risk of contracting HIV. Factors associated with HIV incidence of differing levels were considered to identify high and medium risk levels (Wright et al., 2018). The high-risk factors included (within the last 6 months): regular sex with an HIV-positive partner without condoms, unprotected receptive anal sex with partner(s) of HIV-positive or unknown status, rectal gonorrhoea diagnosis, rectal chlamydia diagnosis, and methamphetamine use.

The findings of HIM study continue to inform the “objective” understandings of risk, PHARMAC funding criteria, and prescribing practices in Aotearoa New Zealand (BPAC NZ, 2019) that mirror earlier Australasian guidelines (Wright et al., 2018). On the other hand, current Australasian guidelines (ASHM, 2019), more widely adopted in Australia, have proposed a departure from this quantitative framing of risk to offer a more nuanced assessment of highly-individualised PrEP suitability.

Self-perceived levels of risk can be variable and the personal motivation for use of PrEP may be only weakly correlated with one’s objectified level of risk (Blumenthal et al., 2019). This in turn raises concerns about the use of drug-based methods of prophylaxis by the so-called “worried well,” for example, persons at very low or no risk of acquiring HIV who experience disproportionate anxiety related to potential transmission. From cost-effectiveness perspective, provision of PrEP to persons at no significant risk of infection appears irrational and potentially dangerous due to poor drug benefits/adverse-effects ratio in that group. However, the grey area between persons at high risk and persons at low risk is wide and includes individuals who, for example, only engage in insertive sex, had experienced repeated condom breakages, or had relatively rare instances of condom non-use which were followed by severe anxiety. These undetermined risk categories, some of which may be more suitable for PEP but when repeated may warrant continuous PrEP use, may not be easily reflected by objectified measures. The personal choice to use PrEP by person with less than high risk as an element of personal strategy for risk management can be understood as taking control of one’s life and a successful method of coping with HIV-related anxiety

prevalent in gay community for decades (Whitfield et al., 2019). Should people who experience significant improvement in their quality of life due to reduction of anxiety be denied access to PrEP? In a commentary entitled “5 Reasons I’m on PrEP but Still Don’t Do Bareback” published in an online version of *The Advocate* magazine, Drew Kiser, a self-identified gay man who uses condoms in a very consistent way explains his motivations:

Despite medical advances, the waiting room in an LGBT health clinic still feels like a martial tribunal in a Soviet state. Personally, I don’t think I will ever fully grow out of this anxiety. But PrEP helps ease the stress. (Kiser, 2016)

In the present research project, I privilege individual risk perceptions over objective risk classifications, as I try to understand how it can motivate PrEP users to access PrEP and, later, influence their sexual practices. I opt for such an approach, because it is the individual perception of risk that informs personal experiences and personal motivations for HIV prevention, regardless of formal classifications or objective risk levels.

Scoping PrEP use

There has been a long debate within the global HIV sector that can be well-summarised with the question: “Who owns AIDS?” (Altman, 1994, p. 119). Are the owners PLHIV? All communities disproportionately affected? Biomedical researchers and epidemiologists? Or are these frontline clinicians? The question touches upon the problems of expertise and professionalisation of HIV response, and inevitably links with larger challenges of maintaining biopower in either top-down or more democratic ways (Schubert, 2019). Of course, I make no attempt to provide any definitive answers to the question, but rather I take it a step forward and reflect on the ownership of HIV prevention.

The present research is interdisciplinary in its scope. It is set against the backdrop of the dominant public health perspectives, but it privileges individual experiences of HIV prevention from the perspective of its users. I take a transdisciplinary approach drawing on the academic literatures of public health research and policy, HIV prevention, and the accounts of Western gay experiences.

In Aotearoa New Zealand, the epidemiological perspective on HIV prevention has been broadly employed that has relied, to a large extent, on quantitative methods. The key studies applied behavioural surveillance methodologies: Gay Auckland Periodic Sex Survey (GAPSS) and Gay men's Online Sex Survey (GOSS) (Saxton et al., 2014). The findings provided information instrumental to designing responsive and evidence-based policies, campaigns, and services. Along with the PrEP demonstration project (Saxton et al., 2019) and PrEP eligibility modelling (Saxton & McAllister, 2019), the public health perspective advanced the local understandings of public health and health systems implications of PrEP rollout.

The user perspective however, especially locally, has received less attention and significant gaps remain. This thesis aims to fill these gaps by conceptualising PrEP from the perspective of the lived experiences of its users.

Lived Experiences and Motivations for PrEP use in Aotearoa New Zealand

Globally, various socio-demographic factors have been associated with greater willingness to use PrEP and these include: younger age, European ethnicity, frequent condomless anal sex, and regular STI screenings (Hoots et al., 2016; Kesler et al., 2016; Lorente et al., 2012). It appears that these factors are all connected with facilitated access to PrEP (with the exemption of frequent UAI) and this may imply that those who are either better educated and/or have more resources can access PrEP more easily. It does not appear that these socio-demographic factors reflect the true community need for PrEP. Local research is lacking that recognises the importance of lived experiences that MSM have with HIV prevention and the practical and sometimes "irrational" or

complex reasons for their intention to use the drug. Of course, most MSM have a clear wish to remain HIV-negative. At the same time, individuals want to enjoy sexual encounters with either regular or casual partner(s) in a way that fully satisfies them. PrEP may be seen as a promising *alternative* (as opposed to *addition*) to condoms as it provides a bridge between individuals' expectations driven by desire, and public health perspectives seeking to reduce the number of new infections.

The inquiry into the lived experiences of individuals who use PrEP in real-life settings and the meanings they associate with PrEP has been very limited in Aotearoa New Zealand. A study rolled out at a similar time to the interviewing phase of the present project examined motivations for PrEP use locally (Punchihewa et al., 2019). The methods included a qualitative analysis of the open-ended questions from the questionnaire completed by the participants of the Auckland PrEP demonstration trial (Saxton et al., 2019). The analysis revealed six key themes relating to the motivation to use PrEP: risky behaviour, engaging in condomless sex, altruism, risk reduction and prevention, early and free access to PrEP, and peace of mind and autonomy. The study authors mapped the findings onto the factors of TPB. This analysis provides important insights into the lived experiences of early PrEP users in Aotearoa New Zealand, revealing that the motivations to use PrEP are multifactorial, and extend beyond attaining its core benefit of reducing risk of HIV infection.

Another qualitative study in Aotearoa New Zealand aimed to assess the knowledge of PrEP among immigrant Asian gay men (Adams et al., 2019). Using qualitative descriptive methodology, the authors identified three themes: "I'm not sure what PrEP is," "PrEP is not proven," and "PrEP is for others, not me." Taken together, these findings suggest that the PrEP may be viewed as an intervention that is targeted only at Aotearoa New Zealand-born non-Asian men, and such perception may create a significant barrier to improved uptake of PrEP. Importantly, immigrant Asian MSM are a population described as an emergent HIV risk group in Australia (Blackshaw et al., 2019) and there have been signals of increasing proportion of Asian men among newly

diagnosed MSM in Aotearoa New Zealand (AIDS Epidemiology Group, 2020), suggesting inequitable gains from declining incidence.

Little is known about PrEP uptake and perceptions among Māori and Pasifika MSM in Aotearoa New Zealand. It is necessary to take proactive steps and meaningfully include tangata whenua and Pasifika people in leading PrEP implementation, considering otherwise inequitable health outcomes among these groups (Came et al., 2020; Talamaivao et al., 2020). An Australian study examined Aboriginal Australian and Torres Strait Islanders' inequities in PrEP access and use (Hope & Haire, 2019). The authors noted that insufficient connection between the largely gay community-led Australian AIDS Councils with Indigenous communities may prevent Aboriginal Australians and Torres Strait Islanders from being able to benefit from PrEP use.

At the initial stages of designing and undertaking this study, both on local and international levels, there was limited research on lived experiences of persons who used PrEP; what literature existed is explored in Chapter Three. However, during the implementation of this study there was great interest in the use of PrEP internationally, and a number of publications started to emerge rapidly in the time between the research design and final write-up phases of the present study. The published studies used both qualitative and quantitative methods. I discuss the findings of the present study in relation to this growing international literature interrogating the experiences, motivations, and barriers to PrEP use, and appropriate references can be found within the relevant chapters (Chapters Six, Seven, Eight, and Nine).

Conclusion

In this chapter I provided an overview of the evolution and contexts of contemporary HIV prevention among MSM in Aotearoa New Zealand. I outlined the methods of HIV prevention, such as condoms, PrEP, PEP, TasP, and situated them within the contemporary combination prevention model. Some comments were provided about the language used in referring to persons of the population at the centre

of this thesis: MSM, along with differential meanings associated with various terms (gay, bisexual, takatāpui, and others).

I also discussed the evolution of living conditions of gay men in Aotearoa New Zealand, along with theoretical approaches in the study of stigma, discrimination, and inequitable health outcomes. Theories surrounding sexual health, risk, and practices were presented that informed the paradigmatic approach of the project. I identified research pertaining to perceptions around PrEP, condomless sex, sexual risks, and their discourses. Lastly, I referenced the limited local qualitative literature surrounding PrEP use and perceptions. In the next chapter, I will provide the epistemological framework of inquiry that informed the methodology of the project and how it linked to the research question.

Chapter Three: Theoretical Framework of Inquiry

This chapter presents an overview of theoretical approaches and foundations of epistemologies that underpin this research. Here, I present the Gadamerian hermeneutic framework that I have chosen, along with phenomenological traditions at its origins. I discuss the importance of researcher reflexivity and interrogating one's subjectivity in qualitative inquiry, along with some of my preunderstandings of the phenomena in question. I also present the complexities of insider/outsider (emic/etic) approaches in research and attempt to position myself in relation to the participants. At this chapter's conclusion, I identify some of the learnings from previous research in this area and how they informed the purpose and shape of this thesis.

As described earlier, the dominant perspectives in PrEP research have focused on the epidemiological factors related to uptake of PrEP in specific socio-demographic groups or risky sexual behaviours (e.g., Dolling et al., 2016; Lorente et al., 2012). Many studies have utilised primarily quantitative methods that measure the effects of PrEP on the incidence of HIV (e.g., Elion et al., 2019; Grulich et al., 2018; LeVasseur et al., 2018), or assess the attitudes and uptake of PrEP (e.g., Chakrapani et al., 2015; Havens et al., 2019; Sagaon-Teyssier et al., 2016). It is clear from the existing research (Grant et al., 2010; Molina et al., 2015) that PrEP has significant biomedical benefits in limiting transmission of HIV. The current research project aims to consider what meanings are associated with the benefits as PrEP users see them in Aotearoa New Zealand. In order to do this, it is necessary to investigate the lived experiences of those who are using PrEP.

Phenomenology and Hermeneutics

The present study is grounded in a phenomenological hermeneutical epistemology. Phenomenology extends beyond orthodoxically understood social constructivist claims that our understanding of human experience cannot move beyond

cultural consciousness. It broadly asserts that 1) human experience is real, 2) it consists of real phenomena as they appear, and 3) that these can be understood. The phenomenological approach may be therefore used to elicit the *authentic* lived experience.

Heidegger understands phenomenology as a study of *Being* or ways of *Being-in-the-world* (*Dasein*) (Heidegger, 1967). He posits that existence can only know itself in relation with others and other objects, and that conscious experience is unique and forms a distinct *phenomenon* (Fleming et al., 2003). As such, the classical Cartesian dualistic reflection that separates mind, body, and the outside world is set aside to allow analysis of *Dasein*, as totality of experience. Being-in-the-world encompasses a generalised phenomenon of consciousness of existence and all the internal processes leading to the emergence of both structure and content of experience; in this way Being is indivisibly the lived experience per se and all that surrounds it (Smith, 2018). Phenomenology does not intend to establish the ontological status of phenomena. Rather, phenomenologists assume phenomena are real because they are experienced (Heidegger, 1967). The focus of research is on analysing the ways in which the phenomena in question are experienced.

The origins of the philosophical position of phenomenology are primarily attributed to Husserl, who viewed it as a descriptive approach allowing for the study of human lived experience before it gets categorised and theorised (Orbe, 2009). There are a number of important epistemological and ontological assumptions of phenomenology, some of which have been carried over to hermeneutics, while others were rejected. Below I present some of these phenomenological assumptions, as described and compiled by Orbe (2009):

- 1) Research cannot be fully objective. It is impossible to entirely eliminate researcher's preconceptions. However, by a process of bracketing, or *ἐποχή*, one can attempt to suspend their judgments. Bracketing was a process emphasised by Husserlian phenomenology but rejected by both Heideggerian

phenomenology (Reiners, 2012) and Gadamer's (1975) hermeneutical approach as impossible. I will explore this point further in this chapter.

- 2) Deeper understanding of meanings of the phenomena occurs as a result of analysis of daily practices, through which they manifest themselves and are reflected; even the seemingly insignificant everyday practices constitute the microcosms of larger phenomena.
- 3) Phenomenology, and in particular its Husserlian branch, differentiates between the study of individuals (a general term) and persons. *Persons* are understood in a way that is emphasising the unique ways they experience their social, cultural, and historical contexts.
- 4) In order to gain understanding of phenomena, the term "data" should be challenged. Some researchers propose to apply the term "capta" instead. Data in social research may be understood as "what is thought," while capta can denote "what is lived" (Lanigan, 1994). Capta can be subsequently given significance through various interpretative processes.¹ While not adopting the term "capta" within this thesis, I will avoid the term "data" to privilege my understanding of participants accounts or sexual stories as what they are: accounts and sexual stories. The term "data" itself has become problematic, and many researchers question its utility, in particular within human-centred qualitative inquiry (Brinkmann, 2014)
- 5) Meaning-making is possible through open dialogue. It is impossible to accurately predict the findings prior to following the discourse, as phenomenological research is oriented towards discovery. Therefore, understanding emerges through a discovery-oriented process of communication.

¹ This term has not found full acceptance in research stemming from phenomenology and is not usually employed in the later hermeneutical approach but may provide a useful contribution to the reflection into the understanding of the epistemological foundations of both approaches.

Heidegger made important contributions to phenomenology; his approach is often described as interpretive, as opposed to Husserlian descriptive phenomenology (Reiners, 2012). This opposition is not antagonistic, but rather indicates an ontological and epistemological tension between the two different currents of phenomenology and their different emphases. The Husserlian approach is focused on *what we know as persons*, assuming that presuppositions can be suspended, while the Heideggerian approach is focused on *what is Being* and assumes that preconceptions are ineffaceable. According to Mohanty (1984), in the Husserlian descriptive current of phenomenology the lived experience is a given, while in the Heideggerian interpretive approach text is the only given and is subject to interpretation. Applebaum (2011) argues that even though this differentiation is important to better understand the philosophical foundations of methodology, qualitative research can and should draw from both. Applebaum (2011) noted that “within the context of qualitative psychological research ... in order to do justice to the interrelatedness of phenomenological description and interpretation, a qualitative method would need to acknowledge both the descriptive and interpretive dimensions of its praxis” (p. 2).

The shift of focus of the two different currents of phenomenology has its practical implications for different types of research. Reiners (2012) asserts:

Interpretive phenomenology is used when the research question asks for the meaning of the phenomenon and the researcher does not bracket their biases and prior engagement with the question under study. Descriptive phenomenology is used when the researcher wants to describe the phenomenon under study and brackets their biases. (Reiners, 2012, p. 2)

Phenomenological and hermeneutical traditions are closely linked, but they are not one and the same. The theory of hermeneutics is informed by earlier traditions of phenomenology, particularly as developed by Heidegger. One of the key concepts of the hermeneutical phenomenology is the *hermeneutic circle*, that relates to the process of gaining understanding of the text (research data, capta, or accounts). Since the nature of *Dasein* is circular (Heidegger, 1967), which means that it constantly reinterprets itself,

moving perpetually from part-to-whole and from whole-to-part again, the process of interpretation should follow that mode. One cannot understand the whole without reference to the individual parts, but at the same time, individual parts cannot be accurately interpreted without keeping the point of reference of the whole in an entangled and immersive process. According to hermeneutical phenomenology, the emergence of understanding stemming from application of the hermeneutic circle principle is crucial for accurate interpretation of text and provides true insight into the analysed phenomena (Debesay et al., 2008).

Gadamer (1975) further develops these ideas by elaborating on the notion of historicity. The conscious *experience* (*Erlebnis*) does not occur in historical void. Everyone is part of history and it is impossible to simply step out and look at one's experience in an objective manner. It is also impossible to bracket one's biases. Unlike the positivist scientific method, suitable for studying the material world, the Gadamerian method for studying human experience calls for analysis of the historic and cultural context. Gadamer largely rejects traditionally understood objectivity as unattainable. He claims that dialogue between persons and texts (and this includes the interaction between the researcher and study participants) is entangled in history. A form of prejudice is intrinsic in it. In hermeneutically oriented Gadamerian research, to avoid the negative connotations, the term "prejudices" is often substituted by *preunderstandings* (e.g., Geanellos, 1999). It is critical to recognise, that preunderstandings, however, do not preclude gaining understanding of the phenomena. On the contrary: it is only through preunderstandings that any understanding is possible (Fleming et al., 2003). When two subjectivities come into contact, the meanings of experience are always negotiated: the truth is intersubjective and can only be established by what is agreed within the interaction. Gadamer's position is that gaining understanding is only possible through the attempt to understand both the *tradition* (understood widely as a historic and linguistic context) and one's preunderstandings. This dialectic of interpretation allows for the truth about the diverse manifestations of experience in numerous cultural contexts to reveal itself to a researcher.

The notions of historicity are of crucial importance particularly in a multicultural context of Aotearoa New Zealand society. There is more than one way of being for MSM and all these diverse ways of being fall into distinctive cultural contexts even though they occur in a physical space limited to one country. As noted earlier, many Māori use the word “takatāpui” to denote roughly what is known as “gay,” “lesbian,” or “queer” in English. The term carries distinct culture-specific meanings (e.g., Hutchings & Aspin, 2007; Kerekere, 2017; Murray, 2003) that are conveyed in te reo Māori but not in English. This is where Gadamer’s notions of language are important: it is through language that we build our understandings of outside world. However, when two subjectivities interact the language always exceeds the meaning ascribed to it by any one of them (Geanellos, 1999). The meanings of words need to be established by interaction and the analysis of the whole text (interview). My preunderstanding of the word “takatāpui” most likely differs from my interviewees’ understanding of it and Gadamer calls for careful establishment of its meaning through engaging in dialogue.

Fusion of Horizons and the Nature of Understanding

In his writings, Gadamer uses the phrase *fusion of horizons* to denote an epistemological event when understanding occurs. There is no understanding unless the fusion transpires: “understanding ... is always the fusion of these horizons which we imagine to exist by themselves” (Gadamer, 1975, p. 273). *Horizons* present the boundaries of individual consciousness; they are frameworks within which the phenomena may be experienced or communicated. In broad terms, understanding can only occur if subjectivities operate within similar limits. However, they do not necessarily need to have identical or even common experiences. The concept has been criticised in philosophy as reductive and unnecessarily homogenising, stipulating unifying perspective and necessitating submission to dominating points of view for understanding to occur (Vilhauer, 2009). However, many researchers claim that the critics based their critique on false assumptions about what horizon truly entails in Gadamer’s system (Vessey, 2009). The notion of a horizon first appears in Husserl’s and

Heidegger's phenomenologies. Gadamer draws from these traditions, but also enriches them in terms of meaning. Horizon involves anchoring in the language and historic context that builds our prejudices and sets a limit to our possible understanding. This does not mean, however, that Gadamer claims that there are radical boundaries of understanding, or that our historic situation immobilises us epistemologically, or that the horizon is closed and set forever. He rejects this kind of historicism and claims that the horizon is a dynamic framework of understanding.

The historical movement of human life consists of the fact that it is never utterly bound to any one standpoint, and hence can never have a truly closed horizon. The horizon is, rather something into which we move and that moves with us. Horizons change for a person who is moving. (Gadamer, 1975, p. 271)

With this changing perspective, the fusion of horizons allows us to place ourselves in the position of another human. This is a key concept of Gadamer's epistemology: this placing within a situation is not merely empathy, nor is it disregard of our own episteme.

This placing of ourselves is not the empathy of one individual for another, nor is it the application to another person of our own criteria, but it always involves the attainment of a higher universality that overcomes, not only our own particularity, but also that of the other. (Gadamer, 1975, p. 272)

The realisation of one's historically constructed preunderstandings brings about the possibility to reach beyond them and to grasp the intersubjective truth about another's lived experience.

Researcher Subjectivity and Preunderstandings

Gadamer asserts that "the essence of the question is the opening up, and keeping open, of possibilities" (1975, p. 266). This has practical implications for the construction of interview techniques and protocols and calls for consideration of one's own preunderstandings. A Gadamerian approach dismisses the concept of objective

interviewing, but instead proposes an intersubjective epistemology, where truth emerges through dialogue with the Other. Before starting the interviewing phase of the study, I needed to become aware of my preunderstandings of the subject. Fleming, Gaidys, and Robb (2003) propose this can be accomplished through discussions with colleagues who work in the field. Having discussed the topic with my supervisors, other young researchers, and people working actively in the field of HIV prevention, I became confident that my views on the subject of PrEP use were quite strong. I was, however, aware of the fact that individual understandings could be very diverse and study participants would not necessarily share my views. Since I viewed the interviewer (in this case: myself) as a research tool, an analysis of my preunderstandings was crucial.

The remainder of this section recounts the outcomes of the process I undertook before interviewing participants. During the research project, my views have evolved and changed. In here, however, I present the assumptions from my notes made prior to interviewing, as they influenced the process of interviewing and may have resonated in the accounts that were shared with me.

My first preunderstanding was that, in general, MSM preferred to engage in sex without condoms and the main reason to use them was to avoid the risk of acquiring HIV and other STIs. At the same time, HIV remained the central concern, as other infections were not seen as equally serious. Having the possibility to avoid or greatly reduce the risk of acquiring HIV, the main incentive for condom use in MSM would be eliminated, as it appeared to me from my experience with testing for HIV. Simply speaking, men do not like condoms, and they would rather not use them provided they did not have to.

My second assumption was that since the 1980s, MSM have experienced significant anxiety related to the possibility of HIV transmission. In my practice as an HIV peer tester, I remembered rare instances of hearing that some clients were not concerned about testing at all and would not be distressed even if the result had been positive. Testing counselling did not provide sufficient space to engage in an in-depth analysis of client's dispositions, however the relative rarity of such disclosures made me

realise that anxiety surrounding testing was much more common experience. I acknowledged that some men who are at risk of HIV could experience low levels of concern or even no concern at all, but for those who did experience anxiety related to the risk of HIV transmission, PrEP would alleviate it.

Another of my preunderstandings was that within gay community, PrEP was desirable and, in some circles at the time of early access, fashionable. In the context of limited availability, use of PrEP was nothing to be ashamed of but could rather indicate its user's high status and resourcefulness. However, I felt the users may not have been comfortable in discussing their PrEP use outside of gay community.

Having awareness of some of my core preunderstandings surrounding PrEP, I was able to address them in an open way with the participants, emphasising the dialogic method of interviewing consistent with Gadamerian hermeneutics. During the interviews, I sometimes expressed my preunderstandings openly and invited participants to elaborate in a way that could make it easier for me to understand their experiences (e.g., p. 131). Following the principle of fusion of horizons, I found this dialogic aspect of interviewing very useful in interrogating the epistemic frameworks and establishing a common ground for understanding to emerge.

Insider (Emic) /Outsider (Etic) Research Perspective

Within the hermeneutical epistemological perspective, the dialectical nature of the interview is emphasised and interactions between different understandings of discussed phenomena are acknowledged. In attempting to understand the lived experience of another, the consideration of the cultural and historic context of the interviewer-interviewee dialogue is important. During the interviews, I identified myself in a dual role of outsider/insider. As a researcher identifying as gay, my research was prone to all the advantages and limitations of an insider-based approach (Kanuha, 2000), but as a foreigner (tauwiwi) from a faraway country I was an outsider.

In cultural and social sciences, the key notions denoting the tensions between different approaches to studying humans are etic and emic perspectives. These terms are neologisms originating from suffixes of words “phonetic” and “phonemic.” They stem from linguistics and help differentiate between the acoustic or mechanical (phonetic) characteristics of speech and the language users-defined parts of speech that carry meaningful distinctions (phonemic) between utterances. Following from this linguistic metaphor, the term *etic* denotes an outsider research perspective that centres around the objective qualities of researched phenomenon, while the term *emic* focuses on subjective qualities and the internal logic of the phenomenon (Harris, 1976). This research privileges the internal logic of participants’ accounts, and in such understanding would subscribe to the general emic paradigm. However, this project is also an example of research where the lines between emic and etic perspectives are blurred. I, as the researcher, am in some ways an insider and in other ways outsider. I will elaborate on this mixed perspective further here.

An important aspect of conducting research, in particular with marginalised groups, is identifying and assessment of the boundaries between the researcher and the research participants (Browne & Nash, 2010). A role of a researcher is not necessarily transparent to the interviewees: the research “interrogation” is a form of human interaction, a dialogue occurring between two subjectivities with an array of social, historical, and cultural effects occurring. Particularly marginalised people may mistrust formal research as they can see the researchers as judgmental or objectifying them. Every interviewer has their own subjectivity and is perceived by participants through socially relevant lens, such as class, race, nationality, age, sexual and gender identity, and others. Researchers might attempt to distance themselves from their research and try to assume the roles of passive observers, but in doing so they risk ignoring the pronounced effects they have on their research participants, and – as a consequence – on their data (Hollway & Jefferson, 2000).

Being an insider may have potential advantages in interviewing. The topics most relevant to my research include sexual practices and my participants may be more

willing to openly discuss these matters with someone sharing their epistemic frameworks. Participants may realise I am unlikely to judge them or be “shocked” by their practices. However, I should note there is no single “gay community” that every gay man feels to be part of (Barrett & Pollack, 2005). I am a representative of certain social categories (European, cisgender, identifying as gay, educated, originating from a middle class) and feelings of “gay brotherhood” may not be shared by some of the study participants with different positionalities. That said, the common experience of stigma is powerful – and shared. This is the shared epistemic framework that may allow me, as a researcher, to better understand the research participants.

Being an insider may as well have limitations. One of them is over-identification with research participants. Assuming sharing unified gay identities with mutually understood cultural codes and signifiers may lead to shaping data towards researcher expectations and not allowing important elements of experience to be voiced, as they can be assumed to be obvious (Kanuha, 2000). I acknowledge the potential limitations of my personal experiences of being gay, including the anxiety surrounding the risk of HIV acquisition and other personal feelings, some of which I may not be fully conscious of.

Some participants may have felt reluctant to open up to me, considering how tightly knit the Aotearoa New Zealand gay community is. They may have felt concerned that we may have some mutual social connections, where I would not be able to maintain confidentiality. I believed that an open and in-depth discussion about the importance of confidentiality within this project would help alleviate some of the concerns.

The relationships of power, often unvoiced in research conducted with queer subjects, may give the researcher-interviewer the role of someone implicitly normalising certain practices and pathologising the others. Even seemingly neutral selection and non-selection of questions needs to be taken into consideration while constructing and analysing qualitative inquiry (Di Feliciano et al., 2017). The question of disclosure of researcher’s non-heteronormative sexuality to the research subjects poses a serious challenge that calls for the interviewer (Murray, 2015) to step out of the role of “blank canvas” (a role that researchers in positivist paradigms sometimes attempt to assume)

and engage in a genuine human dialogue. Different researchers position themselves in various ways in relation to their own identities when confronted with their subject's identities (Heckert, 2010). I believed it was essential for me to be open about my identity of a gay man with the research participants and, therefore, provide shared epistemic standpoint to begin to construct the dialogic relationship. It appears that more and more researchers prefer to be open about their own identities (e.g., Garcia et al., 2016). A Gadamerian approach, with its emphasis on the dialogical nature of interviewing and analysing one's preunderstandings in this process appears to support the need for establishing the researcher's position in social space.

As a Polish man, speaking with an accent that is possibly difficult to position on the map, I am also clearly an outsider. Some participants may trust a foreigner less than a local. However, it may also seem more natural for me to ask questions about issues that appear obvious to Aotearoa New Zealand communities' members; issues that were potentially not voiced before. Since I am an outsider, my ignorance could be excused more easily, which may provide me with opportunity to hear participants' reflections that would otherwise be considered too obvious to discuss.

With my dual role, the classical notions of etic/emic or outsider/insider relationship exist in a space of interplay (Kanuha, 2000). The nature of human dialogue with the familiar alien I may be complex and undoubtedly add to the complexity of contextualising the research findings. The hermeneutical approach, however, allows for accounting for this interplay: a dialogue between two subjectivities, with their own histories and cultural backgrounds forming webs of preunderstandings that can be properly reconciled in the context of genuine human interaction (Walker, 2011).

Learnings from Previous Studies

Different theoretical frameworks and methodologies have been applied to the study of men's motivations and outcomes of PrEP use. This section will present an

overview of relevant studies published prior to the project implementation, along with their benefits and limitations as they informed the present study.

In a UK study, Jaspal and Daramilas (2016) applied the social representations framework (Moscovici, 1988) to identify the three themes commonly associated with the emergence of PrEP: uncertainty and fear, managing relationships with others, and stigma and categorisation. The study authors recruited by snowballing sampling 20 HIV-positive and HIV-negative MSM. The researchers then conducted semi-structured individual interviews with the participants. They concluded that social stigma associated with expressing homosexual desire underpins men's perceptions of PrEP, potentially leading to preventing its use by those who might need it most. The theoretical framework (Moscovici, 1988) applied in the study allowed for identification of social representations (collective beliefs or theories shared within a community about social phenomena) on a given issue by identifying the *anchors* (associating new concepts to previously known phenomena) and processes of *objectification* (associating concepts to material, concrete objects). Social Representations Theory places emphasis on what is considered shared knowledge and proves useful in determining the meanings of various concepts on a wider, social or subcultural, level. When applied appropriately, the research methodology can reflect the local discourses in a rich way, and reveal the associations underlying newly emerging phenomena, yet it offers limited insights into lived experiences of individuals.

Part of qualitative research conducted on PrEP use keeps its theoretical underpinnings implicit, limiting reporting on data analysis to employed techniques. For example, in their study conducted in Berlin, Grov and Kumar (2017) recruited 20 MSM using referrals and self-referrals through various LGBTQ groups and media. Individual semi-structured interviews were conducted. Thematic analysis was used to identify the motivations and assess the level of readiness to start PrEP use among the participants

and, as the researchers found, they had mostly positive views around PrEP.² Methods of thematic analysis, as employed in the Berlin study, allow for effective identification and assessment of commonly occurring patterns of responses but may risk losing nuance especially in cases where theoretical foundations are not explicit (Braun & Clarke, 2006).

Many qualitative studies conducted on PrEP use among MSM focus on the preventative aspects of the behaviours, whilst omitting the pleasure-driven motivations. Researchers employ methodologies that allow for a high degree of descriptive accuracy, such as narrative thematic analysis or grounded theory (e.g., Chakrapani et al., 2015), but at the same time do not necessarily facilitate looking for deeper underlying motivations, some of which may be considered socially undesirable. Further, the over-reliance on one-off semi-structured individual interviews carries the limitation of not establishing rapport with the participants, which lowers the likelihood of gathering more nuanced responses and alleviating social desirability bias. Both the classical phenomenological and hermeneutical approaches stress the importance of historicity and situation-specificity of experienced phenomena. By conducting more than one interview and providing time separation between them, a deeper understanding of changing attitudes can be captured (Read, 2018).

A way to overcome the methodological limitations signalled in the above studies, may be to enhance rapport and depth of analysis. A study conducted among Black MSM focused on homophobia and HIV stigma in relation to uptake of various HIV prevention methods, including PrEP (Garcia et al., 2016). Using a mixed methods approach (ethnographic observation in public, private, and commercial spaces; interviews with men; and interviews with community stakeholders) the authors were able to put prevention methods in context, therefore recognising the subcultural norms and social complexities. Researchers hypothesised that the subjectivity of the interviewer (a Latino gay man) facilitated the rapport with the members of a community that also had sexual

² The question of acceptability of PrEP has been assessed with similar conclusions in a variety of settings, including Colorado, USA (Gersh et al., 2014), Thailand (Wheelock et al., 2013), and India (Chakrapani et al., 2015).

and ethnic minority status. The addition of ethnographic observation to the methods repertoire provided significant insight into the circumstances surrounding lived experiences with HIV prevention and allowed for further contextualising the data. Additionally, by accompanying the men, the interviewer had a chance to develop trust and establish rapport with the research participants.

The present study aimed to consider the benefits offered by different methodological approaches. The following section will outline the key goals of employing the methodology as was used in this study. These goals were: 1) to improve the depth of analysis by following a dialogic approach; 2) to intensify rapport and encourage reflection by arranging more than one interview; and 3) to reflect critically on the researcher subjectivity in order to elicit intersubjective meanings of the phenomena in question.

Study Purpose

The emergence of PrEP occurs in complex social, cultural, and historic contexts. As such, inquiry into the use of PrEP by MSM should use approaches that allow for (1) identification of the context, and (2) analysis within this context. Subcultural norms play a role in perception of PrEP by its users and it is essential to interrogate these as well. Gaining understanding of the meanings of PrEP to its users is possible through open dialogue and careful analysis of what they have to say.

The methods employed in this study shared similarities with methods employed in previous qualitative studies among MSM who use PrEP. However, some significant differences were considered and implemented. The study design included the addition of a second interview in order to: (1) help establish rapport with the participants, and (2) capture the changes in time in men's experiences surrounding PrEP. The loose structure of the interview, following the Gadamerian hermeneutical principles also constituted a point of difference to the commonly employed methods. A departure from structured interviews and keeping the flow of the dialogue dynamic in order to follow the

participants, was hoped to add depth to the analysis and aid in contextualising the issues surrounding PrEP. In keeping with Gadamerian hermeneutics, it was important that the interviews resembled naturally occurring conversations, as a way to acknowledge that human understanding occurs most naturally in such settings.

Further emphasis was placed in this study on the consideration of researcher positionality, highlighting 1) shared epistemic framework, 2) increased openness, and (3) possibly decreased social desirability effects by sharing significant identities.

The methodological framework and study protocols employed within this project were expected to provide answers to questions around PrEP use among MSM in Aotearoa New Zealand beyond the highly socially acceptable themes of HIV prevention, risk reduction, and alleviation of HIV-related anxiety. Engaging in open dialogue about PrEP use, providing less epistemological context by loose structure of the interview and following the participants opened up the possibilities for the lived experiences of men who use PrEP to emerge and highlight the experiences that *they* deemed most relevant. I used the discussed methodological framework and subsequent interpretive procedures to provide space for the participants to express their relationship with the novel method of HIV prevention. My role was to listen and actively try to understand.

Conclusion

This chapter presented an overview of the philosophical foundations underpinning this research. I started with presenting the phenomenological approach that set the theoretical base for the Gadamerian hermeneutical approach employed within the present study.

I provided explanation to some of the central notions of the hermeneutical approach, such as intersubjective approach to truth, dialogical nature of understanding, the hermeneutic circle principle, and fusion of horizons. I delineated how that approach was applied to the research problem, and how I approached my own subjectivity in a

manner consistent with the methodological paradigm. Reflections were also offered in regard to emic/etic axis in research, and I attempted to position this study within it.

In the final section, I discussed some of the learning from previous studies addressing experiences of PrEP use that were available before the study was implemented and how they informed the shape of this project. Lastly, I clarified the purpose of the study as to offer a highly contextualised perspective of PrEP use in Aotearoa New Zealand, that may emphasise the role of social discourses and historicity in HIV prevention.

Chapter Four: Methods

This chapter presents the methods employed within this project. As explained earlier, the Gadamerian hermeneutical approach was used to guide the design and execution of the project. Gadamer, however, offers no procedural or technical instruction on how to conduct qualitative studies, but rather delineates the principles of understanding (Gadamer, 1975). Researchers inspired by Gadamerian hermeneutics use different procedures for conducting research (Debesay et al., 2008; Fleming et al., 2003; Paul, 2012). Brinkmann (2014) likens the “ideal qualitative researcher” to a bricoleur, who creatively uses the available tools that are best suited to the task at hand in a pragmatic way. Such approach emphasises the required flexible reactions to encountering genuine “surprise, bewilderment, or wonder” in qualitative research (Brinkmann, 2014, p. 722). In the present project I attempt to apply procedures that remain faithful to Gadamerian hermeneutical epistemology and recognise the intersubjective nature of co-created truth(s).

Ethical Approval Process and Considerations

Massey University Human Ethics Committee (MUHEC) approved the project on 11 September 2017 (see Appendix). Several ethical considerations were paramount while planning and executing this research. Participant confidentiality was one such issue. MSM continue to experience homophobia and discrimination in Aotearoa New Zealand and reports from overseas suggest that PrEP users may also be subject to stigmatisation within their own communities (Dubov et al., 2018). It was important to consider these factors in order to protect the participants from potential harm.

The focus of our interviews was around intimate practices and sexual health. These issues are considered sensitive, so it was especially important to protect participants’ confidentiality. Participants adopted pseudonyms and some of the details

that could allow for identification were changed for the purpose of thesis writing. Highly identifying information, such as names, places of employment, and others, was removed from transcripts.

It was also possible that during interviews participants could have disclosed illegal behaviours, such as drug use, sexual assault, and others. Due to this and to the intimate nature of issues discussed, the project was classified as sensitive, and the only document where true details of the participants were recorded was the consent form.

Some of the issues discussed could also have caused distress for some participants, as we were talking about discrimination, anxiety about one's health, sexual assault, and other sensitive issues. In the Participant Information Sheet and on the project webpage I provided a list of local services that could provide support free of charge if any of the participants felt they needed it. This was important, as I asked the participants to talk about issues they may not have openly discussed before and to reflect upon their own reactions, their social positions and, perhaps, vulnerabilities. Many of the participants followed up with me after the interviews and said they enjoyed them. They said that the interviews brought them fresh understandings of their own actions and motivations, as well as that they were happy to share their experiences to improve the community understanding of PrEP. None of the participants reported distress associated with the interview, and none appeared visibly distressed.

After gaining ethical approval, ethical reflection continued to play an important part of the project. During the project implementation, new circumstances appeared that prompted me to continuously reflect on ethical implications of engaging in this research. One such example was one of the follow-up interviews, when one of the participants stated that he discontinued PrEP and among the reasons he decided to do so was that the interview made him question his initial motivations to use it. In his understanding, the interview did not directly cause the discontinuation of PrEP, but his involvement in the research project made him critically consider his actions and made the decision to stop easier. This was not a planned consequence of the project, and it was impossible to establish whether he would have continued PrEP if he had not participated in the study.

At the end of the interview, I suggested that he considered discussing PrEP discontinuation with his medical provider to make sure that he makes a decision that is appropriate for his circumstances. I had no personal opinion about his PrEP discontinuation, and I tried to make clear I was not implying I believed it was right or wrong to do. Discontinuation of PrEP is very common (Coy et al., 2019). Many men start and stop it, often repeatedly, so I did not consider this dangerous or unusual. The reason why I reflected critically about the participant stopping using PrEP and addressed it at the conclusion of the final interview was that that he personally drew a link between the interviews and discontinuation.

This incident was a learning experience for me. I realised that research, in particular with qualitative approach, may have unexpected outcomes and its impacts can be unpredictable. It made me reflect upon the nature of the dialogue. What some researchers see simply as “data collection” is a two-directional dialogue that can influence both parties significantly and may even have transformative potential. The researcher-participant interaction, however regulated by pre-planned research procedures and ethical considerations, remains a human-human interaction and this was an important learning for me. I will now return to the description of the project methods, beginning with outlining the process of participants recruitment.

Participant Recruitment

This project’s aim was to explore the experiences of MSM in Aotearoa New Zealand who use or have used pre-exposure prophylaxis. To recruit potential participants and inform them about the details of the study I developed a dedicated webpage. It contained all the relevant information including participant information sheet, consent forms, project details, subscription form, and contact details. Using a process approved by MUHEC, I asked the participants to provide their contact details through the webpage form (phone and/ or e-mail) if they wished to participate. I then followed this up and scheduled the first interview at our mutual convenience. The

participants were informed they would receive a shopping voucher (\$60) as compensation for the time dedicated to the study. They could also request a reimbursement for travel costs if they wished to. The advertised recruitment criteria stated:

- *You currently use or have used PrEP in the past,*
- *You live in New Zealand,*
- *You maintain sexual relations with other guys, whether occasionally or regularly,*
- *You are 16 or older,*
- *You can communicate in English.*

To promote the study, I posted information along with the website link at various Aotearoa New Zealand Facebook groups dedicated to PrEP and to the takatāpui community life. I also printed leaflets and distributed them to Sexual Health clinics in Auckland, offices of New Zealand AIDS Foundation in Auckland, Wellington and Christchurch, Auckland GPs who prescribed PrEP, and sex-on-site venues in Auckland. In an addition to this, I used my own social networks for leaflet distribution.

When attempting to establish the target number of participants I took into consideration the feasibility of interviewing a number of men twice and the need to recruit persons with diverse demographic backgrounds and personal histories to improve the chances that multitude of perspectives were included. I tried to prioritise the recruitment of persons from non-European backgrounds, especially knowing international evidence suggesting PrEP users from ethnic minority groups tended to face more access barriers (e.g., Mayer et al., 2020). I used my personal networks to inform widely about the project, posted information about the study in social media groups where different ethnic communities were active (e.g., takatāpui Facebook group), and included a specific section in the promotional materials encouraging Māori communities to take part in the study.

A large part of contemporary qualitative methods aims to meet the demands of *data saturation* and this concept has become ubiquitous within qualitative research

(Saunders et al., 2018). The term originated from grounded theory and spread across other epistemologies and paradigms. Data saturation is now widely expected in published research and is often viewed as transparent and unproblematic (O'Reilly & Parker, 2013). Data saturation is sometimes viewed as the main indicator of qualitative research validity and some authors (e.g., Fusch & Ness, 2015) heavily criticise target participant numbers and selection methods that may not lead to ensuring data saturation. The hermeneutic theory applied in this project, however, does not rely on this concept, as well as it does not aim to produce "objective" findings. A consensus appears to exist that "theoretical saturation is not sought in hermeneutic studies as the temporality of truth is recognized" (Gentles et al., 2015, p. 514). In other words, important ontological and epistemological aspects of the theory, such as uniqueness of individual experience, co-creation of meaning through discourse, and intersubjective nature of truth lead to rejection of expectation to reach data saturation. In general, hermeneutic inquiry views the essence of posing questions as "opening up, and keeping open, of possibilities" (Gadamer, 1975, p. 266). The aim of this project is not to provide definitive answers to specific questions, but rather to expand the understanding of lived experiences of those who use PrEP. Such theoretical assumptions informed the recruitment, which was not intended to reflect the population in a statistically representative way. Therefore, I considered the question of the target number of participants less important within my chosen methodology and I concentrated on reaching men who would be willing to share their stories and who had diverse experiences. I chose the target number of 10 individually twice-interviewed participants in consideration of financial and time constraints of the project, irrespective of data saturation, which I did not aim for and did not assess.

Seventeen men from around the country filled in their details through the project webpage and I followed this up with all of them. I excluded one man due to my professional relationship with him. Two men resided in Christchurch and despite earlier plans, I was not able to arrange travel to interview them due to financial and organisational constraints. Three men did not return the consent forms and one cancelled the scheduled interview and was unable to arrange a different date. In the end,

ten men were interviewed. Table 1 presents participants' chosen pseudonyms along with basic demographics (in order of the date of first interview).

Table 1

Study Participants With Basic Demographics

Participant (pseudonym)	Ethnicity (self-declared)	Location	Age	Gender and sexual identity (self-declared)
Kevin	European	Large city in Te Ika-a-Māui	Late 20s	Cis-male, gay
Sam	NZ European	Large city in Te Ika-a-Māui	Late 20s	Cis-male, gay
Michael	NZ European	Large city in Te Ika-a-Māui	Early 30s	Cis-male, gay
Allan	NZ European	Large city in Te Ika-a-Māui	Early 60s	Cis-male, gay
Connor	NZ Pākehā	Large city in Te Ika-a-Māui	Early 40s	Non-binary, gay
Karl	White	Large city in Te Ika-a-Māui	Late 30s	Cis-male, gay
Vincent	Asian	Large city in Te Ika-a-Māui	Late 20s	Cis-male, gay
Rewi	Affiliated with iwi of Te Ika-a- Māui	Te Ika-a-Māui region (different from iwi affiliation)	Early 40s	Cis-male, gay and takatāpui
Harvey	Pākehā	Large city in Te Ika-a-Māui	Late 30s	Cis-male, gay
David	European Māori	Te Waipounamu region	Late 20s	Cis-male, gay

Note. Participant demographics are listed in order of interviewing. Some details were altered to maintain confidentiality.

It is important to note here that the statistical representativeness required to allow populational generalisation is not the aim of the present qualitative study. Despite this, it may be worthwhile to reflect on some recruitment considerations that could improve the diversity of the sample, important to this study due to the need of assuring rich representation of experiences and discourses.

The demographics of the men who responded to the advertising and participated in the study are not reflective of the diversity of Aotearoa New Zealand's communities. Most of the men who participated in this study identified as European (7/10) and were in their late 20s and 30s (7/10). There is evidence that purposeful recruitment to meet pre-determined ethnic quotas may be effective (Saxton et al., 2019). Local data were not available on the uptake of PrEP among men by ethnicity and age group during the interviewing phase of the study, but general impressions from within the community suggested there was a skewing towards men of European ethnicity in their 20s and 30s; this was also noticeable in Facebook groups for PrEP users. Although the project did not seek formal evidence or explanations for this, PrEP access equity issues emerged during the interviews and participants themselves were noticing less success in rollout outside these specific demographics. I hypothesise that the recruitment method I used along with the requirement to enrol to the study online may have selected high-functioning and technologically literate men with enough time to dedicate to participating in the project. However, at the time of recruitment, PrEP access pathways and PrEP knowledge dissemination also privileged such men to access PrEP. Data I collected during the interviews strongly supported the finding of limited PrEP accessibility, in particular for less technologically literate persons and those coming from less privileged backgrounds.

Interviews

All of the participants were interviewed individually. I conducted the interviews with each participant twice within a space of 2-12 weeks at their convenience and at the location they chose (all interviews were undertaken before the Covid-19 pandemic).

With permission from the participants, the interviews were audio-recorded. They were transcribed partly by myself and partly by an external transcriber. With one exception, that I will explain shortly, I travelled to all the locations where participants lived. To stay true to the employed hermeneutical methodology, I felt it was important to attempt to interview the participants in the context of the city where they lived and to be there physically. Hermeneutical method emphasises historicity and relies on cultural context, therefore I preferred to be able to interact with the participants face-to-face. I arranged for discreet and convenient locations, such as a counselling room at New Zealand AIDS Foundation in Auckland or Wellington or an office at Massey University, but I always informed them I was happy to travel if they preferred a different location that was more convenient to them. Some of the candidates were therefore interviewed in other places they chose freely, for example, their local library, a meeting room at their workplace, or others. Beforehand, I always made sure to discuss their privacy and their level of comfort around using any given location.

I tried to avoid the use of technologies such as Skype, because I felt that the lagged connection, cropped view, and image and sound distortions could make the rapport less natural and can lead to my and participant's discomfort, particularly when discussing sensitive sexuality-related issues. I also felt that when trying to explore the lived experience of another person, the means of communication that convey the full extent of non-verbal cues and communication styles could aid my understanding. Some practitioners and researchers argued that the shared-reality of communication and rapport is distorted when using video-calling technologies (Bayles, 2012). I made an exception with one of the participants, David, who lived in a town of Te Waipounamu. I initially thought I would be able to secure funding for my travel to his area, but eventually, I realised it would exceed my budget significantly. David was highly motivated to participate in the study and share his story. Due to these factors and my long e-mail communication with him, following several unsuccessful attempts to access other funding sources, after he suggested he was happy to use Skype, I agreed. I felt it was important to include David, as I thought he would offer a unique perspective: he

was of Māori-European heritage and he was a highly qualified healthcare professional himself.

The two interviews David and I had through Skype were very informative and successful, but I felt it was more difficult to connect with him over teleconferencing software and some of the issues could probably have been clearer to me if we spoke face-to-face. The second online interview seemed more comfortable, due to the fact we had already spoken before and had established basic rapport.

When I met other interviewees face-to-face, there was always some introductory time we spent together just having a casual conversation prior to the interview which noticeably improved rapport and, I believed, participants' comfort levels. This was possible because it took some time to walk together to the interview room, offer something to drink, make sure they were comfortable, and just introduce ourselves. This process of "breaking the ice" allowed for a more natural and free-flowing conversation, resembling two peers talking in an everyday context. Therefore, when the recorded interview was starting, we had already been reasonably comfortable with each other.

An important aspect of hermeneutic interviewing is realising that to gain understanding, one needs to confront and challenge their own preunderstandings. My methodology did not assume researcher objectivity, but rather called for transparency and awareness of my own social position(s) and the ways I have come to understand the world. In my communication with participants, I talked not only about my research project and my motivations to study experiences around PrEP, but also about myself. Talking about my whakapapa was a way to be transparent and show respect to the participants who were offering to share some intimate details of their lives with me. I felt this was particularly relevant in my dual role of outsider/insider (see Chapter Three). I had my own preunderstandings around PrEP and some of the things that participants said surprised me, while others were very much similar to what I believed. Sometimes during the interviews, I revealed what my beliefs were about PrEP or related matters and we further engaged in a dialogue. I felt comfortable sharing some of my preunderstandings with the participants and not having to hide myself behind an idea

of objective researcher. This upfront and transparent way to maintain dialogue is, Gadamer claims, natural for human-to-human discourse (Gadamer, 1975) and it is key for gaining understanding of the intersubjective truth of lived experience.

Analysis

The modes and epistemology of inference from qualitative “data” have been a subject of controversy. Different researchers argued for varying degrees of technical complexity aiming to produce findings that can be replicated and generalized to the population(s) (Lewis & Ritchie, 2003). The application of a certain kind of rigour and the promise of objectivity have been postulated to offer unbiased reproducible knowledge, similar to the insights offered by large quantitative studies where objective truths are said to be uncovered through the use of statistical methods (King et al., 1994). Within this study, I take a different approach. Instead of procedural rigour, researcher integrity (Watson & Girard, 2004) is emphasised, while instead of formal inductive/deductive methods of inference, a hermeneutic process that could most closely be described as “abductive” (Brinkmann, 2014) is applied.

The inductive/deductive axis in qualitative research analysis conveys how researchers may approach the material in relation to theory. While deductive analysis remains largely theory-driven, the inductive approach is data-driven (Brinkmann, 2014). The abductive process privileges context-dependence and feelings of wonder, and as such is closely aligned with the Gadamerian natural ways of understanding (Karlsen et al., 2021) which are holistic and circular. Despite the title of his magnum opus, *Wahrheit und Methode* [Truth and Method], Gadamer never proposed a step-by-step method or protocol of uncovering truths about the world or human experience. Furthermore, the nature of truth was questioned and relativised as intersubjective. Interpretation, including interpretation offered in this research, can never be postulated as entirely accurate and Gadamerian hermeneutics emphasise that this should not be the goal of hermeneutic enquiry.

Like hermeneutics, the abductive process is oriented towards discovery and context. Both hermeneutic and abductive processes allow for engagement with theory, however these approaches are not theory-driven; such methods have been likened to the craft of bricolage, where social researchers utilise the tools at hand most suitable for the given interpretive task (Brinkmann, 2014). Such an understanding of the research methodology presented some challenges at the level of inference from participants' accounts and further theorising. As discussed in the previous chapters, a Bourdieusian understanding of sexual and prevention practices as social practices was adopted as I framed participants' accounts. However, with the non-deductive hermeneutical approach I used it was important not to attempt to overinterpret the participants' accounts with a single theoretical angle that could distort the understanding of their experiences. In applying the theoretical Bourdieusian framework, I therefore opted to using this framework as an overarching ontological approach in interpreting HIV prevention as socially contextualised. I also set forth to signal these connections between the participants accounts and Bourdieusian theoretical frameworks where I felt it significantly contributed to deepening my understanding of their experiences.

Mindful of the epistemological considerations, I designed a methodological and analytical process where I interpreted the participants' accounts to be able to formulate conclusions about the possibilities of experiencing PrEP. The primary analyses began shortly after the first interview with each participant when I carefully listened to the given interview several times, took notes, and in some cases transcribed it (or parts of it) immediately. This allowed me to identify some of the themes that I could discuss in-depth in the follow-up interviews. Later in the project, when I had interviewed more participants, this also allowed me to identify themes that were not explored as in-depth as I had been expecting. This process also helped me identify where participants had similar views and where they disagreed.

During the follow-up interviews, I also discussed what appeared to be commonly emerging themes and I then asked participants to share their thoughts surrounding them. Ultimately, the structures of the first and second interviews with each

participant were quite different. The first interview was open and only very loosely structured, which is a usual characteristic of hermeneutic interviewing (Walker, 2011). Such a technique was to allow me to follow the participant's understanding of issues around PrEP, sexuality, and the community norms and practices. The second of the two interviews was, to a certain extent, more structured and informed by the first one. I began the second interview by asking the participant to share his thoughts after the first interview. As the follow-up interview progressed, I tried to revisit some of the themes from the first interview and ask questions about the themes that emerged with the other participants. This linking was to inform the discussion about my understandings of participants' experiences, and to enact the theoretical assumptions of intersubjective nature of truth. Drawing on the principle of hermeneutic circle and the negotiated and intersubjective nature of understanding (Debesay et al., 2008), it appears that this method of follow-up provided good insight into the participants' experience. This process allowed for co-creation of meaning by the participant and me (the researcher).

The final analysis, again, required applying the hermeneutic circle principles. This called for analysing the interviews as a whole and trying to interpret the individual excerpts in light of the whole text. Qualitative researchers, at times, attempt to apply strict procedural and technical methods in order to ensure reproducibility or objectivity of its findings. Gadamer (1975) argues however, that the truth emerging from any text is never objective and that should not be the aim of text interpretation. The intersubjective truth that emerges from interpretation of the text (in this case: the interviews) is a result of interaction between the interpreter and what is interpreted.

Striving to reach conclusive or entirely reproducible findings may transform the hermeneutic circle into a "vicious circle" (Debesay et al., 2008), by creating a phantasm of "true understanding" that can never be reached. Therefore, the analysis of texts is more akin to art than exact science, and such approach was employed in the analysis of the interviews. On a technical level, the process consisted of repeated readings of transcripts, along with listening to the recordings, followed by a more detailed analysis that included coding the relevant fragments into key themes, and then, again, trying to

understand the accounts as a whole by identifying the overarching narratives or meta-themes appearing in several accounts. Qualitative analysis software, NVivo (Version 12), was used initially, for parts of the early stages of analyses, to aid in early categorising and simplifying access to critical fragments of the interviews, but the accounts were later analysed manually, with consideration of the context(s) of the interview and the negotiation of meanings between the interviewer and the interviewee. This method of analysis allowed me to gain deeper understanding of the lived experiences of the participants. In reaching broader conclusions based on the participants' accounts, I focused on contextualising using PrEP with frameworks that participants used to privilege certain angles over others. I established these privileged angles through attention to what participants talked about more than other issues and what they described as important themselves (e.g., dealing with heteronormativity in healthcare, and not, for instance, traffic congestion when attending appointments).

Commonly, qualitative researchers present the identified themes by illustrating them with excerpts from study participants' interviews. I opted for a different approach of findings presentation to emphasise anchoring of the quotes in context of a given participants' story, reflecting the Gadamerian hermeneutical method underscoring the relationship between the whole and pieces. Therefore, in the chapters of the thesis that present the study findings (Chapters Six, Seven, and Eight), themes are illustrated by participants' accounts (as opposed to decontextualized excerpts), with quotes that were selected to reflect the internally consistent or dynamic understandings of the studied phenomena as participants made meanings of them.

Note on Changes Around PrEP Accessibility During the Study

The timing of the study provided a unique opportunity to examine the effects of policy and accessibility change surrounding PrEP in Aotearoa New Zealand. On 14 November 2017, PHARMAC (2017) announced the proposal to fund PrEP for those at

high risk of contracting HIV. Prior to this, there was no local PrEP policy, access to it was unregulated, and the medications were not funded.

From 1 March 2018, individuals have been eligible for funded PrEP provided they meet PHARMAC criteria, presented below (in full to avoid doubt):

Both:

1. Patient has tested HIV negative; and

Either:

2.1 All of the following:

2.1.1 Patient is male or transgender; and

2.1.2 Patient has sex with men; and

2.1.3 Patient is likely to have multiple episodes of condomless anal intercourse in the next 3 months; and

2.1.4 Any of the following:

2.1.4.1 Patient has had at least one episode of condomless receptive anal intercourse with one or more casual male partners in the last 3 months; or

2.1.4.2 A diagnosis of rectal chlamydia, rectal gonorrhoea, or infectious syphilis within the last 3 months; or

2.1.4.3 Patient has used methamphetamine in the last three months; or

2.2 All of the following:

2.2.1 Patient has a regular partner who has HIV infection; and

2.2.2 Partner is either not on treatment or has a detectable viral load; and

2.2.3 Condoms have not been consistently used. (PHARMAC, 2018)

In summary, PHARMAC criteria enabled access to funded PrEP for HIV-negative men (cis and trans) who have sex with men and transgender women at high risk of infection, provided they had a documented history of: condomless receptive anal sex with casual partners, rectal chlamydia or gonorrhoea, infectious syphilis, or methamphetamine use. In addition to this, regular partners (of any gender and sexuality) of PLHIV with detectable viral loads were eligible for funded PrEP in Aotearoa New Zealand.

This change followed a consultation process. Stakeholders, communities affected, and the public were invited to submit their feedback to which PHARMAC responded. The changes met with overwhelmingly positive responses from community (PHARMAC, 2018).

In its announcement of the final decision, PHARMAC (2018) summarised the feedback they had received from the public. The submissions raised various points, and as a result PHARMAC altered the criteria to broaden access to funded PrEP to all transgender individuals (as opposed to restricting it to transgender women only as outlined in their initial proposal). Many other technical remarks were sent; notably to include men engaging in insertive anal sex only, which was dismissed by PHARMAC as not falling into the high-risk category.

Some concerns were expressed in the submissions around various aspects of the funding, including economic and ethical reservations. PHARMAC's response to some of the feedback (PHARMAC did not identify the authors of feedback received) stating it was not appropriate to fund treatments for those who put themselves at risk is noteworthy. Declining to discuss the ethical aspects of funding PrEP, the agency pragmatically stated that "PHARMAC does not consider the cause of a health need when deciding whether to fund a pharmaceutical for it" (PHARMAC, 2018).

There were very few media stories or news reports criticising the policy change. *Spinoff* published an opinion piece where the author, a gay man, argued that PrEP is not a cost-effective public health intervention, and that PHARMAC funding of PrEP cost taxpayers unreasonably much for the allegedly limited benefits it brings (Berry, 2018). Declaring himself a proponent of PrEP, he argued that self-funding and importation of the drugs by interested individuals is a better method of seeking more universal PrEP coverage and responds better to the need of optimising public spending. Such voices from within the LGBTQ community appeared isolated and uncommon, and most of the media coverage and feedback submitted was positive (e.g., New Zealand AIDS Foundation, 2018; Stuff NZ, 2018).

Many of the initial interviews for this project took place before the funding shift occurred, and one of the themes that emerged in the participants' accounts involved the changes in accessing PrEP as the public and community discussion around them was unfolding. Because I conducted two time-spaced interviews, some of the study participants had accessed PrEP in different ways during the project and I expected this change in access to affect their experiences of PrEP. Participants accounts later confirmed this expectation (see Chapter Five).

Noticeable media coverage of the changes, along with community-wide discussion may have aided me in recruitment of the study participants. The Facebook page I used for the purpose of participant recruitment was, to some extent, dedicated to sharing experiences and practical advice around accessing PrEP prior to the changes and after. Individuals seeking information or guidance on PrEP accessing process generated a substantial part of the online traffic there. Some of them may have already been either keen to share information with others or may have been actively seeking information themselves. These groups of men were more likely to have seen my advertising, and therefore enrol in the study. One of the assumptions guiding this study is that at the time of conducting the interviews PrEP had not been a well-established social construct and the uptake of this medical technology could have been in large part driven by early adopters. There is evidence suggesting that PrEP early adopters may be generally characterised by very high-risk sexual practices (Saxton et al., 2019). They may also have some unique experiences. They could be subjected to stigma surrounding not using "traditional" or commonly accepted forms of prevention, such as condoms (Klassen et al., 2017). During the recruitment process and while conducting the interviews I was aware that the PrEP users I spoke to were a unique group of people in a unique moment in HIV prevention history. I will present their stories in the following chapters.

Conclusion

In this chapter, I presented the methods employed in the present study. I discussed some ethical considerations, focusing on ensuring participant confidentiality, and indicated that ethics approval for this project had been received from MUHEC (Appendix). I discussed participants online recruitment process as driven by online study advertising and leaflet distribution.

I described the interviewing process that included two individual interviews with each participant. Having follow-up interviews was an important part of ensuring building rapport with participants and interrogation of HIV prevention discourses along with my own preunderstandings in relation to participants' accounts.

I also outlined the method of analysis of participants' accounts that allowed for appreciation of Gadamerian principles and emphasised hermeneutic circle as well as dialogic and intersubjective epistemic orientation towards the stories shared. Lastly, I provided a note on changing PrEP policy contexts that coincided with the interviews and may have had impacted on participants' experiences.

PART TWO: FINDINGS AND DISCUSSION

Chapter Five: Participants

The second part of the thesis presents the study findings and the conclusions drawn from this research. In the first chapter of this part, Chapter Five, I provide a narrative introduction of the study participants and theorise on the issues of identity to demonstrate how the framing of identity informed my understandings of participants' experiences. I draw on Kevin's account to underline the importance of individualised identity construction in framing HIV prevention and I highlight it as an important research gap in need of further enquiry. I present the narrative description of the participants and some reflections on identity as a separate chapter in order to help the reader envisage the participants and provide a reference for the further data chapters where the presentation of the accounts is organised in a less traditional way: participant-by-participant. In the further chapters of Part Two, I present the specific findings of the study (Chapters Six, Seven, and Eight) and the final conclusions and recommendations (Chapter Nine).

Gadamer (1975) emphasises that to gain deeper understanding of the text, one needs to interpret it with regard to a given moment in history. In qualitative interviewing, this moment in history indicates not only the historic and cultural context, but may also extend to situating the interviews within specific frame of *personal* history of each participant. Such understanding is further emphasised by the concept of temporality of truth in Gadamerian text analysis, and it is often considered critical for applying the hermeneutic method (Whitehead, 2004). Such understanding can also be extended to generational analysis; in following chapters I will draw on the understanding of generations as culture (Gentile et al., 2014). The hermeneutic epistemology sets aside the search for objective truth, in order to pursue the more contextually-defined intersubjective truth that appears in the dialogue with the text (participants' accounts), therefore emphasising individual histories.

Some of the participants' details presented invoke the notion of identity. In most cases, I use the terms that participants used to describe themselves. This is an important notion, because a particular choice of words may convey specific meanings for each participant. It may be particularly useful when one considers the "interview data" as personal stories that the participants choose to share with the interviewer. The choice of words, the disclosed contexts, and the intentional or unintentional omissions may all carry meanings that can be particularly rich when analysing one's sexual stories (Plummer, 1995).

Careful consideration of identity construction is emphasised in the understanding of the post-traditional identity proposed by Giddens (1991). He describes self-identity as the force that organises personal history. It is not to be found in behaviours or the perceptions of others, but is rather a "capacity to keep a particular narrative going" (Giddens, 1991, p. 54). In Giddens's understanding, self-identity becomes a continuously revised and reflexive project. The sense of *identity* one possesses maintains consistency, but its contents may change and become contextualised ("segmented"). To describe this, Giddens introduces a narrower term of a *lifestyle sector* (Giddens, 1991, p. 83). Lifestyle sector describes smaller, highly contextualised parts of self-identity: these may relate to interactions with any part of wider society or communities. This split into sectors often occurs between private and public domains, but any spatial or temporal dimensions may be involved, and they may intersect and change over time. In this regard, there are similarities to the concept of *liquid modernity*, as introduced by Bauman (2000), and its positioning of identity. Bauman goes further, however, and points that in liquid modernity, identities change and morph continuously, and an individual is inclined to move from one self-ontology to the next one in nomadic fashion. Capitalist society and its reliance on individualism further enables such liquidity by offering (and possibly monetising) a range of competing identities. Bauman's emphasis on incessant change underlines the challenges of identity formation in liquid modernity. If one accepts these notions, the hermeneutic concepts of intersubjectivity and temporality of truth become even more pronounced, despite their distant philosophical origins and differences in ontologies.

In the context of this study, I asked participants to share how they would like me to identify them during analysis in regard to their gender, sexual, and ethnic identity. For some, this question was very unproblematic, but for others, this called for a longer discussion. It was important for me to understand why and how the ways they constructed their identities informed their interaction with PrEP, sexuality, and health. I did not fully realise the significance of how people identified in relation to different social categories until later in the interviewing process. I noticed that some participants had truly robust stories to share regarding how they described, expressed, and reflected on their identity and I started to link these to their sexual and preventive practices. Only in hindsight did I realise that I did not explore these issues equally in-depth with all participants, which was an important learning for me as a qualitative researcher. Perhaps if I had encouraged them to problematise what was for them unproblematic, then the participants would have shared even more of the deeper meanings of PrEP as they saw it.

I will introduce the participants in order of when they were first interviewed, for reference for the further chapters. I will follow this by providing an illustration (Connor's account) of how complex identity development and expression processes may contribute to the more holistic understandings of a participant's story. Some details have been changed to protect the participants' anonymity. A more succinct summary of the study participants' basic demographics is also available for quick reference in Chapter Three (p. 66).

Kevin

At the time of the interviews, Kevin was a gay man in his late 20s who lived in a large city in Te Ika-a-Māui. He identified as European. He was a highly educated professional working in human services, while at the same time continuing his education. Before the first interview, he had been using PrEP for 10 months.

He lived in a long-term stable relationship with a man whom he described as significantly older than he was. They had an agreement that it was an open relationship,

which meant they were allowed to have sexual contacts with other men. Kevin said that at the time of the study, his partner was not using PrEP.

Kevin appeared well connected to the gay community: he had many gay friends whom he socialised with, and he regularly used gay media outlets.

Sam

Sam was in his late 20s when I first met him for the interview, identified as gay and lived in a large city in Te Ika-a-Māui. He identified as New Zealand European. He was highly educated and worked in research himself, which partly motivated him to participate in the study. He had been using PrEP for a year before the interview.

He was in an open relationship with a man who, Sam said, also used PrEP. Sam shared that they made the decision to start using PrEP together and they accessed it through the same channels.

Sam belonged to the gay bear community and he regularly attended events held for the bears both nationally and overseas. He also identified with the gay BDSM community and he described himself as sexually adventurous and open to non-mainstream sexual practices.

Michael

When I first met him, Michael was a gay man in his early 30s, who lived in a large city in Te Ika-a-Māui. He self-identified as New Zealand European. He worked in a highly skilled technical occupation. Before the first interview, he had been using PrEP for a year.

At the beginning of the interviewing process, Michael had a regular partner who was living with HIV with whom they had been in an open relationship. They ended their relationship between the first and second interview.

Michael was very connected to the gay community: he was actively involved in volunteering for different gay causes, and he often attended gay events. He also actively

participated in community activities to spread awareness about PrEP and educate gay men around HIV prevention.

Allan

Allan was a gay man in his early 60s when I met him. He lived in a large city in Te Ika-a-Māui. He self-identified as New Zealand European and had a skilled occupation. He wanted to share his story about PrEP use to benefit others who could want to decide to use it. Allan had started using PrEP around 12 months before the first interview took place.

Allan lived in a long-term open relationship with his partner who, by Allan's account, also used PrEP. He emphasised that the fact they had sex outside of their relationship contributed greatly to the quality of their communication and their sex life.

Allan felt well connected to the gay community in Aotearoa New Zealand. In the 1980s, when the news about the AIDS crisis started surfacing in the media, he was volunteering for gay organisations across the country. The AIDS crisis and his involvement had left a lasting impression on him.

Connor

When we met, Connor was in his early 40s and identified as non-binary and gay. At the time of the interviews, he used male pronouns. He lived in a large city in Te Ika-a-Māui, where he had a highly skilled technical job. He had been using PrEP for over six months before the first interview.

Connor had multiple polyamorous relationships that he described as more meaningful than "fuck friends." He also maintained casual relationships with other men. Some of the men he regularly had sex with used PrEP, while others did not.

He was part of an alternative subculture within the wider gay community. The group formed a community around shared ideas of non-religious spirituality, anti-consumerism, care for the environment, and free gender and sexual expression. He

described them as inclusive and sex-positive, and he found support in their affirming attitudes towards him and others who, he said, could not “fit to the [mainstream] idea of normal.”

Karl

Karl was a White gay man in his late 30s who lived in a large city in Te Ika-a-Māui when we met. He worked in a technical field and had a highly skilled role. He was born and raised overseas and moved to Aotearoa New Zealand in his 20s. He had been using PrEP for around 6 months before the first interview.

Karl had a long-term partner who, according to Karl, was also using PrEP and they maintained an open relationship. They usually discussed their sexual activities which happened outside their partnership and they tried to use condoms for sex with casual partners, but not when they had sex with each other.

Karl was an active member of the local gay community: he regularly attended gay events and spent a lot of his spare time socialising with other gay men.

Vincent

When I met him, Vincent was a gay man in his late 20s who lived in a large city in Te Ika-a-Māui but was planning to move overseas for work soon after the interviews. He identified as Asian¹ and was born in an Asian country, although he spent much of his childhood and teenage years in Aotearoa New Zealand. Vincent was highly educated. He was not using PrEP at the time of the study; he had used it, however, for six months when he had been temporarily living overseas.

At the time of the study, he was single and not sexually active. The main reason for him to use PrEP in the past was to have the confidence he would not contract HIV

¹ “Asian” was the term Vincent chose as a self-identity provided within this project. More precise terms or a more specific description of his cultural background are purposefully not used in the thesis to avoid participant identification.

from his former partner who was living with HIV. He discontinued PrEP, because he had not been sexually active since his relationship ended.

Vincent reported many gay friends and he regularly socialised with them.

Rewi

Rewi was a gay man in his early 40s who also identified as takatāpui. He was of Māori heritage and identified with one of Te Ika-a-Māui iwi. He lived in a small town in another of Te Ika-a-Māui regions where he had moved to shortly before the first interview. He had a skilled professional role and was familiar with kaupapa Māori due to his professional and personal backgrounds. He had been using PrEP for over a year before the first interview.

At the time of interviewing, he was single and reported sex with different partners; some of them were regular and others were casual.

He was very well connected with gay and takatāpui communities. He was passionate about takatāpui inclusive policies and practices.

Harvey

Upon meeting him, Harvey was a gay man in his late 30s who lived in a large city in Te Ika-a-Māui. He identified as Pākehā and was continuing his tertiary education at the time of interviewing. He had discontinued using PrEP before the interview after a trial of a few months, because he had been experiencing gastrointestinal adverse effects.

Shortly before interviewing, Harvey had started seeing a new partner with whom they had an exclusive relationship. At the time of interviewing, they were discussing the option of opening up their relationship but had not made any decisions. Harvey said that they had both recently tested as HIV-negative and were not using condoms.

Harvey was well connected with the gay community, both through socialising with gay friends and being active in the gay internet communities.

David

When we first spoke, David was a gay man in his late 20s who lived in one of the cities of Te Waipounamu, but his tribal affiliation belonged to one of Te Ika-a-Māui iwi. He identified as European-Māori. He was a highly educated healthcare professional. David had been using PrEP for over a year before the first interview.

He had a long-term partner and they maintained an open relationship. According to David, his partner also used PrEP.

David was well connected with his local gay community, and he also provided health services to patients who, he said, came to him specifically looking for a gay provider.

Fluid Identities: Challenging the Binary

The following section exemplifies how identities may morph over time, and, in particular, how they may persist in a state of flux, evading classification, but at the same time constituting an important or even defining characteristic of self. Connor described his difficulty with finding the right words to describe his gender identity as he felt that none of the words could accurately describe his experience:

I use the word non-binary, because people, you know, it's a common word. It wouldn't be like my first choice, maybe genderqueer, or gender-fluid, I don't know, I just want to click "unsubscribe" on the gender option. (Connor)

Paradoxically, for Connor, the defining characteristic of his gender identity was the lack of clear identification and the prevailing unease with the social pressure to situate himself in the traditionally clearly demarcated gender binary. He settled for the term "non-binary," but only because it was commonly understood. Connor's situation calls to mind Wittgenstein's famous words, "the limits of my language are the limits of

my world” (Wittgenstein, 1961). However, Connor’s dilemma highlights a problem that constitutes the direct opposite: where one’s world exceeds the limits of their language.

Difficulties in trying to find the correct words to describe himself were only a part of the problem Connor saw with the gender binary.

I forget that there should be a lot of things that I should be doing as a man, but ... it’s not exactly how I’m wired. ... Men are supposed to be stoic and not show their feelings and be really tough, and I’m like really emotional most of the time, really in touch with how I’m feeling and aware of how other people are feeling as well. ... Stereotypically [it has been] in the sphere assigned to women. (Connor)

For Connor, that set of characteristics was not something he wanted to identify with, and he felt he was not able to fit his life experience into binary categories. Traditionally, gender identities contained a large set of characteristics assigned to one of the two genders.

Social responses to presenting as non-binary, whether online or professionally, have caused a lot of frustrations for Connor.

[In the gender box in dating apps,] I put male, because when you put non-binary, people stop messaging you. And this is part of the reason why I’m presenting polished, shirt and jeans today. ...

[When looking for jobs] The first set of CVs I sent out, my CV was really obviously genderqueer, ‘cause I was using the name [redacted female name] and then my legal name. ... I got zero call-backs, which is unusual because [the demand for my skills is high]. The second set of CVs that I sent were very like, male, my inbox lit up. ... I got to earn a living, so I’m just gonna suck it up and go to work like this, because I’m not so committed to the cause that I want to fuck up my ability to pay my rent. (Connor)

At times, due to gender non-conforming, Connor experienced rejection from gay men and even difficulty in finding employment, despite being a highly skilled

professional. These experiences led him to attempting to try to contain his gender expression to appear more masculine, so it would be easier for him to fit in, both in dating, and in his professional life.

Connor spoke about not being “wired” in a gendered way and he noticed that his own understandings of his identity were changing over time.

I don't remember consenting to [being raised as a male]. ... For the longest time I thought I was just a kind of a faggot and that's it, but then Tumblr happened in my life, and “oh, look, all these millennials talking about like other alternatives to gender, other than male and female.” ... I've been cross-dressing since I was a kid, the minute my mother was out of the house, “oh, let's get [out] the eyeliner!” That's kind of been a constant throughout my life. (Connor)

Connor had previously identified as a gay male, and only after he saw that other options existed, he re-established his non-binary sense of self. His engagement with the first non-binary online communities through Tumblr was a defining moment for him to relabel his identity. If identity is a “capacity to keep a particular narrative going” (Giddens, 1991, p. 54), then, in Connor's case, that capacity evolved and was used to retroactively re-tell the story of his life, and maintain a sense of continuity of identity, despite changing labels. The discovery of a possibility of non-gendered identity had not, of course, changed his earlier experiences, but was used as a tool to organise the self-narrative in retrospect and align it with his sense of self.

The evolution of identity appeared as a process of reconstruction and reassessment. In about seven weeks between the interviews, Connor reflected on his own gender identity and shared that he discovered that he had become more comfortable with himself as a non-binary person.

In the previous job I kind of have gone in and been like “oh, I'm non-binary and I'm gonna wear lipstick.” ... The whole time I felt like I was kind of forcing myself to do it. 'Cause actually I like wearing the clothes that I'm wearing now [traditionally male clothing]. I know a lot of women just wear clothes like I'm wearing right now,

because it's very practical. ... I think maybe because I'm more at peace, 'cause it's working quite well for me. (Connor)

Connor started feeling that his internal sense of gender (or gender fluidity) did not necessarily need to align with his gender expression. He also shared his understanding that the traditional gender attributes, in this case lipstick versus comfortable clothing, were not defining his internal sense of self, and he did not need to feel pressured to continuously express his gender fluidity.

Connor linked increased comfort with his non-binary gender identity with discontinuing using PrEP, situating PrEP as bareback sex enabler (as will be explored further in later chapters). Bareback sex, however, was a gendered notion.

I think there's something masculine about bareback fucking as well, 'cause there's an element of risk involved and that's what we like in our heroes; they take risks, you know, they slay dragons, they ride the rocket ships, they do risky things. Yeah, bareback sex is risky. (Connor)

Bareback sex, as carrying notions of risk, was understood as masculine. It encompassed the notions of adventure, discovery, but also: danger. On the other hand, bareback sex required a certain level of courage to brave the risks associated with not using condoms. The notions associated with condomless sex, sexual risk, and PrEP will be further explored in this thesis in the chapters that follow. However, in this section I tried to signal how evolving identities and their constantly self-assessing nature impacted on Connor's perceptions of health prevention and sexual risk-taking.

In sharing sexual stories, the understandings of self (sometimes implicit) and situating oneself in a narrative context are of paramount importance. Assessing these connections was not the primary objective of this thesis, however I treated participants' identities as important parts of their personal histories. To continuously reflect upon participants' self-identities was an important part of analysis, that aimed to encompass the consequences the way they constructed identities may have had on their relationships with PrEP and wider sexual practices.

Conclusion

In this chapter, I provided a narrative introduction to the study participants. I also discussed how I understood the notions of identity within this research and offered reflection about how complex and evolving identities may inform the life course of individuals.

Finally, I drew on Connor's account to highlight how identity construction can influence individual sexual practices and how gendered discourses surrounding social practices may lead to behavioural outcomes.

Chapter Six: Accessing PrEP Through Healthcare

In Chapters Six to Eight, I present the study findings situating them in the context(s) of participants' stories. Such approach is an attempt to highlight a given problem by relating it to a larger context of participants' experience. Through such account presentation, I want to emphasise the contextualised ways in which I was making understand of the participants' histories as they emerged during the interviews. I found such method of account presentation useful in realising the hermeneutic circle principles of analysis, where individual fragments gain meaning only in light of the entirety of text. The discussion of findings in the context of literature and theory follows the presentation of participants accounts in each of the three chapters.

The overarching aim of this project is to understand the meanings of the biomedical prevention method (PrEP) in social and cultural contexts of the lived experiences of MSM in Aotearoa New Zealand. This chapter will focus on participant's experiences in context of healthcare use for accessing and managing PrEP. As a prescription-only medication, PrEP makes it necessary for its users to engage with healthcare relatively intensively. This context shapes the experiences of men who wish to use it and may pre-determine who will eventually access it.

As described earlier, the participants were accessing PrEP in the context of changing policies and evolving body of knowledge surrounding it. Many men who took part in the interviews were early adopters and may have had unique characteristics that privileged them to succeeding in accessing PrEP early. This early timing also offered insight into some of the first users' experiences of healthcare services and medical culture surrounding PrEP and wider HIV prevention.

During the interviews, participants reflected on how their experiences were shaped by the quality of interactions with their medical providers, and how their levels of comfort and perceptions of service quality were influenced by their providers'

characteristics. The interviewees also shared that their connection with the gay community gave them an informed and empowered status to seek PrEP. Many demonstrated resilience and persevered in an environment often still unprepared to respond adequately to their sexual health needs. Some unique challenges in providing care to sexual minority men were identified, stemming from their life experiences that led to anticipating homophobia. Participants also pointed to pervasive heteronormativity and cultural inappropriateness in healthcare as sources of difficulties, and they reflected on their methods to navigate around them. Some offered ways to remedy these issues. The motivations of the participants were centred around individual pleasure and anxiety alleviation, but also on community cohesion and well-being. The orientation on collective well-being became evident as participants reflected on the access inequities and community benefits of PrEP use, for example, as a way of bridging the serodivide, and maintaining solidarity with those living with HIV.

Self-Induction to PrEP

The histories of participants' initial interest in PrEP were strikingly similar. Each of them learnt about PrEP from other members of their community or from gay media. Notably, none of the participants mentioned first learning about PrEP from any of their healthcare providers.

Allan was already involved with the gay community, and because he had known about the events organised by the local HIV organisation, he was able to attend a meeting to learn more about PrEP.

I went along to an AIDS Foundation evening and I thought [about PrEP]: "that's for me." There were a number of things I liked about it. ... The next day, I phoned my doctor and made an appointment. (Allan)

Allan had heard about PrEP before going to the meeting and wanted to learn more. Because the information that he had received at the community-run event suggested that

PrEP would be an appropriate option for him, Allan had become confident he should start using it before talking to his physician. He decided to take steps to access PrEP as soon as possible. He understood that the only way to obtain it was through linking with his medical provider.

Arranging access to PrEP was easy for Allan. He was registered with a GP who was gay himself and who was involved in promoting and informing about PrEP.

I go to [a named doctor], who was also at the [community] meeting. I deliberately go to him, because he's a gay doctor and I've been going to him for years. I think it's just invaluable having a GP you get on with, who knows your history, it just makes life a lot easier! I talked to him, he was very knowledgeable, and he was quite happy to write out a script for me. He did all the appropriate checks to make sure I was a suitable candidate. (Allan)

Allan described his relationship with his GP in very positive terms, emphasising how the fact that they shared sexual identity improved their rapport. The enhanced quality of this relationship was associated with a shared epistemology and relatable life experience. Allan had no doubt that the care he was receiving from his gay physician was “appropriate” and that this was enabled by the trust that developed between him and his physician. Even though Allan’s GP was supportive of him starting PrEP, it is unclear why he had not offered it to him beforehand; they had discussed the issues of HIV prevention before, and his GP had been offering Allan regular sexual health screenings before. Possibly, their previous appointments had taken place before PrEP became available in Aotearoa New Zealand.

Inadequate Care Despite Privileged Access

For Kevin, similarly to Allan’s experience, a prior connection to the community was an essential element paving way to learning, enquiring about, and, finally, accessing

PrEP. Kevin clearly identified that it was access to gay media that was critical for him to realise that PrEP was an option for HIV prevention.

I knew about PrEP. I learned about it online, from gay media. Which is a very white, male, gay outlook that I access in terms of my gay media. (Kevin)

He was well aware that his social positionality of a white cis-gendered gay man gave him privileged access to community knowledge about PrEP. The fact that he had already known about PrEP before interacting with healthcare providers granted him a very autonomous status and empowered him to take active steps to access it.

Unlike Allan, Kevin had not previously had a gay doctor, and he only recently deliberately changed providers to be able to have comfortable conversations about his sexual life and PrEP with a physician who was also gay. He shared how different the experience with his new GP was, as compared to his previous appointments with presumably heterosexual physicians.

I had straight doctors previously, and it is amazing to have a gay doctor who is able to inform me about sexual health. I have my hepatitis vaccines done which I never knew I had to have done. So, it's a whole lot better in terms of that. Even asking for an HIV test was a whole lot easier. When I asked before I would have been grilled around injectables. And I don't know if I offer druggie vibes, but that's not why I'm there. So yeah, it's great. (Kevin)

Kevin felt he was adequately understood by his new GP, which he attributed to his physician being gay. He felt that the conversations about sexual health were easier, and that his personal circumstances, including sexual risk, were understood better. He recalled how his previous physicians had been framing the conversations about HIV around injecting drug use, which was not part of his experience, and Kevin felt that emphasising substance use was not adequate; if not offensive. Kevin believed he and his new GP operated within the same epistemology of gay experience, and the “ease” in communication he talked about reflected no longer needing to explain the fundamentals of his sexuality to his provider.

Kevin's initial good experiences with his new GP were followed by what he saw as poor follow-up from allied medical professionals. He related his experience with the laboratory staff who were unable to explain the sample collection procedures for STI screenings required for PrEP initiation.

So: rectal gonorrhoea test. The lab ... people didn't know how to do that. And she [lab technician] went to another lab test technician and she wasn't sure. ... So, I didn't do those tests that time, because I didn't know how to do them. ... [Later] I had to YouTube or Google how to do it. ... Should I have to be the one that educates [lab] technicians how to help someone or tell someone how to administer the rectal gonorrhoea test? ... It's annoying, and it's, again, that subpar healthcare that you get and that your health concerns are just "less than," which again feeds into that whole annoyance around only certain amount of people having access to PrEP.
(Kevin)

Kevin understood that the rectal gonorrhoea swabbing was primarily used for MSM. He believed that this was the reason why the lab technicians were unaware of the methods of specimen collection and its processing. In Kevin's view, this reflected the wider problem of gay communities receiving "subpar" healthcare because the providers did not understand their needs. In this case, the lab technicians may have been operating from a heteronormative standpoint, defaulting to heterosexual (genital only) sites of infection for STIs. Despite some basic level of consultation on their end (a lab technician consulted a colleague), the staff were unable to advise Kevin appropriately, and sent him away without performing the required tests. He was forced to come to the lab one more time, after having to self-educate himself on the proper technique of performing the swabbing. This event led to frustration, as Kevin did not see it as an isolated event, but rather as one of many manifestations of healthcare system's inability to meet the needs of his community.

Empowerment to Establish Self-Autonomy

A recurring motif across the interviews was that the participants were usually not only well connected to the gay communities, but also had exceptional levels of health literacy stemming from their education or occupation. PrEP access required a certain degree of empowerment and ability to navigate effectively within the health system, as has been the case for accessing appropriate care since the beginning of HIV pandemic (Shilts, 1988). For Harvey, a professional interest in the administrative process of accessing PrEP was directly involved in his motivation to start using it.

Working in [redacted] I had a professional curiosity about the whole process-interface of your GP, what it was like, what the side effects were like, how easy it was to apply, just all that sort of stuff. The second was to control an element of sexual health risk and, thirdly, would be pleasure related. (Harvey)

Notably, Harvey mentioned “professional curiosity” about accessing PrEP as his first reason to start PrEP. He knew that the introduction of PrEP meant a significant change in the landscape of HIV prevention, which could force some changes in the interactions with the providers. He wanted to understand the process and experience it first-hand. Harvey also mentioned the risk reduction and pleasure-related motivations to use PrEP, but they were only secondary to the motivation to directly observe the PrEP accessing process. Above all, Harvey wanted to witness the change for his community.

He had first learnt about PrEP from another gay man, whom he had met through a dating app, and a conversation with him prompted Harvey to investigate further and try to access PrEP himself.

I met an Australian guy who was in New Zealand on business for about 2 weeks and he was on PrEP. ... I talked about it with my GP a couple of times, but he really had no knowledge about it at all. In the end, I just demanded that he write me a prescription. (Harvey)

Even though Harvey had known about PrEP, researched it thoroughly, and made appointments with his GP to access it, he did not succeed because his physician did not have sufficient knowledge about PrEP. Harvey stressed that, finally, during one of the appointments he “demanded” the prescription. He felt empowered enough to make “demands,” and express autonomy over his sexual health as he wanted to make sure he got access to prevention options he considered appropriate for himself.

Harvey realised that the level of resolve that characterised him, stemming from his level of education and empowerment associated with it, would not necessarily be shared by all other PrEP candidates.

I guess I could see many steps at which other people would've just given up, perhaps.

I think it might have been my third time talking to my GP about it. (Harvey)

These first few failed attempts to access PrEP were disheartening. Harvey recognised that his level of determination was unusual, and others in his situation would not be as persistent as he was in their attempts to access PrEP. He was referring to his awareness of his rights as a patient and to his level of knowledge (both associated with the fact that he was well-educated), that made him exceptionally health literate. It is worth noting that the three appointments prior to receiving PrEP required payment of three appointment fees, which could lead to a significant financial burden for less affluent men.

Resilience in Face of Adverse Circumstances

Karl was feeling he was not getting an appropriate service or value for money when trying to access PrEP through his usual GP. He had previously acknowledged the good intentions of his provider, but because he felt the service he was receiving was inadequate to his needs, he did not view the patient-clinician relationship as worth maintaining. Karl shared how his engagement with his physician ended.

I called my GP and told her that, "Hey, don't worry about it, I've worked out how to do it, thanks for all of your help, I am no longer going to pay [a GP fee] a pop to come and see you." (Karl)

Karl understood the steps he had to take to access PrEP and he decided to take matters into his own hands. He arranged to initiate PrEP with a local specialised sexual health clinic, and he framed this switch in terms of seeking good value for money. Because he did not perceive the lasting relationship with his physician as founded on understanding of his needs and experiences, it was not relevant to him which physician provided PrEP to him. The tone I found slightly accusatory that Karl used to describe this exchange was a way of expressing disappointment or anger about poor services he was receiving. It is worth noting that Karl knew he had a right as a patient to receive the best possible sexual health care, and when this had not happened, his frustration prompted him to seek other solutions and ultimately access the services he saw as appropriate.

Feelings of being misunderstood by medical doctors occurred to him later as well, after he had started using PrEP.

After I started PrEP, I had [redacted description of procedure] in hospital. ... I remember having a chat with the doctor in there. I said, "I take my [redacted medication for unrelated chronic condition], I take my PrEP daily." "What? What is PrEP?" "It's Truvada, this is the bottle here, this is what it does, this is why to take it." ... [In shocked tone:] "Why would you take that?" "Well, because!" And then when I got my discharge notes after my [procedure] two days later, it said on the bottom of them, "homosexual, no regular partner." Okay, that wasn't what I meant, you fuck-wit. ... I actually had a regular partner. (Karl)

Karl recalled an exchange between one of the hospital physicians and himself about PrEP during an unrelated medical episode. Firstly, he was annoyed by the physician expressing his shock when he learnt Karl had been using PrEP and questioning his reasons to do so. Secondly, he was angry that the surgeon had drawn

unfounded conclusions about his relationship status; he assumed Karl was single, which was not the case. These assumptions were based on a heteronormative notion that sexually exclusive monogamous relationships constitute the only acceptable way in which people enter into meaningful partnerships. Following this erroneous logic, the physician reached the erroneous conclusion that because Karl implicitly disclosed (by explaining PrEP use) he had multiple sexual partners, he could not be in a relationship. Making unjustified conclusions was only a part of a larger problem Karl was facing when interacting with many medical professionals: a disconnect between his and their (hetero) life experiences.

You end up having to talk about your sexual life with this person standing there, and probably one kid aged six, and one age three, and enormous mortgage. They hate their mother-in-law, they're looking at you, and you realise: wow, we have nothing in common. [I'm sure the physician wasn't a closeted gay guy,] Not dressed like that.

(Karl)

Karl used sarcasm to describe the disconnect he felt from his healthcare providers. He illustrated how their ontological and epistemological circumstances were entirely dissimilar to his experience. The stereotyping jokes (that straight men would not dress fashionably) he used to address this difference were used to describe experiences which he found unpleasant or that caused him discomfort. Karl used humour as a way of coping with difficult situations. The sarcastic comments were a manifestation of Karl's resilience, and his own way of asserting his position in the heteronormative reality of interacting with healthcare. When Karl mentioned the state of his surgeon's clothes as "evidence" for his heterosexuality, it was not a statement of fact or expression of his genuine belief about the intrinsic connection between different tastes and sexual identities. It was rather a joke in the aesthetics of camp (Sontag, 1964): a way of distancing from the real world and establishing a reversed order where the relationships of power are suspended in irony, witty humour and over-indulgence in aesthetics.

Across many levels of service provision, Karl noted how the providers failed to demonstrate an adequate level of understanding of his needs. He described his

discomfort when he ran out of pills and was trying to find a pharmacy that stocked them. The “relaxed” attitude of the pharmacist whom he saw as not taking the matters of HIV prevention seriously seemed confusing to him. He believed that the pharmacists’ approach would be different if the stocking issues were related to different types of medication, not PrEP.

It [PrEP] was a medical product and she was really relaxed about it. ... I found it really weird that she hadn't thought to take it seriously. ... I don't know whether that's because she knew what it was for and therefore didn't think that. If it had been different, if it had been heart pills, or epilepsy, or something. But it was kind of interesting that she was just so laid back about it. (Karl)

Karl had a clear idea that it was a professional duty of the pharmacist to explain the stocking issues and provide adequate advice on accessing the medication he was prescribed. He had been waiting for PrEP to be finally available in Aotearoa New Zealand pharmacies, and remembered that importing medication independently was stressful and he had hoped that local stocking would help.

Just importing medicines from overseas [is making me nervous]. I don't know anything about Swaziland, I've never been to Swaziland, I haven't really heard of Swaziland! I am not sure what the quality control is like, I don't know what's in the bottle, the bottle is sealed and that's great, [but] could be anything in there. I don't know what's in Truvada, and I don't know what's in the supply chain in New Zealand, but it feels a bit more trustworthy when it's coming over the counter of my local [pharmacy] than when it's travelled from Swaziland in Africa. (Karl)

The repetitive manner in which Karl talked about Swaziland¹ revealed that he saw the need to import the medication from a distant African county as ridiculous. He had no deeper knowledge about this developing country, and he had little confidence in the

¹ Formerly known as Swaziland, the African state is currently recognised as the Kingdom of Eswatini. The formal name change occurred around the time of the interview.

medication handling and supply processes there. Therefore, when the policy and market changes around PrEP accessibility in Aotearoa New Zealand occurred, Karl was enthusiastic about it.

Karl's ways of coping with a system which was not geared towards meeting his needs stemmed from frustration and anger. He used sarcasm as a way to describe his challenging experiences; these were, however, intertwined with the feelings of empowerment and self-efficacy. He was aware of his rights, and he retained high expectations for the standard of care, even though the healthcare providers failed to meet them on numerous occasions. I admired the resilience that shone through his ways of addressing the heteronormativity of healthcare. During the interviews with Karl, I was aware that he was a high-achieving man in his professional life. I realised that the high standards he developed along with his somewhat demanding attitude were necessary to allow him to effectively navigate through healthcare system.

Intersectional Challenges: Takatāpui Experience

At the time of the interviews, some dated attitudes were, unfortunately, still present among some of the healthcare staff in Aotearoa New Zealand. It was disappointing to listen to the account of a situation that triggered a strong response from Rewi. He shared his encounter with a receptionist at his local medical provider, in a town where he recently moved into.

I went [to the specified medical provider] and then the [receptionist said,] "I suppose you've learnt a lesson, haven't you?" ... I said, "Yeah, 'cause I fucking hate waiting for hours at a fucking [specified medical provider.]" She looked at me shocked, and I said, "Yeah, equally as critical as the comment you just said to me." ... She just kept her head down. I said, "How long will I be waiting here?" She goes, "How long is a ball of string?" ... Yeah, welcome to [my town]. I said, "Obviously you won't have a job for too much longer, aye?" I was waiting there for 3 hours. Then, I just got up and walked out, because I could have driven to [a named larger city nearby] and

gotten service within 1 or 2 hours. So, welcome to [my town]. [My town] don't do customer service very well, you also have to watch out; such small town. ... [You can] meet them again at the supermarket or you know, [I met her later,] "Hey, I'm the one with the STIs, the one that you gave all that fucking attitude at the clinic!" and she quickly walked away. I said, "I live in this town, bitch, I will see you." She won't do that to somebody else. (Rewi)

This situation angered Rewi to the extent that, following the heated exchange with the receptionist he eventually left the office without receiving the service he came for. Rewi described the receptionist's reaction to his comments as "shock," because, possibly, it was the first time somebody from his community in his town responded so strongly. Perhaps, other takatāpui men would have withdrawn in shame. Even though he immediately labelled her comments as simply poor "customer service," he felt the need to protect other members of his own community from similar remarks. He did not wish others to have such poor experiences. Indeed, he later confronted the women when they (coincidentally) met outside the clinic. Rewi was fed up by what he saw as inexcusably poor service and his strong reaction reflected it. Similarly to the situation earlier described by Karl, Rewi was confident enough to voice his frustration, and he strongly felt it was his duty to act not only in his best interest, but also to set a standard for the communities that he belonged to.

In our conversations, Rewi likened his approach to the "head of an arrow," in that it *leads* social response. He later explained that the social involvement and a certain level of advocacy was part of his whakapapa, or his family legacy.

That was the way that we were brought up. So, in our family, there's particular families who are leaders, so there's that expectation that you have a higher level of social consciousness. You'll fight the fight and help people out and that sort of thing too. So, there are those leadership qualities. ... I do just have to trust to a certain degree what people are, and what they believe and what they think is unjust needs addressing. (Rewi)

Rewi believed that “social consciousness” was ingrained in his identity through family history. Leadership in addressing the injustices or social problems was an important imperative, passed in a transgenerational way. This strong conviction was tested repeatedly, not only during the earlier exchange following the unprofessional comments by the receptionist. In fact, Rewi saw a large number of issues arising from the fundamental heteronormativity he saw as pervasive in the healthcare institutions:

They [local sexual health clinic clinical staff] found it hard to understand how I was able to contract the STI, given that I had been consistent with my condom use. ... That's when I realised, "Oh, no, I have been using condoms when I have sex, except when they have been giving me oral sex." And in this case, it was a straight tradie that liked to rim big bottom boys like myself. And he gave me an STI from his mouth to my ass. ... Doctors and nurses at sexual health clinic said that's a bit weird that a straight man would be rimming a big bottom Brown boy from the North Island. ... It was at that point that I realised that they didn't understand me, that they were straight, that they had not dealt with enough GLBT [sic] people before to understand our unique ways, our lifestyle, and the unique way we need our services delivered to us, the common language, and all of our ideas that we talked about. ... I realised that they were being really heteronormative in the delivery of their sexual health services to GLBT [sic] people, and that wasn't good enough. (Rewi)

Rewi felt that the experiences of LGBTQ persons were radically different from that of the heteronormative populations. When he shared the intimate details of his practices that were part of his familiar sexual experience, the medical staff's disbelieving reaction provoked a reflection that the clinicians were not equipped to see his experiences as valid and placed them outside of what they understood as normal. The labelling of his experience as “weird” was a way of othering through abjection. Importantly, in his account, Rewi ironically invoked the stereotypically loaded social categories of a “straight tradie” and a “big bottom Brown boy from the North Island.” He felt that healthcare providers would not understand the complex realities of enacting same-sex desires outside of the binary gay/straight categories. Rewi suggested that to the sexual

health staff, the experiences of this rural “Brown boy” did not fit into stereotypically defined matrices. The choice of language emphasising these almost archetypal figures signifying intersectional identities and following a camp aesthetic allowed Rewi to distance himself from the experience of being othered by the healthcare professionals, and therefore could be seen as a coping mechanism. Nonetheless, these were his real-life experiences, and he believed that professional services needed to provide space to express them and validate them.

Because Rewi felt so strongly about his leadership role conferred on him by his heritage, he was aware that all the limitations surrounding the provision of services in his area could affect the less assertive or self-confident Māori MSM to a more worrying extent. Rewi had a firm understanding of the PrEP access criteria, and he was adamant to share his knowledge and guide other Māori men in their endeavours to start using it.

Because there's quite a few [Māori men] here and they were all wanting to know how [arranging PrEP for myself] went. ... When I was talking to this Māori guy, who [has] kids and that sort of stuff, he was genuinely scared about going to the clinic. I said, "It's gonna go like this: they're gonna ask you these particular questions, ideally you're gonna put yourself into high risk category." He said, "What do you mean by that?" "You're gonna be having sex with people of dubious sexual nature, you're gonna be having sex with people who probably have HIV." ... He goes, "That puts me in a high risk?" I said, "Yes, just get them to tick all those boxes." (Rewi)

Rewi implied in his story that the man he was talking to was not publicly known to have sex with men, and he was apparently in a relationship with a woman. He suggested that the other man wanted to access PrEP, but was scared of going to the clinic, because he was concerned about his privacy. He was unfamiliar with the process, so Rewi wanted to help him by detailing how he should present his case at the clinic to receive PrEP. Guidance for those who were less experienced in dealing with the healthcare services was an important part of Rewi's “head of an arrow” approach. Presenting the healthcare providers with a pre-prepared narrative ultimately constituted

a way to navigate effectively in an unfamiliar environment that did not offer understanding of one's sexual experience.

Rewi felt that PrEP access issues were linked to the overarching problems around inequitable healthcare that gay men received. He saw introducing public funding for PrEP as a step in the right direction and situated it within equity framework. Rewi shared that he had believed for some time that the standard of care for his community was long overdue to be improved and PrEP proved him right. The health needs of gay men, and takatāpui men in particular, needed to be considered as equally important to the needs of heterosexual population.

It was just a matter of time before we would start to [see] really good drugs coming through. ... For me, I see my own sexuality in relation to and comparable to heterosexuality, so it should be the same, it really should be the same. So, heterosexual people are getting access to good medications for their issues, homosexual and takatāpui should be getting access to that same sort of medication as well. If heterosexual people can have natural or condomless sex and that sort of stuff too, then the same should be for me. (Rewi)

Rewi recognised safe condomless sex as a right that gay men should have, mirroring what he saw as heterosexual norm. He understood using PrEP to enable condom non-use as a way of maintaining self-autonomy. He also regarded not using condoms as a “natural” way to have sex.

For Rewi, the introduction of PrEP indicated progress in advancing this right, similar to the introduction of pharmacological contraception methods for women in the past.

When ... women first got the pregnancy pill, you know, they could take control of their own bodies from there, instead of demanding that a man must wear a condom. (Rewi)

It has been frequently argued (Mowlabocus, 2019) that PrEP encourages “promiscuous” behaviours or, in other words, that it is unethical to provide treatments that would enable having more partners or condom non-use. Such arguments were also raised in the local context of introducing funding for PrEP by PHARMAC (2018). Rewi, however, demonstrated a different perspective, drawing clear analogy with the contraceptive pill, which was historically opposed from similar positions. He argued, that since hormonal contraception for heterosexual women had been embraced, and it had finally been recognised that it contributed to the liberation of women by enabling increased bodily autonomy, he should be allowed to use PrEP on similar terms, without judgment. He pointed out to the power imbalance in terms of prevention options for the receptive partner in anal intercourse, likening it to the power imbalance in heterosexual couples. Rewi demanded that he was offered the same options that heterosexual women were offered to make their own sexual health choices.

The PrEP and contraceptive pill analogy coupled with his strong belief that he needed to fight for his and his community’s rights, empowered Rewi to argue his case in interactions with clinicians. When talking to a physician he believed was exhibiting judgmental attitudes, Rewi referred to this argument and he felt it really had an impact.

Equality, yeah! ... One of the doctors here, he sort of began to approach [slut shaming], asked me why I wanted to have PrEP. I said to him, “Cause I want to have sex like you have with your wife,” and he sort of “zip!” Everything just zipped up, and he went real quiet. Yeah, equality of choices and opportunity. (Rewi)

The contraceptive pill analogy, expressed directly in the earlier quote and implicitly in others, was used as a weapon to fight for Rewi’s own case. Orientation within the equity ethic and strong advocacy focus had additional meanings for Rewi, whose understandings were grounded in te ao Māori. He believed that the healthcare system he encountered was not only strongly heteronormative, but also culturally inappropriate for Māori, which led to more acute intersectional problems for the takatāpui. He felt that the sexual health system needed a significant reconstruction and employing kaupapa Māori process was necessary to start providing more appropriate

services to members of his community. He called for greater implementation of iwi-based services, where takatāpui involvement would be a fundamental element of planning, delivery, and management of services.

Using kaupapa Māori methodologies, wānanga is one of those methodologies when we come together as a group ... do our engagement with the sexual health group together. So, one delivery method is takatāpui people all come together on a marae at a certain time and day, and the health service comes up to the marae. So, the health services come to the actual community. We do the sexual health test together, we do all our interviews, and we do all of our blood tests, and all the samples, all together. ... We can have them all together in the same room if we want to, or we can have them individually and that sort of stuff too, but it's ultimately all determined in the wānanga, and that consultation group. So, that's just one example of doing it. The other thing is using Māori culture as context to the delivery of the particular service. So, what I mean by that is that all of the services are delivered in te reo. All of the frameworks, all the diagnostic tools, and all the either theoretical or whatever [aspects] are all Māori and even the data management principles ... are all Māori as well. (Rewi)

Rewi proposed the grounding of all services in te ao Māori, including using te reo Māori for service delivery. He also stressed the importance of meaningful participation of the takatāpui at each stage of service planning. His repeated pointing out to the need of inclusion of Māori process in healthcare delivery suggested he saw all these domains as areas currently lacking in kaupapa Māori. Rewi postulated for a radical restructure of the health service that would no longer offer simple 15-minute slots with providers, but a more appropriate and kaupapa-Māori-led service.

Rewi's story of accessing PrEP was a narrative of exhibiting great resilience in the context of interacting with healthcare providers who made his journey challenging. He braved the heteronormative environment thanks to his personal resources: the transgenerationally transferred social justice focus as well as his assertiveness. Rewi also

supported other, possibly less resilient, gay men and takatāpui in navigating around PrEP and managing their sexual health, because he felt this was his social duty.

Anticipated Stigma

Adult gay men are subjected to a lifetime of conditioning stipulating that their feelings and experiences are at least not as valid as those of the heterosexual majority, if not aberrant (van der Toorn et al., 2020). Unlike members of many other minority groups, non-heterosexual persons do not typically grow up with the members of shared minority identity groups that would enable the intergenerational transfer of protective mechanisms or identity affirmations (Huebner et al., 2002). These circumstances may lead to internalising homophobia and, through conditioning, they may set foundations for an acute hypervigilance to anti-gay stigmatisation, or *rejection sensitivity* (Pachankis et al., 2014). David, who lived in an open relationship, shared how he felt during one of the appointments with a physician at a specialised sexual health clinic:

There were a couple [of physicians] where I kind of had to explain the fact that I was in an open relationship and they might not agree with it, and you [could] tell. I did see one GP write in my file in quotes, "open relationship." I thought, "oh, that's a bit stigmatising," but for me, it's water off a duck's back. ... I'm not gonna be upset that they wrote that. I feel like this guy was an older GP, yeah, I do remember thinking, if I was someone who was quite sensitive, I would find that quite offensive, but I'm not. (David)

Interestingly, David was not able to specify what led him to believe that the physician had allegedly disagreed with the concept of open relationships. Nevertheless, the unspecified subtle and non-verbal cues that led David to believing his physician did not approve of his open relationship somehow resonated strongly with him. The factual statement from the notes appeared as threatening and stigmatising, because of the lack of rapport he had with the physician. Even though David denied taking offense to the non-verbal reactions or the clinical notes, he presumed that other gay men who could be

living in open relationships would feel uncomfortable or stigmatised. It is difficult to distinguish whether the physician's apparent "disagreement" with the concept of open relationship was a fact or a projection of David's concerns about the homophobic attitudes among physicians, especially from older generations; likely, a combination of both was at play. David, like many other gay men possibly would, arrived at the clinic with a set of concerns and worries, anticipating stigmatising attitudes and with hyper-awareness of possible micro-aggressions, experiencing rejection sensitivity (Pachankis et al., 2014).

The anticipated stigma surfaced again during another ambiguous exchange with a pharmacist when David went to pick up his PrEP pills.

First time I got [PrEP], the pharmacist, she asked me about it. I think I must have been one of the first people to come, and she said, "we don't have it here, could you come back tomorrow?" I said, "that's fine." I didn't really feel like I got judged, but she did ask me what it's for, I told her that's none of her business. ... I don't know [why I said it]. I think she was kind of probing about it, in my mind, she would have all the information in front of her. So, if she really wanted to know, she could look it up. ... It's not like I was going to tell her. "oh, it's because I'm in an open relationship" in front of everyone else at the pharmacy. (David)

Once again, David did not feel comfortable during his interaction with the provider. He was not able to point to specific stigmatising practices and attitudes of the pharmacist. In fact, to me, the question she asked appeared unthreatening, and there were potentially several valid reasons for the pharmacist to ask it, which David later acknowledged. His initial reaction revealed that he anticipated stigma, before it happened. Taken together, the exchanges with the pharmacist and the sexual health physician, showed that even for gay men who are open about their sexuality and generally comfortable with it, discussing it in healthcare settings could invoke discomfort, due to anticipated stigma. Gay men may anticipate stigma for a variety of reasons, that include generalising from prior experiences and others. This form of rejection sensitivity (Pachankis et al., 2014) may also lead to poor engagement with

medical providers, including in accessing PrEP (Brooks et al., 2019). In David's accounts, he denied experiencing discomfort, and this denial was unprompted; he felt it was important to note that he did not feel stigmatised or judged. In a way, he perceived there were reasons for him to feel uncomfortable, but because he was resilient enough, he would not allow them to affect him. This observation led him to worry about other queer men who would be less resilient. Despite significant advances in societal attitudes towards gay men, some significant levels of resilience may still be required to navigate successfully and confidently in the healthcare contexts.

David understood that the contexts in which the conversations with the healthcare providers took place were complex and intersectional. He anticipated that gay Māori men may experience even higher levels of discomfort, due to cultural reasons.

Maybe, I think a lot of [Māori gay men] might feel ashamed to go to the doctor to ask about it [PrEP], especially in a small city or small town because everyone will know everyone. So, having a Māori practitioner or having someone who is a Māori queer person to kind of educate them and not to feel whakamā, which is kind of feeling embarrassed to talk about it, someone who could break a kind of barrier would be great. (David)

David believed that for many gay Māori men, actively pursuing PrEP can be challenging due to feelings of shame or shyness associated with discussing sexual health issues, but also due to concerns around privacy in the contexts of less urbanised areas. These issues could be overcome by being able to discuss them with Māori practitioners or Māori peer educators who could dismantle the stigma associated with seeking PrEP and help to normalise its use. David referred to the concept of *whakamā*, which has been translated into English as shame, self-abasement, feeling inferior, inadequate and with self-doubt, shyness, excessive modesty and withdrawal (Sachdev, 1990). The etymological roots of the concept, with "ma" denoting "white, pale," and "whaka-" used as prefix to signify the subsequent word "being caused to happen," literally denote "becoming/causing to become white or pale." This metaphoric approximation can illustrate the bodily response to whakamā; similar to English expressions (present in

many languages from different language groups) of “turning white as a sheet,” or “blanching,” which also convey an element of psychological or physiological distress.

David may have known more about the internal culture and stigmatising attitudes among the healthcare providers than other gay men who were interviewed. He had a unique first-hand perspective: he was a healthcare professional himself. He attributed the negative experiences of gay men with healthcare providers to the lack of familiarity among medical practitioners’ with wider LGBTQ issues that in turn stemmed from lack of adequate training.

[During training] I was not taught a specific module or specific part of a paper on how to interact with gay, lesbian, trans patients, people living with HIV. ... You know, we weren't taught that. And I feel like [because I am] part of the queer community ... I have a lot of queer patients, because I think they just feel comfortable coming to me and not my heterosexual colleagues. That's the thing: in [my] degree in New Zealand, we're not taught that, and it is something that should be done.

(David)

Being under 30, David represented a younger generation of healthcare providers practicing in Aotearoa New Zealand. Notably, his earlier comment about the “older” physician suggested he considered as significant the generational differences in approaching sexual minority patients. However, even though his training happened relatively recently, it did not include any LGBTQ content. David believed his patients felt more comfortable with him than with his non-queer colleagues. He felt his improved rapport with the LGBTQ patients stemmed from his own queer status, which was demonstrated by his large LGBTQ client base. Of course, shared epistemic frameworks allowed for David’s improved rapport with his patients, but that did not necessarily mean that only queer providers could offer their queer patients appropriate services. David believed this could be also accomplished by appropriate training, had the LGBTQ contents been included and emphasised more in the training curricula.

David's story was complex, because the lens he used to talk about PrEP was so multidimensional. He was a PrEP user, but also a healthcare provider. He identified as part-European and part-Māori. He also mentioned before one of the interviews, that he felt he was typically perceived as European due to his lighter skin colour and physical features, even though a significant part of his growing up was marae-based. Due to his professional high-level education in health, when accessing medication, he was an insider and outsider at the same time. He was well aware of the stigmatising attitudes of providers, and this anticipated stigma may have been strengthened by culturally informed whakamā. On the other hand, he was academically educated about these possible aspects of patient experience, which helped him rationalise these perceptions, and gave him the resilience to persevere, despite fear of stigma.

Individual Benefit and Community Wellbeing

Connor did not deny the benefits that PrEP had for him as an individual. He started using it after an incident when he failed to use condoms and experienced, in his words, "angry and neurotic thoughts about this." Since starting using it, he stopped feeling anxious around the risk of contracting HIV and he also felt that PrEP enhanced the sexual experience by allowing not using condoms and increasing intimacy between partners.

[Using PrEP] is unequivocally more intimate than having a piece of latex around my genitals and his [partner's] rectum. (Connor)

Despite the obvious individual benefits, Connor situated the issues of HIV prevention, and PrEP specifically, within the entire affected community, not just in individuals. He believed universalising PrEP access could help change the power and responsibility dynamics in the gay community.

HIV affects the individual, but HIV also affects the community. This isn't about condoms at all actually, it's about drugs. So, up until PrEP, the only, like, we're all

affected by the epidemic, but the only people that have to take medication are the guys who are positive. Now, it's like everyone can take medication and that burden of medication is now spread throughout the entire community instead of just being on the individual. (Connor)

Connor saw the medication use as a community responsibility to prevent the spread of HIV. He referred to the importance of TasP in controlling the epidemic, but also saw medication taking in HIV-negative men as a manifestation of solidarity with HIV-positive members of the community. Pill taking was a burden, regardless whether it was for treatment or prevention, and the introduction of PrEP meant that this burden could be spread on a more equitable basis in order to stop the new HIV infections. Altruistic motivation have long been described as important in motivating gay men to using HIV prevention leading to a culture of *prevention caretaking* (Nimmons, 1998). Community solidarity aspects of PrEP taking (NAPWHA, 2019) have been emphasised, yet these motivations were not typically framed as sharing “the burden of medication.”

This strong community focus meant that that all gay men had a responsibility to control HIV, and this responsibility was anchored in belonging with the community itself. Executing the community duty of care was not easy, as Connor believed the healthcare agencies and funding policies did not prioritise HIV prevention at an appropriate level. He believed gay men sought ways to use healthcare system in ways that suited their needs and which would facilitate their access to PrEP. He described how he and others were trying to navigate or manipulate the funding criteria system through misrepresenting levels of risk to access subsidised PrEP.

If one of us goes in, finds out what the criteria is: everyone knows what the criteria is. So, we're all saying, “yeah, I take it up the ass, fuckin', leaking cum from my ass, love it so much, jizz in my butt, just give me PrEP.” (Connor)

Connor described the community of gay men interested in PrEP as an interconnected group that shared information between each other in order to facilitate accessing PrEP. He used the vivid hyperbole to convey that risk exaggeration was seen

as a necessary step to acquire PrEP, because accurate risk representation would not be effective. Knowing the rules of the hostile system and manipulating it to one's community advantage was used as means to an end of establishing community solidarity and cohesion with those living with HIV.

Even though Connor stopped using PrEP, he wanted to make sure that he could access it on his own terms, regardless of what his providers believed was appropriate for him. He shared how he mistrusted the state agencies, and the state itself, and how he would not want to leave his prevention options in their hands.

I've still got the pills and I'm going to get the repeat prescription and not use them. ... I don't trust PHARMAC and the government. It would be good for me to have those pills in my pocket. (Connor)

The need to maintain full control over the accessing process was present at every step of engaging with Connor's healthcare providers, even when he was deciding to discontinue using PrEP. Connor saw accessing PrEP as exercising his right to appropriate HIV prevention, which he believed should be recognised and realised by the state. The preservation of one's agency over sexual health and, thus, one's corporeal autonomy was a crucial aspect in navigating PrEP access. However, individual bodily sovereignty was not the only goal, as maintaining this autonomy was strongly community-based and community-oriented. The allocentric (Triandis et al., 1985) motivations of community well-being and idiocentric motivations of pleasure-seeking and anxiety-alleviation were intertwined, and led to a greater individual and community benefit.

Discussion

This chapter focuses on findings about healthcare contexts of PrEP use. Participants shared how their access to PrEP was self-initiated and self-managed. They contrasted their own successful experiences of accessing PrEP with the community

hurdles in providing it at scale. For some, being engaged with a gay physician who understood the different aspects of their non-heteronormative lives was crucial for access, and some chose to seek gay physicians for this particular reason. Their knowledge of PrEP usually stemmed from prior engagement with the gay community or gay media; none of the participants described learning about PrEP from their healthcare provider. Despite belonging to a sexual minority group, the men interviewed demonstrated high levels of resilience, self-agency, and sexual health knowledge. They were well educated and highly motivated to access PrEP (likely to be further emphasised by the project's selection effect), and this allowed them to be effective. Participants noted inequities in access to PrEP, realising that their social circumstances gave them privileged access that could not be guaranteed for other, less-privileged men. Their early experiences signalled significant challenges in both PrEP provision and general level of care that they received as gay men. The participants noted strong heteronormativity in healthcare contexts, understood as assuming that monogamous male-female partnerships are the only valid or default ways of expressing sexual desire that warrant social and medical attention and care. Anticipating such sentiments from healthcare providers led to increased vigilance around them and to interpreting complex or ambiguous situations as potentially stigmatising. One of the participants, Rewi, strongly emphasised the similarity of the social positioning of PrEP to hormonal contraception in women in that both were initially stigmatised with the label of "leading to promiscuity," while in fact, they enabled empowered bodily autonomy. Each participant reported unique ways of coping and adapting to the perceived heteronormativity, and many used humour as a way to address the difficulties, thus making it a coping mechanism. Participants demonstrated high-levels of self-advocacy; they were motivated to access PrEP for HIV risk reduction and sexual pleasure-related reasons.

What also became clear during the interviews, was the exceptional level of community advocacy. A view that PrEP led to greater community benefit, including showing and enacting solidarity with men living with HIV, and thus bridging the community that was split by the serodivide. This community orientation led to strong support of widening PrEP availability and making access easier, but also contributed to

personal willingness to use it. Both Māori participants indicated that, in its current form, the services provided for takatāpui were not culturally appropriate, due to issues such as whakamā, experienced more strongly in the context of sexual health services, but also due to current service provision models. A radical overhaul of services, emphasising iwi engagement at all levels of planning and provision, with marae-based delivery could be one of the ways in which improvements could be accomplished. More training for the healthcare workforce, particularly in primary care, but also for allied personnel, such as lab technicians, pharmacists, and administrative staff to raise awareness of gay men's unique health challenges appeared critical to improve PrEP access.

Contextualising historic PrEP Agency

The self-management of accessing PrEP was apparent in participants accounts. Agentic and self-driven actions can be contextualised in the history of AIDS response in the Western contexts, and in Aotearoa New Zealand. In many developed countries, the epicentre of AIDS response has been grounded within queer communities from the beginning of the epidemic. Starting with the Gay Men's Health Crisis (GMHC) in the United States, and the signing of Denver principles that changed the understanding of PLHIV from 'passive sufferers' to active, engaged agents of the response, followed by numerous other initiatives, the community response has been strong worldwide (UNAIDS, 2011). In Aotearoa New Zealand, Bruce Burnett was regarded as the key figure of the organised, gay community-led response to AIDS; he also had a key role in establishing the largest local HIV organisation, the New Zealand AIDS Foundation (Lindberg & McMorland, 1996).

Many scholars argued that the involvement of the gay communities in the AIDS response did not only shape the response: it also changed gay communities (e.g., Rofes, 1998; Shilts, 1988). The trauma caused by the epidemic set up foundations for constructing new and empowered communities, strengthening their cohesion, and eventually leading to advancement of gay rights by, among other factors, increasing the

movement's visibility (Rimmerman, 2015). This history constitutes a symbolic community whakapapa of gay men taking ownership over the matters of HIV prevention and refusing the role of passive objects of public health interventions, but rather aiming to become at least equal partners in the response, if not the leaders. The autonomy can manifest itself on many levels, but even simple acts of taking time and doing one's own research about a new method of HIV prevention, and actively seeking connection to sexual services can be seen as stemming from that long tradition of agency. The history of individual responses in the early AIDS era is full of cases when gay men were active agents in their treatment, seeking the best, novel, or promising therapies, instead of relying on the grim prognoses of premature death at that time, that included the famous buyer's clubs in the United States, which increased access of PLHIV to life-prolonging medication (Halkitis, 2014). Organised, informal, and at times illegal forms of facilitating access to antiretroviral treatments were present in Aotearoa New Zealand for decades, at first managed by a long-time former CEO of Auckland's Body Positive (Phillips, 2017).

Today, despite different contexts and outcomes of HIV prevention and treatment, the study participants were characterised by the same agency that surfaced in an earlier era of the AIDS crisis, arranging access to PrEP for themselves, and sometimes demonstrating information levels greater than those of their treating physicians. Decades of HIV prevention education had profound impact on gay men, with some becoming true experts in it, which coupled with the community whakapapa, resulted in new manifestations of the ethics of personal and community responsibility. The study participants overall had little expectations about their physicians to inform them about PrEP. Rather, they were, at most, hopeful their health care providers would be able to assist and supply them with it. I propose that this should be interpreted as taking ownership, and therefore continuing the long-held tradition of HIV response community leadership.

The ownership of one's own HIV prevention methods and strong commitment to self-agency led some participants to present their behaviours deceptively when trying

to access methods they saw fit for their needs. PrEP's perceived benefits extended beyond simply reducing the risk of HIV in those that are seen as high-risk by the clinicians. The alleviation of anxiety, the ability to experience greater pleasure, and the transfer of the locus of control from the agreement over condom use by both (or more) partners to an individual are all important motivators for PrEP use internationally (Collins et al., 2017; Gamarel & Golub, 2015; Goldenberg, 2016; Underhill, 2015; Whitfield et al., 2019), and, as will be demonstrated, locally. None of these issues are reflected in the current funding criteria, that emphasise a documented history of high-risk practices in order to qualify for PrEP.

This disconnection between the funding criteria and real-life motivations prevents some men who wish to use PrEP to attain these benefits from accessing it. There are proponents of the view that supports PrEP use as "demand-driven," meaning that the potential candidates should be the ones that make the decision whether they wish to use it or not (Cairns et al., 2016). These arguments are increasingly influential and have been reflected in the 2019 update to the Australasian PrEP guidelines (2019). This update recommends moving from discussing PrEP "eligibility" in terms of history of risk, to considering PrEP "suitability" by considering PrEP for anticipated risk and for those who experience significant HIV-related anxiety in the absence of immediately high risk. These changes indicate a practical shift from "physician-expert" risk assessment to a patient-driven (or patient-inclusive) model of decision making. Endorsing the changes by the Aotearoa New Zealand public health policy could improve the trust levels between the gay community and their providers through allowing greater consideration of the autonomous decision-making process by the communities most affected by HIV. Skewing one's sexual risk history in order to receive prevention medication would thus become unnecessary.

Heteronormativity

Heteronormativity has been defined as “the presumption that heterosexuality is the default, preferred, ‘normal’ state for human beings because of the belief that people fall into one or other category of a strict gender binary” (Harris & White, 2018). Heteronormativity includes the assumption that socially and legally privileged ways of living, along with their institutions, such as marriage, are natural, inevitable and desirable (Montgomery & Stewart, 2012).

AIDS history has known numerous physicians and allied healthcare professionals whose contribution was instrumental not only to dramatically improving the biological outcomes of the HIV infection, but to shifting the healthcare culture into a more inclusive, and patient-centred environment (Bayer & Oppenheimer, 2002). Despite this, Aotearoa New Zealand LGBTQ communities still experience challenges when engaging with healthcare providers. A 2015 study (Ludlam et al.) indicated that only 50.5% of gay and bisexual men believed their usual GPs were aware of their sexual identity. Despite significant differences in the survey methods that make the results difficult to compare directly, this is not an improvement from the results of an almost decade older study (Neville & Henrickson, 2006) which indicated that 64.7% of gay and bisexual men disclosed their sexual identity to their providers. Neville and Henrickson (2006) also found that 65.8% of the gay and bisexual male respondents believed that their healthcare providers usually or always presumed they were heterosexual. Making a presumption of heterosexuality as a “default” option for human sexuality constitutes the very definition of heteronormativity. Even though even well-meaning providers are usually unable to resolve themselves the structural and systemic barriers to access quality healthcare, it has been evidenced that heteronormativity in healthcare provision, and in particular in patient-provider relationships is one of the factors contributing to health disparities among sexual minorities (Utamsingh et al., 2016). It has also been found that disclosing one’s sexual identity to the physician is a strong predictor of engagement in healthcare in non-heterosexual patients (Steele et al., 2006).

All of the study participants had to make sure their providers were aware of their sexual identity, as this was a necessary step to access PrEP. Some of the participants (e.g., Kevin) identified seeking a gay physician as a way to facilitate disclosure and ensure appropriate and non-heteronormative care. They were acutely aware of the heteronormativity in healthcare, often labelled it as such, and identified it as a barrier, especially for those hypothetical patients who would be less resilient. They pointed to the lack of LGBTQ-inclusive provider education, lack of experience with sexual minority patients, or simply conservative or bigoted personal beliefs as the source of heteronormative attitudes.

The scope of heteronormativity extends beyond the simple notion of normalised “opposite sex” desire, and leads to a construction of a default and ideal model of socially accepted sexual, partnering, or intimate practices in order to attain the intimate citizenship (Plummer, 2003). The idealised and normalised bodies of white, male, middle-class, heterosexual, and able-bodied subjects are those whose sexual experience is socially accepted and viewed as normal (Ignagni et al., 2016), and unquestioningly becomes the frame of reference to identify what are abnormal, and therefore abjected practices and bodies (Dowsett, 2017).

Resilience: Camp, Subversive Humour, and Irony as Ways of Coping

Even though the participants experienced some stigmatising attitudes, they demonstrated remarkable resilience by overcoming discomfort and, later, creatively addressing and reflectively describing their experiences during the study interviews. A striking feature of the interviews was the use of subversive humour by participants to describe their experiences. The style of a significant part of their comments could be described as “camp”: exaggeration, application of humour to describe the challenging circumstances, focus on aesthetics, and irony were some of the characteristics of participants’ narratives. It was Sontag who first critically addressed and described some of the features and roles of this aesthetic in her now-classic essay *Notes on “Camp”* (1964).

She asserted that “the whole point of Camp is to dethrone the serious. Camp is playful, anti-serious. More precisely, Camp involves a new, more complex relation to ‘the serious.’ One can be serious about the frivolous, frivolous about the serious” (Sontag, 1964, p. 527).

It has been long postulated that humour in general may be an effective coping mechanism (Vaillant, 2000). Like for a number of socially complex phenomena, study of the effects of the use of humour on emotional regulation and health has produced inconsistent results. This led some researchers to conclude that only certain types of humour (positive humour as opposed to negative humour) can lead to empirically verifiable benefits in well-being (Samson & Gross, 2012). Whether or not camp meets the definition of narrowly demarcated positive humour that can lead to “objective” gains in emotional well-being is a question that I will not attempt to answer in this thesis. However, throughout the history of gay liberation movement and AIDS responses in gay men, camp, as an expression of gay humour has been identified as a way to cope with trauma and build meaningful narratives around the tragic experiences (Andriote, 2019). The analysis of participants’ accounts extends the understanding that camp humour may be used to cope with the burden of HIV infection to include navigating prevention.

Different scholars examined the subversive, reclaiming-autonomy aspects of cultural adaptations to HIV, that were specific to the gay culture(s). Brouwer (2010) provided a detailed analysis of the camp humour and its functions and effects in two zines released in the United States between 1990-1999: *Infected Faggot Perspectives* and *Diseased Pariah News*. The titles themselves reveal much about the subversive re-appropriative style of writing that was deeply revolutionary. They were at the same time, however, building community. With figures such as “AIDS Barbie” and “KS [Kaposi sarcoma] Ken” the zines were deconstructing important camp notions such as “glamour” and creatively reconstructing them, alongside claiming ownership over bodies in decay. By circulating oppositional understandings of infection and cultivating resistant frames, the communities involved in the zine production and readership were

setting the stage for more inclusive political and economic conditions, which formed the essence of their risibility politics (Brouwer, 2010). The AIDS-diagnosed writers were not willing to agree to any form of externally imposed identity, even if these were meant to convey compassion or add a sense of nobility to their suffering. Through dark humour and camp aesthetics they wished to maintain control of their own self-image, and rejected redemptive or sentimental representations of people living with AIDS (De Moor, 2005).

I argue that by creative invocation of the camp-aestheticised narratives the participants of the study continued the spiritual whakapapa of the gay-led AIDS activism in order to uncover and critique the prevailing heteronormative norms in healthcare. Camp humour, sometimes unapologetic and founded on exaggeration, play with stereotypes, or occasional vulgarity was a way to address the inequities and name-and-shame discriminatory practices and stigma. Through this, the participants were able to address these important challenges in a less threatening manner.

The Community Ethics of PrEP: Solidarity and the Serodivide

Serosorting, that is selecting partners with the same HIV status, is one of the methods of HIV prevention. It can be practiced both by HIV-positive (Shuper & Fisher, 2008) and HIV-negative MSM (Horvath et al., 2008). Serosorting of course assumes knowledge and often disclosure of one's HIV status. The gravity of an HIV-positive status disclosure is very different from the gravity of negative status disclosure. When persons living with HIV disclose their status to prospective sexual partners, it can create the dynamic of "confession," that constitutes an imbalanced power dynamic (Armendinger, 2009). The serodivide has been understood as exclusion of men of different HIV status from engaging in sexual activities despite the availability of effective prevention measures (Koester et al., 2018). Research has shown that PrEP may be effective at dismantling this invisible barrier (Koester et al., 2018) by granting both sides of the divide more certainty about the virtual elimination of risk and rendering

unnecessary the need to “confess.” The impact of PrEP not only on HIV-negative gay men, but also on gay men living with HIV has been recognised, and the proliferation of PrEP led to increased hopes of eliminating HIV stigma (NAPWHA, 2019).

Alleviation of anxiety surrounding engaging in sex with HIV-positive men (Collins et al., 2017) while using PrEP is only one of the beneficial effects of PrEP. In fact, some of the participants strongly believed that the introduction of PrEP may inform a new culture of “shared burden” (Connor), or shared responsibility between HIV-positive and negative members of the gay community. Sexuality has been an important aspect of building community and connection between gay men, building on what has been termed sexual citizenship, understood as shared sexual belonging (e.g., Davis, 2008). The community that had been decades ago divided on a political level by the AIDS trauma and split sexually by the risk of infection, coupled with the imagery of death, guilt, and dirt, could be now bridged owing to PrEP. This sentiment produces a sense of urgency to make sure that PrEP is accessible and available to those who wish to take it, because its effects extend beyond individual preventive measures and serve a greater community purpose.

The distrust participants placed in healthcare providers provoked care for other members of the community and feelings of solidarity. It was common for participants to raise concerns around PrEP access for other members of their communities that could be less resilient, or less resourceful. This solidarity resonated with a search for appropriate ethics that would allow more equitable access to PrEP, that would not merely cater to a state-imposed control of individual sexual selves but rather subvert that control to address wider community needs. The misrepresentation of individual risk was not seen as morally problematic because it led to greater community cohesion and improved PrEP access. I argue that such ethics do not simply constitute justification of manipulative or deceptive practices, but rather represent a relocation of the locus of care to participants, or what has been termed *preventive caretaking* (Nimmons, 1998).

Previous research has indicated that altruistic motivations are among the primary groups of reasons why gay men seek participation in HIV prevention trials

(D'Angelo et al., 2019). The findings of this study support and build on the notions of the importance of community orientation and solidarity (as opposed to idiocentric orientation) among gay men who access PrEP outside of the trials. Contrary to approaches that emphasise individualised risks/benefits ratios, it appears that some gay men maintain their community prevention focus and appear to situate their individual PrEP uptake in the larger social context. This is not a new perspective: researchers have identified altruistic motivation as an important driver for HIV prevention well before emergence of PrEP (e.g., Nimmons, 1998). Research has found that there are strong links between adherence to values such as social responsibility or altruism and avoidance of CAI (Martin et al., 2014). Despite this, the dominant approach in promoting PrEP remains focused on individualistically construed personal risk profiles, largely disregarding this important community perspective.

The freshness of the perspectives provided by the participants of this study lies at the intersection between the community focus and the interactions gay men had with their healthcare providers along with their understandings of healthcare access inequities. Even though they were able to access PrEP themselves, they were disappointed by the barriers other members of the community faced in accessing it. Some participants were happy to share their know-how on PrEP access and meeting the funding criteria, so that other members of the community could use PrEP themselves. When the participants misrepresented their risks or instructed others about the best ways to do this, their intention was to attain that community benefit, to stop the new transmissions regardless of whether they could affect them individually. In this context, the healthcare providers who identified as gay were seen as more likely allies subscribing to familiar ethical frameworks, which contributed to seeing them as more understanding and providing more appropriate care.

A growing body of research questions the assumptions surrounding the “erosion” or “loss” of gay communities, often ascribed to the emergence of dating apps and increasing inclusion of gay men into the mainstream (e.g., Baudinette, 2019; Davis, 2008). Community focus and community solidarity appear to remain important frames

of reference for many gay men (Wilkinson et al., 2012), despite the demise of geographically distinct gay spaces (Gorman-Murray & Nash, 2014). The participants of this study often referred to and expressed care towards other members of the gay community. The subjects of this care included both named members of their personal networks and the hypothetical “more vulnerable” community members. In this study, the community ties were strong and were a source of resilience for the participants.

Inequities in Takatāpui PrEP Access

Institutional and systemic racism contributes significantly to the health disparities experienced by Māori communities (Came, 2012; Talamaivao et al., 2020). The additive effects of heterosexist attitudes, practices, and policies result in particularly challenging conditions that make access to healthcare difficult for takatāpui. In the present study, the issues pertaining to the inequities in healthcare access were highlighted in the accounts of the two Māori participants, through the lens of intersecting discrimination.

Limited research is available on health inequities experienced by takatāpui in Aotearoa New Zealand. A study from 2004 (Grierson et al.) found that Māori New Zealanders living with HIV, among whom majority were MSM, had good access to healthcare that, as the authors assessed, was on par with the healthcare standards provided to Pākehā New Zealanders. The authors noted that these findings were in contrast to the systemic healthcare inequities and racism experienced by Māori in Aotearoa New Zealand (Talamaivao et al., 2020), but did not provide interpretations of this striking difference.

A report from 1998 (Aspin et al.) indicated that Māori gay men often felt they belonged less to the gay community; a finding consistent with the results of a later study by Henrickson (2006). All the men in the present study, including those who identified as Māori, reported good connection to the gay community, and they clearly identified that this helped them access PrEP effectively. The concerns participants expressed

surrounding PrEP access for other takatāpui men were revolving either around those that they felt were less resourceful or less connected, including those who would identify or function socially as straight.

Because Māori MSM may or may not identify as gay or takatāpui, significant change may be needed to provide Māori-focused, as opposed to gay-focused, PrEP provision. Culturally specific phenomena such as whakamā may be experienced acutely and generate additional barriers, if significant steps are not taken to address them appropriately in the healthcare settings. These could be remedied through greater reliance on kaupapa Māori service provision, and grounding it within the iwi, as well as leading the policy development and implementation by takatāpui men.

Conclusion

This chapter presented the aspects of the participants' accounts that were surrounding accessing PrEP through interactions with healthcare providers. Participants shared how these experiences were sometimes challenging and required perseverance. They often felt the negative interactions with providers negatively influenced the perceptions of the relationships they had with them as the participants felt their providers' knowledge levels and interest in gay men's sexual health were limited. The relationships were viewed notably more favourably by those participants whose physicians were members of the gay community themselves. Participants pointed to heteronormativity in healthcare as the main source of difficulties, and they reflected on their methods to cope with it, including actively confronting their physicians and using subversive humour to challenge these attitudes.

Some participants positioned their motivation to access PrEP and share information about accessing it with other members of their communities within the whakapapa of collective HIV prevention and care advocacy that originated in the times of the AIDS crisis. The benefits of PrEP were expected to contribute to a collective project of increased community well-being and cohesion, by locating the burden of

pharmacological HIV prevention on all sexually active gay men, not only those living with HIV, emphasising altruistic motivations to PrEP use.

The two Māori participants emphasised some of the unique challenges experienced by takatāpui and other Māori MSM in accessing PrEP, that required culturally appropriate responses. These included both the intersecting difficulties in accessing heteronormative and culturally unsafe medical settings, aggravated by lack of understanding of cultural phenomena such as whakamā, and lack of kaupapa-informed and Māori-led services.

Chapter Seven: Generational Shifts

This and the following chapters will present the participants' accounts in relation to their real-life motivations to use PrEP, the meanings they ascribed to condomless sex, sexual health, sexual risk, condomless sex, and sexual pleasure. In these two chapters, I will explore the different meanings the participants attached to enacting their sexual desires and the changes that were associated with their use of PrEP. The analyses will challenge the understanding of gay sex as "a dangerous mode of HIV transmission" that needs to be sanitised by public health interventions to gain validity as one of the ways to express human connection.

The present and the following (Chapter Eight) chapters are organised to underscore the generational differences and similarities in the participants' experiences, based on their experience of the AIDS crisis. While Chapter Eight focuses on the experiences of many participants, the present chapter follows the account of only one study participant. I chose to focus on Allan as an individual because he belongs to the generation of gay men who personally experienced the loss of their peers due to AIDS as it was emerging globally and in Aotearoa New Zealand. Importantly though, men of his generation also experienced the reality of sexual connection with men before HIV appeared, unlike other participants of the study. In organising the accounts presentation in this way, I want to highlight the understanding that generations can be seen as distinct cultures (Gentile et al., 2014), with differential epistemic frameworks. The importance of historicity of experience is a crucial aspect of understanding in hermeneutical phenomenology (Gadamer, 1975).

As discussed earlier, the benefits of PrEP use to reduce the risk of HIV are clear and strongly evidenced, both in personal and population health. The effectiveness of PrEP alone is so high that on a practical level, when used correctly, it virtually removes the risk of HIV for its users (BPAC NZ, 2019; Molina, 2019). With PrEP use, condom benefits are still present in relation to reducing the risk of contracting other STIs;

however these are associated with much less perceived burden than HIV (Wells, 2020). Through the removal of the condom imperative, PrEP challenges the well-established norm of condom use in the gay community and enables critical understanding of the impacts of public health interventions on the embodied and enacted desires in the gay community.

I argue that gay men's sexual desire, like human sexuality in general, is mediated by an array of cultural norms, beliefs, and socially accepted or deviant practices. Dean (2015) claims that "raw sex does not exist," (p. 224) emphasising that all sexual activity is mediated by social discourse, and therefore a "natural" way of embodying desire can never be uncovered. In the context of gay sexuality and HIV prevention, this notion is highlighted in analysing differences between different terms denoting essentially identical practices, that may carry vastly different social meanings. These terms include seemingly neutral "condomless sex," vilified "bareback sex," and clinical "UAI," (Mowlabocus et al., 2014) with "safe sex" denoting essentially any non-problematic gay sex. One may pose a question: what would *ordinary* gay sex mean today?

By way of background to this chapter, it is useful to signal some general historical developments that set the stage for participants' accounts. I will develop these contexts further, following the analysis of Allan's account. PrEP emerged in a complex social setting of the aftermath from the AIDS-crisis and its trauma. In the early 1980s, AIDS seemed to have appeared out of nowhere and spread rapidly through the communities, first deemed "high-risk." At the time, AIDS equalled death ("AIDS = DEATH," as was emphasised by the famous ACT UP slogan) and there were no effective treatments to help those diagnosed (Shilts, 1988). However, meaningful community responses and almost unprecedented medical advances led to spectacular leaps in treatment and profound improvements of outcomes (Palella et al., 1998) within just two decades. In other words, men born in the mid-1960s or earlier witnessed distinctly different eras of sexual safety and enacting same-sex desire. Firstly, there was the pre-AIDS era, when condoms were used solely for unwanted pregnancy prevention in heterosexual couples

and there were no apparent mortal health threats associated with same-sex practices.¹ Secondly, there was a sudden emergence of an unexpected, deadly and quickly spreading disease that caused deaths of a significant number of gay men. This resulted in the naturalisation of imperative to reduce sexual activity and use condoms to evade the existential threat and preserve life. Such reconstructions of the history of gay desire post-AIDS have been contested, and the detrimental consequences of AIDS discourses for the sexual cultures of gay men have been demonstrated (Rofes, 1998).

The initial challenge to the life-saving imperatives of avoiding the transmission of deadly disease took place in the late 1980s with the advent of zidovudine (AZT). In the 1990s, the significant treatment advancement, development of protease inhibitors and HAART, marked the time when HIV infection started to transform into a chronic illness that would not necessarily lead to an inevitable death. These changes were associated with profound impacts on those affected, with some calling the effects of new treatments “Lazarus syndrome” to describe the experiences of those who reconciled with imminent death to later discover that they would live (Brashers et al., 1999). Two most recent decades were characterised by gradual improvements of therapies and quality of life of PLHIV who could access one of many available treatments, however still facing persisting social stigma. Despite the advancements, HIV continues to have deadly sequelae for those with severely delayed diagnosis or poor access to medical treatments. The emergence of conclusive evidence that virally suppressed individuals cannot transmit HIV sexually (U=U) marked a significant milestone both on the level of HIV prevention, and in the context of combatting HIV stigma (Prevention Access Campaign, 2016).

This short historic summary shows how different generations of gay men had lived their sexual lives in distinct contexts surrounding the threats associated with enacting their sexual desires. As mentioned at the outset of this chapter, only one of the

¹ This is of course a simplified perspective. It should be noted that discrimination, along with medical inequities (and activism) were present among the gay communities before the AIDS crisis: this has been documented in literature (e.g., Batza, 2018).

participants of this study, Allan, witnessed these changes, while others grew up and started exploring their sexuality later, having never experienced the pre-AIDS reality. This chapter presents Allan's story.

Historic Breakthrough: Unlearning the Condom

As I discussed earlier, one of my preunderstandings of PrEP was that it was a positive development for HIV prevention, that could contribute greatly to the well-being of gay communities. Its psychological benefits were also evidenced by qualitative research overseas (e.g., Collins et al., 2017; Whitfield et al., 2019). When I was interviewing Allan, I understood that I was roughly half his age and my ideas of radical change in the well-being of gay communities following changes in HIV prevention could be vastly different from his, because I had not personally experienced the AIDS crisis in the same way. Following the Gadamerian principles of co-creation of truth, I shared my preunderstandings with Allan, to try to understand if and how he saw the radical change PrEP brought about:

[Interviewer: I obviously come from a different generation. So, when I started meeting guys, for me that was the default: condoms. I can't even fathom the pre-AIDS era, when you didn't think about condoms. For me that was such a default, throughout my entire life. When I was a child, "Philadelphia," the movie, was there, I can't relate personally to that experience of pre-AIDS era, but you've obviously been through that era and then through the worst of AIDS. So, do you think PrEP is such a milestone here?]

[Participant:] I think it's a huge milestone, I think PrEP in conjunction with U=U, I think they're both huge milestones, they're both complete game-changers. (Allan)

Allan shared the view that PrEP was a "game-changer" for the gay communities, and HIV prevention. He added that this was the case for both new effective biomedical interventions: PrEP and the knowledge about undetectable viral load stopping ongoing

HIV transmissions. During the interview Allan elaborated on the context in which he saw PrEP and shared how the AIDS crisis impacted on his young adulthood.

I think I mentioned to you in my twenties, I had my first overseas trip and I followed the gay man's sort of holiday. I went to San Francisco, New York, and just two or three months before I left, the first news of AIDS, headlines of Kaposi's sarcoma. I just didn't want to know! I was going on holiday and I was going to have fun. ... I went and ... I knew absolutely nothing. I was involved quite politically at the time, with the [named gay organisation]. ... When the first news started coming out of San Francisco in 1981, we heard that, I heard it. It was just, we didn't know what to make of it, gay men started to die of Kaposi's sarcoma, it wasn't known why or how, I was going on my big holiday overseas! I was going to the hotspots and I was going to have fun, and nothing was going to stop me. [And I had fun]. I wasn't going to have a baby, so why use condoms? When I got back then, I came back with gonorrhoea and was ... getting more information coming through. Then it really hit me, just really sank in, I thought, "holy shit." As soon as the test, it took time, but when tests became available, I had a test as soon as they were available, incredibly relieved to find I was negative. But at that stage people [were] starting to come down with HIV, come down with being really sick and I started to, you were at the stage when someone went into hospital, with just that isolation! Wave at them through a glass, with a note, that sort of thing. People just disappeared! They'd start getting sick and then they go back to where they live, go back to family, and never hear or see them again. ... Most ended up going back to their families and their families just closed around, shut up, because it's such a shameful thing. Isolated them and we'd find out later they'd died. ... Yes, I was incredibly lucky, so I just became, I suppose, in a way, quite evangelical about using condoms [and] doing what I could to spread the safe sex message. (Allan)

Through this powerful account, Allan positioned HIV prevention in the context of his life course as superimposed on the historic trajectory of AIDS over the last few decades. He realised he had been at heightened risk, when no preventative measures

were known or used, and he considered himself lucky to survive through this period. At the time, he believed his risk was extremely high; and in the 1980s, an HIV diagnosis meant effectively a death sentence for many. His first HIV test was a source of distress, followed by unexpected relief when the result came back as negative. He was a first-hand witness to people he had known dying in shame and isolation, and this trauma led him to use condoms religiously as well as to become an avid supporter of “safe sex message.” This generation-defining experience was what informed Allan’s sexual health choices for decades to come, and bound condom use with the notion of surviving.

The gravity of the condom-survival connection, and the long-term adherence to the safe sex rules led Allan to initially assume, that he would never discontinue condom use, and simply use PrEP as an extra layer of protection:

When I went on PrEP, my thoughts were [that] I’ll stick to my current regime of using condoms and so on. [But] that dissolved very quickly. ... I talked to my partner about my thoughts. ... After I’d been on PrEP for a week, I thought I’d go to a [sex-on-site] venue, see what happens. [I] went to grab the condoms and he said, “Why are you taking those?” (Allan)

Allan shared how he chose not to use condoms after starting PrEP, despite initial reservations. This was a decision informed by communication with his partner who was also using PrEP, but in the end, it happened without much deliberation, despite the zealous application of condoms before. The mutual understanding between partners, that condom use was no longer mandatory, but could be something that one can question, became established. That night, having been on PrEP for a week (the period typically required for daily PrEP to offer optimal protection) Allan did not take condoms with him.

Allan’s first experiences without condoms after starting using PrEP were confusing and overwhelming, but ultimately very rewarding:

It was surprisingly easy [to stop using condoms] in a way, but it still hits me. I’m still processing it, even though it’s been 12 months. I sort of go through waves. The

first time I went to a venue and had sex without condoms, and it was just amazing, incredibly joyous in a way. I could connect with someone with such intimacy and share such a feeling without the: "Do [I] see the risk? No, I'm not, yes, I am, no I'm not" going on in my head. It was just amazing, just the joy of being able to relate to the person I was having sex with in a completely different way without the, I just didn't realise after those decades, just what the constant caution does to your thinking and your pleasure. But then going through that every now and again I have that, I go through periods of, it sort of catches up with me, "Woah! what am I doing?" and then [I] just process it, what I'm doing, why, oh, yeah, right. (Allan)

Allan did not expect that (de)conditioning away from condom use would be such a dynamic process; he had been using them for decades. However, unlearning the now-obsolete safe sex messages triggered a reflective process and he discovered that the necessity to stay vigilant around having sex had impacted him more profoundly than he had ever thought and affected the way he derived pleasure from sex. He spoke of the joy, and strong feelings of connection to his sexual partners. These feelings were earlier suppressed by anxiety which formed a barrier stopping him from experiencing genuine human connection with other men. Owing to PrEP, this caution was alleviated, and it felt right to him.

Transformative Power of PrEP

The wish to share his story – and Allan felt this was also the story of his generation – was one of the primary reasons why he decided to participate in the study.

I think one of the main reasons that I came along here [to the interview] is, I read a couple of reports mainly from North America, of gay men similar age to me who had been through the worst of the AIDS crisis, come out the other end. Completely, totally unexpected reaction of going on PrEP and suddenly peeling away, very quickly, peeling away all these layers of caution, shame, guilt. Just be able, I don't

know any other way of describing [the] absolute joy, of pleasure, of just being able to enjoy other men. (Allan)

Starting PrEP had a profound emotional impact on Allan, and that was not something he had been expecting. When he read the accounts of other PrEP users of similar age from the United States, with personal biographies that were quite like his, the similarity of their experiences resonated strongly with him. In the quote above, Allan recounted all the feelings that had become attached to expressing himself sexually, and that PrEP has now removed: caution, guilt, and shame. The process of disassociating sexuality from these strong negative connotations was cathartic. For Allan, PrEP was an agent of transformation that replaced the difficult emotions with pure joy, pleasure, and feelings of connectedness to other men. The metaphor of “peeling away the layers” that Allan used to describe this process suggests that these “layers” were in fact a residue of living with fear of HIV that was distorting the connections with other men and genuine sexual experience.

It's almost like pinching myself at time. ... Just something that just wouldn't and couldn't happen 12 months ago, or 18 months ago. It's not only the perspective of condoms, it's the whole, it's the thing that I wasn't expecting. It was the whole emotional change of how [I have] emotionally adapted to being safe and being cautious and it influenced and pervaded just being intimate with people. (Allan)

Only through the removal of strong negative feelings associated with connecting with other men, Allan was able to fully recognise the extent to which fear of HIV impacted his relationships and his quality of life. He recounted how unexpected the emotional transformation owing to PrEP had been for him. From this new perspective, Allan was able to see that many decades of caution caused by fear of HIV diminished his ability to become intimate with other men.

Intimacy and Connectedness

Critically, for Allan, other than being an enjoyable experience, sex with other men was a method of seeking connectedness with the Other:

Even anonymously ... like in a sex club with someone I've never met before, if they're having a good time and seem to be enjoying themselves and I'm enjoying myself, we may only be together a half an hour ... I think it's a much better social communication than many other forms of social communication. (Allan)

Allan understood engaging in sex, even with anonymous partners, as a meaningful way to communicate with his fellow men. Sharing pleasure was an important way of connecting that could even be superior to many other forms of social communication, as it involved opening up to the Other and reflecting one another's emotional and sensual states.

The transformative potential of PrEP allowed this process of connecting to unfold uninterrupted, but it is worth noting that condomless sex was not a goal in itself for Allan, but rather a means to enhance intimacy:

[I don't use condoms now] unless someone else specifically asks for them. ... Sex is about sharing pleasure and sharing intimacy. If someone else is going to feel uncomfortable about their safety, that's not sharing. (Allan)

Allan made it clear that his choice not to use condoms was to allow greater intimacy with his sexual partners. However, he was ready to use condoms, if his partners needed them to feel safe and comfortable when having sex. He recognised that while condomless sex while using PrEP was what provided him with the feelings of safety, for others, that same comfort could only be achieved by sex with condoms. In other words, Allan valued the connection afforded by sexual contact with other men, when both partners felt safe and comfortable, and the choice of the method of prevention used was to serve that goal of intimacy.

Discontinuing Serosorting

The positive changes owing to PrEP had an impact on more of Allan's partnering practices. Allan was conscious of the fracture in the community, the serodivide, that prevented him from engaging intimately with HIV-positive men due to fear.

I found a big thing with me afterwards [after starting to use PrEP]. I'm not discriminating! I'm not! ... On the odd occasions when I did have bareback sex before I would always ask, I don't want to ask someone their status, but I would turn around and say, "I'm HIV-negative," when I last had a test, so and so, and encourage them to volunteer. Yeah, I was trying to serosort, which in a way, which is discriminating in a way. I found since going on PrEP, it doesn't matter and I'm not discriminating anymore. [I am] meeting people I wouldn't have been close to, friendly to in the past. (Allan)

Despite Allan's conviction that serosorting was in fact a discriminatory practice, it had been difficult for him to discontinue it before PrEP. The uncomfortable discussions preceding sexual contacts in the time prior to PrEP required some tactful manoeuvring and had not always gone according to plan. Allan used to feel uncomfortable in explicitly querying about his partners' HIV status, because he did not want to be seen as discriminating against PLHIV. PrEP effectively removed the utility to have that conversation and Allan believed that this opened the possibility to connect sexually with men living with HIV. Of course, the goal was not to be able to have sex with men from a larger pool of possible partners, but rather to stop the practice that Allan felt was ethically problematic and excluded HIV-positive men. When seen in a larger context of Allan's earlier life activism and the community AIDS trauma, it becomes self-evident that the possibility to comfortably discontinue serosorting had profound significance.

Connectedness to Primary Partner

Allan was sexually active with different partners, some of them were incidental and anonymous, but this group also included his long-time primary partner who was HIV-negative. They managed their HIV prevention in their open relationship through clear communication and trust.

Yes. I've always trusted him with it. I've always sort of had the attitude that you can only do so much to be safe, if something goes, if we are both out having sex, I've occasionally had a slip-up, he has, he's human too. And particularly as time has gone on, and it's changed from HIV being a death sentence to becoming something that is manageable. It's becoming easier to rationalise, if worst comes to worst, then what difference would it really make? It's [HIV is] something we'd end up managing together. (Allan)

Allan contextualised the possibility of becoming infected with HIV by situating it within his primary relationship. He shared that managing this risk required trust, and openness, along with a degree of leniency towards himself and his partner. He believed that accidental imperfect condom use ("slip-ups") was a fact of life, and therefore the couple could not entirely eliminate the risk of HIV infection. Trust was the crucial element that gave him the assurance that if one of such incidents resulted in HIV infection, the partners would have each other's full support. During his long-term relationship, the realities of living with HIV changed significantly, shifting away from being an untreatable, deadly condition, and Allan realised that the consequences of acquiring it now would be more benign when compared to the early days of the epidemic.

Owing to the high level of trust, Allan and his partner enjoyed a satisfying open partnership, where having sex outside the primary relationship contributed to the quality of their sexual interactions. This further improved with PrEP:

[Since we started using PrEP,] the sex and stuff in our relationship has increased too. ... We've always had an open relationship; I've been with my partner for [over

twenty years]. When I first met him, and things started looking serious I was very open and honest with him and said, "You realise you're dating a slut and it would be hard for me to monogamous." He accepted that, he quite enjoys having sex outside the relationship as well. ... If he's having sex with someone, if we're together or if he's gone off, I actually find it quite horny, go [let] yourself go, and enjoy himself having a good time, I know he'll come back to me. When he comes back home, we often have sex then, and talk too, it just adds to the, it's better than porn. (Allan)

Allan recounted that since he and his partner started using PrEP, their sexual life has improved. He did not explain the mechanism explicitly, but one can infer from the context that there had always been a certain degree of risk built into his open relationship, and PrEP removed that uncertainty. Similar to enabling focus on joy and pleasure of sexual contact with casual partners, PrEP improved the way Allan viewed his sexual contacts with his regular partner too. The casual relationships with other men led to the feelings of compersion (Mogilski et al., 2019). Allan knew that sexual contacts with other men were not presenting a threat to the stability of their relationship, as he fully trusted that his partner would not ultimately choose them over him. Sharing intimate details of sex outside of their relationship served as a foreplay to arouse each other, and, owing to PrEP, no longer contained an element of health risk.

Physical Pleasure

It is widely presumed that people, regardless of gender and sexual identity or practices, prefer not to use condoms when this is possible, and that was one of my preunderstandings before interviewing Allan. He felt the same way: he did not enjoy using condoms, and part of it was due to technical or physical comfort-related reasons.

Why I stopped using condoms? Probably a number of reasons. Probably number one: sex just feels better without condoms. I tried importing the non-latex ones which were better than the latex condoms. I tried experimenting with the female condoms for anal sex. ... Bit of a pain. (Allan)

Despite trialling different types of condoms, including various materials and shapes, Allan did not enjoy the sensations or practicalities associated with condom use. There were many problems with them that were particularly acute when he was in the receptive sex role:

I much prefer to bottom without condoms. I used to think ... there's very little difference, but, yes, there is [difference]. I used to find if someone was [fucking] me, unless they were being very liberal with lube, it would start to get uncomfortable after 10 or 15 minutes or so. But now without condoms, I just presume it's the difference between latex and skin: that I can be receptive for much longer. (Allan)

Rectal discomfort caused by the artificial materials used to make condoms made longer episodes of anal sex unpleasant for Allan. He was able to partly remedy this by using a large amount of lubricant, but even then, the sensations were not allowing him to have sex for as long as he would wish to. Allan believed that direct skin-to-skin contact provided the most optimal conditions to experience satisfying anal intercourse.

Intrusion of Fear Into the Moment

Physical sensation-related disadvantages of condom use were apparent and obvious to Allan, but he felt that the reasons he preferred not to use them were also psychological. Condoms were a symbol of a type of sex that was potentially dangerous and a reminder that intimate contact with other men may result in life-changing consequences.

There have been guys that were sort of regular fuck-friends. We both knew [them] pretty well, and talked to, and when we had sex, [sometimes it was] bareback sex. ... There was always the "what if" feeling. I'm very well aware of the mathematical, mathematics behind equations, the more people have sex, the risk goes up exponentially, and completely relying on the other person, what they are doing in the two weeks you don't see them. Are they practicing safe sex with [others] all the

time? Even if they are, there's that, has there been an accident? It's just that total reliance on someone else in the situation and the risk just goes, starts climbing rapidly. So just that knowledge is always there. (Allan)

Even though before PrEP Allan typically engaged in condomless sex infrequently and only after significant deliberation with select few regular partners, he always experienced some levels of anxiety. In his understanding, the statistical and epidemiological conditions of HIV transmission, in practice, translated to a single slip-up having possibly serious consequences. He was not fully comfortable with placing stakes this high with the regular “fuck-friends,” and even though he preferred not to use condoms and did not use them with them, the consciousness of the risk remained. Allan knew that the locus of control over this risk was beyond him when he was not using condoms, and he feared that.

Before PrEP, whenever Allan and his partners did decide not to use condoms, the anxiety affected him not only in the moment, but in the aftermath as well. A layer of guilt was added whenever he had not used condoms:

There's always anxiety about testing [for HIV], it adds, it always added a bit of anxiety, during the sex as well, and more afterwards. It always, it would always take away the feeling, “You're hot, I'd like to do that again, no I can't.” You'd rather someone say, “Yeah, that was great, I'd like to do that again sometime.” (Allan)

The fear of testing positive for HIV, even knowing that it was no longer a death sentence, was ubiquitous in Allan's life. He felt guilty when he believed he had put himself at risk and the guilt that followed prevented him from reconnecting with some of the men he had enjoyable experiences with. In result, both condom use and non-use provoked ambiguous emotional responses. Effectively, more sexually gratifying experiences (condomless sex) were associated with significant anxiety, while less gratifying encounters (sex with condoms) were less anxiety-inducing.

One of the ways in which Allan managed the process of navigating safe sex involved planning ahead and negotiating with his partners prior to the intercourse.

[Before PrEP] If I was at a [sex-on-site] venue or something like that, I would try and have a brief discussion, like, when it became obvious we were going to have sex, then I would try and have a brief discussion right at the start, saying, "this is my safety plan, this is what I do." ... I would try and sort of frame it [that] I want that serious stuff out of the way now, so we can have fun without having to worry. I'd try and do it that way, rather than you start doing something and you start wondering: when do I ask him to put on a condom? Or when do I, or how far do I let it go before my assumption turn into a request sort of thing, or vice versa. (Allan)

The quote above demonstrates how much planning and logical reasoning was involved in navigating safely around sexual encounters with men. Prior to starting PrEP, Allan was looking for ways to separate HIV from sex, and he wanted to make this distinction clear by dealing with the "serious stuff" first. Through this process, he was able to avoid part of the ambiguity and gain cognitive closure: having had the discussion first, he would not have to worry about his safety during the act.

Sexual Boundary Crossing

For Allan, one of the purposes of sex with other men was to find social connection. However, sexual contacts had metaphysical meanings and had the potential to remove Allan from the routines of daily life.

It [adhering to condoms] just takes away the spontaneity. Rather than just going with your feels, going with interpreting the other person, hard to describe it. Having sex with someone is, can be, an incredibly passionate thing, you just abandon yourself and go with your feelings and go with other person's feelings, and to suddenly stop that and ask a serious question can change the whole flow of the whole thing. (Allan)

In order to serve its metaphysical role, sex had to contain an element of spontaneity and allow full immersion into the passion between two lovers. In Allan's experience,

discussing risk and using condoms interrupted the natural progression of the sexual encounter and distorted the connection between partners.

Semen exchange, or having a partner ejaculate inside him, had some strong meanings for Allan.

I really enjoy taking someone else, and taking a load too. If someone else wants to fuck me, and I get a load: that's the icing on the cake sort of thing, and vice versa. ... I think it's more emotional than physical. I can't really feel it, there are not a lot of nerves in the arse, so not the sensation [of ejaculating inside] that I'm particularly aware of, but more pleasure. I think [it is] just more an emotional thing, just knowing that someone's shared part of themselves with me as it were. (Allan)

Allan shared that having partners ejaculate inside him, or ejaculating inside his partners, gave him the feeling of completeness of the experience (“icing on the cake”). He did not associate it with any particular physical sensation; instead it had symbolic meanings that gave him great satisfaction. Semen exchange served as a bodily metaphor of sharing part of each other with the partner on an emotional level. The metaphysical nature of sex involved breaking the connection of the subject with itself (“abandoning yourself”), and semen exchange, through blurring the lines between subjectivities (jouissance; Longstaff, 2019), clearly led Allan to accomplishing this purpose.

Guilt and Shame of Breaking Up With “Safe Sex”

Homonormative expectations requiring all “responsible” and “good” gay men to adhere to prescribed measures of safe sex exist and inform many community interactions. These norms control what is considered mainstream in the community and what becomes fringe in an attempt to sanitise the perceptions of gay sexuality as a variant of “normality” established by similarity to heteronormative matrices (Duggan, 2002). PrEP constitutes a significant change in the paradigm of what safe sex practices mean. Allan was among the first Aotearoa New Zealand PrEP users, so I was curious to

learn what the community reception had been. During one of the interviews Allan mentioned the topic of “slut-shaming,” and considering this issue had also received significant scholarly attention (e.g., Calabrese & Underhill, 2015; Dubov et al., 2018), I wanted to follow up on this:

[Interviewer: Have you ever experienced any form of slut shaming or anything like that around PrEP, personally directed at you?]

No, and I've been a little bit surprised about that, because I had been expecting it and particularly because I'd been reading it on the American Facebook group in particular, it seems to be quite, not uncommon, but in the States it was above the UK. I haven't personally experienced it, I'm sure it must exist here. I wonder if it's perhaps less of an issue here, I think probably [it] is less of an issue. I have seen a couple of online comments in New Zealand where I've thought it's probably more [of] a matter of education, rather than anything else. Nothing serious. (Allan)

Contrary to my and his own expectations, Allan had not experienced any distressing slut-shaming for PrEP use. He had known about it, because he had read reports or personal accounts coming from the United States or the United Kingdom. He mentioned some infrequent, minor comments he saw online, but he attributed them to lack of education about PrEP, rather than prejudiced or judgmental opinions. Despite not having experienced slut-shaming himself, Allan strongly suspected there was an undercurrent of prejudiced attitudes in the gay communities, but questioned how strong they were, and presumed they would be weaker than in other countries.

The lack of first-hand experience of slut-shaming led Allan to question why he had such a strong expectation that it would happen to him.

I had wondered, I sometimes wonder if it's my fear of slut-shaming that mostly has led to an expectation to be so, who knows. ... I don't know, I wonder if it's my sort of feelings about sex. Because I sometimes have Calvinistic thoughts as well, that I have to sort of rationalise. Is it just ... Calvinist in me sort of saying, "You're just a

dirty slut, shame on you”? ... For me, I wonder if it’s more an echo of the past decades of ... “I must use condoms all the time.” (Allan)

Allan felt that his expectations of anti-PrEP sentiment in the community may have been stemming from his internalised reservations towards sexuality. Calling his thoughts “Calvinistic,” he referred to the strict, conservative mores that largely rejected sexuality, and especially pleasure-oriented sexuality. He recounted the internal moral struggle (“you’re just a dirty slut, shame on you”) around the ethics of sexual expression that he linked with the newer homonormative notions of “good and responsible” homosexual men that needed to shy away from condom non-use. In a way, Allan experienced *internalised* slut-shaming from himself by incorporating the homonormative standards.

The Impact of PrEP

Between the two interviews, Allan reflected upon the changes within the community norms surrounding condom use. He felt that the impact of PrEP was very strong.

[On specific date] when it’s very much group sex [at a sex-on-site venue], 18 months ago the norm was to use condoms and I would [be] there with my socks stuffed with condoms. ... [Now] it’s unusual for someone to say they want to use condoms, if they want to use condoms, then [they] use it. But the norm there is “don’t use condoms.” (Allan)

Allan observed that within a relatively short timeframe, a group of men who used to regularly use condoms in a sex-on-site venue were now mostly engaging in condomless sex. He saw this as a tremendous change of paradigm, and he felt that he changed along with his community.

He summarised the impact PrEP had on his life using a mental exercise, when he imagined that PrEP was no longer available and that he had to stop using it.

[If I had to stop PrEP] I would be very disappointed! It has been incredible, very much so. I think it's just because, when I first came out condoms were for preventing pregnancy. So, I'm not making anyone pregnant, and then, what now seems to be almost overnight, the whole behaviour is changing and just having to go through decades just being very cautious and very considered about what I'm doing, then suddenly going on a pill. Not only has it flipped right back again but it's flipped back again at a time when I'm older! I'm probably a lot more confident than I was when I was younger, just an age-related thing, different world view, different attitude to people, and behaviour, that's the thing. I'm feeling now that when I was younger, I tended to [be a] relatively cautious person. But people who enjoyed themselves more are dead. I just feel in some ways very lucky, but now I can enjoy myself. I'm [in my sixties], I'm not 22, and I can enjoy myself without having to worry sort of going through, and to lose that again would be very, very difficult. (Allan)

In this powerful quote Allan positioned the arrival of PrEP in his own biography. The changes he experienced were truly transformative, and he felt grateful for them. He felt that because he went through decades of caution and fear, he was prepared to appreciate the changes brought upon by PrEP that restored some aspects of the pre-AIDS era and, in a way, brought him a second youth. Allan felt that he had survived the advent of the epidemic because he was so cautious in his youth, while others, perhaps more sexually adventurous men, had not. Allan also believed he matured emotionally. He became more confident and he felt that PrEP was even more appropriate for the older version of himself, as he could appreciate it more. Even only imagining letting go of the changes brought upon by PrEP was a difficult experience, as he was confident that PrEP improved his life greatly.

Discussion

This chapter focused on the account of Allan whose generational experience led to some unique insights into the historic and social contexts in which PrEP use may occur in Aotearoa New Zealand.

For Allan, the arrival of PrEP marked the beginning of a new era in gay men's sexual health and well-being, that for the very first time combined the joy of the pre-AIDS sexual experience with social advancements of gay rights. Allan clearly remembered the time when gay men did not use condoms at all, as these were reserved for preventing unwanted pregnancy. The AIDS epidemic, however, caused a substantial change in practices of the gay community and led Allan to start using condoms consistently. Of course, the need to use condoms and the meanings they entailed had an impact on Allan's relationships and the feelings of connectedness with other men. Physical intimacy with other men was contaminated by fear of transmission of a deadly virus, and the feelings of doubt, mistrust, and insecurity started to accompany his encounters.

The introduction of PrEP had a profound transformative effect on Allan's sexual well-being. He was able to, once again, experience the *unlimited* (Dean, 2009) joy and pleasure from connecting with other men and experiencing greater intimacy. Discontinuing condom use enabled him to realise that sexual connectedness was one of the ways of achieving meaningful social connection with other human beings. He noticed that PrEP gave him the confidence to entirely stop serosorting his partners: a practice that he saw as exclusionary and difficult to justify from an ethical standpoint. One of the unexpected benefits of PrEP was that it improved the quality of his primary partnership by allowing both partners to be more adventurous and relaxed about sexual expression both within and outside of their relationship. The new perspective allowed Allan to discover how deeply his sexual experiences were earlier affected by the fear of HIV, which was now removed. Sex with other men used to be associated with feelings of guilt and shame, and these extended beyond the given encounter. PrEP removed these as well, replacing them with pure pleasure and recovered an important function of

sexual experience: transcending the boundaries of individuality in connection with a partner. Allan was happy that he was able to see these changes, and he felt he was able to fully appreciate them, because of his rich life experience. He saw all the effects of PrEP as profound, and he considered them to be life changing.

Generational Trauma

The impact of the AIDS crisis on the lives and identity construction of gay men who lived through it was profound. Some scholars concluded that the social effects of HIV were so significant that they led to a differentiation of specific generational identities in gay men (e.g., Bower et al., 2019; Gardiner, 2018; Halkitis, 2014, 2019; Hammack et al., 2018). The expected and observed intergenerational differences between the study participants were among the reasons I decided to analyse Allan's account separately, to assure its uniqueness was acknowledged.

The theoretical assumptions underpinning the generational analysis stem largely from the life course theory (Elder et al., 2003). In order to define the *generation* (often used interchangeably with *cohort*), important *cohort-defining events* must be identified that occur during the *critical periods*, typically: puberty and emerging adulthood (Hammack et al., 2018). Various attempts have been made to define these critical events and their associated generations, and for gay male communities they typically centred around gay rights and HIV. Identification of these constituting moments from the perspective of their contemporary observants as they unfold may be extremely difficult. However, some authors proposed that PrEP may be one such event, as it dramatically changes the notion of gay sex as a source of contagion (Hammack et al., 2018). Of course, within a given generation, there may be diverse reactions and personal beliefs developing in response to the critical events, and the extents to which people are affected may vary greatly. In this way, the life course theory emphasises the intragenerational similarity and intergenerational differences, while paying less attention to individual differences (Elder et al., 2003).

Relying on the time when gay men came of age in the United States, Halkitis (2019) proposed three distinct generations with their approximately defined yearly brackets. The Stonewall Generation constituted a broad group of men who reached adolescence from late 1950s to early 1970s, the AIDS Generation encompassed those who came of age from late 1970s to early 1990s, while those reaching adulthood around 2000s and later were labelled the Queer Generation. These labels refer to the critical and defining moments or concepts of gay men's lives. The Stonewall Generation men almost universally lived through their young adulthood in the closet, and the first struggles for civil rights and social acceptance were their most important historic moment. Later, the AIDS Generation inherited and further built upon some significant social improvements owing to the activism of their predecessors and their most impactful and life-defining moment was the AIDS crisis with its biological and social trauma (Halkitis, 2014).

Another generational division was proposed by Hammack et al. (2018), and, similarly to Halkitis' classification, relies on the cohort-defining events, with strong emphasis on impacts of AIDS. The authors distinguished five cohorts, labelling them by referencing to the critical notions contemporary to the time of coming of age. These generations were (Hammack et al., 2018):

- Sickness Generation: came of age when same-sex desire was classified as an illness, born in the 1930s;
- Liberation Generation: experienced early adulthood when gay rights movement was gaining momentum and their social and romantic networks were strongly impacted by AIDS, born in the 1940s;
- AIDS-1 Generation: experienced early adulthood at the height of AIDS crisis and experienced loss of friends and lovers, born in 1950s and 1960s;
- AIDS-2 Generation: experienced fewer personal losses due to AIDS, but gay sex was equated with death, born in 1970s and 1980s;
- Equality Generation: experienced significant advancements in recognition and acceptance of gay men, along with establishment of effective HIV treatments, born in the 1990s.

It is worth noting, that even though these generations are defined in the US contexts, the cohort-defining moments are not unique to the American experience, but can be, to a certain extent, extrapolated to the Aotearoa New Zealand context. The Stonewall Riots, for example, and their aftermaths were a sociological phenomenon that rippled through many developed nations, even though the legal and social contexts may have been substantially different, and additional important cohort-defining events could be more relevant locally.

In many Commonwealth countries, including Aotearoa New Zealand, many legal and cultural frames of reference that may be of relevance when attempting any periodisation of gay rights advancement are situated in the United Kingdom. An important milestone in the law reform both in the United Kingdom and, later, in Aotearoa New Zealand (Bennett, 2009) was the release of 1957 *Report of the Departmental Committee on Homosexual Offences and Prostitution* (better known as *Wolfenden Report*) calling for decriminalisation of consensual and private homosexual activity. It influenced the legal systems in many Commonwealth jurisdictions.² The recommendations from the Report were, however, implemented at different pace in different countries (Kirby, 2008), with England and Wales decriminalising homosexuality first: in 1967, a decade after the *Report* was published.

The New Zealand Homosexual Law Reform Act of 1986 and its preceding community activism encouraged by legal changes in other countries following the release of the *Wolfenden Report* (Bennett, 2009) were likely the local cohort-defining moment. The legal and political changes also coincided with the trauma of AIDS. Importantly, the community organisations that were first created to advocate for the rights of gay men, such as National Gay Rights Coalition, or community outlets dedicated to gay rights, like *Pink Triangle* were the ones that provided the first social response and focused on the issues of HIV prevention (Lindberg & McMorland, 1996). The National Gay Rights Coalition that discontinued its activity in 1981 was specifically

² Despite significant progress in many jurisdictions, as of 2018, 37 out of 57 Commonwealth countries continued to criminalise homosexuality (BBC, 2018).

reactivated in 1983 to provide advocacy and community support and education around HIV/AIDS (Parkinson & Hughes, 1987). Allan's story clearly illustrated this changing landscape, as for him, the early AIDS activism he was involved in naturally evolved from his earlier participation in the gay rights movement, reflecting the wider social processes.

The generational trauma of the AIDS crisis affected the men of Allan's age cohort deeply (Hammack et al., 2018). Many men experienced fear of death, loss of loved ones, increasing stigma, along with feelings of guilt and shame (Halkitis, 2014). However, this trauma also produced some productive and positive perspectives in its survivors. Bower et al. (2019) discovered that building upon their past experiences, LGBTQ older adults found meaning in sharing their learnt resilience with younger generations and hoped to leave behind their legacy of facing the social stigma together and adapting to new threats in order to preserve life. The participants of Bower's study felt the need to memorialise their loved ones and leave behind their legacy. These narratives, labelled jointly as generativity narratives, were seen as providing deeper meaning to participants in the face of social stigma and personal trauma (Bower et al., 2019). Such understandings have been found to contribute to resilience and successful ageing (Emlet & Harris, 2018).

The responses to PrEP when comparing the AIDS-1 Generation with younger groups do not present a clear-cut picture. However – contrary to some popular opinions about the group's conservativeness – in an American study, older men tended to share positive views on PrEP with the youngest generations. They especially emphasised the HIV spread-control benefits of PrEP, but appreciated less its anxiety-reducing and sex-enhancing qualities when compared to younger groups. (Hammack et al., 2019).

Erotic Habitus of Pre-AIDS and Post-AIDS Eras

Gay men have formed unique cultural practices around expressing, sharing, and manifesting sexuality. They were strongly influenced, if not transformed, by the biological reality and threat of AIDS, which resulted in radical changes in sexual

practices (Crossley, 2004), activism and advocacy (Hindman, 2019), and identity formation (Grierson & Smith, 2005).

In the present study, Allan was the only participant who witnessed these changes first-hand. Importantly, he was the only participant who had memories from the time when condoms were not used by gay men, as there were no known life-threatening sexually transmitted infections.

Crossley (2004) argues that the notions of *resistance* and *transgression* form an important part of gay men's social and individual habitus, since the early days of the liberation movement. The author employs Bourdieu's (1977) notion of habitus emphasising the subconscious "embodied dispositions" that govern making sense of the world and social practices of individuals and larger social units. As was explained in Chapter Two, the notion of habitus emphasises the social and historical forces, instead of only internal motivations. In analysing Allan's account, I was aware of the challenges in analysing habitus from the perspective of voiced intentions and motivations. However, the concept of habitus successfully deals with the problem of intentionality of social practices in explaining the relative constancy of the social order(s):

*Each agent, wittingly or unwittingly, willy nilly, is a producer and reproducer of objective meaning. Because his actions and works are the product of a **modus operandi** of which he is not the producer and has no conscious mastery, they contain an "objective intention," as the Scholastics put it, which always outruns his conscious intentions. (Bourdieu, 1977, p. 79)*

Critically, one is not aware of the habitus, even though they follow its rules and praxis closely. Therefore, in its teleology, habitus leads to a certain outcome: to reproduction of an intra-group status quo, but without conscious purposefulness. It is important to remember that the concept of habitus does not need to be strictly deterministic and may allow for a degree of deliberate change within the existing structures (Yang, 2014).

Crossley (2007) argues that gay men's sexual habitus is more complex than some of the simplistic public health models would picture it, and is intrinsically connected to the notions of transgression, resistance, and liberation through sexuality. Because habitus reproduces itself and maintains the intragroup status quo, these notions have not disappeared with the arrival of AIDS. Rofes (1998) provides an interesting response to questions surrounding the reasons why gay men with good knowledge of HIV/AIDS at times engage in some riskier sex practices:

Many gay men consider sex to be an activity of central value to our identities and lives. We may see it as a survival strategy that makes living satisfying and worthwhile. This does not mean we are obsessed with sex or have no interests or activities besides sex. It means we value the enactment of our desires and will not always give them up in a grand gesture of sacrifice to the epidemic. (Rofes, 1998, p. 225)

Allan's story speaks at length to the notions of importance of experiencing sex to him and men of his generation. Sex meant connection, intimacy, social inclusion, belonging to the community, regardless of whether it was with a stable long-term partner, or during a casual encounter. The rediscovery of "original" generational meanings of gay sex, later obstructed and *reconstructed* by the AIDS crisis and its aftermath, was only possible to men who had experienced it earlier. After starting PrEP, the ease with which Allan was able to peel away "the layers" of shame and guilt associated with expressing his sexuality to retrieve the original meanings of sex was possible because of the embodied habitus of enacting the deeper social meanings of sex, or, as Bourdieu put it, his *modus operandi*.

Contamination of Gay Men's Bodies and Shame

It has been argued that the AIDS crisis effectively "de-sexed" the gay liberation movement and its culture in the West (Hindman, 2019). The prevailing narrative informs that the emergence of a serious biological threat and the menace of the early epidemic

creeping out of its initial gay “pockets” put pressure on the gay movements to restrain the march towards greater sexual liberation and start self-policing the dangerous sexual practices of its members (Hindman, 2019). The perfect storm for these processes to develop occurred in connection with a wider phenomenon of a largely consumerist drive to “normal” social participation (Duggan, 2002) and “de-queering” in order to be granted “a place at the table” (Bawer, 1993) in the mainstream political landscape.

The sanitisation of gay practices and bodies within the gay communities may be a response to their earlier biological and symbolic contamination by HIV.³ Allan’s story reflected these narratives well, as he spoke about the mistrust, fear, and reservations he had been experiencing prior to the use of PrEP. In his account, PrEP purified the male body, which was no longer seen as a threat, but rather an object of desire and a source of pleasure. As discussed earlier, and robustly theorised (e.g., Dean, 2009; Garcia, 2013; Holmes & Warner, 2005) the allure of bareback sex (as opposed to bug chasing) lies not in the possibility of contamination, but rather fantasies about insemination, creation, reproduction, and connection through symbolic kinship. Now, with PrEP, these fantasies can be successfully, and safely, recovered for those who remembered the pre-AIDS era.

During his interviews, Allan raised numerous times the issue of shame and guilt associated with condomless sex with multiple partners. He attributed these feelings to the “Calvinistic” undercurrent in the postcolonial Aotearoa culture, but when I later listened to the recordings and re-read the transcripts, it surprised me how quickly starting using PrEP removed these feelings from his experience. If it was indeed only the prevailing puritanism of mainstream culture to be blamed, why would PrEP be so effective at alleviating these negative feelings? Rofes (1998) wrote, “I believe increasing evidence that many gay men occasionally fuck without condoms taps into an immense

³ The proliferation of the term “clean” in the gay community to denote HIV-negative individuals with its implicit antonym of “dirty” provides a linguistic key to making sense of the symbolic representations of HIV.

pool of sexual shame long lurking just under the surface of gay men's communities" (p. 157).

The history of HIV prevention discourses involved constructing the narrative of the opposition between the relative acceptability and safety of sanitised sex and the terror of transgressing its boundaries. At the same time, the inherently transgressive, defiant nature of same-sex desire was ignored, despite it being strongly implicated in the construction of gay identity (Crossley, 2002). With the privatisation and domestication of gay experience to better suit the assimilationist project (e.g., gay marriage), problematic sexual practices were removed from sight and cast out to the margins of gay culture, like the BDSM communities (Weiss, 2008). To earn the social perception of gay normalcy, the newly emerged mainstreamed gay culture used shame to abject and police the practices and agents who did not fit into the categories of rationality and social desirability (Duggan, 2002; Hindman, 2019; Weiss, 2008). The tension between these two contradictory aspects of the new gay habitus (transgression and homonormative assimilation), manifested with the ambivalence around condomless sex, where it was both desired and despised.

In Allan's story, PrEP was instrumental in reconciling these opposing elements of the gay habitus. While condomless sex was still, at a deeper level, seen as transgressive of the symbolic boundaries and a forbidden fruit, PrEP allowed it to be also a reasonable and safer alternative to the imperative of consistent condom use. It removed the symbolic boundary established by condoms and enabled Allan to have his sexual desire actualised to completion. To repeat his own words: "if someone else wants to fuck me, and I get a load: that's the icing on the cake."

Mending the Broken Community

Another source of feelings of guilt Allan was experiencing prior to PrEP was serosorting that he sometimes employed as a supplementary method of HIV prevention. Because of his earlier personal losses, along with witnessing profound isolation of HIV-

positive members of his community in the early days of the AIDS crisis, he considered the avoidance of PLHIV as sexual partners a discriminatory and ethically dubious practice. Despite this, he felt compelled to serosort because of fear. The construction of serodivide does not have to be a malicious or deliberate practice for its community-dividing effects to become invariably destructive: Allan acknowledged it and observed that PrEP finally afforded him the confidence to discontinue the practice.

There is research supporting the notion that PrEP may facilitate bridging the serodivide (Koester et al., 2018), a fact appreciated by the members of the community of PLHIV (e.g., NAPWHA, 2019). In fact, PrEP may allow an HIV-status-neutral partner selection, and Canadian data (Wang et al., 2019) suggests that gay PrEP users select partners from pools of HIV-positive and HIV-negative men at rates roughly proportionate to their numbers in the community; such pattern contrasting with practices of PrEP non-users, who often serosort.

In summary, from Allan's perspective, the serodivide-bridging effect of PrEP achieved more than simply expand the pool of possible sexual partners. It mended the community that was broken by AIDS crisis, helped to include men living with HIV among those who belonged intimately, and enabled unfettered connection with men of any HIV-status.

Conclusion

The manifestations of the erotic habitus and the generational identity implications of different stages of social and biomedical history of AIDS were explored through analysis of Allan's account. The arrival of PrEP marked the beginning of a qualitatively different era and can be read from the historic and generational angle to reveal how its proliferation formed a loop undoing some of the psychological and community impacts of the AIDS crisis and its aftermath.

Bourdieu's theory of habitus provided useful lens to understanding how the conflicting, yet self-reproducing practices could motivate and be motivated by embodied and socially constructed dispositions.

The meanings of condomless sex for Allan, as a representative of a certain generation, were deeper than mechanistically understood pursuit of pleasure and entailed seeking connection, transcending everyday experience, and transgressing earlier boundaries as a way of achieving social liberation, mending the broken community, and removing the learnt feelings of shame.

Chapter Eight: Beyond Prevention and Pleasure

As I tried to demonstrate through analysing Allan's story, the meanings of PrEP are complex and entrenched in the generational contexts that shaped the trajectories of sexual histories of its users. Because PrEP is indicated for and used by men who do at times engage in condomless sex, analysis of its effects cannot be divorced from inquiry into the meanings of condomless sex.

In this somewhat lengthy chapter, I will further examine the ways that the study participants understood and performed their sexuality before and after starting using PrEP, and what functions it served in making sense of their own sexuality and sexual practices. I will focus on the boundary between the public-health-constructed and abjected idea of CAI, from the perspective of juxtaposition to corporeally and emotionally experienced condomless (natural, bareback, raw) sex.

The anxieties situated around HIV and STI transmission, and the associated public health messaging are constantly influencing the erotic habitus of gay men (Crossley, 2004). The social norms regulate what can constitute the sexual norm, and what will be deemed extreme. Furthermore, beyond the boundary of the general societal mores, gay communities also construct norms that surround and regulate gay men's sexual practices, distinguishing between the acceptable and the excessive. The ongoing process of increasing inclusion of gay sexuality into the mainstream, has resulted in blurring of the hetero-homo boundary and overlapping of the sexual norms; however, at the expense of marginalising less orthodox practices and segments of the gay communities (Ashford, 2015).

Numerous international studies reported the benefits of PrEP in alleviating fear of HIV (e.g., Whitfield et al., 2019). In fact, current Australasian guidelines support the provision of PrEP to men who experience significant distress associated with the risk of HIV transmission, even in the absence of objectively defined high risk (ASHM, 2019).

This led some medical experts to raise concerns that PrEP becomes an “anti-anxiety pill,” as it had already been painted as party pill, or bareback-pill (Mowlabocus, 2019). This ethical argument can be addressed from two positions: medical and critical. The medical approach may provide a simple answer that, if the levels of anxiety are distressing, and can be greatly reduced by provision of patient-requested and well-tolerated agent, then there is clear utility for initiating such treatment from the perspective of quality of life. The further medical concerns will be, however, focusing around the *unnecessary* medical treatment. The critical perspective, however, provides a lens to interrogate some of the assumptions behind “provision of anti-anxiety pill,” by examining the power relationships between the medical providers and PrEP users (Schubert, 2019). In such viewpoint, the biomedical establishment (pharmaceutical industry, healthcare providers, and government or private funders) maintains control of the biochemical agents, such as PrEP, and retains the full right to make decisions about the valid applications for their use, while at the same time classifying the potential recipients into eligible or non-eligible. The ethical question is who and for what reason is judging the appropriateness of a given agent application. For application of many pharmaceutical agents, and in particular for these relating to human sexuality, for example, phosphodiesterase-5 inhibitors (Viagra), contraceptive agents, testosterone, and other sex hormones the lines between treating disease and maintaining subjective autonomy are blurred. Some queer theorists argued that through appropriating and self-managing of the use of medication, individuals may retain their self-autonomy and free themselves from social control (Preciado, 2017).

The public health approach positions the benefits of preventative measures in the context of maintaining health, including reducing the burden of STIs other than HIV. The interactions with PrEP and changes in the sexual practices that follow lead to shifts in risk of acquisition of other STIs. This is a well appreciated factor in considering the impacts of PrEP, noted among physicians worldwide (e.g., Kolodziej et al., 2016) and researchers (Quaife et al., 2019), however little is known about how Aotearoa New Zealand PrEP users make meaning of this potential risk, and how they may navigate around this.

Because PrEP is intrinsically linked to condomless sex, which in turn may increase the risk of acquisition of STIs, this chapter aims to draw connections between experiencing the effects of PrEP, and meanings of condomless sex, without losing sight of STI risk elevation. However, the central themes of this chapter revolve around condomless sex, as contrasted to sex with condoms, and the erotic habitus as experienced and enacted by PrEP users.

It is worth noting that among the study participants, some decided to stop using condoms for the most part of their sexual encounters, while others continued condom use to varying degrees, under different circumstances. One of the goals of the analysis in this chapter is to try to understand the motivations that led participants to make these decisions.

I will analyse the accounts of men younger than Allan, belonging to generations that were aware of HIV since the early formative years of their gay identities. Before PrEP, they have not experienced condomless sex that would be free from the risk of HIV, and for some, in their formative years, condomless sex effectively meant the risk of death (Halkitis, 2019). I assumed that PrEP had the power to challenge these notions, and I wanted to understand how the participants made meanings of the changing biological and social contexts of their sexual practices.

Sexual Sovereignty, Vulnerability, and Liberation

Kevin was among the study participants who discontinued using condoms in most sexual encounters. For him, PrEP provided a way to experience sexual freedom and, at the same time, keep himself and his long-term partner safe:

Me and my partner are in an open relationship and so it was about protection, not only for myself. Also, I like the idea of freedom when it came to sex and kind of [feeling] liberated. ... It's about not having the anxiety around protection. It's about

being more free with your sexuality as well, taking away some of the concerns that you have when you engage in anal sex. (Kevin)

Kevin shared that prior to using PrEP, sexual encounters with other men were associated with anxiety. He found these feelings restraining, as he felt he was not able to fully enjoy anal sex. Now, with PrEP, he was able to take full control of both his sexual pleasure and his and his partner's safety.

Retaining full agency over his safety was so important for Kevin, because, in the past, he had experienced situations when he felt vulnerable to his sexual partners' actions he had not consented to. One such example was when his partners removed condoms during penetration, without his prior approval:

And also, I guess, that risk of stealthing as well, of guys putting on a condom and then taking it off halfway through sex, that's always been a thing, that's always concerned me. ... So, I would be having sex, and before any penetration I would say, "we need to use a condom" and that person would be like, "yeah, cool, no worries." And then halfway through you might stop and ask, "where has that condom gone?" and he would say, "oh well, it broke, so I took it off." And for me, it's just, it enters into that territory of not being consensual sex. Because it's not fully informed, and that's happened to me a couple of times, so I guess that's another reason as to why to use PrEP. I have that control and power over that situation, and I can have my own sexual autonomy as well. (Kevin)

Stealthing is a practice of removing a condom while having penetrative sex, without the knowledge or consent of one's sexual partner (Brotsky, 2017). It is not rare: 19% of MSM patients of Melbourne sexual health clinic report having the history of falling victim to stealthing (Latimer et al., 2018). Kevin experienced it more than once, and it left him feeling powerless and vulnerable. With PrEP, he felt he was no longer at risk of stealthing, and he was able to maintain full control of his sexual safety, regardless of whether his partners were taking any safety precautions or not.

Apart from the infrequent and quite extreme contexts of stealthing, condom use or non-use was typically something that was decided by Kevin and his partners prior to or at the time of having sex. However, Kevin felt that it was not a decision that took place just between the two partners, but rather in the context of established norms of the gay community and public health messaging. Since the prevailing norms strongly stipulated consistent condom use, Kevin felt condom non-use was a form of political resistance.

I think there's also some sort of rebellion against having to use a condom. ... You know, condom use is so political! And you're being told so often to use them, and you're being policed all the time, and shamed if you don't.

[Interviewer: By who?]

I'd say the wider gay community. I think a lot of those adverts that are being put out can be quite shaming. So, I think that is that side of me that likes to rebel against that. And I think it ties to that freedom, as well of being able to do what I want sexually. (Kevin)

Kevin shared how sex with condoms has become the only acceptable form of sexual contact within the gay community. As a consequence, condomless sex has become associated with shame, and that was reinforced by public health messaging surrounding sexual health. To retain his sense of sexual sovereignty, Kevin felt he needed to rebel against these externally enforced norms by not using condoms, which gave him a feeling of freedom.

After PrEP had enabled condomless sex, Kevin was able to interrogate the praxis of exchanging bodily fluids, and what was associated with it.

Yeah, I think I do enjoy that [men cumming inside me]. I think it is, I do get pleasure from that, I think it's hot, it's super sexy and I think part of that is the freedom to do that without the fear of "now I got AIDS," but then that's kind of, that's when my joy comes out of it. It's the freedom to do that without the shame ... being locked into us. ... I don't know if it's the act of cumming inside me that I find joyful, but the freedom that comes with that. (Kevin)

As discussed earlier, condomless sex is often construed as a lapse in judgment, or the pursuit of improved sensory pleasure (e.g., Goodroad et al., 2000). For Kevin, however, the act of internal ejaculation conveyed different meanings. It symbolised the freedom from the fear of contagion and stigma associated with it. In earlier chapter, Allan shared that for him, internal ejaculation was the “icing on the cake” (see p. 143), and Kevin’s narrative can be read in a similar vein. For both Allan and Kevin, cumming inside was the materialised and embodied evidence of the removal of fear and shame that had been embedded in their sexual practices.

In contrast to his personal experiences, Kevin believed that the community sexual ethics have equated condomless sex with wrongdoing:

I think a lot of it is about the political side of condom use, and if you don't use condoms, you're a bad person, which I just think is wrong. (Kevin)

Kevin disagreed with the positioning of condom use in moral, homonormative (political) terms. He further elaborated that gay men used condoms, because it was established as the only acceptable option through a normative process:

Condom is just a thing you have to do. And you do it out of indoctrination, you do it out of a whole lot of stuff. Blind trust – that it is the way to go. And obviously, scientifically it is 100% backed up. But to not have to use it, it just feels new, it just feels like a new part of experiencing sexuality. (Kevin)

Kevin labelled the proliferation of condom use imperative among gay men as an effect of “indoctrination.” Importantly, he was not the only study participant who used this term to describe various aspects of condom education (e.g.; see p. 197). Kevin made it clear that he was not questioning condom effectiveness or the scientific foundations supporting its use. However, he felt that condom use was not motivated by understanding the benefits of barrier prevention, but rather by an existence of unspoken set of rules and abjection of condom non-use and non-users. The emotional burden associated with transgressing this unchallenged normativity was lifted with the arrival of PrEP that enabled safe condomless sex, and thus reinforced sexual freedom. These

feelings of liberation had not been a part of Kevin's experience ever before, because, unlike men from older generations, he was subjected to condom "indoctrination" from his earliest formative years.

Kevin attributed externally the source of internalised condom norms among gay men and believed that condom use was normalised in a forceful manner by gay community and public health agencies. The advertising that was part of the process of "indoctrination" contained elements that made Kevin feel alienated:

I think you can have just a normal looking guy [in condom advertising]. And by that, I mean average Kiwi bloke. I don't mean hairless, waxed, blond, blue-eyed supermodel, those twinks, so, it feels very elitist the way that condoms are used in that. I just find that image very off-putting and I guess it can cause harm in the way that gay men see their bodies, so I guess that the whole condom movement is quite problematic, and I've never identified with that. (Kevin)

Kevin shared how he was unable to identify with the idealised bodies employed to represent and advertise condom use. He wished the images were more representative of more ordinary shapes and sizes of male physiques. Instead, in the process of conveying safe sex messaging, condom promoters were promoting unattainable beauty standards and damaged gay men's body image. Kevin felt these aspects of safe sex messaging were distancing him from what he called the "condom movement," and he needed to resist it. The same transgressive habitus that earlier predisposed Kevin's senior Allan to question homonormative norms of sanitised sexual safety, manifested itself in Kevin's rebellion against the monolithic aesthetics of pre-PrEP HIV prevention messaging.

The issues pertaining to condom promotion and community norms around their use were akin to a larger problem of strict policing of practices and ways of expression in the gay communities:

We [gay men] police each other. Even in terms of how feminine you are as a gay man, some say, "oh, you just need to butch up, man up a bit. Because you're not a good

gay." I work [redacted; historically male-dominated work environment]. The way that macho gays would treat more feminine gays is horrible. We all police each other! And how could you not do it? Because we've been raised in a society where we frowned upon gay men from young age. (Kevin)

Kevin drew a connection between strict condom surveillance and policing the gendered ways of self-expression within the gay communities. He shared that men with more masculine gender expression were often belittling or even bullying men with more feminine gender presentations. He felt that this was the effect of internalised homophobia stemming from heteronormativity, where during social development, gay men learnt that non-adherence to strict social gender roles was somehow wrong. Kevin invoked a notion of "a good gay," referring to the idealised ways in which gay men were supposed to act, look, and express themselves in order to attain community approval. Overall, a "good gay" would be someone with manly gender expression, masculine and attractive physique, and who used condoms regularly. That homonormative standard that notably included adherence to a code of safe sex practices, was difficult to attain.

Moreover, according to Kevin, the different ways in which users accessed PrEP could also signal their adherence or non-adherence to the homonormative ideal. It became apparent when, between the interviews, Kevin switched from the generic self-imported PrEP pills, to state funded branded product:

Yeah, well, my situation has changed around PrEP. I got told by the doctor that the funding got approved for me to get Truvada. ...

I was thinking I wouldn't tell people that I was on Truvada because that has an association of being high-risk. ... I thought maybe I would just not tell people that I was on Truvada and that I just import it [the generic], because that might be more palatable or less stigmatising. ...

I think because most people don't qualify; to qualify most people have to [have] engaged in most risky sexual behaviours, that I'm considered a risky person when it comes to sex. So, which I don't consider myself to be risky, but other people's

perceptions and judgments of that, might see it as risky, [that] I'm just a slut or whatever it might be. (Kevin)

Kevin was concerned about the community perceptions of accessing publicly funded PrEP that could equate qualifying for it with sexual “high-risk.” He was afraid that if he shared the fact that he was using branded Truvada with other men, they could consider him a “slut.” Kevin believed it was common knowledge among MSM that only “high-risk” men were eligible to receive branded PrEP, making its use a proxy for high-risk behaviour or promiscuity. He wanted to avoid the stigma associated with the assumption of being a “risky person” and was considering telling people he was still using the generic version, which would not carry such burden of social stigma. At the same time, Kevin believed that most gay men would not qualify for the funded version, which, as a consequence, positioned his sexual practices off from the mainstream of community practices.

Kevin elaborated on the feelings invoked by the two modes of accessing PrEP he used:

I guess the Truvada, it makes me feel vulnerable, whereas the generic made me feel empowered. I was an active agent in that, whereas [with] the Truvada the government has the power over me in terms of whether I can or can't get that drug, whereas before it was up to me, it was my choice. (Kevin)

The relative difficulty in accessing generic PrEP prior to public subsidy, and the largely self-driven process of obtaining it reinforced Kevin’s sense of empowerment and sovereignty. With the approval of public funding for Kevin’s PrEP, and the process occurred with little of his direct involvement, these feelings diminished. Now, he felt like a passive object of the governmental health policy, as contrasted with his previous self-perception of being an active agent in pursuit of personal and sexual freedom. Kevin suggested that by providing him with PrEP, the biopolitical regime inadvertently sent him a signal that his sexual wellbeing and liberties were now subjected to its whims.

Kevin's story told of a tension between maintaining one's agency in the context of strong homonormative expectations. Resisting the prevailing narratives that were sometimes relentlessly imposed, from both the mainstream society and Kevin's own community was of great value to him. PrEP had a strong role in enabling the realisation of the various social pressures Kevin experienced, and it also allowed him to critically interrogate his own and his community's practices. With the removal of risk of HIV infection, Kevin recovered what he felt was the reality of the social practice of condom use. It was no longer a simple prophylactic measure with obvious and rationally perceived benefits, but a ritualised process whose objective was to reproduce the homonormative ideal of a "good gay." This ideal was difficult to attain, and Kevin could see some of its aspects as problematic and unhealthy. Resisting the pursuit of this social ideal, and condom use along with it while using PrEP, became his way of establishing autonomy and healthy relationship with his own body, other men, and his sexual desire.

Testing and Pushing Sexual Boundaries

Similar to Kevin's account, one of the central points of Sam's story was the idea of PrEP offering liberational potential to its users. However, an additional facet of this liberation was to enable engaging in sexual practices that were previously off limits for Sam:

Because, honestly, I don't enjoy condommed sex very much. I'm one of the people that never feel very much through a condom, and so, I couldn't top very much through my first years having sex, because I wouldn't stay hard once I put the condom on. So, that feeling was quite liberating, that was a big appeal for me. I was very drawn to the idea that I could have condomless sex without being scared of HIV transmission. (Sam)

Before starting PrEP, the sensation-diminishing properties of condoms were making it challenging for Sam to assume the insertive role during anal sex with his partners. The loss of sensation was leading to erectile difficulties, but this was remedied

by discontinuing condom use after starting to use PrEP. For Sam, these changes were “liberating” as they allowed him to practice the sexual techniques he always wanted to practice, and at the same time it “liberated” him from the consistent fear of contracting HIV that was part of his experience.

It is important to understand the psychological contexts in which Sam was embodying his sexual desires. That context was defined on a generational level by anxieties surrounding the risk of HIV.

There was always fear. The entirety of my sexual life, it's been understanding that I could contract a deadly disease from whoever I was having sex with. And that was just taken for granted, that's the thing. On PrEP I can have sex with someone and not worry about contracting HIV. As before, I always worried at the back of my mind. (Sam)

The risk of HIV became a fact of life for gay men before Sam even started to be sexually active, so, consequently, it was always something he had to consider when engaging in sex with other men. The men who were to become his sexual partners were not seen only as sexual connections, but also a potential threat and a source of contagion. Before PrEP, Sam did not reflect on it, as this was the only reality he had ever known, yet he had been experiencing fear on an almost constant basis.

Sam shared a powerful reflection with me, that illustrated to what extent the fear of contracting HIV had been affecting him before he started using PrEP:

I wasn't really concerned about HIV killing me, I was more concerned about having to deal with it for the rest of my life. Having to take medication, having to communicate to every partner whether there was a risk of transmission, that I had it. ... I would see there were moments when I was young when I was flirting with the idea of stopping to worry about it and just having the kind of sex that I wanted to have, which was condomless anonymous sex, and if I got HIV I know that it's something I could live with; it's annoying but it might be worth the benefit of having that kind of sex that I wanted to have for the rest of my life. And this was when I was

younger, and much hornier, and a little bit stupid. I never got close to executing on that, I never would, but it was definitely a thought that was in my mind. (Sam)

Sam described his fantasy of contracting HIV for the sake of no longer worrying about it as juvenile and admitted that he had never genuinely sought to realise it. However, I understood this perspective was only possible from within a generational perspective. From this angle, HIV was not seen as a deadly disease, but its devastating effects were mostly attributed to the social stigma. Importantly, in this context, the psychological effects of the fear of HIV were possibly worse than contracting the infection; something hard to imagine for many men who suffered personal losses during the earlier days of AIDS history (see Chapter Seven). From Sam's perspective, the fear of HIV effectively prevented him from engaging in the type of sex that he sought: anonymous and condomless.

During the interviews, I was aware that it could be difficult for participants to put their sexual desires in words, and even more so, to try to explain their appeal to me, a stranger. Sam clearly identified that anonymous and condomless sex was something that he fantasised about and enjoyed doing, so I asked him to try to explain to me what personal meanings these experiences had for him:

For me, I do like the idea of cum and I like the idea of having multiple people cumming into someone over the course of a session, that's the thing that gets me off. And it's something that I've been fantasising for a long time but I haven't been able to do. So, it was inaccessible fantasy for me until I found PrEP, and I was able to do it without the fear of HIV transmission. (Sam)

Sam shared that the ejaculate and the act of ejaculation (particularly in group sex contexts) were central notions in his desire surrounding condomless and anonymous sex. Engaging with these practices was, however, impossible for him before PrEP, because of the high risk of HIV transmission involved.

There were many aspects of internal ejaculation and condomless sex that Sam enjoyed. They were relating to different sexual contexts, some of which involved more personal relationships with other men:

I feel having a barrier there [with condoms], that gives me a bit of a mental barrier in terms of connecting with the other person. Yeah, there is a part of me that feels like if I'm having sex with a condom, I'm actually not really touching them. ...

It's a very personal thing [cumming inside], it's very much about that personal connection. (Sam)

Like many other participants, Sam saw the condoms as a physical and symbolic barrier to connecting with other men. Despite the physical thinness of condoms, Sam believed they formed an impenetrable barrier not only to HIV, but to *real* touch. In a similar vein, internal ejaculation's role was to symbolically seal the connection between sexual partners and signal that the relationship between them was meaningful and personal.

The intimacy-building functions applied to the significant relationships in Sam's life. Different roles of sharing bodily fluids were apparent when engaging in casual and anonymous contacts:

I like that idea of someone taking multiple loads because of that idea of being used. There's a bit of BDSM in my life as well, so part of it comes from an interplay of dominance and submission and having a submissive [man] who is submitting to multiple doms at once. it's a turn on for me. And cum itself, part of it would be the taboo of it originally. It's kinda interesting, 'cause for a long time, bareback sex would be something that I wouldn't have. Or only in very specific circumstances, or that it was always a bit of a forbidden thing that I wasn't allowed to do. And because of that it probably made its way to one of my major fantasies. (Sam)

Sam was interested and actively engaged in BDSM practices. He described what is colloquially known as "gang-bang": a sexual practice where a central receptive partner engages in simultaneous or successive intercourse with multiple insertive partners

(Dalzell & Victor, 2013). For Sam, the submission/domination aspects, central to the BDSM fantasies and practices, were symbolically enriched by passing the ejaculate into the submissive partner in an act that can be likened to establishing ownership and objectification (“the idea of being used”). Another aspect that enhanced the sexual appeal of semen exchange for Sam was the “forbidden thing” narrative centred around sharing ejaculate; he drew great sexual pleasure from transgressing the previously inaccessible boundaries demarcated by societal taboos.

Sam was aware of the social stigmas surrounding non-mainstream sexual practices. He was also aware that not all gay men shared his open and accepting attitudes towards those who preferred practices that were not normative. He described *sex positivity* as an ethical standpoint contrasting it with more judgmental attitudes:

Yeah, for me, sex positivity is not associating negative feelings or being condescending towards people based on the sex that they choose to have. So, for example, for being a gay man, number one to even have sex they have to be breaking societal taboos. I've mentioned that I enjoy ... BDSM and I'm part of that community, so being sex positive means not thinking things are gross when you don't do it yourself, or don't like it yourself. It means not saying someone shouldn't be having the kind of sex they're having just 'cause I don't think I would enjoy it. It means not looking down on someone for the sexual practices they choose to have even if you think they might be damaging as long as they're doing it consensually. It depends on the level of damage; damage is a hard word there. ... Also, yeah, sex positive doesn't mean that you have a lot of sex or you sleep with a lot of people. Sex positive doesn't mean you're in an open relationship and that won't ever change. Sex positive means just not being shitty towards people because of the sex they want to have. (Sam)

Sam pointed out that in a heteronormative society, any homosexual practice may be seen as transgressive to the social order. The taboo-breaking aspects become the more pronounced the more dissimilar the practices are to the heterosexual model of what constitutes acceptable sexual practices. For Sam, the BDSM practices he enjoyed were

part of his everyday sexual experience, and he was aware of different societal and community attitudes towards them. He made a distinction between stigmatising positions of others (kink-shaming) and non-stigmatising attitudes informed by sex positive sexual ethics. The basic principle of the latter approach was to suspend judgment even with visceral reactions of disgust, provided that the practices were fully consensual. Importantly, the central notion of consent trumped the subjective and blurry idea of “damage.”¹ Sex positivity did not set to prescribe a set of practices but, instead, was an accepting approach towards the practices of others, regardless whether they were normative or not. The liberatory elements of the gay habitus, or what many authors described as a legacy of asserting pleasure as means of political liberation (e.g., Altman, 2013), were connected to its transgressive elements that made gay sex “taboo” by default. Reclaiming sexual enjoyment through community-established sex positivity norms was a way of reproducing the community order in a way that was oppositional to the mainstream norms and allowed Sam’s community to create pleasure-oriented fields where heteronormative values were suspended.

Sam emphasised that the framework within which the discussion of PrEP public funding took place was based on conservative moral foundations. He believed that opposition to the promotion and wider provision of PrEP had ethical and political (as opposed to pragmatical and medical) roots:

There’s one of the big pushbacks with PrEP is people saying is that you should just keep using condoms and then we won’t have to pay for your PrEP. It’s true, and you could say the same for the pill for women. Like it should [not] be funded because you could just use condoms but that’s ignoring “A,” the reality that people won’t always use condoms like there will be risk involved; “B,” there’s elements of sexual shaming in that, it’s saying that you shouldn’t be having this kind of sex anyway, and

¹ Extensive literature discusses the ethical aspects of BDSM practices, emphasising the problem of consent in role-play, consent withdrawal, safe words, and the ethical grey areas in what has been called “safe, sane, and consensual” BDSM praxis from a multitude of positions (e.g., Fanghanel, 2019; Parchev & Langdrige, 2018; Rocha, 2016).

therefore we're going to say that you just don't have that sex and you'd be safe as if you were taking PrEP. It comes from a place of elitism in terms of what you view sex as. (Sam)

Like other participants, Sam drew historic parallels between PrEP use among gay men and the contraceptive pill for women. He stressed that, like in the early criticisms of hormonal contraception, the reservations for wider PrEP promotion were based on skewed logics and moral judgments. Sam believed that both PrEP and the pill responded to real-world problems surrounding the use of other contemporarily available methods of preventing HIV or unwanted pregnancy and effectively eliminated their shortcomings, like the need for perfect compliance. The practical benefits were, however, overshadowed by a moral judgment that through eliminating risks, PrEP and pill would lead to disinhibition and enable sexual practices that could be evading social control. For Sam, the removal of risks offered the empowerment of the individual to make choices based on their own preferences. The opposing conservative stance was seen as certain "elitism," denoting, in this context, the privileged position to normalise or pathologise given sexual practices and deeming them acceptable or not.

Sam's narrative enabled drawing a connection between the implicit moral undertones surrounding the homonormative narratives of what may be labelled as responsible sexual conduct and the real-world individual experience. By sharing an account of engaging in non-mainstream sexual practices, Sam provided a lens through which PrEP became an enabler of consensual practices that were earlier limited to exist in the realm of sexual fantasies only. The meanings of condomless sex becoming a goal on its own (and not just a functional aspect of sexual contact, for example, by increasing intimacy) included the notions of submissive/dominant sexual narratives along with transgressing the limits imposed by the social order (breaking the taboo). By extending the boundary of what was normative, and by sharing his understandings of radical acceptance of all consensual sexual practice, Sam provided insight into what for him were the meanings of sexual encounters. In his understanding, any sexual act could be subjectively meaningful even when it was not viewed as aligned with the hegemonic

social mores. PrEP was an agent of personal liberation, but also social change, and served the gay community by interrogating the rigid notions of normalcy and allowing opening the horizons of experience, free from fear and shame.

The New Norms of Safe Sex

Michael, like many of the participants, preferred not to use condoms when this was possible. He shared that unlearning the routine of condom use was initially challenging, and required a conscious effort:

Admittedly it took a while for me to change my mindset around that, just going on to something new, where you're having to rely on a drug as opposed to a physical protection. The condom you can see it, you can touch it, you know there's that protection but taking a drug when you're taking it every morning and then this [is] very unrelated to the sex, you know you're not taking [PrEP] there and then, while you're having sex. To rely on something, I guess my mindset was: I take vaccinations before I travel, if I've got a headache, I take a Panadol, if I'm feeling sick, I'll take drugs. ... So, it's relying on the fact that pharmaceuticals do work and convincing yourself you got to trust the science. ... Just sort of doing research and reading everything that I could on PrEP and sort of wanting to know as much as I could and looking at statistics of the studies and sort, or proof that it was a safe option rather than just relying on the drug, seeing the studies and seeing the information as well.
(Michael)

The acute awareness of a condom's presence that disturbed many participants, for Michael also conveyed the clear message of safety. Unlike those of PrEP, the protective mechanisms of condoms were obvious and immediately verifiable. Michael had to rationally convince himself that the lack of barrier protection did not signify risk but was analogous to all the others pharmacological methods he used as treatments or preventive measures in other areas of his health. He spent a lot of time educating himself on the effects of PrEP, its mechanism of action, and the statistical evidence for its effectiveness

to have the rational proof he could rely on. Unlike condoms that were used exactly at the moment when HIV prevention was required, PrEP was temporally divorced from the possible risk event. On one hand, this removed the feelings of security afforded by using a measure of protection. On the other hand, after acknowledging the effects of PrEP, there were also benefits of disassociating the risk of HIV from sex.

The new condomless norm that Michael soon established in his sexual life applied to the majority of sexual interactions he had with other men. However, there were still situations where he would prefer to use condoms:

Just thinking [I'd consider using condoms] if someone was, someone looked like or I considered them to be higher risk or something, but that's, I don't know if would ever get myself in that situation. Having sex with someone who I would consider high risk. ...

[I would consider them high risk,] I would say that someone who looks dirty. I know their, if you go into their place and, if at their house rather than at your place, the house is a little bit messy or unkept or something. If they come across as someone who would do this regularly with lots of partners or something like that. ... I don't think I would likely put myself in that situation. But if did, that would be [with condoms]. (Michael)

Michael shared there were rare situations when he would prefer to use condoms. I felt it was difficult for him to specify what cues about the event or partner(s) would prompt him to opt to use condoms. His hesitation to describe it led me to believe that he may have felt that what he was saying was not socially acceptable, especially in the context of his otherwise non-stigmatising positions on expressing sexual desire. Michael equated carelessness or dirtiness with the need to barrier himself from the prospective partner(s), which was not in line with his belief system. However, his reticence revealed the deeply ingrained associations between filth and disease: central notions of social abjection process (Krecic & Zizek, 2016). I felt Michael was a very rational person, well-read in the social and epidemiological aspects of sexual health, who was also actively resisting stigmatising and judgmental attitudes across various of his community

activities. The fact that Michael shared this perception so hesitatingly, exemplified how deep the underlying currents of the gay community belief systems were that surrounded the notions of cleanliness and health that contrasted with dirtiness and disease links.

Michael was well connected to the gay community and he was active in sharing the knowledge about PrEP with other men. He established a set of norms of partner selection, that he believed were shared among many PrEP users. They related to inclusiveness for persons living with HIV who were virally suppressed and other PrEP users.

My preference is someone who is on PrEP or undetectable [as] someone I would have sex with, just because I guess the other risk being [are] STIs. You know that someone who's on PrEP is actually getting checked regularly. Same with someone who is positive undetectable, you know that they are getting checked every 3 months, whereas someone who's not, it could have been a very long time since they were checked. So, even though I'm safe against HIV, the other STIs I don't want to deal with. (Michael)

Michael preferred to select partners who were PrEP users themselves or those living with HIV with undetectable viral loads. What these two groups had in common was engagement with sexual health services and regular screenings for STIs, because Michael realised that PrEP did not reduce the risk of transmission of infections other than HIV. Interestingly, this narrative invalidated the difference between men living with HIV and PrEP users, and instead emphasised the difference between those assumed to be linked to sexual health services and those not linked. Implicitly, PrEP use or undetectable viral load status signalled good sexual health screening practices, that reduced the risks of transmitting other STIs. There is evidence that selection of partners following this logic has become increasingly widespread among PrEP users in other national contexts (Wang et al., 2019). It is unclear whether this process may lead to PrEP elitism, by partnering exclusion of men who choose to rely on other, less medicalised methods of HIV prevention.

With PrEP, the main risk-related driver of partner selection was the expected threat of STIs other than HIV. In Michael's view, however, the gravity of contracting an STI was low, as opposed to serious consequences of contracting HIV.

No [I am not concerned about STIs], they can all be treated. Getting tested regularly means that you're not letting any of those STIs develop into these third stages. Things like syphilis, if you catch it early, there's no issues. It's only when it goes further down, then you start having actual problems or issues, so yeah, I think the whole test and treat early mantra is fine. (Michael)

Michael addressed the public health messaging of "test and treat" approach that emphasised the excellent prognosis for common STIs when diagnosed and treated early. PrEP prescribing guidelines demand that persons using it be regularly screened for STIs, and for Michael that was one of the benefits of PrEP. The treatability and typically benign early course of bacterial STIs meant that the perception of risk and therefore level of concern were low.

In speaking about his own experiences with the occasional diagnosis of an STI, Michael focused on the annoyance he felt when he needed to manage it.

I guess it's this frustration [to contract STIs]. ... So there's that, well, okay, now I gotta go and get the treatment, and gotta contact everybody you've slept with, wait the stand down period before you can have sex again, so it's sort of more of a life admin. Having to contact people, and having to wait, and drive to the clinic, get injections or pills. (Michael)

There is rich literature suggesting that stigma is an important factor underlying the individual responses to STIs, and experiencing stigma is a common experience accompanying the screening process and eventual diagnosis (e.g., Hood & Friedman, 2011). However, in discussing the main problems arising from contracting an STI, Michael focused on administrative difficulties that were entailed in dealing with it responsibly. These included accessing the stretched healthcare services to get treatment, avoiding sexual contacts for a given period of time, and notifying sexual partners.

Notably, none of the participants in the study discussed community stigma associated with contracting an STI. On the contrary: participants commonly shared that occasional STI diagnosis is a fact of life: a manageable situation, that needs to be dealt with quickly, rationally, and efficiently.

During the interviews, I was expecting to hear that STI partner notification may invoke the feelings of shame, as disclosing personal STI diagnosis could be read as signalling promiscuity, and some accounts of the participants suggested having many partners continued to be viewed negatively in the community. However, Michael described a different set of practices surrounding being diagnosed with an STI, where notifying partners was simply an expected norm:

[I] messaged them [sexual partners] and said, "just to let you know that I've tested positive for this and you should go and get tested." ... All of them were, "thanks for letting me know, I'll go get tested." ...

I think [it's normal]. I think people appreciate that they're being told. Some people can be pissed off that they also have to go and get tested, as I have too. But you just accept it. It's part of the risk, I guess. (Michael)

Occasionally contracting STIs was a fact of life and Michael realised that it was a relatively common experience for other gay men to be diagnosed with one. He shared one recent occasion when he had to message his sexual partners to let them know about his diagnosis. All partners accepted the fact in a calm manner, thanked him for sharing the information, and assured Michael they would get tested too. That recent occasion was no different from previous ones, including those before PrEP. Only rarely partners would be upset, but even then, Michael understood, this was related to the administrative hurdles of managing the infections. The well-established norms in Michael's milieu that surrounded being diagnosed with an STI, seeking treatment, and notifying sexual partners, suggested that the elimination of the risk of HIV transmission associated with PrEP played a much larger role in contextualising condomless sex than the risk of other STIs.

In fact, contrary to some common social concerns, Michael saw the benefits of PrEP in reducing the incidence of other STIs, regardless of condom use.

The more people on PrEP, the more people getting tested every three months, the quicker it's [STI] picked up. And these things are dealt with. It's not like someone that's got it for two or three years [is] spreading it through the system. It gets picked up, treated, dealt with pretty quickly. And if you've got a good relationship with these people, they'll let you know, and hopefully other people so they'll remove that STI from the system. (Michael)

Michael believed that through upscaling of regular screening among PrEP users, they could contribute to less overall infections in the MSM population. Men who were on PrEP were screened as a requirement of continuing the use of PrEP, and therefore would not spread infections in their sexual networks for prolonged periods of time. Michael was highly health-literate and had spent a lot of time researching PrEP and sharing his knowledge with other members of the community. He was most likely alluding to the modelling studies that received some scientific media coverage shortly before the interviewing and predicted that increased STI surveillance among MSM could lead to reduced incidence of STIs, through the process that he accurately summarised in the quote above (e.g., Jenness et al., 2017).

The norms surrounding condom use or non-use, partner selection, and individual and sexual network responses to STIs started to evolve with the introduction of PrEP. Some men were less receptive to the changes in practices among some other pockets of gay men communities, and this led to pushback which was occasionally expressed in an aggressive manner.

That guy on Grindr, from [a named town in Te Ika-a-Māui] or something down that way, who abused me a lot, told me that I was trying to push drugs, that he's gonna report me to the police, and all this kind of stuff. [He] reported my profile on Grindr, got me banned from there, all these kinds of things. And I had to go back to Grindr and [I] explained, and they said sorry, and unblocked me. But yeah, it was just an

older guy who obviously didn't understand or didn't get what PrEP is. But his instant response was, "you're pushing drugs, that's not something that should be done." (Michael)

Michael shared a story of an unpleasant incident when another dating app user harassed him over his profile where he disclosed using PrEP and that he was keen to share his knowledge about it. Michael described the user as an older man, living outside of the major urban centres of Aotearoa New Zealand. He believed his resistance to PrEP stemmed mostly from ignorance, but he was taken aback by his strong negative reaction. Michael felt the man was abusive, as he eventually led to Michael's profile being temporarily blocked. On this occasion, the generational divide could be attributed to differential exposure to knowledge of changing realities of HIV prevention between younger and older men.

Michael believed that the differences in perception of PrEP and condomless sex between younger and older men were, in essence, differences in values that resulted from generational experience of the AIDS crisis.

I'd say that almost all of them [the man opposing PrEP] would be 50-plus, so they were alive during, and sexually active during the AIDS epidemic, through the mid-80s, into the early 90s. They probably lost friends and know people who have died and have got a much stronger connection to that, and also have that sort of fear drilled into them, and the fact that [using] condoms is the only way to stay safe is drilled into them as well. So, they see that's, from what I can tell, the only option. That's why I try and provide sound logical argument, so that they can have some facts and hopefully go away and look at that information, and ideally change their minds, and realise that things have progressed a huge amount, especially in the last 10 years, in terms of prevention and treatment. (Michael)

Through his community engagement channels, such as dating apps, Michael discussed PrEP with numerous men. He noticed that gay men who opposed PrEP were primarily men of older generations. Michael believed that their reservations stemmed

from personal loss and trauma of the AIDS crisis and that decades of safe sex campaigning had “drilled” the condom imperative into them. Their reluctance to accept the changing meanings of safer practices was a result of deeply rooted belief that condoms were the only effective prophylactic. Michael felt it was his duty to the community to challenge these perceptions through evidence-based education to enable other men’s views to better align with what he saw as a more contemporary approach. This novel approach extended to both treatment and prevention, and it was quite clear that Michael referred to good HIV treatment outcomes, treatment as prevention, and PrEP. All these elements heralded a new era, and Michael wanted the entire gay community to be able to benefit from these scientific advancements.

Michael recognised that his own generation was succeeded by younger men with different sets of norms and understandings of sexual practices.

[The younger guys] don't have that fear, they don't have that very strong negative association with HIV and AIDS. I talked to a lot of younger guys. ... They are [the] opposite: they don't even bother with PrEP. [Younger men believe:] "If I get it [HIV], the chances are very low, but if I do, I just take a couple of pills for the rest of my life and that's fine." (Michael)

Michael believed that different generational experience laid foundations for less fearful approach to sexuality, and much less HIV concerns in younger men compared not only to men older than himself, but also his own generation. In his view, among younger men, the disconnection from the first-hand personal trauma and even second-hand experience of the threat of HIV as a deadly disease resulted in disregard of any concerns. He felt that younger men were not afraid of contracting HIV, because they viewed the risk as low and the potential consequences as mild, because they were growing up in the context where HIV was a chronic yet manageable illness. Importantly, Michael did not feel that younger men were motivated to use PrEP, because the benefits would not be worth the hassle of accessing it. Michael’s perception of younger gay men provided a lens through which he implicitly characterised his own, transitional, generation. It was situated in-between the older, deeply traumatised cohort of men who

lived through the AIDS crisis, and the younger generation of relatively carefree individuals, who would not appreciate the sexual health risks.

Michael's story illustrates how dynamically the norms surrounding condomless sex and engaging with pleasure were changing influenced by PrEP. His initial doubts about PrEP effectiveness faded when Michael systematically learnt about the science behind it. He was partly motivated by his dislike of condoms, which he viewed as a barrier between himself and his partner(s). The lingering connection between sexual risk and some social notions of "dirtiness" were partially challenged and eventually led to differentiation of *safer* groups of men. Classification as safer or less safe groups was no longer based on HIV status, but rather on biomedical sexual health engagement status. PrEP users and men living with HIV with undetectable viral load were seen as desirable partners, because using antiretroviral medication provided a clue that they were rational individuals seeking to minimise their sexual health risks. With the use of PrEP, these risks were also much more benign. Having eliminated the risk of HIV, the STIs were seen as easily treatable and largely free of stigma. They were just a part of everyday experience; despite some level of life disruption they could bring. Members of Michael's sexual networks had established norms around managing and communicating these risks, and these included full disclosure and collaboration to eliminate STIs efficiently; PrEP only aided these efforts. Michael experienced some harassment over his use of PrEP, that came from an older gay man, and he believed it stemmed from generational trauma. He also observed pushback towards PrEP from some other men of older generation and sought to actively challenge it by knowledge-sharing. He saw his generation as being uniquely placed between the older men, for whom it was very difficult to liberate themselves from the fear of HIV, and the younger men, who did not appreciate the sexual risks.

Beyond the Ordinary

Connor was among the participants who openly informed others about their PrEP use through dating apps and established a set of rules governing whether to use condoms with specific partners or in particular circumstances. He shared with humour and aplomb, how he navigated his sexual encounters:

I think it's [PrEP using status] on my profile, ... 'cause it's a checkbox. It's available so people can see it, but I'm like, "I'm using a condom with you because I don't [know] how many cocks have been up that nasty ass." (Connor)

Despite readily sharing the information that he was using PrEP, Connor did not want other app users to assume that it automatically signalled his readiness for condomless sex. He joked that this was due to his lack of knowledge about his prospective partners' sexual histories, and to a certain extent this humorous take conveyed his real motivations. His partners' sexual histories were out of his control, and Connor wanted to take precautions to maintain control of the situation.

In reality, Connor reserved condomless sex for encounters that held some personal significance. He felt that a degree of risk was worth taking in return for the enhanced experience of the condomless encounter.

If I'm going to put myself at risk of a sexually transmitted infection aside from HIV, and also HIV because PrEP isn't like a complete panacea to transmission, I'm not going to do it with some guy that I just met on the internet. So, I guess in my mind, like, sex with no condom is a special thing for people I care enough about to want to take a risk with my own health, to have that sex with intimacy in the moment. (Connor)

Connor realised PrEP offered no protection from STIs, and he also believed that there remained a residual level of risk of HIV infection associated with its use. These inherent limitations of PrEP meant that the intimacy gains associated with condomless sex would need to outweigh the risks. In significant relationships, the benefits of increased intimacy were apparent, and Connor felt that taking the risk was justified and

he was willing to stop using condoms. Importantly, at the time of interviewing Connor maintained several polyamorous relationships, which meant there was no expectation of sexual exclusivity.

Like most of the study participants, Connor's coming of age transpired at the height of AIDS messaging, and he could not remember the pre-AIDS era. Because of the constant presence of safe sex campaigns when he was growing up, he always linked his sexual practices with risk. At the same time, he was able to maintain perfect condom use.

When I was 16 and coming out and starting to have sex with men, [it] would've been the early [or] mid-90s, and HIV awareness campaigns ... were really prevalent in the media. So much so that I had a CD by rap group called Salt-N-Pepa and basically the seventh track on that CD was basically a PSA about condom use. I was getting repeated messages to use condoms from like, television, radio, CDs in my car and I kind of came away with [that] people still die of AIDS. The mid-90s wasn't as bad as the earlier part of the plague, but it was still bad. People got sick and died and so, there was much more of a kind of a fear motivation. I remember waiting for HIV test [results] 'cause it used to take days in those days and in between waiting there were really unhappy times. Yeah, and so consequently I always used condoms. Even when I was really wasted actually I still kind of managed to like get it together to use condoms with sex. (Connor)

In Connor's memories of his coming of age, the AIDS "plague" appeared as omnipresent, and the public health messaging was impossible to avoid. Popular culture was filled with messages of urgency, as for example, in the song by a hip-hop girl group Salt-N-Pepa. Connor likely referred to a 1993 song *Let's talk about AIDS*: a rendition of

the group's earlier hit song *Let's talk about sex*.² This cultural context of a significant period of Connor's life led to the development of a strong imperative of condom use. The message he carried from his formative years was that HIV effectively meant AIDS, which was a deadly threat. Connor recalled that, before starting to use PrEP, even at times when he was heavily intoxicated, he was able to maintain the perfect rate of condom use.

Initiating PrEP allowed Connor to interrogate the meanings he associated with cum and internal ejaculation. Engaging in practices that involved these bodily fluids was earlier largely impossible because of the associated risks.

I think there's a real, I almost call [it] a spiritual profundity about having someone cum inside your body. Like there's potent symbols and sense of, someone who's human, even though, like, scientifically, it might just be some amino acids and salty water, on a kind of, like poetic, spiritual level, it's really significant. This is the stuff that can make life. It's inside, you put [it] inside someone or it's inside you, it's a big deal for a lot of guys. Partners that I've talked to about it have said it's, like, having your cum inside me is kind of transcendent moment. (Connor)

For Connor, on a material level, the ejaculate had no particular function in gay men's sexual practices. However, on a symbolic level, cum was a profoundly important substance carrying meanings that transcended the everyday experience. The idea that ejaculate had the potential to create life contributed to these metaphysical meanings and made internal ejaculation a highly significant practice. I felt that Connor struggled to find words to describe the spiritual nature of his experiences. I understood this was

² On that note, popular culture of the late 80s and early to mid-90s contained numerous examples of using HIV/AIDS themes. While *Let's talk about AIDS* had educational value and provided listeners with balanced knowledge and encouraged frequent testing, that was not always the case, even within the same wider hip-hop genre. A very popular TLC (Etheridge et al., 1995) song *Waterfalls*, used the notion of HIV ("three letters took him to his final resting place") as a somehow well-deserved punishment for unbalanced and irresponsible lifestyle.

difficult, as putting transcendental experiences into words may be very challenging, as they by nature evade the constraints of everyday language.

Because of the sense of profundity of the symbolic meanings associated with cum and internal ejaculation, I queried how Connor's perceptions of these aspects of his sexual practices changed when he started using PrEP.

Well, it's [cum] also made more powerful because we've been so scared of cum for so long. So, one of the other things being on PrEP has meant, 'cause I have like a little gum disease, sometimes my gums bleed a little bit when I floss, and I use a mouth wash. I've always been like, oh man, I hope I don't get cum on my gums [and] get the "hiv." Now that I'm on PrEP, like, that anxiety is just gone and now all of a sudden, the thing that was [scary], it's [a] representation of sexual ecstasy, right. That is what cum means: this attraction between two people is so profound that there's this emission that's produced. ... You can see, you can point to it. It goes from being this thing that you're a bit scared about to something, becomes, like, all the fear is gone and it's a relief. (Connor)

Connor identified the transformational potential of PrEP, which was able to purify the bodily fluids which once signified contamination and fear, but these associations were now being replaced by sexual ecstasy. It recovered the deeper meanings of cum being a physical manifestation of the depth of sexual connection between two people. The "relief" Connor described was the result of the decades-long fear finally being lifted. Despite generational differences between Connor and Allan (whose account was explored in Chapter Seven), it was striking how similar the narratives were of removing the long-lasting burden and purifying the contaminated bodily fluids.

Connor further recounted an experience he shared with one of his past sexual partners. It revealed some of the constraints he used to apply to his sexual practices that hindered the process of experiencing deep emotional connection with his partners.

I remember years ago being fucked by a guy and you know: the rules are when you finish fucking, pinch the base of the condom and withdraw the penis as it comes out.

He just wanted to lie on top of me with his dick in me for a while, which I was really into and he was into, but after, I thought, "ah, no, maybe some cum got in me." ... Moments like that, the kind of anxiety about this representation of something that is really potent, having that gone and then having that thing represent love instead of fear, it's a huge deal. (Connor)

The commonly recommended practice of effective condom use involves following a prescriptively defined procedure of condom application and condom removal (Centers for Disease Control and Prevention, 2016). The final step entails careful withdrawal of the penis while holding the condom at the base, typically immediately after the penetration to avoid any leakages due to erection loss that follows ejaculation. In Connor's account, he did not comply with the immediate withdrawal rule, and that caused significant anxiety after the fact. However, in the moment, both partners had a strong wish to simply continue lying together, especially in the context of the meanings of cum and orgasm as the pinnacle of connection between sexual partners. The described events happened prior to PrEP use and caused Connor to experience highly ambiguous emotions. On one hand he wished to cherish the connection between himself and his partner, but on the other hand, the non-adherence to the safe sex rules led to fear. PrEP effectively eliminated this contradiction, leaving space to only experience the "love" generated through sexual connection.

Connor identified himself as polyamorous, which meant that he was open to maintaining more than one significant romantic relationship at a time. In addition to this, he was sexually active with other men on a regular or casual basis. He believed that the wider society, and sometimes also gay community members, were not accepting of sexually intensive lifestyles, and these attitudes led to slut-shaming.

I think that's what slut-shaming is: "you're not being normal; you're having too much sex." Not having too much sex is normal, too much sex is abnormal, you're a slut. (Connor)

According to Connor, strict social norms governing the acceptability of various sexual practices and lifestyles stipulate that any excess in this domain is abnormal. The social construct of a “slut” and the associated imposition of shame on individuals who may be engaging in sexual excess are expressions of social control and aim to curtail the undesirable behaviours.

The stringent social rules create additional problems when they are applied to sexual practices that are common in the gay communities. According to Connor, the sexual practices of gay men are qualitatively different from those accepted by the mainstream society.

I think, if the world knew how much sex gay men have, and the crazy different kind of wild crazy sex, they'd be like, "oh wow!" ...

[Recently,] I had a week off between jobs. I had this threesome in the suburbs, and it was terrible. ... I didn't even cum, so I left. Then, later on, I was still really horny, so, I like hooked up with another guy and got my rocks off and it was amazing. That is what I mean, that is a lot. If you tell a straight guy you can have sex with three different women, including a three-way in a day, they would cry bitter tears of envy.

...

We've done it to ourselves. "Let's get marriage equality!" And I'm like, yeah, of course, so we can get married and pretend we're monogamous. Gay sexuality is really different from anything, really, [it's] like dogs humping. (Connor)

Connor believed that what would seem like sexual excess when judged using mainstream social norms was an everyday norm for many men within the gay community. Both the number of partners, and types of sexual practices enacted by gay men on a regular basis had the potential to shock the straight majority. As a recent example, Connor recounted a personal story of a disappointing threesome followed by a more satisfying encounter with another partner. Connor joked that most straight men would be impressed by how easy it was for gay men to arrange and engage in sexual encounters with eager partners. He believed that sexual freedom was a valuable asset of the gay culture, and in fact, it was part of the very nature of gay men. At the same time,

the civil rights efforts focusing on the homonormative project, such as gay marriage, were contradicting the nature of gay sexuality. In fact, gay sexuality could be characterised in primal or animalistic terms, as following innate sexual instincts.

Between the interviews, Connor started reflecting on his practices and his perspective on PrEP, sexual health, and the notions of risk. This deeper consideration of his own preventive options led him to discontinuing using PrEP.

I think this might be an unfortunate effect of when the observation changes the experiment. I thought about my reactions, like what I said during the [first] interview. In conjunction with me watching "Cosmos" [science documentary series] which has a lot about the scientific method in it, and I thought, man, there is like a lot of magical thinking going on in some of the answers that I was giving. Like, if I loved someone, if they were like my primary [partner], like, managing risk and I'm like; man! That is some, like, some wishful thinking on my part. I haven't had sex with anyone for maybe like a month and a half 'cause I started this new job. ... I'm taking this blue pill every morning, it has side-effects and affects my kidneys, it can affect bone density, it can, like, redistribute fat around my body, on the face and on the back of the neck. Particularly that last one, pretty undesirable side-effect for me. ... What am doing? I'm not in North America. Like my original plan was to go on PrEP while I was traveling in the States. I was going to come off PrEP when I came back to New Zealand and then I was still taking PrEP, having a bit of bareback sex 'cause it feels good, and [now] I'm not even having any sex. (Connor)

Between the interviews Connor reevaluated his motivations to use PrEP. He linked it to the fact that the first interview of this project triggered a process of introspection in him. As a result, he started to think that his decision to continue using PrEP was not rational. He contradicted his earlier motivations, which he described as "magical thinking" with a rational, scientific paradigm of methodical weighing of costs and benefits. Connor started paying more attention to the possible long-term effects of the drugs, and the fact that his continuous use of PrEP contradicted his initial plans to only

use it while travelling. He noticed that because he was much less sexually active now, there was no need for him to continue using PrEP.

After the first interview, Connor also started reconsidering the role of condoms in the repertoire of HIV prevention methods. In fact, he started thinking that condoms were better suited for him and he would prefer to use them instead of PrEP.

A condom protects me more than the pill does, and, in fact, I've managed to stay HIV-negative and be extremely sexually active through my 20s and 30s. I've slowed down heaps now and have dodged it, HIV and most STIs as well, the whole time probably because ... [I] reliably used condoms. [PrEP prescribing physician] said as well, "look, actually, if you're being really compliant with condoms maybe we should think about a strategy of coming off PrEP as well." ... So, all of those things kind of added up and I'm, yeah, I'm going to stop taking it. Use a condom if I have sex. It's not worth, like, the kind of sex I'd be having in [a large city in Te Ika-a-Māui]. Probably if I have some sex now it would be a casual hook-up with, like, some guy and that is not worth contracting an STI if I can dodge it, [I will] use a condom. That's where I'm at now: back to condoms. (Connor)

Connor believed that condoms were more effective than PrEP, as evidenced by the fact that he had not contracted HIV or many STIs throughout his most sexually active periods of life. This was the rational reason he required to make an informed decision to discontinue using PrEP. The decision was further reinforced when his physician suggested that PrEP use was not necessary, because of his high level of adherence to condoms. He reflected that the type and intensity of sexual practices he was engaging in his city did not warrant regularly taking medications, unlike his earlier practices in the United States where he was very sexually active. The sexual contacts he had now were mostly with casual partners that he shared little emotional connection with. Having condomless sex with random men did not offer him the meaningful connection worthy of heightened risk of STIs.

The change in Connor's approach to sexual risk and PrEP that occurred between the two interviews appeared radical. He indicated that the reflection that led to his eventual discontinuation of PrEP, was associated with different sets of values in conflict.

I did talk about that transcendence at the last session a little bit, and sex always seems to offer that in the heat of the moment, kind of, like, transcend life. Having had some experience with it, I'm like, nah, it was okay, but. ... I guess it's like that kind of Buddhist thing, where you can eat a lot of really yummy food or have a lot of really good sex, look at some really beautiful art, at the end of the day, you're still you, like it doesn't change anything! I guess, I kind of had a bit of a dose of that somehow, yeah. (Connor)

During the first interview, Connor extensively referred to transcendental or ecstatic aspects of sexual connection with his partner(s). I understood that he saw spiritual value in these connections that extended beyond simple sensual pleasure and he was seeking sexual fulfilment as a way of escaping everyday reality. In retrospect, Connor called these motivations "Buddhist," which hinted to a significant spiritual component. He described his earlier narratives as following a kind of epicurean philosophy, where the pursuit of pleasure or beauty presented a great value and was a goal of self-actualisation or self-fulfilment. Now, weeks later, Connor found these motivations irrational and, in the end, insignificant. Upon reflection, he concluded that these positive sensual experiences did not enrich his life in any meaningful spiritual way, and, however pleasant, they were not worth the inherent risks.

During the period between the interviews, Connor also reconsidered how he viewed the risks associated with contracting STIs. The change was motivated by the experience of an increase in frequency of STI diagnoses since he started using PrEP.

I'm like, yeah, chlamydia, gonorrhoea, fucking I don't want that in my butt. There's a bunch of other STIs that I would rather not have, and it turns out, actually, that I started getting. We talked about anxiety; this is really key. When I got my second STI screen I was, like, more relieved than I should have been that it came back

negative for other STIs, 'cause I knew that I was being a ratbag: casual partners and not using a condom. I'm like, yeah, maybe I've got the clap, I don't know. (Connor)

Even though the relief from anxiety associated with HIV was profound, it was not complete, because Connor still feared contracting diseases from partners. He noticed that since he started using PrEP, he was contracting other STIs more frequently. On occasions when his regular screenings were coming back as negative, he was surprised, because he had known that his sexual practices had in fact predisposed him to STIs. He believed that condoms were able to offer him more protection, by extending the risk reduction qualities to other STIs.

I was surprised to hear how radical the change in perception was for Connor. During the first interview, he confidently discussed the relative risks and benefits associated with using condoms and PrEP, and he identified the fear of STIs as being of much lower concern than HIV, perhaps even of no concern at all. He was clearly aware of the inherent risks before the first interview. The shift was a change of perspective on the facts well known to him beforehand, and I was curious if Connor realised how profound the change was and what contributed to it the most.

[Interviewer: You didn't seem to care [about the other STIs] when we spoke the last time. You said something like: "you know: if it comes, it comes."]

Yeah, I've changed my mind about that. I changed my mind, 'cause I had to, like, face it in reality. It wasn't just like, you know, this magical thinking that I keep referring to. Actually, I was in a clinic getting some blood drawn and then they gave me a bunch of ... swabs and sample collection jars. Like, I do my own samples to take to the pathology lab to be tested before I go in, so we're ready to roll. So, in my bedroom, I've got like a bunch of swabs and urine collection stuff. I'm like, holy fuck, and it became very real at that point. I'm like, Jesus Christ, I've turned my body into like this biochemistry experiment by not using condoms. Like this is the reality of not using condoms per se, like fucking anal swabs every 3 months. That changed my perception of it, like, all fun and games, until. (Connor)

The experience of contracting STIs and the necessity to submit to a regime of scrupulous SIT testing influenced Connor's change of perspective. Before starting PrEP, and owing to his earlier rigorous condom use, Connor was to some extent shielded from STIs. Now, with the increase of risk stemming from less frequent condom use, he started feeling like his body was at risk, and he felt he was becoming dependent on the biomedical regime of repeated sexual health checks. He realised that condoms, as opposed to PrEP, afforded him some independence from these risks, because of their protection from STIs. His initial light treatment of the risks of STIs was a result of lack of personal experience with them which he linked with the "magical thinking" as opposed to rational decision making. I noticed that Connor's initial motivation to use PrEP was to establish greater sovereignty over his sexual health and practices, and to gain the feeling of freedom associated with it. With continued use of PrEP, however, Connor started to feel like his dependence on condoms and earlier fear were now being replaced by dependence on the biomedical system and elaborate health regime of testing and treatment for STIs. He described his experience as a "biochemical experiment" emphasising his perception of becoming an object in need of clinical interventions, and not a sovereign agent in control of his sexuality. In the end, for Connor, PrEP could not fulfil the promise of greater sexual freedom and agency, because of its entanglement in the biomedical regime.

Belonging to a generation of gay men for whom HIV was an ever-present threat since he remembered, Connor used to be a very reliable condom user. The arrival of PrEP allowed him to uncover the deeper meanings of sexual connections with other men and condomless sex. During the first interview, Connor emphasised the ecstatic and transcendental potential of sexual connections with other men. He experienced the sexual contacts as providing him with an experience that allowed him to break free from the constraints of everyday life. Ejaculate and barrierless sex were potent symbols of genuine human connection and intimacy and, through the transformative power of PrEP, started to symbolise life and love. The profundity of the symbolism was further underscored as this was a radical change from the lingering associations between cum and fear and death. At the same time, Connor believed that an important component of

what made gay men sexuality unique was the intensity of contacts and the vastness of sexual networks. The homonormative project that included gay marriage could have been a disservice to gay men, by imposing an expectation to experience sexuality which mirrored the heterosexual ideal: monogamous and restrained. The homonormative model contradicted the amorphous and anti-restrictive sexual praxis that could better characterise gay men. Being able to realise their sexual potential to its full extent was what distinguished gay men from the heterosexual majority and provided meaningful community connection. This freedom-oriented sexual habitus was reinforced by PrEP that took away the fear-related sexual reservations, symbolically purified the bodily fluids, and enabled unrestrained pursuit of sexual pleasure.

During the second interview, Connor emphasised how rational, scientific method-driven reasoning made him reconsider his practices to make a decision to discontinue PrEP. He felt that the spiritual meanings of condomless sex and sexual connection would no longer be a deciding factor when making choices about his sexual practices, and that the transcendental experiences possibly afforded by condomless sex were, in fact, not worth the inherent risks of PrEP, such as increased risks of STIs. Based on his lived experiences of intensified sexual health screenings and more STI diagnoses, he started to consider these infections a major burden on his life, that he could easily avoid by returning to consistent condom use. In addition to that, Connor was worried by his increasing objectification by the biomedical regime that came with the use of PrEP in what he described in terms of a scientific experiment on his own body.

I noticed that most of the study participants presented a largely consistent outlook on several issues across the first and second interview. Typically, the follow up interview gave them a chance to elaborate, and for me to interrogate some of the key notions. However, the two interviews with Connor presented very different insights into his experiences and the meanings he made in relation to PrEP, condomless sex, STIs, and the notions of sexual risk and liberty. The conflicting values were anchored around the seemingly opposing motivations of transcendental corporeal pleasure or sensual experience versus rational, methodical thinking. Both ways of thinking were informing

Connor's practices, and at different times one or the other appeared to dominate. Eventually, Connor conceded that the liberating potential of PrEP was severely limited by the need to subject to the biomedical regime. I felt the tensions Connor talked about mirrored the existing community tensions between the drive for fulfilment of bodily or emotional needs and the expectation to subject to the universe of social norms. These tensions further revealed the elements of the gay habitus evolving under the influence of PrEP, where the transgressive dispositions were clashing with the seemingly successful incorporation of the gay experience into the dominant biomedical regime. The two interviews shed light on two different aspects of Connor's motivations, and at the same time enabled him to put into words the tensions between them.

Natural Sex and Freedom From Indoctrination

Like many other participants, before starting to use PrEP, Rewi was a consistent condom user. This was gradually changing and at the time of our first interview, Rewi was carefully selecting men with whom he would feel comfortable not using condoms from a larger pool of his sexual partners.

I don't think it [condomless sex]'s better or any worse, but I like the opportunity and freedom of choice. If I am looking at a guy and he doesn't look too, he doesn't look too clean, he's putting a condom on, straight away. Not because he might have HIV, it's because there's other STIs and that sort of stuff. You know, you get an STI and you're out of business for the next two weeks. (Rewi)

Initially, Rewi would not describe condomless sex as "better" when compared to sex with condoms. However, the liberty to make free choices, as opposed to feeling as if he was forced by fear or community expectations to use condoms, was a major benefit of PrEP. Despite now having the option to have condomless sex with all his partners, Rewi reserved it for those who appeared to take better care of themselves or held themselves up to what he saw as higher standards of personal hygiene. He believed that men who seemed unclean would be at higher risk of STIs as they appeared careless.

Rewi realised that PrEP offered no protection from STIs and he believed that avoiding condomless sex with dirty-looking men could reduce his risk of contracting them. Even though other STIs were not as serious as HIV and treatable, they were still a problem because being diagnosed with one meant he would not be able to have sex for a few weeks while the infection was being treated.

For Rewi, the biggest concern around condomless sex has always been the risk of contracting HIV, not other STIs which he has occasionally picked up and treated promptly.

[Sexual health screenings were not stressful, because] I was pretty consistent with my condom use and that sort of stuff. The only thing that I did have was the odd STI from oral sex and stuff. ... Yeah, [these STIs were] expected. 'Cause if you're gonna engage in sex, regardless whether you're gay or straight, there is always that risk that you may get something. (Rewi)

Unlike for some of the other participants, for Rewi, the sexual health screenings were never associated with high levels of stress, even before he started using PrEP. He had always been consistent with condom use, and he knew that this afforded him a very reliable level of protection from HIV. Even though he occasionally contracted other STIs through oral sex, he saw these infections as a natural part of life of any sexually active person and Rewi was not surprised or upset by the new diagnoses. This relaxed approach to STIs signalled a clear distinction between HIV and other STIs, where HIV was still seen as something very serious that needed to be feared, while the other infections were only a minor nuisance and not a reason to worry.

The constant threat of HIV and the resulting strict adherence to condoms were entangled in feelings of guilt if this adherence was ever imperfect.

[If] I am gonna have sex with you without a condom, [then I will] feel a little bit guilty though, associated with [that] I may still be infecting you, I don't really absolutely know. There is still that measure of guilt there. (Rewi)

The guilt arising from condom non-use was linked to his ethos of social responsibility and communal effort to stop the spread of HIV in the community. For Rewi, the guilt was not centred around putting himself in danger, but rather stemmed from the duty of extending his care to his sexual partners. Before starting using PrEP, he felt he was never able to confidently claim his HIV status was negative, and he believed that a residual risk he would be putting his partners at was something unacceptable. This way of thinking revealed how strongly HIV risk was ingrained in Rewi's daily experience before he started using PrEP. Despite accessing regular HIV screenings and very consistent condom use, Rewi felt that at a community level, he could still be a threat to other men.

Rewi elaborated that at a conscious level he was aware that there was very little HIV risk in his life, due to his strict condom adherence. However, some of these feelings of uncertainty and guilt lingered on and were still present when he was starting to use PrEP.

Yeah, even though there is no actual threat, it's that indoctrination, condom indoctrination. Thirty, forty years of use of condoms, and it's still very, very hard to shift people from that position. ... Because I'm of that age group: we got that sexual health message really early on ... coupled with a bit of religious and Anglican guilt to make sure that if you're gonna have sex, you better have condoms as well. (Rewi)

In referring to the public health messaging surrounding condoms Rewi used the phrase "condom indoctrination." This choice of words suggested that he did not perceive it as something stemming from within the community he identified with and that he could rationally consider and then consciously accept. He rather saw this "indoctrination" as a forceful intervention coming from an external source. He noted he was very young when condoms started to be promoted as a method of HIV prevention, which meant he followed the imperative to use them for several decades. Rewi felt that the colonial religious concepts emphasising feelings of personal guilt provided fertile ground for high compliance with the condom messaging among his generation. A clear message associating sex with the moral imperative to use condoms proved very

persistent for Rewi and he felt it was very difficult for men of his generation to disassociate condomless sex from the notions of risk and guilt.

Despite his earlier reservations, Rewi trusted in the effectiveness of PrEP and stopped using condoms for most of his sexual encounters as soon as he started taking the pills. These early experiences of PrEP use had a profound effect on his perceptions of sexual risk and Rewi's wellbeing.

Crunch time came after that 3-month period when you had to go back, pee and test. ... No [I was not using condoms]. I was totally relying on the medications and the will of God and sort of stuff and I saw, after three months, about seventy partners just over that three-month period. ...

When I got those tests results back, I realised, I just felt so free. ... There was still a threat [of other STIs], I was still at risk, but I felt freer. I just felt like a whole load off my shoulders came off as well, I started feeling more attractive and, you know, 'cause I didn't have these worries anymore, and I started losing weight which is weird as. (Rewi)

Initially after starting PrEP, Rewi still worried that he may have been putting himself at risk of HIV by not using condoms and continuing to have multiple sexual partners. The first of the series of three-monthly tests was a stressful experience. It was new to Rewi to no longer depend on condoms to provide protection, and instead to rely on pills along with fate ("the will of God"). However, the tests came back negative, which provided Rewi with the evidence of the reliability of PrEP. Consistent with other study participants, the primary change Rewi saw in his life after he had verified that PrEP was effective was a newly emerged feeling of freedom. Along with the previously mentioned freedom to be able to choose whether he wanted to use condoms or not with a given partner, Rewi felt liberated from the burden of fear, guilt, and the constant threat that was associated with the risk of HIV and what he perceived as the condom indoctrination. These liberating effects were so profound that they positively affected his feelings of physical attractiveness, and even manifested themselves physically, in the form of Rewi's desired weight loss.

At the time of the second interview, Rewi's group of sexual partners mostly constituted of men with whom he had more meaningful, personal connection.

I think with all the guys that I'm sort of seeing at the moment, we'll have natural sex, I call it, because I like them a lot and there is a, I feel a lot more connected with them when we're having sex in that way. ...

I think it's a greater level of intimacy in, between me and my lover, or me and the person that I'm hooking up with. Don't get me wrong, not everybody gets to cum in the old back fanny, and that sort of stuff. (Rewi)

Rewi recalled that he had condomless sex with all his sexual partners at the time. These were men with whom he felt he had meaningful connection, and he felt that this connection was further strengthened by the fact they were able not to use condoms. The "natural sex" was therefore both the effect and the cause of this deeper connection, through heightened sense of intimacy between partners, regardless whether these were regular or random encounters. At the same time, if Rewi felt there was no potential for a meaningful connection, he would not be comfortable with having partners ejaculate in him, as he noted with humour. Condomless sex was therefore closely connected with intimacy that manifested itself between partners, even when these were just casual encounters.

I wanted to understand if, like in the accounts of other participants, Rewi saw a role of bodily fluids or cum exchange in increasing these feelings of intimacy. He shared that his perceptions of the human flesh, including bodily fluids, were rooted in his knowledge of rongoā Māori (traditional Māori medicine).

Well, you know [I am familiar with] traditional Māori healing ... so the human body is normal to me. All of its excretions and all that sort of stuff are normal, and I don't have, sort of, have any judgments or expectations or anything about ... cum and that sort of stuff too. Now, that guys do cum in me though: there is a heightened degree of pleasure for me. (Rewi)

The approach of traditional Māori medicine informed Rewi's perceptions of all bodily secretions, including cum. He saw them all as natural, and Rewi alluded that this was in opposition to the Christian colonial perceptions that have abjected the body and, in particular, its excretions (Douglas, 1966). According to Rewi, the Indigenous practice normalised the bodily fluids, and he took care to see them unreservedly: as they were. Rewi's personal experience, however, was that the sexual connection with other men that included cum exchange had the potential to bring about more sexual pleasure. In context of his previous words, I understood that this increased pleasure developed in connection with the more "natural" kind of sex, unmediated by the "condom indoctrination."

Mātauranga Māori also informed Rewi's understandings of PrEP as a medicinal product, which showed how the use of PrEP could be adapted in culturally appropriate ways among Māori communities.

[PrEP]'s a synthetic drug based on a plant originally. ... All medicine is synthetic, based on a plant in its original form and then it's grown in test tube and a Petri dish as bacteria, and they produce the medication from that bacteria, no longer from the original plant. (Rewi)

For Rewi, all contemporary medicinal products were stemming from naturally occurring compounds. He saw an essentially unsevered connection between the natural, plant-based substances that were transformed into more refined medicinal products that were later used to treat diseases. This connection was important because it helped to avoid the potential opposition of technology juxtaposing nature. The healing potential of nature was preserved, and therefore PrEP could be used without disturbing the natural order. This connection to nature differentiated PrEP from condoms. While the medicine carried on its intrinsic natural origin, condoms disturbed the natural sexual connection. Condomless sex remained the type that could be labelled "natural," as described in Rewi's previous comments, and therefore more intimate, and the promotion of condoms, necessary to prevent HIV, required aggressive "indoctrination." Such understandings of condomless sex strongly reminded me of other participants'

perceptions of condomless sex as providing a less constricted spiritual connection with another human being, both on a material (lack of physical barrier) and symbolic levels. Rewi's familiarity with rongoā Māori facilitated his focus on the natural (as opposed to socially or technologically mediated) experience with a strong spiritual component.

The holistic view of PrEP had an important role to play in promoting it among Māori communities in line with the principles of rongoā Māori. Rewi pointed out that manufacturing was only one of the steps in PrEP provision to communities that should remain culturally adequate.

So, in PrEP, I can't create my own PrEP by going out into the forest and mixing it up, but what I can do, I can use my lived experience in order to help others access PrEP and introduce them to it and ask them to consider using it. I work with a lot of different clients, one of my client groups are [redacted; male dominated group]. So, they've come from really hard backgrounds [redacted] and that sort of stuff too. Not saying that they're all homosexual or gay or anything like that, but, you know, at least having PrEP would make them, give them the freedom of choice that I have as well. (Rewi)

The complex technologies required to synthesise PrEP through pharmaceutical technologies were not possible to be reproduced by natural healers, but there was still an important role left for them. Owing to his familiarity with rongoā Māori along with his personal and professional experiences, Rewi was uniquely placed to understand and share his understanding of PrEP with other Māori men. The group who Rewi felt could benefit from PrEP was not limited to takatāpui but included men who would likely identify as heterosexual and had chiefly heterosexual experiences. They could also benefit from the greater freedom that PrEP could offer them. This way, PrEP could become an equitable tool extending its benefits of enabling the "natural" sexual experience, that carried the spiritual value of unmediated intimacy, free from the risk of HIV.

Rewi's account underlined the dynamic trajectory of unlearning and resisting the condom messaging which was seen as communicated in an intrusive manner. Following decades of consistent condom use, at first, Rewi was not able to imagine how staying and keeping his partners safe could be possible while having condomless sex. PrEP enabled that by removing the threat of HIV and finally allowing deeper connection between partners and experiencing unmediated intimacy of "natural sex." Before using PrEP, on rare occasions when he would not use condoms, Rewi felt guilty that he could be unknowingly transmitting HIV to his sexual partners. After starting to use PrEP, these feelings disappeared and made room for genuine intimacy between partners. Removing this burden of worry affected Rewi's wellbeing so profoundly that he started to feel more attractive and was even able to lose some of the body weight he believed was excessive without making any effort.

Rewi felt the benefits of PrEP should be shared with the wider community, both takatāpui men and other Māori. He believed that the Western processes and techniques used to develop and produce medicines, including PrEP, were amplifying the inherent properties of the natural world and were therefore natural themselves. Although he was not able to replicate the effects of PrEP in reducing the risk of HIV using traditional methods, he was able to incorporate it into his health promotion efforts and use his lived experiences to share the benefits of PrEP with others.

Intimacy and Rationality

Vincent's sexual history was mostly limited to his long-term monogamous partners. Because of the evolving dynamics of these relationships, the pattern of Vincent's condom use was a result of careful planning and negotiations.

Because most of my sexual activities are with long-term partners, so, if we do go condomless, then it's always on the basis that we have been tested. ... I do not want to risk my life because of some pleasure. (Vincent)

Vincent was very clear he would not be willing to take risks associated with condomless sex, unless he and his partner were tested for HIV. Vincent described his decision-making process surrounding condom use as a rational risk assessment. In this vein, condomless sex appeared as gambling with his life for the insignificant benefit of mechanistic sensual pleasure. When stakes were kept this high, avoiding condomless sex remained the only reasonable option.

Vincent believed that, despite the risks involved, condomless sex was able to offer greater intimacy which he highly valued in his new long-term relationships. He shared how he started to use PrEP to minimise the risk of contracting HIV from his partner while being able to enjoy condomless sex.

We didn't want to use the condom since, it feels to be more intimate when you don't use a condom. ... But because I'm aware of the prevalence of STIs in the [gay] community I wanted to make sure that we were protected. So, on the basis of that, when I requested that information [of HIV status], he [my partner] mentioned to me that he was HIV-positive, he's been HIV-positive for five or six years. He mentioned that he regularly has doctor visits and takes medication on a daily basis to make sure his viral load is undetectable. So, I mean, I'm okay with someone in my life who has HIV, but I wouldn't want to contract it myself. Having that information, I was doing a bit of research myself ... whether, besides that person being undetectable, whether there is something that I can do to prevent myself from contracting the disease, on the basis that we don't want to use a condom. From there, I found PrEP and basically started to, I looked into the different research that's been done through PrEP and what sort of chances there are to actually not contracting the disease and what sort of trials there are going on. Whether there are any significant side-effects that would, that would decrease my quality of life. From there, assessing the cost-benefit analysis I [felt] that it wouldn't affect me too much by taking the medication. So then, I decided to access that medication and start taking it. From there we started to have condomless sex. (Vincent)

Vincent rationally explained his stepped approach to keeping himself safe. He shared that his initial interest in PrEP was a result of seeing another man who was living with HIV. While it was important for Vincent to remain HIV-negative, he accepted his partner's HIV status disclosure, and shared that it was not a problem for him. He knew his partner was under regular care and maintained an undetectable viral load. Vincent realised that this greatly reduced the risk of HIV transmission. At the time when Vincent started seeing his HIV-positive partner, it was common for messaging around undetectable viral load to imply risk reduction, but not elimination. Vincent wanted to take all the possible active measures to prevent HIV, rather than only relying on his partner's undetectable viral load. Despite the concerns about HIV, expressed clearly in the previous quotation, he wanted to explore the options which would not involve the use of condoms, for intimacy benefit. Following his research (which was easy as Vincent's occupation meant he was well-versed in accessing scientific information) he learnt about PrEP, studied the scientific literature and available materials, and followed the "cost-benefit analysis." In result, he decided that the benefits exceeded the risks, and set out to access PrEP, with full confidence that the two combined biomedical interventions (TasP and PrEP) were effective enough to enable him and his partner to have condomless sex feeling safe.

Interviewing Vincent, I noticed that his retelling of his story was very rational and revolved around a highly scientific approach to his decision-making. However, I felt that the rationality that emerged from his story obstructed some of the more emotional aspects he would only briefly signal at times. I wanted to understand what personal meanings condomless sex had for Vincent that would motivate him to actively seek methods to enable it, despite his earlier rejection of the pursuit of "some pleasure," when "risking life" was at stake.

I think it's like the psychological effect [of condomless sex], because I think in terms of physical, I don't know [if] it is actually more pleasurable, in terms of, I feel it's like a mental pleasure, I suppose. The idea that there's a barrier between you two, so it's not a physical barrier, but the psychological barrier that you have with that condom.

So, it kind of feels more intimate when you don't use a condom during intercourse.

(Vincent)

The benefit of condomless sex extended beyond the physical sensation and related to the quality of relationship-building role of sexual connection. Condoms constituted and symbolised a barrier (both material and psychological) between partners and prevented feelings of intimacy from developing to their full extent.

Vincent would not normally engage in casual sex. He only had sex with partners he wished to pursue romantic relationships with, therefore the unbound intimacy of condomless sex played an important role in strengthening these new partnerships and helping them become meaningful in his life.

For me sex is not really something that I just do to relieve my physiological [pressure]. I feel it's a tool that I use to really belong and connect with people. So, therefore, when I have sex, it's always on the basis [that] I want to develop a long-term relationship with this person. So, on the basis of that, I feel that I want to find someone that feels the same way, so that it doesn't feel what we have, the sexual interaction we have, is cheap, I guess. (Vincent)

Vincent rejected the notion of casual sex, which he perceived as a way of seeking commitment-free tension relief. The role of sex was to build a connection and feeling of belonging, and that was reserved for relationships that at least had the potential of becoming lasting and meaningful. Vincent did not take sexual connection with others lightly and expected the same from his partners. Such expectations assured that their sexual connection remained special and meaningful. On the other hand, for Vincent, the sexual connection that was separate from long-term relationship felt cheap and irrelevant.

Vincent recounted that in his experience, many Asian men shared similar values and attitudes surrounding the expression of sexual desires, which made it easier for him to find the common ground to start a new relationship.

I feel that Asian guys are more likely to be in that long-term relationship, that's sort of my perception. I feel that in Western societies, the meaning of sex sort of has become devalued, it's something that is more like a fast-food consumer mentality. ... I feel that the meaning of sex [is] more inferior in Western societies. (Vincent)

Vincent contrasted the attitudes he ascribed as common among Asian men with those prevailing in the Western culture dominant in Aotearoa New Zealand. In his view, consumerist attitudes of the Western societies extended to human sexuality, which meant that sex was increasingly becoming a commodity, while losing its personal and social significance. Asian men were more likely to reject such perspectives of sexuality and see sex as a component of important partnerships.

The challenge with maintaining this appreciative view of sex as something reserved only for meaningful relationships was that it could lead to stigmatisation of people who would engage in casual practices. Vincent believed that Asian communities would be more likely to exude such stigmatising attitudes.

In general, my impression is that Asian people do value sex ... as something that is not just for casual fun, so there is stigmatisation if you're someone, that you're sleeping around with lots of different people and that's usually perceived negatively compared to other ethnicities. So, because of that, I would imagine that HIV, because it would, because it would be, although it's not a causation but probably [HIV infection is] associated with higher frequencies of sleeping with other people so, I guess from that I would think it would be higher stigmatised in Asian population. (Vincent)

Vincent believed there was a link between rejection of sex as a commodity-type pleasure and stigmatisation of PLHIV. He felt that people who had multiple sexual partners were accepted way among Asian communities, and there was an assumption that contracting HIV was a result of promiscuity.

Vincent saw these conservative attitudes as problematic, and he experienced their consequences himself. He shared that he would not be comfortable disclosing to other

people, including his gay Asian friends, that he was in a relationship with someone living with HIV.

No one knows that I had a HIV [-positive] partner, it's not something that I disclose to people. I don't really disclose my sexual activities to people, either. Yeah, it's not something we talk about. I don't really like to disclose a lot of my personal information to other people. ... it's not easy for me to trust people with this sort of information. I feel that people are quick to misunderstand, quick to label, quick to gossip, so I don't want to disclose that sort of personal information. (Vincent)

Vincent never disclosed to anyone he was in a relationship with a partner who was living with HIV. He believed it was a deeply personal fact of life and talking about it would be similar to talking about sexual practices; and that was not something he would do either. Vincent shared that he had many reservations about sharing any personal information with others, because that would leave him vulnerable to judgmental attitudes and possibly social ostracism. I understood that he felt that other people would make assumptions he recounted earlier: assumptions that HIV infection was a result of promiscuity.

The fear of social stigma of HIV resulted in the need to maintain an elaborate strategy to avoid contracting the infection, especially within developing relationships. Vincent shared how he navigated safety with new partners and how PrEP could influence this process. Importantly, as noted earlier (see Chapter Five), he was not using PrEP at the time of the interviews because he was not sexually active. However, Vincent did not exclude starting PrEP again, with new partner(s).

I would [have condomless sex with a new partner]. That's obviously on the premise that we both know our testing results and we confess that to each other. ...

Yeah, the reason why I can feel I can continue to keep using PrEP if we [me and my new partner] both tested negative is, firstly, the window period. As I mentioned that, this person may not know they have HIV. Secondly, this person may go out and do

other things which I may not know about, so I want to protect myself from that...

(Vincent)

Vincent would only have condomless sex with a partner after they both tested for HIV and shared their results with one another. Even if the results were negative, he would still consider using PrEP to account for the testing window period. A further motivation to keep using PrEP in a monogamous relationship with a partner who has tested negative, would be to ringfence himself from risk in case Vincent's partner was unfaithful to him or did not disclose all of his past and present practices. Similar to the preventive measures he undertook with his former partner, Vincent was willing to apply a rationally designed, fail-safe safety net, that he could be in full control of.

Vincent's account underscored the tension between rational behaviour planning that accounted for all the inherent risks of sexual practices and the need for intimacy and relation building. The role of PrEP was to boost confidence he remained safe and in control of his own health, while developing the meaningful relationship with his partner living with HIV. Through the use of PrEP, Vincent was able to ensure independently from his partner that all possible rational steps were taken not to contract HIV, which still appeared as a "risk to life." For him, PrEP had the power to transform condomless sex into safe sex, regardless of the use of condoms. Even though Vincent no longer used PrEP because his circumstances changed, he believed he would likely consider using it in the future.

Vincent contextualised his experience within the cultural norms existing within the Asian gay community. He believed that, unlike the mainstream Western gay culture, Asian gay men prioritised long-term relationships, and the primary function of sex was to build meaningful relationships. Vincent felt that the Asian gay communities perceived casual sex as immoral and that fed into the stigma of HIV; there was an assumption that people who contracted HIV would be likely to frequently engage in casual sex. Conservative attitudes were previously described as common among Asian gay MSM living in Aotearoa New Zealand (Adams & Neville, 2014). Vincent never told anyone he was in a relationship with a man living with HIV, because of concerns of judgmental

attitudes or becoming a subject of gossip. While maintaining the feelings of intimacy in a developing relationship, PrEP provided him with a safety net that could not only shield him from the biological risks of infection, but also its social consequences in the form of stigma.

Discussion

While sharing diverse experiences, the participants whose accounts I presented within this chapter told a consistent story of PrEP as primarily a liberating agent. The freedom which it afforded was a freedom from the constraints of conventional and restrictive sexual ethics, from fear of HIV infection, from taboos associated with living one's corporeality, from coercion, and from the established notions of what "safe sex" meant. Through redefinition of the term, PrEP enabled a new *safe sex* that did not require the use of condoms or negotiating with partners but was simply a matter of personal choice to use a pill. PrEP resulted in more than only the removal of constraints to the enjoyment of sexuality with partners. It created conditions that allowed personal agency to the realisation of a positive freedom (understood as *freedom to*; Berlin, 1966) to explore one's sexuality, and safely transgress the boundaries of homonormative practices. In other words, PrEP was the enabling agent that laid foundations for the discovery of sexual sovereignty and independence.

Unlike condoms, PrEP offered the participants the benefit of retaining full control over their sexual safety, in a manner entirely independent from their partners. In some of the accounts PrEP protected its users from partner(s) attempting to stealth them and it offered additional security in situations where partners would not disclose their sexual history or HIV status. On the other hand, PrEP also protected participants from unknowingly transmitting HIV to their sexual partners, and in doing so, shielded them from feelings of guilt.

Participants shared that using PrEP resulted in increased intimacy afforded by enabling condomless sex; it removed the physical and symbolic barriers between the

partners. PrEP also offered some participants a transcendent or *ecstatic* experience of fully committing to sexual connection with a partner(s), which they described in spiritual terms. This led to radical acceptance of sexual practices, as long as they were consensual.

The participants were mindful of PrEP not offering protection from other infections, but were mostly willing to accept the risk, as they realised their PrEP regimes included frequent screenings which would be followed by prompt curative treatment in the event of infection. Most of the participants viewed the risks associated with the risk of STIs as minor, because of their typically mild course and curability, as well as less social stigma. Some of the participants shared that they were aware of the modelling studies that indicated that PrEP had the potential to decrease the community incidence of STIs, when coupled with frequent screening.

Some of the participants shared that PrEP also encouraged them to seek partners who used a form of biomedical HIV prevention, whether it was PrEP or antiretroviral treatment, as they both resulted in more frequent STI screening and implicated self-care. This biomedical-sorting presented a clear shift from the earlier described serosorting, and participants tended to view this as a more rational and morally acceptable way of selecting sexual partners.

Critically, for some participants, PrEP use and the enabled condomless sex offered a chance to safely transgress the social norms and interrogate what constituted normative practices and identities, and for what reasons. Resistance against externally imposed norms ranged from resisting the extrapolation of heteronormative notions of sexuality onto gay communities (homonormativity) and the enforced ideas of gendered and/or normative desirability to resisting Pākehā ownership of PrEP. A participant of Asian heritage shared that PrEP emerged in the context of his resistance against sexual objectification which he perceived as common among many mainstream gay communities in Aotearoa New Zealand.

Transgressive Intimacies

The decided improvement in the quality of connection with partners was raised as one of the main benefits of condomless sex enabled by PrEP in this project. Intimacy-seeking has been noted in literature as a key driver to condom non-use among gay and bisexual men, likely of more significance in predicting sexual behaviours than perceived risk reduction and attitudes centred around the loss of physical pleasure (Golub et al., 2012). Studies also found that expectations around intimacy increase were central to PrEP motivation in male couples (Gamarel & Golub, 2015): a finding that was echoed among the present study participants who were in non-exclusive relationships, but also among those who were single. Intimacy has been often understood narrowly as a component of human connection (love), that develops gradually within meaningful and lasting relationships (e.g., Sternberg, 1997). However, in the accounts of the participants of the present study, intimacy was a quality that could emerge in any sexual relationship with another man and strengthen and make meaningful the bond, no matter how long- or short-lived. It is worth observing that in the participants' accounts, the lines demarcating the boundaries between physical and emotional intimacy were blurred.

Notably, the participants of the study were among a group of men who started using PrEP early in Aotearoa New Zealand and had to demonstrate resilience and significant personal motivation to access it (see Chapter Six). Additionally, they had to guide their own learning about PrEP and they typically reached the decision to start using it independently from their healthcare providers. In other words, PrEP initiation required significant commitment from the outset of its use, so the expected benefits had to be significant to persevere. I would argue, that for most of the participants those benefits centred around intimacy gains. This intimacy, however, should be understood broadly: as a feeling of connection with partner(s), but also as an attempt to transgress the boundaries of everyday experience together.

A promising lens of interrogation to understanding of pleasure derived from intimacy made available to gay and bisexual men through condomless sex has been offered by Longstaff (2019). He described bareback sex and its pornographic

representations in connection to the concept of *jouissance*. Within Lacanian psychoanalysis, *jouissance*, which can be roughly translated to “enjoyment,” denotes a “pleasure” that evades the understanding of Freudian pleasure principle (Krecic & Zizek, 2016). It can be understood as deriving joy from transgressing the boundaries of pleasure, thus becoming an *excess* of pleasure. Experiencing *jouissance* as opposed to experiencing *plaisir* is not necessarily an *enjoyable* experience in the traditional meaning of the word. It can be experienced as pain or excess of sensation (too much). From a Lacanian psychoanalytical perspective, the experience of *jouissance* is derived from splitting or division of the Self (Longstaff, 2019). I argue that when one of the participants, Connor, referred to *ecstatic*³ experience, it was a phenomenon alike *jouissance* that allowed him to transcend everyday life and experience the connection with his partner on a spiritual level. Some authors discuss *jouissance* in the context of non-mainstream or extreme sexual practices, from consensual BDSM sex to sadistically motivated homicide (Benedicto, 2019), but also in the context of bug chasing understood as deliberate attempt to contract HIV (Tomso, 2008). The concept of *jouissance* was proposed by Lacan largely in opposition to the Freudian death drive (Vincent, 2020): the auto-aggressive component is therefore clear for practices such as BDSM or bug chasing. However, such strong experience of *jouissance* of condomless sex while on PrEP, with the risk of HIV transmission eliminated, can only be derived within the historic context of AIDS, and this was represented in the accounts of the study participants when they talked about transgressing the rules of safe sex, or in other words, aiming for the forbidden fruit.

Using critical discourse analysis, Souleymanov et al. (2019) found that biomedical HIV prevention methods shifted the discourses resulting in reinterpretation of HIV prevention practices, which also became apparent in the accounts of participants of the present study. While gay and bisexual men were earlier socialised to rely on

³ It is noteworthy that the word “ecstasy” derives from Ancient Greek *ἔκστασις* (*ékstasis*), and could be translated as “standing outside” (Blackburn, 2008), denoting the state of being outside of normal inner (mental) state.

behavioural methods (chiefly condoms), the contemporarily prevailing discourses started underlining using medication and relying on biomedical markers, such as viral loads. The authors stressed that inequitable access to PrEP resulting from barriers experienced disproportionately severely by individuals of certain demographics (e.g., people of colour, with diverse gender identities or expressions, lower socioeconomic status, rural-living, and others) may result in further exclusion of those unable to access it. Studies (Wang et al., 2019) suggesting an increase in the extent of biomedical-sorting (or PrEP-sorting) overseas appear to provide preliminary support for such concerns, as biomedical-sorting can result in dividing communities into those who can access modern prevention and those who cannot. Therefore, great care should be taken to ensure access to PrEP is equitable. It is worth noting that studies conducted in Aotearoa New Zealand provided evidence that with purposeful programmes, increasing equitable PrEP uptake is possible (Saxton et al., 2019).

Confronting and breaking taboo is erotic (Bataille, 1986). Participants identified that condom non-use was continuously transgressive. Through decades of public health messaging and consistent community practices, condoms had become synonymous with safe sex. In connection to the fear of HIV and negative labelling of unreliable users, condoms had also become the epitome of responsibility and a proxy to classify gay men as moral or immoral. Despite PrEP eliminating a large part of sexual risk, this moral connection lingered and required the participants to position themselves within this larger context. The perception that condom use had become moralised was also identified earlier in an American qualitative study of PrEP users (Dubov et al., 2018), but such notions were not previously confirmed within Aotearoa New Zealand among gay and bisexual men. Importantly, participants in the present study shared that PrEP empowered them to critically reflect upon such moralisations and unpack the community sexual ethics which they earlier accepted without much reflection, as they appeared natural (dehistoricised).

In a blog entry provocatively and meaningfully entitled *Your Mother Liked It Bareback*, King (2013) noted that condomless sex can only become moralised to the

extreme extent when discussed in the context of non-heteronormative sexualities. For heterosexuals, condomless sex is simply sex: it is naturalised and dehistoricised, viewed as ordinary. In heteronormative cultural discourses, non-reproductive sex of homosexual subjects, however, is presented as less valuable, empty, purposeless, and vain, and as such becomes an easy target of moral scrutinising and condemnation (Edelman, 2004). In other words, the strong cultural contexts of HIV/AIDS along with “deviant” sexuality, together facilitate pathologising the phenomenon of not using barrier protection.

Resisting the moralisation of prevention message and of the gay erotic habitus has not only emerged with the introduction of PrEP. Rofes (2002) pointed that some community groups viewed condomless sex and other taboo-driven realisations of desire as a right of gay men as they constituted resistance to colonisation of the space of community sexuality. Public health messaging and its proponents became the coloniser: an alien element eager to violently impose values and therefore control the communities. The resulting moralisation of prevention within gay communities which equated condom use with the “good” and condomless sex with the “bad” was therefore a natural consequence of the rise of homonormativity.

The idea that gay men accepted their citizenship in return for repudiating the forbidden practices (Ashford, 2015) had significant consequences for discourses surrounding HIV prevention. It is notable that many years after the emergence of HIV, the understandings of failings of modern HIV prevention continue to rely on the familiar repertoire of individual guilt attribution. In a chapter of his book, published posthumously in 2007, Rofes wrote:

Most contemporary discussion of HIV and gay men today romanticizes gay men's AIDS response in the 1980s and blames current shifts in gay men's attention to issues and sexual practices to either the new treatments, young men's supposed sense of invulnerability, or the so-called complacency of contemporary gay men. Health providers and activists alike, unable to consider big picture questions about gay men's identities and desires, default to shaming and fearmongering. The primary

approach to education and prevention continues to be an attempt to re-create the crisis culture we inhabited in the 1980s. Absent the urgency linked to catastrophic decimation, preventionists seem at a loss about what to do. (p. 6)

Despite the increasing presence of sex-positive messaging, and rejection of fear-based prevention campaigns in many countries, including in Aotearoa New Zealand, participants in the present study spoke about the continuous presence of a strong discourse of urgency within the community, reflected by a ubiquitous sense of danger and pervasive fear of infection. The use of PrEP, however, offered them an alternative from making the choice between what used to be oppositional values: personal safety and freedom to explore their desires. During the interviews, some participants shared their views that gay identity was rooted in the pursuit of desire, and that was what differentiated them from the heteronormative majority. The ethos of sexual experimentation distinguished gay culture from the mainstream and offered them a sense of community linked together by shared values and meaningful participation in sometimes non-normative sexual practices (such as BDSM or orgies). In many ways, the construction of these alternative communities, facilitated by the use of PrEP, was subversive against the heteronormative and homonormative orders.

Loss of Anxiety and Risk of STIs

The loss of sexual anxiety following the initiation of PrEP has been well evidenced in other qualitative (e.g., Whitfield et al., 2019) and quantitative (e.g., Keen et al., 2020; Moeller et al., 2020) studies. The feelings of sexual freedom, and enhanced pleasure and intimacy were also identified among gay and bisexual PrEP users who had used condoms inconsistently prior to PrEP overseas (Quinn et al., 2020). Notably, most participants of the present study reported no or very rare condom non-use prior to PrEP initiation, followed by a loss of consistency in condom use after starting it. Such findings are in line with other studies signalling the possibility of the so-called risk compensation after PrEP had been started (Milam et al., 2019). However, it is important to note that the

large scale extent of risk compensation is debatable, and many large PrEP studies failed to observe such effects in their samples (Marcus et al., 2018). In light of the participants' accounts, I would propose that in some cases the "risk compensation" may not be the effect of loss of motivation to use condoms because of lower perceived risk, but rather the very reason for PrEP initiation, or one of the main motivators for its use.

Aside from reservations relating to morality, common concerns surrounding the proliferation of PrEP among MSM include the risk compensation as a causal factor leading to increased STI incidence (e.g., Kolodziej et al., 2016). It is worth noting, that the implications for the incidence of other STIs resulting from lowered condom use among PrEP users are unclear, with studies showing mixed results (Quaife et al., 2019). There is not much debate that PrEP user populations tend to be characterised by higher incidence of STIs (Ong et al., 2019). However, it is difficult to distinguish the cause and effect, as PrEP users tend to recruit from the high-risk sub-populations of the MSM communities, and in most settings the criteria for PrEP provision require a history of high-risk sexual practices; therefore making assumptions about the causal connection between PrEP use and STI incidence controversial (Marcus et al., 2018).

It is plausible that increased STI incidence among PrEP users may be a result of underlying high-risk practices that increase the likelihood of initiating PrEP. When coupled with comprehensive STI screening, as is currently recommended by guidelines (ASHM, 2019) and required in Aotearoa New Zealand (PHARMAC, 2018), PrEP has the potential to reduce the burden of STIs among populations at high risk of HIV infection (Werner et al., 2018) through diagnosing and treating infections early, effectively breaking the chains of transmission.

Liberation Through Biomedicalisation

Participants consistently spoke about feelings of freedom or liberation across different contexts. Clearly, the main feeling participants wished to free themselves from was fear. However, the experience of freedom extended also to letting go of the condom-

mediated sex in order to be able pursuit what participants viewed as more spontaneous or even transcendental experience of condomless sex. These findings echoed the results of the qualitative Canadian study (Grace et al., 2018), which identified liberation-centred narratives emphasising liberation as freeing from constraints of reliance on condom use. The authors of that study found that PrEP illuminated for its users the structural stigmas around sex and sexuality, particularly stemming from the anti-gay beliefs.

The accounts of the participants presented in this chapter seemed to emphasise the internalised community moralisations of HIV prevention, that were not necessarily a direct result of external homophobia or anti-gay prejudice. I interpreted them as the direct effect of a persisting entanglement of HIV threat and sexuality within the gay community (Ashford, 2015), which in turn resulted in moralisation of HIV prevention discourses.

It is important to note some limitations of the freedom that was afforded by PrEP. For condomless sex to be safe, it is still required to access medical care, and use a pharmaceutical agent. In his reflective account, Connor (p. 192) shared that upon initiation of PrEP, along with the immediate freedom from fear and emerging feelings of independence, came reliance on medical screenings, STI treatments, prescribing system, and other oppressive biomedical elements. In other words, what freedom was gained in letting go of the barrier prevention constraints, it was lost by having to subject to the governing system of biopower. In a paradoxical way, PrEP led to feelings of entrapment in the system.

Barebacking and Eradication of Risk

None of the participants identified themselves with either an identity or subculture of “barebackers.” The use of the word “barebacking” appeared limited to describing practices of condomless sex, and there appeared to be no preference for the term over other descriptive terms used, such as “condomless sex,” “sex without condoms,” “unprotected sex,” occasionally “raw,” “natural sex,” and others. In light of

the practices that appeared to dominate within the group of the study participants, namely: consistent condom use prior to PrEP initiation, I would argue that the participants were specifically not barebackers in a subcultural sense.

As described in more detail earlier (Chapter Two), some authors (Dean, 2009) propose that the subculture of barebackers exists, that could be characterised by common understanding of risks around condomless sex and making a decision to bareback regardless of – or perhaps in response to – these risks. I propose that the participants in the present study believed they effectively eradicated the risks with the use of PrEP, and, after a period of adjustment, were able to enjoy condomless sex without feeling at risk. It is important to note, that true PrEP failures (not due to lack of adherence or undiagnosed acute retroviral infection before PrEP initiation) are considered to be rare (Molina, 2019). All of the participants in the study engaged in significant research to make sure that their decisions were well-founded on evidence, and most were comfortable enough with the level of efficacy afforded by PrEP to have condomless sex without fear.

The decision to use PrEP and trust in its effectiveness, despite being largely driven by intimacy- or pleasure-seeking, was internally rational and followed by careful risk analysis. As a result, participants reported a range of intentions related to frequency of condom use. For some of the participants, the remaining risks, such as extremely small residual risk of HIV infection or risk of other STIs were significant enough to continue warranting using condoms in some or most circumstances. However, also for those who did not see the risks as justifying continuing condom use, the resulting decision was taken in a rational manner, carefully weighing the risks and benefits, and considering the emotional or sensual benefits.

Conclusion

Dean (2015) argues that PrEP offers “a license to enjoyment” and presents an “*idea* about what worry-free sex between men in the 21st century might be” (p. 229). He

further argues that “it is this idea that has provoked such strong and opposing reactions, especially among gay men” (Dean, 2015, p. 229). As I have demonstrated throughout this chapter, within participants’ accounts lingered a tension between the pursuit of liberating sensual and interpersonal pleasure and the moralised “correct and sensible” ways to prevent HIV based on decades of barrier prevention education and public health messaging. PrEP has redefined the boundaries of these notions and reinforced the inherently transgressive habitus of desire, while at the same time creating space where the former beliefs could be suspended and interrogated. The different ways in which the participants made meanings of PrEP demonstrated a range of motivations for its use that were positioned on fluid and no longer mutually exclusive dimensions of rationality and pleasure-seeking. The accounts also served as an example how enacting non-normative desires may aid in constructing subversive communities. In the next chapter, I will summarize the findings of this study, identify how they contribute to theory, and offer some recommendations for practice

Chapter Nine: Conclusions and Recommendations

...In that Empire, the Art of Cartography attained such Perfection that the map of a single Province occupied the entirety of a City, and the map of the Empire, the entirety of a Province. (Borges, 1998, p. 325)

By way of introduction to this final chapter, I present a fragment from a short story *On Exactitude in Science* by Jose Luis Borges (1998). It tells a legend of a fictional ancient empire, whose main scientific focus became cartography, and so, its scientists set out on a pursuit of creating the perfect map. Their efforts had culminated in creating a 1:1 representation of the empire, which they then imposed on its land, point for point. As a result, this hyper-exact map, of course, could not serve any practical purpose, yet its remains were all that was left of the empire's scientific accomplishments after its later demise. After Baudrillard (1994), I refer to this short story as a metaphor of how the dehistoricised hyperrealities become constructed as seemingly ahistoric, objective "truths" that obstruct the underlying realities and generate principles guiding individuals and communities to establishing the boundaries of possible discourses (doxa).

In this chapter, I will summarise the findings of the project, and I will offer recommendations regarding its implications for theory and practice of engaging with individuals who use or could benefit from using PrEP. I will also identify how the project may help inform public health messaging.

This research project sought to answer the question about the meanings gay men make of PrEP use in the diverse social, cultural, and historic contexts in which they access and continue (or discontinue) using it. Through the enquiry I found that there is no simple answer to this question, and this chapter will summarise the multifarious practices and meanings I discovered through engaging with the participants' accounts.

This study contributes to the body of knowledge concerning personal motivations to use biomedical methods of health prevention by marginalised populations. The findings of the thesis, as informed by methodology that emphasised the co-creation of knowledge by participants and the researcher, revealed the complexities of navigating biomedicalised interventions and retaining (or even increasing) feelings of individual agency.

The study contributes to the literature in informing the understanding that disease avoidance may not be the key motivator to engage with HIV prevention, at least among some of its users. The lived experience framework used, through privileging the user experience, extended the knowledge that preventive practices are phenomena lived in the socio-historical contexts of moralised hetero- and homonormative discourses which may morph over time and influence the production of new discourses that, in turn, will inform these practices.

The study adds to the body of knowledge about the possibilities surrounding using prevention (both PrEP and condoms) at the intersections of desire and risk in socially relevant contexts. Through the project, I found that accessing and navigating novel methods of prevention may require resilience in navigating heteronormative and Pākehā-centred services, especially in primary care. Facilitating factors may include empowerment through the cultural legacy of pioneering HIV prevention among gay-identifying men and feelings of community responsibility. An important contribution to the existing literature was documenting that some men who have experienced the AIDS crisis first-hand may now experience the end of an era afforded by removing some of the social burdens of HIV risk.

The study further extended the knowledge that erotic gay habitus may entail resistance to heteronormativity and transgression. Some HIV prevention users may continue to resist the prevailing preventive narratives, and novel methods of prevention may enable doing this safely. This is because they are not yet submerged in dominant discourses and thus enable autonomous construction of new narratives around them that can be owned by communities.

The study also extended the understanding of intimacy as a broader phenomenon that gay men may perceive as significant regardless of relationship exclusivity, longevity, or personal commitment. Previous research identified intimacy as an important motivator to condomless sex (Golub et al., 2012), signalling that individuals in exclusive, long-term relationships may be less inclined to use condoms. However, the present study found that intimacy-seeking may be an important factor also in relationships that are very short-lived or casual.

As I found, among gay communities in Aotearoa New Zealand, condom use served as a proxy measure of one's morality. The redefinition of the risk context with novel methods of prevention, through removing an obvious link between condomless sex and HIV risk, may not necessarily immediately remove the moralised loading of condomless sex.

On the theoretical level, I found that interrogating sexual and health "behaviours" as *practices* in a Bourdieusian understanding enriches the understanding of minority populations epistemic frameworks. Resistance can constitute an important component of the minority group habitus. This may be seen as somehow paradoxical, as habitus is typically purported to support and reproduce the social order(s). I found that this *transgressive habitus* is not oxymoronic, as it reflects and reproduces the (heteronormative) social order that requires non-heteronormative populations to construct oppositional systems of understanding and functioning to reproduce the differential social positionality. There is value in constructing these minority understandings that, I found, can successfully provide meaning, agency, and feelings of freedom when integrated into evolving systems of beliefs and discourses. I propose then, that in researching minority populations, consideration of internally coherent discourses (whether oppositional or not) is useful in understanding the agentic and subversive meanings in accessing and using emerging new health technologies.

Researcher Subjectivity: My Research Journey

Because of the intersubjective epistemological orientation of this project that emphasised the need to acknowledge the researcher's prejudices and subjectivity, I will start with reflecting upon my doctoral journey and the research process that ultimately led to submission of this thesis.

In previous chapters, I discussed my initial motivations to undertake this research (Chapter One), and theoretical frameworks informing my understanding of research reflexivity along with my preunderstandings surrounding the use of PrEP (Chapter Three).

Reflexivity is an important part of qualitative research (Maso, 2003). In essence, reflexivity, as I understood it during undertaking this project, means making explicit the researcher subjectivity, and uncovering what in positivist research could be called "biases." When these "biases" are laid out and made conscious, they can contribute to the understanding of research phenomena, instead of being treated as confounders or distracting factors. Such understanding of researcher reflexivity is particularly useful (and emphasised) within the epistemological framework of Gadamerian hermeneutical phenomenology (Gadamer, 1975) that seeks to establish intersubjective truths about phenomena that emerge enabled by fusion of horizons in pursuit of understanding (Vessey, 2009). Laying bare researcher preunderstandings is a necessary element of assuring researcher integrity, as "prejudices are viewed as essential to the process of understanding, because they are inevitably used with every act of understanding" (Watson & Girard, 2004, p. 877). In contrast with some other phenomenological currents (e.g., Husserl's approach), Gadamer stipulates that bracketing, understood as suspending own judgments, is never possible (Laverty, 2003).

This research project spanned over four years and played out within a rapidly changing landscape of HIV prevention, including significant changes in PrEP policy and accessibility, but also the introduction of universal antiretroviral coverage across

Aotearoa New Zealand. At the same time, my involvement in the project had a great impact on my life, on both professional and personal levels.

The undertaking of this project was the direct reason for me to migrate to Aotearoa New Zealand from my native country (Poland). It was my first experience of immersing myself in long-term life in a foreign country and speaking a foreign language on an everyday basis. As I discussed earlier in the thesis, I was aware of the implications of assuming a dual role of an insider-outsider when engaging with the participants. During the project, and my stay in Aotearoa New Zealand, I got to experience the duality of the role: as someone identifying with the LGBTQ community, but also an outsider, with unclear social identity, an unusual and difficult-to-clearly-identify foreign accent, and different life experiences.¹ The project prompted me to interrogate my belonging to the gay community in Aotearoa New Zealand, and the Western LGBTQ community altogether. I discovered that my personal experiences of social stigmas of queer identity and social positioning of non-heteronormative practices, despite some similarities, was distinct to the participants'. Poland has been recently classified as the most LGBTQ-unfriendly state of the European Union (ILGA Europe, 2020), and I believe this classification is an accurate representation of the living conditions of many individuals belonging to gender and sexuality minorities. The reasons behind this are complex. The social and political realities of anti-LGBTQ prejudice in Poland extend beyond the essentialising narratives of "Eastern European, post-communist mentalities" or viewing civil rights advancement of LGBTQ communities as simply delayed in relation to Western Europe. The historical contexts for legal recognition (or persecution) of non-heteronormative sexualities are very different between Poland and many Western European states, which highlights that gay rights advancement processes do not always follow the same Western patterns. For instance, contrary to the Commonwealth states or

¹ Eastern European identity status is complex. It has been argued that, in many Western countries, Eastern European identities are racialised and positioned outside of the hegemonic categories as "not-quite-white" (Lapiņa & Vertelytė, 2020). These issues become more complex when taking into account the increasingly racist rhetoric of some of the Eastern European governments, including the Polish government, that draws on radically essentialising views surrounding ethnic identities (Böröcz & Sarkar, 2017).

the countries of former Soviet Union, Polish laws (whether in sovereign Poland or under the communist regime) have never criminalised consensual homosexual practices.

Despite significant overrepresentation of gay men among PLHIV in Poland, the AIDS crisis was largely invisible (much like the communities most affected) to the mainstream society. Even though I was professionally involved with the HIV sector in Poland, I have never felt there was a shared legacy of the AIDS crisis within the gay community except for the increased social stigma against persons living with HIV, typically assumed to be gay or having a history of injecting drug use. Only when I moved to Aotearoa New Zealand, and especially after having worked with Body Positive, I started to truly understand the community whakapapa of AIDS responses, and it made me reflect on the sad reality of the suppression of voices of Polish gay men who suffered great losses during in the first phases of AIDS epidemic.

I outlined these reflections on my positionality to make explicit the contexts of personal experiences within which I navigated as a researcher and an interviewer as I was trying to understand the meanings participants made in connection to the history of HIV and prevention. Some of these thoughts only occurred to me at the final stages of working on this thesis, while others were constantly present. In some ways my subjectivity presented a privileged position of “best of both worlds,” of insider-outsider, emic-etic (Harris, 1976) interviewing. Being an outsider helped me during the interviews, because it was easy for me to interrogate some notions that participants believed were obvious or unworthy of mentioning. On the other hand, I felt my insider status of a gay man helped me gain their trust because of certain shared epistemic frameworks.

The research I undertook also affected me deeply as a researcher. Before engaging with this project, despite my psychology and psychotherapy experiences and training, I had little exposure to qualitative research. My initial research proposal submitted to Graduate Research School at Massey University relied primarily on quantitative methods. Only during the project development, I really started to learn

about the use of qualitative research methods, and I understood their role in the social sciences repertoire.

Considering the profound changes in my personal life that followed directly or indirectly from the project and involved changing countries, jobs, finding new social networks, and starting a new long-term relationship, I must admit that this research project of over four years has transformed my life.

Summary of Findings

The aim of the project was to provide insights into the meanings PrEP users make of PrEP use in the diverse social, cultural, and historic contexts in which they access and continue (or discontinue) using it. The focus of the thesis was therefore on the socially and historically contextualised lived experiences of PrEP users. One of the key problems that the project provided answers to was how PrEP impacted on the ways in which participants navigated the intersections between desire and risk.

The presentation of the participants accounts was divided into three chapters (Part Two: Chapters Six to Eight). The first of these chapters (Chapter Six) focused on accessing PrEP, and discussed learning about it independently from healthcare practitioners, followed by their pursuit of access, and motivations to its use. It also focused on the barriers to access, including heteronormative practices in healthcare and deficits in culturally appropriate services, including for takatāpui clients. I argued that the self-initiation of PrEP followed the cultural whakapapa of Aotearoa New Zealand gay communities, accustomed to taking ownership of the community and individual HIV prevention, and active self-advocacy. Participants shared how they faced heteronormative and sometimes stigmatising practices from healthcare providers, and how they showed resilience in persevering through the difficulties to successfully access services they needed. An important strategy of coping with difficulties was through subversive humour, either while facing the challenges or retrospectively discussing them. The participants also raised the issues of community ethics, where PrEP was not

merely an agent of personalised risk reduction but rather served dual eudaimonic purposes, and they attributed these functions as guiding their motivations to use it. Firstly, the use of PrEP had the potential to bridge the serodivide and allow safe connections with men living with HIV. Secondly, the use of PrEP was viewed as good for the community disproportionately affected by HIV and stigmatised by wider society, and so the participants were highly motivated to share and facilitate access to PrEP for others. Additional challenges were signalled by the Māori participants, who shared that they needed to demonstrate significant resilience to be able to access sexual health and PrEP services, which were not geared towards meeting the needs of takatāpui. They recognised that other, less resilient or less health-literate men, in particular those living outside the main urban centres, could be unable to effectively learn about and initiate PrEP.

The second of the findings chapters (Chapter Seven) followed the unique experiences of Allan, a participant who came of age during the AIDS crisis and therefore had a distinct generational experience. Allan described PrEP as a gamechanger, or a significant milestone in the history of HIV within the gay communities. He believed that PrEP coupled with the well-established knowledge that maintaining suppressed viremia leads to non-infectiousness (U=U) were needed to finally bridge the divided community and undo some of the social and psychological damage of the AIDS crisis and its sequelae. Allan shared how PrEP, by redefining safety in sexual connection, had the potential to recover the lost erotic habitus of gay men which relied on reproducing boundless intimacy and connection as means of transgressive intimacy that differentiated gay communities from the heteronormative majority. In Allan's account, PrEP decontaminated (purified) gay bodies and bodily fluids and at the same time removed anxiety and mistrust that had become entangled with sexual connection as a result of the AIDS crisis. I argued that Allan's experience illustrated a circular trajectory of experiencing HIV and prevention that was now complete and had the potential to recover the pre-AIDS meanings of sexual connections for men of the AIDS generation.

The third and final of the findings chapters (Chapter Eight) focused on the experiences of the remaining participants who used PrEP placing emphasis on the meanings they made of the changes in their sexual practices and experiencing pleasure, intimacy, and desire. Because PrEP was seen as a liberating agent – and part of this liberation was to free its users from the imperative to use condoms – I interrogated notions of condomless sex, and their opposite: sex with condoms. In their accounts, the participants also shared their perceptions of the potential increased exposure to other STIs, often raised by the health sector as a concern when discussing the implications of PrEP use. Notably, most participants did not perceive STIs to be seriously threatening. They usually recognised that an appropriate way of addressing the risk of STIs was to access regular screening, as part of PrEP provision, and maintaining open channels of communication to notify sexual partners. Throughout Chapter Eight, I presented participants’ accounts that shared a perspective of PrEP as a liberating agent, that encouraged agency and increased intimacy. The liberation that followed PrEP initiation removed the constraints of moralised barrier prevention, that equated moral “good” with condom use, and was ultimately a manifestation of a homonormative order. By redefining the boundaries of sexual risk, PrEP allowed the participants to safely interrogate notions such as “safe sex” and rediscover sex as a spiritual experience, that allowed to disconnect from the constraints of everyday life and create new intimate connections or even sexual communities free from fear. At the same time, PrEP allowed participants to experience sexual sovereignty, where their preventive options no longer required negotiation, and were entirely within their control. Some of the participants felt that PrEP also protected them from partner coercion or deception (e.g., stealing). An important aspect of the transformed sexual experience was an increase in feelings of intimacy and sexual connection afforded by *safe* condomless sex. Participants shared how these experiences were now perceived as more meaningful, bringing more pleasure, and for some of the participants, they were deeply spiritual or even transcendental. At the same time these experiences allowed safe interrogation and transgression of moralised boundaries of sexual practices, that were now uniformly permitted, provided they were consensual. For the study participants, PrEP use was

transformative and encouraged a redefinition of safety/risk dimensions, which now enabled enacting non-normative desires without compromising participants' and their partners' safety.

Limitations: Truth Within the Method

The hermeneutical epistemological underpinnings of this project emphasise the intersubjectively derived "truth" of the phenomenon, that emerges in the interaction between the researcher and the text. Such method of analysis is highly interpretive, and encourages selective reading, in search of new horizons (Paul, 2012), therefore explicitly recognising researchers' preunderstandings or prejudices (Whitehead, 2004). In earlier chapters, I attempted to outline my preunderstandings and I indicated how they may have affected the interviews I conducted with the participants. It is useful to restate here that these preunderstandings were also present when selecting the participant quotes to include in this thesis, therefore privileging parts of participants' experiences, possibly at the expense of others. Watson and Girard (2004) emphasised that awareness of own preunderstandings is a necessary part of ensuring researcher integrity, and I aimed to signal them throughout the thesis.²

From the perspective of the study findings interpretation, it is important to recognise some limitations associated with the design of the study and circumstances of participant recruitment and data collection.

The number of study participants was relatively small and provided for limited participant diversity. In Chapter Four, I outlined why the data saturation approach was not consistent with the epistemological orientation underpinning this research. In essence, the hermeneutic framework employed in the study emphasised the uniqueness

² *Integrity* has been proposed to replace "scientific rigor," as this latter term may be more appropriate for more positivist quantitative epistemologies where establishing "objective truths" is the aim (Watson & Girard, 2004).

of individual experience, and I was careful throughout the research process not to draw unjustified conclusions from participants' accounts, but rather describe the open possibilities of how PrEP can be construed and contextualised. That said, even though it is not the purpose of qualitative studies rooted in (broadly) phenomenological or constructivist paradigms to produce "truths" generalisable to larger populations using statistical methods (this would be rather a positivist undertaking; Crotty, 1998), it is possible that with the inclusion of a larger number of participants, more diverse findings could emerge. At the same time, seven out of ten of the participants identified with European ethnicities, even though efforts were made to recruit more diverse populations, and especially Māori participants. In hindsight, a longer time of recruitment, along with more intense efforts to facilitate chain referrals through Māori communities or targeted hook-up/dating app advertising were some measures that could aid in providing for more non-European representation. It is important that future research includes focus on PrEP agency as well as access issues among takatāpui and other Māori MSM populations. Incorporating kaupapa Māori research methodologies would likely aid in understandings of PrEP among the Aotearoa New Zealand Indigenous communities.

Secondly, participants' stories were shared with me at a very particular moment of PrEP roll-out in Aotearoa New Zealand. As discussed in Chapter Two, PrEP received public funding during the interviewing phase of the project, and this was reflected in participants' accounts. Even though this changing landscape resulted in the present study providing a unique perspective on the policy and implementation change, it also meant that some community practices and discourses were evolving. It is possible that between the data collection and the thesis submission phases of the study, along with PrEP use becoming more widespread in Aotearoa New Zealand, new practices started to emerge. However, it is worth noting that these radical policy and practice changes served as a reminder that HIV prevention and enacting desire always exist in dynamically contextualised environments.

Implications of the Study

Discussion of the detailed findings of the study can be found in individual chapters (Chapters Six to Eight), however, there are also some high-level considerations to be made. They stem from the entirety of the findings and pertain to theoretical underpinnings of enacting desire by gay men and understanding of their social spaces and conditions under which the sexual practices are practised. All of these factors constitute a backdrop against which HIV prevention plays out and they form a nexus within which individuals may access and continue engaging with preventive options.

The thesis examined the lived experiences of gay men living in Aotearoa New Zealand who used PrEP, but also attempted to portray how PrEP use affected their sexual practices and interrogate how they enacted desire in the changing contexts of HIV prevention. I drew on Bourdieusian frameworks of habitus to describe an evolving set of common social practices and argued that the gay habitus entailed elements of resistance and transgression aimed at existing in opposition to hetero- (and homo-) normativity. Even though desire is enacted as a social practice and within social contexts, it would be reductive to describe desire purely from the perspective of social practice, without considering its intrapersonal dynamics. Green (2008) argues that there is a need to provide a more unifying theoretical framework for desire that would overcome the limitations of psychodynamic and sociological approaches. Bourdieu proposes that habitus is always embodied, and this allows for its perpetual reproduction, without requiring intentional or deliberate action (Bourdieu, 1977). As a consequence of such understanding, there may be a temptation to see desire in a narrow way, reducing it to an embodied disposition mirroring the social order and one's position within it, and therefore contributing to the reduction of social practice theory to social determinism, incapable of providing space for change (Green, 2008).

Yang (2014) argues that habitus theory enables change, provided specific social conditions are met. Together, these conditions allow for recognition that there is a "mismatch," or an incompatibility of habitus and field.

Change can only happen when there is an open system that provides possibilities; there also have to be 'interrupters' who take advantage of that open system; and, lastly, 'reflexivity' has to overtake the inertia generated by the dysfunctional habitus when the interrupters enter the new field. (Yang, 2014, p. 1536)

I argue that the transformative function of PrEP was so successfully realised among many of the study participants because the conditions (as outlined by Yang) were met. PrEP was a catalyst that opened up the possibilities allowing new reflective interrogation of sexual practices and encouraged its users to become “interrupters” and question the moralised symbolic order of enacting desire.

Crossley (2004) proposes that understanding transgression and resistance within the gay culture(s) may provide better recognition of potentially risky sexual practices. Components of gay culture, such as pursuit of “forbidden” masculinised bodily pleasure, were transformed from what used to be covert safer spaces for enacting desire (such as men’s public toilets and glory holes) to contemporary fetishist cruising accessories and venues. Writing in pre-PrEP era, Crossley (2004) argued for unpacking the utility of transgressive habitus and for reflective moralisation of preventive practices, suggesting that mechanistic or amoral public health messaging may not be impactful enough. He argued that as consumerist societies tend to disconnect production (e.g., mass meat production industry or poor working conditions in manufacturing in many industries) from the worry-free pleasure of consumption, the same processes applied to contemporary gay culture when it attempts to repress the biological risks of condomless sex. In the present study however, participants shared how persevering the associations between immorality and sex were, even when the connection between risk and sex was severed, speaking to the effectiveness of pre-PrEP health campaigns in moralising sexual practices.

This thesis leans upon a broadly relativist understanding of sexual ethics, and throughout the interviews I understood that the normative codes associated with sexual behaviours are socially constructed, even though they may be seamlessly incorporated into an individual’s health beliefs system. Many participants shared this understanding

and put forward a radically sex-positive sexual ethic, that emphasised consent as both *sine qua non* and sufficient condition of permissible sexual practices. However, as I have tried to show, these sex-positive ethics were not only individually oriented, but extended to provision of PrEP to the community, with a strong inclination to extend the benefits of PrEP widely and equitably.

One of the key meta-themes of the study was that HIV prevention discourses are moralised and entangled in the homonormative order; or homonormative *fields* using Bourdieusian terms. Practices surrounding condom use or non-use were to a similar extent pragmatic as they were moral, and condom use/non-use played a role in positioning oneself in the homonormative moral order. This realisation was only enabled by PrEP, and participants found that their past preventative practices were driven by the prevailing moral norms that equated condom non-use with irrationality or “bad” behaviour, and condom use as enlightenment and “good” behaviour. In other words, condom practices became a proxy to use as a (self-) surveillance tool.

Baudrillard describes the relationships between reality and social symbols and practices in the contemporary societies in terms of simulation (Baudrillard, 1994). The social interactions become simulated operations occurring not in reality, but rather in hyperreality: an order where connection to reality is blurred, if not absent.³ Drawing on Baudrillard’s theory, it can be postulated that the introduction of PrEP made visible the disconnection between the reality where condom use materially reduces the risk of contracting an infection, and hyperreality where condom use is a goal on its own as a proxy measure of ethical behaviour or “decency.”

Altman (2013) argued that the right to sexual pleasure remains an important political demand among gay communities, despite the emerging assimilationist (homonormative) agendas. There are parts of gay communities for whom condomless

³ One classic example of hyperreality may be the capitalist system, under which exchange value has made use-value obsolete, or in other words: products or labour are *worth* as much as they represent in monetary terms, and not in terms of content or effort of labour. In late capitalism, sign-value (the expression of prestige, luxury or power) predominates over exchange value (Kellner, 2019).

sex is a manifestation of personal liberty (Dean, 2009). Whether it is disregarding or deliberately taking the risk of contracting HIV, engaging in condomless sex against the advice of public health bodies may signal an inclination to subvert the societal norms. It can be argued, writes Dean (2015), that “adopting Truvada risks defeating the purpose of bareback as a practice of resistance to mainstream health norms” (p. 233). As I found in the present study, PrEP redefines the boundaries of risk-taking, making transgressive or subversive motivations more complex. Building on Dean’s statement, I argue that adopting PrEP enables *safe* practice of resistance to moralised sexual norms.

On the other hand, resistance to health norms appears to be a possible reason not to use PrEP as it is currently provided. As I tried to demonstrate in analysing Connor’s account (Chapter Eight), gaining personal freedom from removing anxiety that comes with PrEP, may occur at the expense of increased dependency on the healthcare system. The biopolitical system of governance can be perceived as highly intrusive to some individuals, especially those embodying the habitus of transgressive desire, and so moving the locus of responsibility for HIV prevention from the individual to the health system can be undesirable. Dean later explains, “to be clear, I am not arguing that gay men should not take Truvada, only that there exist biopolitical side-effects (in addition to physiological ones) to mass compliance with pharmaceutical mandates” (Dean, 2015, p. 234).

It may be challenging for health professionals to assert their epistemic position within the resistance/biomedicalisation axis. It is useful to acknowledge that PrEP use is not equivalent to (undesirable) barebacking, yet it has the potential to entirely redefine sexual safety. It appears that for some PrEP users, STIs other than HIV seem benign and avoiding them is not a sufficient motivator for condom use. In assuming clinical or public health perspectives, however, reducing the number of STIs is an obvious public health goal. It should be noted here again, however, that the combined effects on STIs incidence of possible PrEP-related condom use reduction and increased screenings are still unclear on a populational level (e.g., Marcus et al., 2018). There is emerging research seeking to understand the nuanced ways of understanding STI risk and risk

compensation among PrEP users (Wells, 2020). Acknowledging these nuanced views could contribute to more effective ways of providing health messaging that seek to inform but not moralise, as an important goal of HIV prevention.

It is important that health messaging maintains a possibility of open dialogue with the affected communities and acknowledges relational and sexual drivers of health practices in contextualising HIV prevention. Understanding of the audience is the critical part of producing effective and well-received campaigns, making enabling dialogue on sets of values shared by different communities a key undertaking. Moralising discourses that follow a long history of HIV moral panics and seek to construct PrEP as a modern villain and a threat to public health (González, 2019) may hinder these efforts. The findings of this study highlight the understanding of PrEP as the enabler of physical and emotional intimacy and pleasure, alleviating fear in the context of multigenerational AIDS trauma. There may be benefits of acknowledging such construction of PrEP as one of the ways people engage with HIV prevention.

It appears that the risks associated with biomedicalisation of HIV prevention are outweighed by the benefits of HIV risk reduction at a populational level. Nonetheless, it is important to critically acknowledge these “biopolitical side-effects,” (Dean, 2015, p. 234) in order to meaningfully engage with those for whom resistance and transgression are part of their habitus. Brisson and Nguyen (2017), shed some light on how these risks can be navigated drawing on their research with HIV-positive gay men. They argue that for the truly political resistance to biomedical technology to be possible, this technology needs first to be available and accessible to all. Yet, still inequitable access to PrEP appears to be larger problem. PrEP uptake in Aotearoa New Zealand remains well below the estimated target of those eligible (Macpherson et al., 2020). To put the notion of biomedicalisation into perspective, I should note that the sentiment that PrEP was difficult to access was shared by all of the study participants, including those who later felt uncomfortable by their increasing dependence on the healthcare system. The idea that biomedicalisation is necessarily oppressive has been critiqued (Rose, 2007). It is becoming increasingly accepted that biomedicalisation may also have some beneficial

effects on communities and individuals, for example, by validation of individual’s problems by deeming them medically legitimate as opposed to existing “just in their heads” (Cacchioni & Tiefer, 2012). In fact, the present study participants’ accounts presented a diverse range of perspectives on PrEP, with most of them describing this undoubtedly highly medicalised intervention as liberating and profoundly positive.

The study participants navigated in the complex ecosystem of biopower, and in this sense their agency around PrEP was biopolitically meaningful. Biopolitics can be discussed in a narrow understanding, and be seen as inherently oppressive if not violent towards the individual; as an extension of the state’s control over its subjects’ bodies and removal of personal agency (e.g., Giami & Perrey, 2012). Schubert (2019) argues that HIV activism and PrEP itself are examples of *democratic biopolitics*. Democratic biopower, as opposed to traditional biopower which remains structured top-down, situates the locus of agency within communities taking active steps and mobilising voluntary action to improve their health outcomes. Figure 1 presents the conceptualisation (Schubert, 2019) of differential sets of narratives within PrEP discourses expressed by different camps of stakeholders.

Figure 1

Stakeholder Positions Surrounding PrEP

	Gay	Professional
Pro-PrEP	<i>Gay pro-PrEP</i>	<i>Professional pro-PrEP</i>
Anti-PrEP	<i>Gay anti-PrEP</i>	<i>Professional anti-PrEP</i>

Note: Figure based on concept from Schubert (2019).

The notions of public health, personal freedom, community responsibility, morality, and different understandings of risk receive different levels of attention in each of these groups. The varying levels of legitimisation or, giving voice to different discourse actors, lead to differentiating biopolitical balances. The arguments emphasising the rights to pleasure and intimacy among gay pro-PrEP camps are

challenged by the professional anti-PrEP's arguments which aim to build a dichotomy of pleasure versus responsibility. Schubert further argues that these positions clash in an uneven field regulated by pervasive homonormative ethics where condom use becomes a proxy of being one of the "good gays." PrEP changes these subjectivities by untangling previously naturalised condom use from the archetypical "evil" represented by illness and death.

An analogy can be drawn between PrEP and the contraceptive pill, and such analogies were drawn by some of the study participants. Similar to PrEP, the contraceptive pill transformed preventative practices from behavioural to biomedical. At the same time, "the pill" has been considered liberating as allowing control over one's own body and therefore critical for the advancement of women's rights (May, 2011), despite its emplacement within the medical establishment. However, concerns have been raised that medical contraception also created a pharmaceutical mega-market of consumers and contributed to dependence of personal reproductive choices on the medical establishment (Tone, 2012). The findings of this study suggest that gay men may hold a range of beliefs surrounding ceding their agency towards the medical establishment, especially in context of heteronormativity of healthcare in Aotearoa New Zealand (Fraser, 2020). For some of the present study participants, maintaining the locus of control over their sexuality and HIV prevention options included intentional exaggeration in describing their sexual practices as a way to increase their chances of accessing PrEP.

Lastly, it is important to note that the social lives of drugs extend beyond their medical applications (van der Geest et al., 1996). Their significance and implications for individuals' identity construction have been studied across diverse contexts (e.g., Hodgetts et al., 2011). The present study contributes to such social perspective of medication use and the participants' accounts demonstrate that accessing and using medication is in fact a social practice and may have important identity implications.

I argue that PrEP use and HIV prevention among gay communities in Aotearoa New Zealand are entangled in the history of AIDS crisis and the community response.

Prevention practices can be characterised by a tension between the need to meet the primary objective of sexual health interventions (the avoidance of disease) and the complex interplay of desire, intimacy, and the habitus of transgressive and subversive sexualities.

Recommendations and Further Research

This research project provides insights into the lived experiences of ten early users of PrEP in Aotearoa New Zealand. Analysis of their accounts can help formulate some recommendations for practice, as well as highlight areas where more research is needed. These recommendations should support maintaining good health of gay men, consistent with the spirit of WHO definition of what constitutes sexual health, presented once again below:

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. (World Health Organization, 2006, p. 5)

Even though identification of barriers to accessing PrEP was not the primary goal of the project, clear signs of inequities to PrEP access emerged from the interviews. Some specific goals behind the recommendations therefore include improving access to PrEP, bettering the experiences of persons who seek or may benefit from its use, and aiding in creating a culture which enables the gay communities to maintain good health, sense of agency, and sexual enjoyment: free from feelings of shame and guilt. The recommendations extend both to the practice of PrEP provision and public health messaging.

1. Equip staff across the health system with resources and training to provide appropriate non-heteronormative care.

Research surrounding the experiences of rainbow communities in Aotearoa New Zealand strongly suggests that healthcare services continue to be perceived as hetero- and cisnormative (e.g., Fraser, 2020). Furthermore, around half of gay and bisexual men in Aotearoa New Zealand believe their GPs are not aware of their sexual orientation (Ludlam et al., 2015). The findings of the present study are consistent with the previous research. Notably, many of the participants took care to actively seek assumingly gay-friendly healthcare providers, whether they were gay physicians or sexual health specialists. On an individual level, such strategy was effective, but it is unlikely that most prospective PrEP users will be determined and resourceful enough to access physicians with whom they would feel comfortable to discuss their sexuality.

Non-heteronormative persons should have the right to assume that all healthcare professionals have accepting attitudes towards their sexualities. Assuring that providers across the entire health system, including within community practice, have the skills and sensitivity to properly address gay men's sexual health is essential to provide optimal coverage of PrEP, currently remaining at approximately a quarter of those eligible (Macpherson et al., 2020). It is advisable that LGBTQ-specific training is included both as a compulsory segment in the medical schools curricula and within workforce development programmes to aid in overcoming these barriers. Locally developed resources are available for motivated practitioners to support their care for rainbow communities (e.g., Fraser, 2019) and PrEP provision (e.g., New Zealand AIDS Foundation, 2020), yet their use is optional and requires active interest in gay men's health. An example of a comprehensive training module has been developed by the Royal College of General Practitioners (2020) in the UK. It consists of six modules, covering a broad range of LGBTQ topics including provision of PrEP, PEP, and wider sexual health care. The development of educational programmes that would respond to the needs of the diverse local gay communities is needed.

2. Investigate novel ways or PrEP provision that emphasise user's agency and options for less medicalised PrEP access.

PrEP is generally desirable by MSM in Aotearoa New Zealand, regardless of age group, with very high acceptability levels: a large majority of local MSM who do not currently use PrEP declare wishing to use it (Kolodziej et al., 2019). Novel models of PrEP delivery that move away from the clinic may be required to cater to those among the gay community, who are hesitant to access PrEP through traditional medical settings. In 2019, Californian legislature allowed PrEP initiation through pharmacies (Gardiner, 2019), effectively removing the step of accessing medical clinics before PrEP is started. There is evidence (Havens et al., 2019; Lopez et al., 2020) that PrEP can be safely and effectively managed with the support of a pharmacist, while alternative arrangements are made for self-collection or self-testing for STIs.

Other programmes may emphasise the involvement of community organisations. One of the world's first such programmes was Princess PrEP programme, run in Thailand (Phanuphak et al., 2018). It involved trained non-medical community organisation staff who delivered PrEP using an algorithm that assured client safety and referrals to medical specialists, when necessary. Transferring the locus of agency to the individual and their community may support persons for whom accessing mainstream healthcare system constitutes a key barrier. A programme run in Vietnam, focused on establishing a community-led one-stop clinic for transgender persons; the clinic also provided PrEP as part of their routine operations (Green, 2020). A critical component of the programme was to integrate PrEP provision within gender-affirming services, which resulted in increased PrEP uptake. The well-established acceptability of community organisations-based HIV testing in many settings suggests this could be an appropriate venue for PrEP provision. Furthermore, the experiences from the Southeast Asian trials support the idea that community-managed PrEP can be a safe and effective way to initiate and maintain PrEP use. In Aotearoa New Zealand, a hybrid programme was launched by Body Positive where clients access first assessments through the organisation to be then referred to virtual reviews and consultations with select

prescribers (Body Positive, 2020). The findings of the present study support further development and strengthening of such programmes as a way to emphasise PrEP user agency and PrEP ownership.

3. Affirm the diversity of sexual experience and normalise PrEP use.

Despite increasing acceptance of gay communities by the mainstream, HIV prevention continues to be moralised within gay communities (Dubov et al., 2018). Furthermore, in a fiscal environment where different healthcare needs must compete for financial resources, opponents of public funding for PrEP argue that biomedical HIV prevention should be privatised because sexual risks are seen as arising from personal choices. Such voices can be noted among the mainstream society as well.⁴ Providers should be aware of the moralised environments and make active efforts to challenge judgmental attitudes, as these may deter those who could benefit from PrEP from accessing it (Quinn et al., 2018).

On the other hand, some segments of gay communities may be relatively conservative (Adams et al., 2019). PrEP messaging should reflect this diversity by constructing an image of PrEP as something that can be used to attain diverse benefits. It is advisable to avoid stipulating that PrEP is only indicated for those at highest levels of risk as this may strengthen the association of PrEP with “promiscuity.” Messaging around PrEP should reflect the diverse motivations for its use, including those normative and non-normative.

⁴ For instance, the hosts of a popular breakfast TV show, *The AM Show*, during an interview with Jason Myers, the CEO of New Zealand AIDS Foundation, dedicated to PrEP and changing HIV prevention landscape contrasted public funding of PrEP with “morally justified” healthcare spending on cystic fibrosis treatment. One of the hosts, Mark Richardson, argued, “With cystic fibrosis: no choice, there’s nothing you can do. ... But people will argue here [about PrEP] that there are other things you can do, other than being on this drug. That will make it difficult to get public funding for the drug” (Newshub, 2020).

PrEP's potential to *purify* bodily fluids extends to biological, ethical, and symbolic planes enhancing sexual experience and opening the sexual possibilities that had earlier been considered too dangerous. Sex-positive messaging should affirm the diversity of consensual sexual practices and emphasise that PrEP can be used regardless of personal or community values thus enabling *safety* in all circumstances.

Normalisation of PrEP as one of the methods of reducing risk of HIV serves as an important way of increasing uptake to assure optimal coverage of PrEP among those at risk of HIV. Including knowledge about PrEP in formal sexual education could normalise its use. However, Greteman (2019) stipulates that “[formal] education, as a broadly conservative enterprise, seeks to orient students toward particular ways of being and acting” (p. 226) and therefore would be unlikely to ever include PrEP in official curriculum. Perhaps this pessimistic view is correct, yet it would be of great benefit to the sexual health of non-heteronormative young people, if appropriate and non-judgmental educatory approaches acknowledged the full spectrum of embodying sexual desire, or at least presented a full spectrum of harm-minimisation methods.

Extending provision of PrEP to all groups affected by HIV in Aotearoa New Zealand should be considered on both policy and implementation levels. More research is needed to address the needs of other communities affected by HIV in Aotearoa New Zealand. Members of Black African communities continue to represent a disproportionately large number of PLHIV despite lower number of new diagnoses within that group in recent years (AIDS Epidemiology Group, 2020). Little is known about the acceptability of PrEP among this population in Aotearoa New Zealand. Considering that HIV has profoundly affected Black Africans' livelihoods (Fouché et al., 2001), there is a significant research need to determine in what ways PrEP provision could improve the experiences of impacts of HIV on these communities.

4. Incorporate Tikanga Māori care in sexual health provision and messaging, with foundations in Kaupapa Māori research.

As set out by Te Tiriti o Waitangi (1840) obligations, it is necessary that Māori communities receive best available healthcare and health services. These should include sexual health care and the provision of PrEP. The health needs of takatāpui and Māori gay and bisexual men require appropriate recognition and a health system that responds to those needs. Due to systematic racism embedded in the colonial society, Māori have not been receiving healthcare that would lead to optimal outcomes (Came, 2012).

In order to provide equitable outcomes, dedicated sexual health services should be established, run by Māori, using the principles of Tikanga Māori, and informed by Kaupapa Māori research expertise. The shape of these services should be established by the iwi, Māori leaders in healthcare, and takatāpui community. To normalise PrEP use, culturally appropriate and bilingual information should be developed for Māori communities, and the benefits of its use should be clearly presented, not only for the individual, but also for the iwi and whānau.

5. Align PrEP provision guidelines and current practice with client needs and ensure these guidelines acknowledge benefits of PrEP extending beyond HIV prevention.

Real-world use of PrEP is complex, and the motivations of persons who want to use it are multifarious. Prospective PrEP users may be focused on attaining the benefits of PrEP (such as increased intimacy if having condomless sex, or loss of anxiety), as opposed to reducing their objectively quantified HIV risk. Additionally, risk patterns are highly dynamic, and clients may frequently move in and out of risk categories (Underhill et al., 2018), which was also apparent in participants' accounts. In context of limited trust, when providers are seen as gatekeepers to using PrEP, participants' stories exemplified that clients may be inclined to overreport risky sexual practices which may further erode the rapport between clients and providers. Current ASHM (2019) guidelines emphasise

flexibility in prescribing PrEP, including considering PrEP provision to those who suffer from high anxiety levels surrounding the risk of HIV and individuals who report prospective risk (e.g., when ending monogamous long-term relationships) as opposed to history of risk.

Counselling surrounding increased sexual risk may be challenging for providers in contexts where client's motivations for PrEP use centre around increased pleasure or intimacy of condomless sex. These motivations may not align with providers' values, and for some they may appear as irrational or irresponsible. It is important, however, to recognise that clients may have differential understandings of sexuality and sexual risk and these should be acknowledged from a non-judgmental perspective that remains focused on risk minimisation. Increased rates of STIs are an important concern for clinicians and persons providing sexual risk counselling, and therefore encouraging regular and consistent STI screenings is essential. However, discouraging PrEP use or reducing access to it based on concerns this may lead to more STI acquisitions is unlikely to be a useful strategy to minimise STI risks.

6. Continue to research the real-world PrEP use in Aotearoa New Zealand along with its cultural foundations and monitor its transformations.

More research is needed to understand the cultural contexts of PrEP use in Aotearoa New Zealand, especially among Māori, Pasifika, and other ethnic groups. Increases in the number of new HIV infections among Asian MSM (AIDS Epidemiology Group, 2020) suggest urgent attention is needed in addressing these emerging trends. Large-scale studies are needed to monitor the populational effects of possibly changing condom culture among gay and bisexual men, and to identify emerging inequities in accessing PrEP along with their demographic determinants. Some local qualitative studies have already started to address these inequities (e.g., Adams et al., 2019), however more research is necessary to provide in-depth understanding of the structural, social, and cultural barriers to PrEP uptake.

Conclusion

The study participants were early-adopting PrEP users who shared their accounts of learning about PrEP, accessing it, experiencing its effects, and making meaning of its continued (or discontinued) use. Their stories emphasised the necessary resilience required to effectively navigate healthcare system that was not always equipped to respond to their non-heteronormative experience. Many of the participants underlined the importance of altruistic motivations to PrEP use, such as sexual bridging of the serodivide, sharing the burden of pharmacological treatments with men living with HIV, and participating in a common struggle of the gay communities to stop HIV transmission.

Reception of PrEP transpired in the long aftermath of the AIDS crisis and decades of HIV prevention messaging which resulted in the need to navigate around morally loaded discourses of HIV prevention that set up the limits of understanding sexual practices. The transgressive habitus of desire and community whakapapa of resistance to hetero- and homonormativity led the participants to redefine the meanings of previously unchallenged notions of sexual risk in relation to pleasure, intimacy, and connection; all interwoven with sexual ethics. The agentic practice of taking ownership of one's sexual risk/pleasure led to feelings of (re-)gaining personal freedom and enabled enhanced experience of emotional and physical intimacies.

The use of HIV prevention methods plays out against a backdrop of complex and multi-contextual social and cultural environments. The perceptions of sexual risk may enforce the matrixed sexual ethics, where internalised (as well as experienced from external sources) heteronormative values conflate risk with immorality and vulnerability with irrationality. Novel methods of prevention can effectively transform these environments, creating conditions for challenging the existing discourses and agentic practice to emerge.

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Appendix: MUHEC Ethical Approval



Date: 11 September 2017

Dear Jacek Kolodziej

Re: Ethics Notification - NOR 17/43 - Why do men who have sex with men in New Zealand use pre-exposure prophylaxis?

Thank you for the above application that was considered by the Massey University Human Ethics Committee: Human Ethics Northern Committee at their meeting held on Monday, 11 September,

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Brian Finch
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)