Special Issue Article: Mediating PrEP

Sexualities
0(0) 1–16

DOI: 10.1177/1363460719886556
journals.sagepub.com/home/sex


PrEP (HIV pre-exposure prophylaxis) and its possibilities for clinical practice

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Abstract

In this article, we reflect on the possibilities that PrEP (HIV pre-exposure prophylaxis) raises for HIV specialist clinicians. Often neglected, yet a direct participant at the intersection of a complex tension within public health debates on how to reduce HIV transmission and the sexual sociability of individuals, we reflect on current thinking of health practitioners involved in the day-to-day practice of prescribing PrEP. Drawing on interviews with practitioners in the context of UK sexual health and HIV specialist medicine, while bearing in mind neoliberal critiques and process studies of medical science, we propose that PrEP invites the possibility for reconstituting approaches to sex and risk.

Keywords

Clinical medicine, HIV PrEP, neoliberalism, process studies, sex and drugs

Although the prospect of a daily pill, PrEP (HIV pre-exposure prophylaxis), to protect against HIV infection might have been expected to receive unqualified support, it has raised and, in some ways, reignited a long-standing debate on prevention in relation to the sexual cultures of gay men, men who have sex with men (MSM) and trans people. Underpinning much of the debate is a connection that has been made between the introduction of treatments and a decline in condom use (Ostrow et al., 2002; Stolte et al., 2004). While the availability of PrEP is proposed to address this decline, some see it as having the potential to exacerbate the decline

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amongst others who are neither on PrEP nor taking HIV treatment (which can also prevent HIV transmission), with the paradoxical consequence of not less but sustained or, even, increased HIV infection rates. Psychological phrases such as 'risk disinhibition' or 'risk compensation' drawn from a theory that 'predicts that people are more likely to participate in risky practices with the advent of biomedical disease-prevention strategies' are often used to explain this concern with PrEP (Grant et al., 2014: 820. See also Blumenthal and Haubrich, 2014; Cassell et al., 2006; Holt and Murphy, 2017; Underhill, 2013).

However, while there may be some ground for concern, including a rise in other sexually transmitted infections (STIs), insofar as the theory is underpinned by the neoliberal presupposition that individuals should and can be responsible for their health but, in practice, are *unlikely to be so* (Greco, 2017: 112), it can be argued that this theory eclipses much of what has contributed to existing modes of HIV prevention. The embracing of notions of 'self' and 'community responsibility' have been at the forefront of highly successful prevention efforts by gay self-identified men and MSM (Kippax and Race, 2003; Watney, 1990). Indeed, it would seem that the anticipation of 'risk disinhibition' or 'risk compensation' piggybacks on how condom use has become a norm for determining responsible conduct (Adam, 2005; Thomann, 2018).

Not surprisingly, a series of arguments have been mounted to broaden the response to PrEP and, specifically, to redress what amounts to a neglect of the complex possibilities posed by PrEP in relation to sex, HIV and other STIs. Much of the focus on the decline in condom use tends to overlook substantive social research that shows inventive strategies may be employed by gay men and MSM to avoid HIV exposure (Kippax and Race, 2003; Parsons et al., 2005; Rosengarten, 2009) while conflating the avoidance of STIs with condom use.[1] It also neglects what Holt (2015:436) discusses concerning the honesty that gay men have shown in providing detailed articulation of the limitations of their current practices including, in some cases, acknowledgment that they are likely to continue having sex without condoms. On the basis of Holt's (2015:436) observations, it would seem there may be constructive work to be developed with the evident degrees and modes of trust that are involved in sexual practices as well as those that happen in relation to research and, more particularly, in clinical encounters where STIs may be addressed.

In concert with efforts to broaden the approach to PrEP (Michael and Rosengarten, 2013; Race, 2015; Thomann, 2018), Judith Auerbach and Trevor Hoppe (2015), focus on what they see as an overly determined and moral focus on risk. As they phrase this, 'the potential for PrEP to confer a new level of agency, control and pleasure in sexual relations, in combination with the fears of ''risk compensation,''' does little more than fuel 'a new sexual moralism, particularly within gay communities' (2015: 2). These authors acknowledge that responsibility for the transmission of HIV may well intensify the shift from a community and couple-focused response seen with the introduction of antiretroviral treatments, placing a more individualized onus on those who are HIV-negative. That is to say, it may have consequences for HIV transmission. But they also suggest that it may have other consequences, and that by reducing the fear of HIV and/or the

need for condoms that can mediate sexual pleasure, new styles of negotiation may emerge. Indeed, as Newman et al. (2018) found in their research with policy and clinical stakeholders in PrEP's futurity, not only is there an imagining of whom PrEP will be suited for, but a diversity in this thinking that cautions against deciding in advance who and how these populations may emerge and thus, we add, may continue to change.

Nevertheless, although it is apparent that there is a need for new thinking on HIV prevention and underscored by the complex challenges and possibilities raised in response to PrEP and in relation to gay men and MSM, as is the focus already mentioned, it is conceived largely in the abstract. With some exceptions (Arnold et al., 2012; Koester et al., 2017; Newman et al., 2018; Race, 2015) most research studies have been conducted on the acceptability, awareness of, or barriers to PrEP uptake, prior to any actual or substantive experience of its use by sexual actors at the centre of the debate or with those involved in prescribing it (see for example Frankis et al., 2016; Witzel et al., 2018; Young et al., 2014). Bearing in mind the contours of the debate and the need to extend the repertoire of factors that may affect what PrEP becomes for its users, in this article we discuss what some health practitioners have made of it in practice.

In what follows, we reflect on findings from a an interview-based study ($n = 7$) that we undertook with health practitioners actively involved in prescribing PrEP.[2] Our intention in conducting the study with what may be considered a small number of participants was to learn from the direct experiences of practitioners actively involved in negotiating the sorts of concerns and counter arguments set out in the foregoing paragraphs. As may be evident from the extracts included later in this article, our open-ended interview questions reflected what has been raised about the risks due to the absence of condoms, including an increase in STIs as well as HIV and, also, in relation to the practice of what is referred to in the UK as 'chemsex' or elsewhere as 'party and play', and involves recreational drugs[3] in situations where there may be a number of sexual partners (Bourne et al., 2015; Gilbart et al., 2013; McCall et al., 2015).[4] To be clear, our aim was not to generate findings that would be assumed representative of other health practitioner views. Nor was it done on the assumption that the views we gathered will necessarily remain stable. Indeed, we anticipate that as new issues and practicalities emerge in what we have already noted as a dynamic epidemic of changing sexual patterns and medical developments, so too may practices with PrEP alter amongst our health practitioners as well as may be said of PrEP users.

Our interviewees[5] – six doctors and one sexual health adviser[6] – were selected on the basis that they were working in London-based sexual health clinics involved in a trial called IMPACT,[7] which aims to assess the feasibility of providing PrEP through England's publicly funded National Health Service (NHS).[8] Outside the trial, PrEP was only available at a cost through private clinics or by purchasing generic versions. Although we anticipated that our research participants would be influenced by aspects of the current debate on PrEP, we remained curious about what they made of the various arguments for and against PrEP given their direct 'at

the coal-face' determinations when prescribing PrEP. Although some interviewees reflected on their engagements with PrEP beyond this particular trial, for the most part, interviewees focused on their experiences of prescribing PrEP in the context of IMPACT, which is predominantly populated by gay and MSM and, as such, consistent with HIV prevalence in the UK.

Beyond HIV prevention

Given the pervasiveness of the neoliberal tone of 'risk compensation' or 'risk disinhibition' that constitute individuals as responsible for their health and thus risk, one might assume that healthcare professionals would be likely to stress the importance of personal responsibility and rational choice in sexual decision-making. Indeed, in an article about drug adherence, Maskovsky (2005) notes that when doing research in a clinic in the late 1990s he would often hear clinicians comment that a patient had failed their drugs by taking them incorrectly, rather than attending to the difficulties drug regimens might pose to successful adherence. Thus, while we may have expected to find recourse to neoliberal evaluations of patients by our interviewees, what we offer here suggests that the space of the clinic can be practically attuned to the complex dynamics of sex, HIV and, notwithstanding, recreational drug use.

Resonant across our interviewees, here anonymized with the use of fictitious names, is how PrEP has been incorporated into the already established processes and concerns of the sexual health clinic. This approach occurred early on in an initial sexual risk assessment with patients, while taking account of a number of co-affecting factors pertinent to the situated risk practices and negotiations of the individual patient. For Vida, navigating these factors was made possible by a standardized protocol for gaining insight into multiple issues:

> This is not just about PrEP, this is about other stuff so for example in this clinic we don't just talk about HIV prevention. You do the questionnaire with the drug use disorders identification toolkit, it's a bit like the alcohol audit, where you do a score and a score with 6 for men warrants further exploration. We do alcohol audit score, so a score of 8 or more will warrant some sort of discussion. And we do a PHQ9 and GAD7, which is the depression and anxiety questionnaire. So they fill all of that in prior to seeing the clinician so you kind of see [if] you've got an anxious depressive, that's somebody doing loads of drugs, who wants PrEP, yeah PrEP [would then be] a minority of the consultation [and] we [would] focus on the other stuff. And for people who just need PrEP they just need PrEP, a lot of people are just really well and just don't want to get HIV and that's fine. (Vida)

Insofar as the questionnaire referred to here could be argued as being a participant in shaping the clinical consultation (Michael, 2004; Race, 2012) and in a way that is according to a calculative and, thus, highly normative mode of assessment, it is not surprising that a public health concern for risk – whether HIV, drug use or

depression – prevails and, in some respects, is safeguarded by standardized protocols. However, this did not mean that the risks presumed to be posed in relation to matters of the individual patient were reduced to correcting a patient's practices. While on the one hand, the protocol functioned to set the ground for the clinical encounter, on the other, it was also seen as limited as a consequence of doing so. For Cooper, the standardized approach, reliant on a scale of risk, was considered inadequate to the task of responding to the dynamic constraints of a patient's sex life.

> there are various routes into the clinic but all of them would involve a sexual risk assessment, and that may be self-reported sexual behaviour or it may be clinician collected. So in our walk-in service we actually do a lot of computer assisted self-interview stuff that people type it all onto a screen. Invariably it's not granular enough so most people would then interrogate the patient and understand a little bit more about their sexual behaviours: where they meet their partners, total number of partners, use of barrier methods or contraception [in a] heterosexual context, and then in a more traditional face to face clinical consultation that's obviously part and parcel of routine clinical practice in terms of a sexual history. (Cooper)

When asked about whether the kinds of initial discussions they had with HIV positive patients and HIV negative patients looking to access PrEP differed, all interviewees answered with a very explicit 'no'. In the next extract, William explains that they would be interested in all their patient's sexual practice and other contributing factors to it:

> I like to think my advice wouldn't be different in the sense that I would assess their sexual history, how many partners they had in the past three months, and the types of sex they are having, where they are having sex, is it anonymously and so on, so is it through Grindr [online hookup application], and just try to have a chat with them about why they are accessing these [sites], why they are choosing their sex in . . . particular settings, and if there was any underlying deeper reasons behind it, for example are they having sex in saunas because they feel like they cannot openly go out and meet people, look for people. (William)

Nevertheless, this did not preclude the fact that PrEP created opportunities to broaden the doctor–patient relationship when talking with HIV negative patients. Importantly, and not unlike a more long-standing practice, this involved careful negotiation of public health determinations of wrongful behaviours such as 'chemsex' and 'risk compensation'. But with the aid of PrEP, it became possible to cultivate what could be argued as a practicable response to averting certain risks. As Vida described PrEP, it provided the opportunity to remove the risk of HIV transmission while dealing with other pressing concerns of the field such as chemsex:

> Particularly those having chemsex where sometimes it's HIV that brings them in for PEP [post exposure prophylaxis] or stops them taking the extra bit of drug or

> whatever it is . . . and then for them I just say, 'Well listen, you just need to work out what you're doing about your chemsex issue whilst not getting HIV.' So we just take HIV out of the equation [by using PrEP] and deal with risk [associated with chemsex, which] is bad enough without HIV, as drug induced psychosis is pretty bad . . . it can be permanent if you keep carrying on repeating, [you'll] need drugs, medication forever like [you would if you had] HIV. So, you've got to just think about it as a separate entity and you might as well get to go through your journey with all of that whilst not getting HIV. (Vida)

In some respects, Vida's statement can be viewed as complimentary to what Holt (2015) proposes of the trust by gay men and other MSM have shown in disclosing their sexual practices and the capacity for health practitioners to respond within the clinical encounter. The extract also suggests that at the 'coal face' of medicine, the distinction between biomedical objects and social behaviours can be reworked and in ways that are responsive to this trust. Unlike what has been said of a conception of PrEP as a distinct object with fixed capacities and, as has been argued of the manner by which diagnoses and technological interventions affect and are affected by users or prescribers (Mol, 2003, 2008; Race, 2012; Rosengarten, 2009), in practice the actual prescribing of PrEP reflected a less science-dominated mode of thinking. While it may be that health practitioners proceed according to a logic that presupposes sex and risk as well as drugs are distinct causal entities, their approach was more akin to seeing sexual encounters as contingent on a mix of 'practices, procedures, devices, circumstances, and occasions of cognition' (Race, 2012: 333).

Indeed, a more relational conception of what makes for a risk event can be deduced from how Vida suggests that a patient's sexual relations may differ with different partners and drugs. That is to say, although PrEP was embedded into a systematic mode of assessment constructed according to a standardized assessment of risk, in the day-to-day realities of patients' life styles, our practitioners were, to a degree, attuned to the need for a mode of thinking beyond that of a normative protocol. More particularly, for Vida, a presumed continuum of risks warranted a response attuned to the contingencies of sex in relation to drugs, alcohol, digital hookup technologies as well as what is often termed as related psychological well-being.

Navigating concern for risk

Insofar as the prevailing concern with 'risk compensation' was familiar to our interviewees and in some of the discussions acquired explicit expression, there was the added concern that the decline in condom use may lead to the rise of other STIs. For both clinicians and other members of the HIV field, including those involved in policy development, the issue of STI transmission has a long history that pre-dates its emergence in debate on PrEP (Cairns et al., 2016). Nonetheless, while bearing this in mind, what was relevant to our interviewees was what they perceived as the current reality: some patients would not be using condoms irrespective of the risk of STIs. For this reason, PrEP remained an

important prevention technology. As William described this reality for some of his patients:

> it's interesting when you see people who absolutely are in a way committed to a lifestyle without using condoms, they know they are at risk, they don't use condoms, perhaps there's an element of sexualised drug use, chemsex use on top of that, and then they hear about PrEP as something that all their friends, their mates are doing, and they think well that's a step I'm willing to take, I'm not willing to use condoms, but I'm willing to take a tablet a day to prevent HIV, and that's something that's acceptable to me. (William)

In sum, condomless sex was thought of as a practice that healthcare professionals may not necessarily be able to change, but which PrEP now enabled them to move on from and thus to engage more constructively with the constraints at hand. As such, PrEP was framed not as resolving the difficulties associated with attempting to navigate patients' condom use, but rather as offering an opportunity to assuage the potential harms of condom non-use. Framed in this way, PrEP enabled practitioners to depart from what some otherwise saw as a demand on them to moralize about the need for condoms despite what was felt to be the futility of doing so.

This approach did not ignore what has been said of the possibility of an increase in STIs, although we wish to stress that the prospect of such is unclear. Without entering into the complexities of the concern, our interviewees sought to contend with the issue in a manner that would achieve a practicable difference for patients. When asked about the risk of STIs, some of our interviewees situated themselves as in a field of controversy within which there are 'STI deniers':

> So I think clinicians fall into, this is a bit arbitrary and possibly a bit facetious, but fall into two camps, the STI deniers and the STI accepters, and clearly we're going to see an increase in bacterial STIs and it's nonsense to say that we're not. (Cooper)

> But there are people out there who are STI denialists in the PrEP camp and it's just ridiculous, you get them saying that, but they are saying that because they don't want any barriers to exist to PrEP adoption. But saying that for me doesn't mean it's a barrier to PrEP adoption, I think we should have both and just deal with the STIs more effectively. (Campbell)

While accepting that STIs may increase, William posed the possibility that PrEP could contribute to a *reduction* in STIs where regular STI testing formed part of the PrEP package. Although some interviewees suggested that the regular monitoring for the purposes of the trial may be less frequent in a wider rollout of PrEP, in the context of the trial,

> the aim is not just to give PrEP on its own but also to give them the gold standard advice and to say come back in for your three-monthly screenings, it's the regular

> testings and picking up of early [STIs] before they get transmitted, that will decrease the rates of sexually transmitted infections overall. (William)

Further, although PrEP is often referred to as a standalone object and, as mentioned earlier, presumed to have causal properties irrespective of contingencies affecting what might come of it, all our interviewees spoke of PrEP in relation to what they understood to be a realistic response to a patients' needs and did so by framing PrEP and STIs in the context of broader historical patterns that have been generated by existing studies. As Ghislaine described,

> Of course, what HIV had done was to make STIs go away, so we had very little syphilis and gonorrhea in that period of late 80s and early 90s. And then with the effective treatment of HIV and the arrival of all the dating apps and chems[ex] in the early part of this century things took off again but if you look at the history of STIs over the course of, well [it's been] 101 years now [that] we've been monitoring gonorrhea in this country, you see how it goes up and down with time, see how it goes up in the 60s and 70s, it comes down with HIV and [that's] just the natural fluctuations in STIs. (Ghislaine)

In sum, although an increase in STIs was considered a possibility, there was an acknowledgement of the ways in which technologies – PrEP, STI testing, chemsex, dating apps – participate in patterns of changing sexual practice. In order to think this, all but one of our interviewees drew on the history of the contraceptive pill, either in terms of its introduction or the ways by which women have utilized the pill to navigate sexual practice and the risk of pregnancy. Campbell described this in terms of the fear that some patients express that PrEP will lead them to dispense with condoms altogether:

> you meet women who won't go on the pill because they are worried that it will stop them from being sensible about using condoms, and then they come in for emergency contraception, because they run out of condoms or they are not sensible about condoms because passion is passion. So the reality is we need to get past that conversation, it's not 'either/or' it's 'and'. So, we say to the woman 'go on the pill because it's nice to have belt and braces and if the condom breaks you don't have to come rushing in for emergency contraception', or maybe not the pill, maybe something long acting and reversible like the IUD or the IUS or the implant. But for me it's the same conversation with sexually active gay men, it's let's talk about prevention, let's talk about making sure that it doesn't commit you to have lots of unprotected sex, it just protects you should you need it. (Campbell)

This statement from Campbell is suggestive of an attempt to respond not only to risk, but also to what patients might think of as the potential outcomes of PrEP use for themselves, their own concerns for 'risk compensation'. In attempting to account for complexity, Campbell echoes what can be argued as a neoliberal

framing that is tinged with a putative moralism – condom non-use is a failure to be 'sensible' – but, at the same time, recasting it more practicably. Indeed, it was interesting to us that in the space of the clinic it was necessary to move beyond a neoliberal evaluation and do so by reference to 'passion'.

Again by making reference to the contraceptive pill, Vida spoke of the potential consequences of 'risk compensation' as being much more complex than a simple cause and effect and demanding a pragmatic approach for a wanted difference:

> If we look at what happened to the oral contraceptive pill of the 60s gonorrhoea went up, so I think we will see a bit of that, and I think that's fine, just test and treat more. But then we are now in an era where we can diagnose quicker, treat quicker, and therefore less people get infected. So we may not see the big surge that we saw in the 60s with the oral contraceptive pill introduction because we have got new technologies, better technologies, hopefully better access to testing, even though treatment facilities are shrinking. So I think we shouldn't be ashamed or be backward in coming forward with risk compensation, of course people are going to have a bit more unprotected sex, of course there's going to be a few more STIs, but the question is, is that price worth paying? And I think probably it is, because of the benefits. (Vida)

Although Vida echoes William's earlier suggestion that STI testing may come to limit the potential increase in STI transmission, the acceptance of the possibility, or even likelihood, of an increase in STIs in the context of an ostensibly positive outlook on PrEP may be surprising. However, what resonated throughout the interviews was an often explicit consensus that the answer to the question Vida posed, 'is that a price worth paying?' was 'yes'. As such, our interviewees were engaged not only in considering the various other elements of the HIV event, but also in deciding on which issues should be prioritized when accounting for the various outcomes and possibilities of PrEP.

Not only were they mindful of what was at stake in terms of transmission – of HIV or other STIs – the broader benefits of PrEP were also viewed as being considerably more far reaching than HIV prevention alone, as following the previous quotation, Vida went on to say,

> You don't have a lifelong infection, people can deal with all their screwed up issues around sex and pleasure, anxiety and God knows what the ramifications are for that, it's very difficult to measure, somebody needs to do lots of qualitative interviews to work out what the gains are beyond HIV prevention. So I think to measure it purely as an HIV prevention tool is great but there are other potential benefits. (Vida)

We suggest that Vida's approach allows for a broad set of issues to be at play with the introduction of PrEP. Just as other interviewees chose to frame PrEP and notions of risk compensation according to an extended timeline – one that includes the introduction of other biomedical interventions – for Vida, PrEP has the

potential for outcomes beyond HIV prevention (here, a healthier and happier approach to sex and sexuality). Indeed, it echoes findings from Newman et al.'s (2018) study on stakeholder perspectives on PrEP. Some participants acknowledged that even those who were not deemed to be at high risk of acquiring HIV could benefit from taking it, by way of it having the potential to alleviate anxiety around sex (see also Koester et al., 2017). Importantly, for our interviewees, specialized knowledge obtained from their patients in relation to PrEP afforded an opportunity to cultivate new modes of engaging with concerns around sex and sexuality.

Conversations about sexual practice

As suggested earlier, PrEP was thought of by our interviewees as an opportunity to extend the medical arsenal with the aim of better catering to the wants of patients. But this was not confined to the use of drugs. Rather, considerable importance was placed on how it enabled a conversation to take place between a practitioner and patient that was more 'realist' about what was felt to matter by the patient. That is to say, our interviewees saw themselves as better able to elicit more frank and, thus, practical conversations about condom use. Again, echoing and partnering what Holt (2015) suggests and here, more particularly in relation to PrEP, the availability of a new prevention technology was seen to allow more insight into the ways and extent to which condoms were or were not used by patients:

> I think PrEP gives a space for people to tell you what they're really doing with condoms, I think before that we were . . . obviously the only thing we had to promote was condoms and it was apparent that people were not using them but that was all we had to promote, so that was actually demoralising for staff because they knew that they were banging on and giving people condoms without any motivation of the individual to use them consistently. (Ghislaine)

By displacing or complexifying the morality surrounding condom use already present within the field (Adam, 2005, 2006; Auerbach and Hoppe, 2015), PrEP was described as a gateway to a different style of clinical practice:

> If I think about years ago trying to facilitate a conversation about sexual risk . . . so it's all about someone admitting that something that they 'shouldn't do', they are doing. So, they know they should be using condoms, they know all of that but they still didn't use condoms. They know they shouldn't have been using drugs and alcohol around sex, and they should have had a clear mind when they were talking about sex but they didn't . . . But then when PrEP came into the conversation it changed the conversation, because you could say 'actually just tell me, because there's things I can do to help', and . . . you allow someone to give them more freedom to be honest I felt, and so I felt it really changed the conversations, and I found it quite empowering for people . . . and so you would have those conversations and say 'look just tell me what happened at that party etc, how many times have you done this in the past week, past month etc,

> do you know that actually there's a trial that's available, let's just see if you would be appropriate for it' and then go in that way. And then I found, and I think lots of my colleagues would say it as well, that people were more honest. (Alan)

While it may not remove morality from sex nor from a more pervasive neoliberal mode of responsibility individuals have for their health, the foregoing quotation suggests that PrEP introduces a difference to the clinical encounter. The difference is not some 'thing' for calculable assessment. Rather, it is what enables a move away from what is otherwise foreclosed by a reductive notion of responsibility imposed on clinicians as well as sexual subjects. For our interviewees it was not just a matter of PrEP assisting in the achievement of a more open discussion with patients. As Cooper phrased this, it also allowed health practitioners to, themselves, develop a more realistic understanding of the sexual lives and desires of their patients,

> I am trying to say that talking about it shows that you have some insight into the sexual lifestyle of the person that you're talking to. I think talking about it also helps you, I guess, demonstrate that we understand that sex and sexuality and sexual risk or whatever is complex and it's nuanced in that PrEP may be one arm of it. I think possibly the whole condom argument has been a bit one note, and whilst condoms are the most effective intervention for all sorts of STIs, they have a reek of paternalism about them, and so does reducing a number of partners and all this kind of stuff, or sex on drugs or whatever, and I think talking about PrEP helps us sound a little bit more, I think pragmatic is the wrong word, but 'real world like'. (Cooper)

Insofar as the ability to demonstrate a nuanced, open and non-judgmental understanding of the sexual lives of patients is an important factor in HIV healthcare (cf. Palich et al., 2017), there is something of a resonance here with what Maria Puig de la Bellacasa (2017:4) has argued for as 'a politics of care' that, as she puts it, 'engages much more than a moral stance; it involves affective, ethical, and hands-on agencies of practical and material consequence'. Nevertheless, given our interviewees were at the front line of approaching health as a static condition, presumed to be preserved against a pathological viral or bacterial agent (Canguilhem, 1989) or, indeed, a potentially destructive 'chemsex' drug (McCall et al., 2015), much of what we have included here suggests that PrEP not only warrants a reconfiguring of the prevailing conceptions of risk but, more particularly, how it aligns with what can be made possible for the cultures it is intended to serve.

Conclusion

In this article, we have sought to turn attention to the manner by which health practitioners can be shown to engage with what is reflected in current debates on PrEP in relation to risk of HIV transmission, other STIs and, also, recreational drugs. By extending and entangling PrEP within the various concerns of the clinic, our interviewees suggest that PrEP has the possibility of cultivating a mode of

medical practice that is not only different to a prevailing neoliberalism about what might constitute health but, rather, is appreciative of the actualities that may come to constitute a situation of HIV infection. That is to say, rather than make those engaged in sex responsible for a host of potential consequences including but not exclusive to HIV infection, it is evident from our material that there exists within the medicalized approach opportunities to become more responsive to the situated needs of patients and that PrEP can be an enabling factor for doing so.

No doubt, the terrain we have described in this article, based as it is on a small and highly selective focus on specialist sexual health and HIV medicine, will continue to shift. As PrEP becomes a more commonplace feature of sexual cultures negotiating HIV risk, its possibilities may well change in connection with other familiar factors but also with newcomers such as new drugs, new infections, new styles of sex and drug use. Indeed, it may need to go beyond and may well, in itself, have a bearing on public health framings of risk that are, as suggested by notions of 'risk compensation' and 'risk disinhibition' overly attached to moral notions of a self-willed, autonomous but deficient individual.

As we stressed at the outset of this article, the findings of our study are not presented here as if representative of the views of other sexual health or HIV practitioners. Nonetheless, we suggest that they may have relevance for cultivating prevention possibilities beyond debates that fix on PrEP as no more than an object whose worth can be weighed against risk including but not only that of HIV. Indeed, if as our interviewees have suggested to us, the moralizing dimensions of debates now circulating in relation to what PrEP may do against prevention are not those that necessarily need feature in the prescribing or the everyday take up of PrEP, there is considerable scope for thinking with encounters in the space of the clinic. To be sure, there will always be more to be learnt about the dynamics of sex and medicine for not only what PrEP can do, but for what medical practice can become.

Acknowledgements

We would like to thank our interviewees for generously agreeing to share their experiences, the special section editor Sharif Mowlabocus for bringing about this collection and our reviewers for their thoughtful comments on an earlier draft of this article.

Funding

This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement numbers: Uses of the Past – 649307.

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Notes

1. While beyond the scope of this article, in conversation with colleagues – and supported by a small number of studies (Holmes et al., 2004; Warner and Stone, 2007) – questions have also been raised regarding the protective capacities of condoms for certain STIs.

2. Our research was conducted within a Humanities in the European Research Area (HERA) funded study 'Disentangling European HIV/AIDS Policies: Activism, Citizenship and Health' (EUROPACH), designed to consider the ways in which histories of HIV are mobilized in current policy and activism.
3. Usually crystal methamphetamine, mephedrone, GHB (gamma-hydroxybutyrate) or GBL (gamma-butyrolactone), sometimes used in combination with Viagra.
4. Although it should be noted that the picture is likely to be more complex than much of the discussion on chemsex suggests (Race, 2018).
5. Interviews were conducted by the first author in April and May of 2018.
6. A distinction is not made between the doctors and the sexual health adviser as we found no meaningful qualitative difference between their perspectives. Additionally, although social research often employs the use of racial and ethnic identifiers, it was not considered appropriate to this project. There was no indication that personal details of the professionals interviewed, including their own sexual orientation or gender, was present in the discussions of their professional practice.
7. The PrEP IMPACT Trial is a three-year implementation trial designed to assess the need, uptake and duration of use of PrEP and will be used to determine future commissioning. Trial sites are sexual health clinics across the country and 10,000 places on the trial were made available initially, with places being increased to 13,000 in June 2018 and suggestions that this number may be doubled.
8. PrEP is available for free on the NHS in Scotland for all who meet the eligibility criteria. It is available in Wales through participation in the uncapped PrEPARED Trial; and available in Northern Ireland through a (currently uncapped) pilot.

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