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## **‘The world has changed’: Pharmaceutical citizenship and the reimagining of serodiscordant sexuality among couples with mixed HIV status in Australia**

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**Abstract** In this article, I revisit the question of whether HIV can ever be reimagined and re-embodied as a potentially non-infectious condition, drawing on a current qualitative study of couples with mixed HIV status (serodiscordance) in Australia. Recent clinical trials have consolidated a shift in scientific understandings of HIV infectiousness by showing that antiretroviral treatment effectively prevents the sexual transmission of HIV. Contrary to common critiques, I explore how the increasing biomedicalisation of public health and the allied discourse of ‘normalisation’ can in fact de-marginalise stigmatised relationships and sexualities. Invoking Ecks’s concept of ‘pharmaceutical citizenship’, I consider whether the emerging global strategy of HIV ‘treatment-as-prevention’ (TasP) can open up new trajectories that release serodiscordant sexuality from its historical moorings in discourses of risk and stigma, and whether these processes might re-inscribe serodiscordant sexuality as ‘normal’ and safe, potentially shifting the emphasis in HIV prevention discourses away from sexual practice toward treatment uptake and adherence.

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**Keywords:** HIV, sexuality, qualitative methods, biomedicine, risk, stigma

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### **Introduction**

In the fast-moving field of HIV medicine, it seems prudent to revisit one’s previous research findings every so often, to trace how they refract more readily than congeal, how they morph and multiply in new empirical directions. No more so, perhaps, than at the present moment in the epidemic, as highly publicised clinical trials have prompted a turning point in scientific understandings of HIV infectiousness by confirming a previously tentative and contested concept: that antiretroviral treatment effectively prevents the sexual transmission of HIV (Cohen *et al.* 2011, Rodger *et al.* 2014). Before these ‘treatment-as-prevention’ trials decidedly rearranged the HIV landscape, I examined in this journal how the early beginnings of this shift might play out in the lives of people with HIV (Persson 2013a). I was interested to find out if HIV, a disease demonised as one of the most contagious in history, could potentially be re-embodied as harmless in light of this emergent reinscription of HIV treatment. What I found was people were sceptical of the idea that pharmaceutical suppression of HIV in their blood would render them non-infectious, wedged as they were between this radical new concept, decades of stigmatising discourses of hyper-infectiousness, endless exhortations to keep others safe, and

their own diverse ways of managing the virus sexually. In short, when negotiated through the prism of the discursive history and personal biographies of HIV, the scientific concept of non-infectiousness, with its revolutionary and liberating potential, was not automatically embraced or even necessarily seen as directly relevant to their lives and sexual practices.

But now, a few more years down the track, which has seen a consolidation of this new paradigm, I return to these questions, compelled by stories emerging in my present research with Australian couples who live with mixed HIV statuses, so called ‘serodiscordant’ couples. In particular, I want to explore how the contemporary HIV treatment-as-prevention (TasP) discourse is mobilised among these couples and the implications this might have for ‘citizenship’, understood here in a broad sense as encompassing not only the legal status of a person in society, but also their social status, and their sense of belonging and ‘eligibility’ as citizens. With the expanding ‘pharmaceuticalisation of public health’ (Biehl 2007a), citizenship and its many inflections in the context of biomedicine has attracted growing interest from scholars. Most relevant to my analysis is anthropologist Stefan Ecks’s (2005: 241) concept of pharmaceutical citizenship, defined as the ‘biomedical promise of demarginalization’ (see also Ecks 2008, 2013). Biomedicine, he argues, has emerged as a pivotal citizenship project. Not only has access to effective pharmacological treatment become firmly instated as a human right in global health discourse, but is also increasingly framed as having the power to remove marginality and empower stigmatised and disadvantaged people to re-enter society and regain their full citizenship status (Ecks 2005, Ecks and Sax 2005).

Much of the existing work in this field, including my own (Persson *et al.* forthcoming), focuses on how pharmaceutical citizenship and its allied discourse of ‘normalisation’ can be constrained by social and structural factors, especially in less developed settings, and how it can be transformative in ways that do not always empower, but instead differentiate, exclude and, indeed, marginalise people even further (Biehl 2007a, 2007b, Davis and Squire 2010, Ecks and Sax 2005, Nguyen 2010). Less attention has been given to what can manifest when pharmaceutical citizenship ‘works’, when it actually succeeds in transforming and demarginalising lives in some way. In this article, then, I am concerned with the potentialities rather than limitations of pharmaceutical citizenship. Drawing on concepts such as the afterlife (Meyers 2013) and repurposing (Davis 2015) of medical technologies, I explore whether TasP can open up new trajectories that unshackle serodiscordant sexuality from its historical and cultural moorings in discourses of risk and stigma, and whether this might enable the reimagining of serodiscordance as ‘normal’ and safe, potentially shifting the emphasis in HIV prevention discourses.

## **TasP and biomedicalisation**

Serodiscordant relationships have been considered a primary driver of the HIV epidemic (NIMH 2010, UNAIDS/WHO 2009). This notion is increasingly challenged by epidemiological and clinical research. For some years, there has been broad acceptance that effective antiretroviral treatment of HIV can reduce a person’s infectiousness by reducing the amount of virus in their blood to undetectable levels (Vernazza *et al.* 2008). However, until recently, there was little consensus and much controversy with regards to what this could or should mean for HIV prevention (e.g. Bernard 2008, Vernazza 2009). The results of the now legendary HPTN052 trial provided the ‘hard evidence’ required to bring about a decisive paradigm shift, showing a dramatic 96 per cent reduction in sexual transmission of HIV in heterosexual serodiscordant couples with sustained treatment (Cohen *et al.* 2011). The trial’s nomination as ‘breakthrough of the year’ by the peak journal *Science* (Cohen 2011) gives an indication of its

perceived seismic significance. Any residual doubts appeared to be blown out of the water by the recent interim results of the PARTNER study, which indicated an even greater reduction in HIV transmission risk among both heterosexual and gay couples (Rodger *et al.* 2014).

Owing to the key role serodiscordant couples have played in these trials, WHO (2012a) released new guidelines recommending treatment-as-prevention (TasP) for all such couples. But HIV treatment soon became framed as a general prevention strategy invested with great hopes of 'normalising' HIV and all those who live with the virus, and of ultimately ending the global pandemic (amfAR/AVAC 2012, Havlir & Beyer 2012, Sidibé 2011, UNAIDS 2012). Changes in HIV treatment guidelines in several resource-rich countries, including Australia, reflect a rapidly growing global agenda for early and universal treatment of HIV infection in response to mounting evidence of both its long-term individual health benefits and its capacity as a public health intervention (ASHM 2014, WHO 2012b). There is little disagreement among HIV advocates, clinicians, medical and social scientists that TasP is clinically effective, but there is much debate about its population-level effectiveness, its 'real-world' implementation, and its political and ethical implications for people with HIV (e.g. Cameron and Godwin 2014, Cohen *et al.* 2012, Knight *et al.* 2014, Wilson 2012). There are also concerns that the use of HIV drugs for the dual purpose of health and prevention represents a troubling 're-medicalisation' of HIV that disregards its social complexities (Nguyen *et al.* 2011), signalling an increasingly neoliberal response to the epidemic driven by technical expediency and market rationalities (Ingram 2013). Others have cautioned against expectations that biomedicine will magically erase stigma and 'normalise' HIV by ending its historical imprint as an exceptional disease and turning it into an ordinary chronic illness (Moyer and Hardon 2014, Squire 2010).

Such concerns can be located within broader debates on biomedicalisation (Clarke and Shim 2011) and pharmaceuticalisation (Biehl 2007a, Williams *et al.* 2011), which highlight a growing trend in both public health and consumer culture towards seductive reliance on biotechnological 'fixes' and 'magic bullets' to not only treat and prevent diseases, but to manage an ever-expanding catalogue of 'risks', resolve problems of everyday life, and optimise cognitive, sexual or physical performance (Clarke and Shim 2011, Dumit 2012, Fox and Ward 2008). This trend has produced what Dumit (2002) refers to as a paradigm of 'pharmaceutical normalcy'. In this brave new world, pharmaceutical citizens are enticed to correct their afflictions and improve themselves by utilising 'technologies of optimisation' (Rose 2007). This, Sanabria (2010: 388) suggests, 'renders the disciplinary dimension of these new practices of self-making rather opaque'. It is possible to also read the current TasP agenda in this way, as an exhortation to enact normality through engaging in the responsible work of chemical 'dis-infection', expelling the stain of contagion and producing a sexually eligible body. Indeed, as scholars have noted, pharmaceutical citizenship is premised on the idea that biomedicine can 'demarginalize the suffering individual' and make them acceptable to society (Ecks 2005: 242), but only as long as they fulfil their obligations as citizens by complying with biomedical solutions in the first place (Pound *et al.* 2005; Sanabria 2010).

Medical technologies, however, are more than tools of control; they also have transformative possibilities that allow for new forms of exchange and subjectivity (Biehl and Moran-Thomas 2009). This is less often a focus of scholarly inquiry; how the biomedical promise of demarginalisation might unfold in ways that do more than merely medicalise bodies, discipline lives and intensify norms in the pursuit of health, empowerment or normalcy. This is what I wish to explore; if pharmaceutical citizenship can in fact have an inverse, liberatory effect and coincidentally *un-discipline* bodies and sexualities. Davis's (2015: 399) idea of 'repurposing' provides helpful stimulus here. It describes how the situated practices and effects of biomedical technologies 'are not always pre-figured and predictable'. Instead, such technologies can be reimagined in 'real-world settings' in ways that open up opportunities for expanded agency or

pleasures that transcend or even radically defy their original designation by biomedical regimes of knowledge. As Biehl and Moran-Thomas (2009: 267) suggest; 'human relationships to medical technology are increasingly constituted outside the clinical encounter'.

Relevant here is what anthropologist Todd Meyers (2013: 19) describes as the 'afterlife of therapy'; the unexpected ways therapeutic drugs take on different tenors and trajectories when they relocate from the logics of the clinical space to the 'complex calculus' of everyday lives. This, he argues, is the 'epistemological threshold' where scientific '*knowing* ends' and different histories of treatment take shape; where therapies become 'registers' for other stakes and significances, for human expressions and social positions, for gains and losses that far exceed the ambit of clinical trials and the medicinal purpose of a pill itself (Meyers 2013: 21, 34). And so it is with TasP. The re-branding of HIV treatment is driven by a public health agenda to prevent the transmission of disease, not to optimise individual pleasure, or even to facilitate sex beyond the reduction of risk. But when incorporated into intimate relationships, as I will show, TasP can be repurposed by lived experiences in ways that come to reconfigure the biomedical episteme of TasP and the meanings of serodiscordant sexuality.

## Approach

My discussion draws on *YouMe&HIV*, a qualitative study of serodiscordant gay and heterosexual couples in New South Wales, Australia. As the first study of its kind in Australia, it aimed to build a picture of the social, medical and sexual world of these couples and to understand how they experience and manage their mixed HIV status. The study was conducted by the Centre for Social Research in Health at UNSW Australia in collaboration with the Kirby Institute and the Australian Research Centre in Sex, Health and Society, as well as several community organisations. Following ethics approval by the UNSW Human Research Ethics Committee, participants were recruited through flyers, word-of-mouth, and the websites and print media of HIV community organisations. Study participants had to be 18 years or older, and to be in a committed and sexually active serodiscordant relationship of at least 2 months. The study was open to couples, as well as to individual partners, in order to optimise recruitment, to not disadvantage those whose partner did not want to participate, and to maximise the diversity of stories and relationships represented in the study.

Semi-structured interviews were conducted between March 2013 and September 2014, either face-to-face or by phone depending on participants' preference and location. Except for three couples who opted to be interviewed together, partners were interviewed separately to ensure that they were able to speak freely and confidentially. In all, 38 people took part in an interview, including 30 men, six women and two transpersons, of whom 18 were HIV-positive and 20 HIV-negative. Thirteen couples ( $n = 26$ ) and 12 individual partners participated, representing 25 couples in total (of which one was a self-described 'throuple' with three partners). These included 16 gay couples, seven heterosexual couples, one gay man/transman couple, one heterosexual man/transwoman couple. The high proportion of gay men in the study reflects the pattern of HIV infection in Australia; a low HIV prevalence country with a concentrated epidemic and an estimated 26,800 people with HIV (Kirby Institute 2014). There was considerable diversity among participants in terms of age (25–70 years), cultural background, education, and relationship length, ranging from 2 months to 20 years, with an average of 3–4 years.

Interviews were digitally recorded, transcribed verbatim and de-identified to protect participant confidentiality. For the purpose of this article, interview transcripts were coded by hand, generating 'open' codes to organise the material into thematic categories based on key issues

in the interviews that had explicit or contextual relevance to the analytical concept of pharmaceutical citizenship, with specific focus on narratives about treatment-as-prevention in relation to serodiscordant sexuality and perceptions of infectiousness and transmission risk. Using thematic analysis, the foundational method for qualitative analysis (Guest 2012), these broad categories were organised into sub-categories, focusing on inductive identification of recurrent and divergent themes within and across interviews. The resulting thematic codes were then analysed in detail to build a contextualised understanding of the issues at stake. The author conducted all interviews, coding and analysis.

### **TasP and serodiscordance**

Let me first sketch out the medical and sexual landscape of the study. In Australia, antiretroviral treatment for HIV infection is readily available through both public and private health clinics and is subsidised by the government. Treatment coverage in Australia is relatively high by international standards, with up to 73 per cent of people with HIV reported to be using antiretroviral therapy (Kirby Institute 2014). Surveillance data approximate that 85 per cent of people receiving HIV treatment have an undetectable viral load, suggesting high medication adherence and regular monitoring of blood (Kirby Institute 2013). Early treatment for the dual purpose of health and prevention has become a central component of the domestic HIV strategy (Australian Government Department of Health 2014), a strategy supported by community and clinical HIV organisations (ACON 2013; ASHM 2013, NAPWHA 2013). In New South Wales, where my research took place, treatment-as-prevention (TasP) has been heavily promoted by the state government (NSW Health 2012) and by a lengthy and highly visible community campaign (<http://www.endinghiv.org.au>), which many study participants were aware of.

Given temporal differences, awareness of TasP was unsurprisingly much greater among these couples compared to my earlier research (Persson 2010, 2013a). Regardless of educational level or socioeconomic background, most couples had some knowledge of current research on TasP, with many being attuned to developments in HIV prevention by virtue of being in a serodiscordant relationship, either through their own research or through conversations with their doctor. Of the 25 HIV-positive partners in these couples, 20 were on antiretroviral treatment and three were about to start. There was a consistent pattern among positive partners to describe treatment as a 'given' when in a serodiscordant relationship, as 'doing the right thing', and as being worth any downsides. Having a negative partner was a major motivator for positive partners to regularly monitor their viral load every 3–6 months and remain highly engaged with medical care. HIV-negative partners were usually kept in the loop about viral load test results and felt reassured by this.

There was a spectrum of sexual practices in the study: nine couples (all gay) consistently used condoms with penetrative sex, 11 couples had condomless sex, two did not have penetrative sex, and three couples alternated between condoms and condomless sex (to facilitate or prevent conception in two couples). All heterosexual couples and the transwoman/heterosexual man couple were monogamous, as were half of the gay couples, while the rest had an open relationship or only had sex with others together. Monogamy or open relationships were chiefly based on preference, and were not related to HIV. Thirteen couples met prior to one partner being diagnosed with HIV, while 12 couples met after diagnosis. Couples who met already serodiscordant were much more likely to practice condomless sex than those who had met before diagnosis, especially among gay couples. Heterosexual couples were more likely to practice condomless sex regardless of when they met. These sexual patterns are fairly

consistent with research from across the world, which show that condom use is far from the norm among couples in known serodiscordant relationships (see Persson 2013b).

### *A shifting landscape*

Not all participants were familiar with the actual term ‘treatment-as-prevention’, but there was broad awareness of the concept that treatment reduces viral load and thereby infectiousness. Both positive and negative partners were overwhelmingly positive towards the research on TasP and the emerging global support for antiretroviral therapy as a prevention strategy. Across the interviews, treatment was clearly seen as key to serodiscordant relationships because of its capacity to protect the health of both partners and thereby enable a sense of normality and possibility. Yet, couples provided different perspectives on transmission risk in relation to TasP and hence its implications for sexual practice, as revealed by three distinct themes. In the most common theme, particularly among gay couples, TasP was framed as ‘an extra layer of protection’ alongside continued condom use. Even though these participants believed that treatment drastically reduced transmission risk, TasP was not considered sufficient or safe enough on its own, which largely echoes the dominant public health message in the current TasP era. Citing the HPTN052 study, Cory, a positive partner in his mid-30s, explained:

We’ll still have protected sex . . . ‘Cause [TasP]’s not 100 per cent perfect . . . I don’t want that risk. I don’t want him to get it . . . For me, that 96 per cent report, that’s not good enough . . . I need a lot more . . . At the moment; I’m anti unprotected sex under all circumstances.

Connor, a 25-year old negative partner, echoed this view:

It’s in the single digit percentage range, isn’t it, the risk of transmission when you have an undetectable viral load. So it’s pretty safe . . . [But] I don’t think I’d consider having unsafe sex though.

The conflicting allusions to ‘safe’ and ‘unsafe’ in Connor’s quote hint at the challenges of rethinking safe sex when such a starkly different HIV prevention message has long dominated. Not even the PARTNER Study (Rodger *et al.* 2014), which shows that TasP renders transmission risk negligible, could convince some that it was a risk worth taking, including 51-year old Cameron who had lived through the trauma of the early epidemic and his partner’s diagnosis:

Whether it’s four per cent or .5 per cent, there’s still a risk . . . [and] if there’s any risk, it doesn’t make sense because the implications of that are so great . . . the emotional impact of [partner] knowing that he had given me HIV would be just too awful to bear . . . the upside of not having to think about putting a condom on is just, it is kind of minute in its significance compared to the downside of getting it wrong or being unlucky.

For these participants, while providing a greater sense of safety, TasP had no impact on their sexual practice. This was the case also for another group of couples, but in quite a different way. In the second theme, TasP provided ‘welcome relief, reassurance or validation’ for those who had already practised condomless sex for some time. Thirty-nine-year old Flynn said: ‘The thing is that, this new information . . . sort of confirmed what we did, why I’m still negative’. This is how Georgia, a positive woman in her mid-40s, described the impact of TasP on her existing sexual practice:



[Condomless sex] was very scary at first but, you know, it's something that has to be negotiated as a couple ... But now having seen the release of the [Australian HIV strategy, which endorses TasP] and understanding that this is a common consensus ... it's taken that uncomfortableness away, that fear away ... To me it's even safer now, if you know your status and if you have an undetectable viral load.

But for a handful of couples, TasP did contribute to a change in their existing sexual practice. In the third theme, TasP provided 'permission to commence condomless sex', especially among those who disliked condoms or experienced latex-sensitivity. Merlin, in his late thirties, described how he and his negative partner Daniel were 'very strict' about using condoms when they first met. But their initial intentions were soon challenged by Daniel, a transman, repeatedly getting latex-induced thrush and by 'falling in love'. 'When you're kind of barrelling head-long into that, we did start to have slip-ups', Merlin explained, resulting in 'terrible fits of guilt'. This led him to pull 'away from sex a little bit' to keep Daniel safe. Hearing about the concept of TasP changed all that. The fact that they only had vaginal sex and that Merlin had been undetectable for years meant, in his view, that 'we're really perfect candidates to use that method'. Daniel recalled the moment:

And then that study [HPTN052] came out ... So then we were like relieved, really, and able to kind of go ahead [and have condomless sex] ... I could sit there and go, 'These are the facts. If he has his medication every day ... I'm willing to take the risk because I know he's doing everything he possibly can to keep me safe'.

One theme that cut across all couples, no matter their sexual practice, was that TasP 'lessened anxieties about transmission'. As Georgia said, TasP 'helps you to be able to relax and enjoy your sex life, enjoy your relationship with your partner. It's one less thing to worry about'. The majority of participants claimed to not be worried about HIV transmission, describing the risk as 'very' low or, in negative partner Troy's words, 'Minimal to the point of non-existent'. In this context, it makes sense that those who had condomless sex were generally less concerned about transmission than couples who stayed committed to condoms. Overall, positive partners tended to be more worried. Their narratives were often ambivalent, as if unable or apprehensive to decisively leave behind the paradigm of infectiousness that has long defined the epidemic and embodied experiences of HIV-positivity. As 36-year old Oliver remarked:

I'm slightly paranoid about it ... [But] Simon's going, 'Oh the PARTNER Study says that, if you have an undetectable viral load, it's practically impossible to give HIV to your partner ... You won't give it to me', you know, 'trust me' ... Even my doctor tells me there's no risk in it. But I am a little bit insecure about that ... I take my treatment regularly, because even though [that fear] is deep down in the back of your brain, you know that treatment is one of the best preventative measures. The last thing I ever want is Simon getting HIV ... [But] he is the one who keeps reminding me about all the studies.

Although transmission concerns were not absent among negative partners, they were generally highly invested in refusing the notion of being at risk or of their partner being contagious. Many described the possibility of transmission as simply part of the relationship, on par with any manner of issues that couples live with, and remote enough to not let it define the relationship or be an ongoing concern. Adam, in his mid-30s, said:

I can't see how I can have a loving relationship with Jasmine and be preoccupied with fear about becoming HIV-positive ... it just seems incompatible.

Keeping things in perspective was a common theme, as were references to TasP research. Simon, who practised condomless anal sex, was fully immersed in this new territory:

I'm not scared of [HIV] at all ... I know the probability of getting it is not zero, but I know it's extremely low, extremely low. And my doctor's an HIV doctor and I've spoken to him about that too ... New studies have come out showing that, if the viral load is down as undetectable, the probability of getting HIV is extremely, extremely low ... I know there's still that slight risk there, but there's a slight risk with anything in life ... The probability of that happening, if we play our cards right, I feel is extremely, extremely low... We do look at the science.

Signalling this shifting terrain, as Simon's quote illustrates, was the centrality of *undetectability* in narratives of sex. Nearly all volunteered that their or their partner's viral load was undetectable, as if this clinical information was privileged with implicit significance over any specific sexual information. That is, 'undetectable' was invariably deployed as shorthand for the safety of serodiscordant sex, no matter what a couple's sexual activities. Miles, in his late sixties, described how learning about the science around viral load eliminated HIV as a potential relationship issue when he fell in love:

Lucinda and I met, and hugged, and it was just perfect ... I had no great medical knowledge of [HIV] ... One thing [Lucinda's doctor] helped me with is to talk about the [research] and the implications of it ... And he said that, as Lucinda had said, that there's something like a 0.00024 chance of cross-contamination if the viral load is undetectable ... So I just settled into being with Lucinda and the HIV wasn't really an issue to me.

Undetectability was so pivotal to most couples' relationship and intimacy that many found it difficult to envisage how their life together would work in the absence of the sense of safety and normality effective treatment provided. As Cameron put it, 'that kind of continuity and stability allows you to keep [HIV] in the background, to be honest'. This was a particularly common theme among negative partners. 'If Lucinda had a detectable load, everything would be re-thunk', Miles pondered. 'I don't know what we'd be doing'. Others echoed this, explaining they would have to reconsider not only their sexual practice but, in some cases, the whole relationship. For 40-year old Jack, treatment was a deal-breaker due to the catastrophic effect an HIV diagnosis would have on his own chronic health condition:

I know how much it reduces the risk ... So absolutely, there's no way in the world I'd be with a [positive] man who wasn't on treatment.

Others, including Daniel, emphasised that their positive partner's health was critical to the viability of the relationship:

I said to Merlin, 'If you weren't taking your medication every single day', which he does and he has major panics if he doesn't ... 'if you were just going at it half-half ... that would be a totally different situation'. There would be no relationship because he's not taking responsibility for his health.



Those few whose positive partner did not have an undetectable viral load tended to feel anxious about their partner's health and their own. 'It just makes things so much harder', 28-year old Damien explained, who had tried to convince his partner to start treatment since his diagnosis a year earlier. 'I'll be a lot more comfortable when he's on medication ... It should resolve a number of tensions'. Thirty-eight-year old Ramón spoke of similar tensions, but felt powerless to change his partner's mind about treatment:

He's trying to deal with [HIV] just with diet and meditation ... I would prefer him to be on the medication ... [It] makes me wary having intimacy with him because I don't know how infectious he would be ... if my partner was [on] treatment, it would give me a lot of peace of mind ... you know that he won't get sick as easily.

As we have seen here, TasP and undetectability emerged as greatly enabling for serodiscordant relationships, marking out a notably different terrain compared to my previous study conducted five years ago with heterosexual couples (Persson 2010, 2013a). There was a sense that TasP is dislocating HIV from its history of being perceived and managed as exceedingly infectious. 'That's pretty awesome', 42-year old Blake said about the new discourse of HIV risk:

Because no-one was saying that for all those years ... So to turn around now and hear people going, 'Well, look, it's so minimal risk, if you're undetectable on medication'. It changes the landscape a bit.

In this changing landscape, as I argue next, TasP does more than reduce transmission concerns and expand couple's sexual options.

### *Reimagining serodiscordant sexuality*

There were signs that TasP might transform serodiscordant sexuality beyond prevention. Although these signs were nascent rather than comprehensive across the interviews, they nonetheless point to potential movements away from dominant discourses and practices of serodiscordance as TasP becomes more widely known. One such sign of transformation was: 'shifting perceptions of what constitutes safe sex'. In the post-HPTN052 era, the long-standing synonymy between 'safe sex' and condoms still largely prevails in public health messages, albeit increasingly less categorically. When asked, most participants provided this textbook definition of safe sex. Yet their own sexual accounts repeatedly blurred and belied this definition as they discussed TasP research and their own situated perceptions of risk, conjuring a prevention landscape in transition. In Georgia's words:

I think I can safely say that my partner and I believe that safe sex now, because we've made that decision, is having an undetectable viral load on its own.

To quote Blake again, whose partner was taking pre-exposure prophylaxis to prevent HIV infection:

This whole idea is all changing about what I consider to be safe and unsafe, you know. It's just opened up a whole new realm of mitigated risk, risk management, if you like, of degrees of safety, degrees of risk. It's just changed so much ... because of, yeah, treatment. Because of the research that we've done into, you know, how do we manage and reduce risk ... it just all changes that whole risk framework ... So safe sex becomes

something completely different. Now safe sex is like, 'Oh we're both on medications, okay. That's as safe as we can get' ... Not 100 per cent, no. But, you know, I guess neither are condoms.

Echoing a fledging narrative in US gay communities, several negative partners emphasised that they were much safer having sex with their undetectable positive partner than they would be in other sexual situations (Grindley, 2014, LeBlanc, 2014, Sobo 2014). As Jack said, 'I know what I'm dealing with'. Forty-eight-year old Charlie explained:

I'm safer with [my positive partner] because I know it and I can face it head on, and do something about it rather than thinking that someone is negative and being at total risk.

Or, as Flynn said of his partner:

I know this person, I can trust this person. This person is not going to lie to me. So, if he say he's undetectable, he's on treatment, he has no STIs, that's all the tick.

This is an emergent narrative that hints at a potentially radical inversion of what constitutes safe and risky sex in the context of HIV. Another sign of serodiscordant sexuality being re-inscribed was the notion that *TasP* provides a bridge across the sero-divide. For many participants, discourses of 'risk' and 'difference' are at the core of considerable stigma around serodiscordant relationships and a perceived divide between HIV-positive and HIV-negative people in affected communities, what Daniel and Merlin referred to as 'the apartheid'. Because of this, couples did not generally disclose their serodiscordance to other people. 'We don't really advertise it', Merlin explained, 'Because I guess we are worried about judgements'. Charlie, a negative partner, spoke along similar lines:

You tell people, 'I'm in an HIV pos-neg relationship and I'm not using condoms', and the reaction you get is absolute horror ... So I don't tell people.

The sero-divide and its silencing effect had made serodiscordant relationships invisible in the community, 35-year old Cody noted:

I didn't even know what [serodiscordance] meant until it was actually relevant to me ... I realise now my understanding was fuck-all ... I just don't think it's visible, because people don't usually wanna disclose.

Another effect of the sero-divide was that it positioned serodiscordant relationships as unviable, as Simon, a negative partner, remarked:

Some people, unfortunately, don't go into relationships with a positive person because they have this mentality, 'I could never do a relationship, I could never have sex with a positive person'. Those attitudes are still loud and clear in the gay community, in many respects, unfortunately.

The sero-divide worked both ways, as Blake explained when reflecting on his budding serodiscordant relationship with Charlie: 'I never thought I'd see myself entering into this world'. When diagnosed 15 years ago, Blake ruled out ever again having sex or an intimate partnership with an HIV-negative person:

I just decided many, many years ago that . . . it's just a no-go zone, which kind of narrowed my field down a little bit to just positive men.

When he met Charlie by chance in a bar, Blake made this clear upfront, despite their immediate attraction to each other. But Charlie refused to take no for an answer or deem their serodiscordance an obstacle. 'I was just completely blown away by that approach and just his openness to that', Blake said. '[So] here I am sort of manoeuvring through a serodiscordant relationship'. As their relationship slowly developed, they set about doing as much research as they could, discovering that TasP had 'changed the world':

There just seems to be this movement towards it now, which is awesome, you know, it's great. So it's just opened my eyes to a whole new world, really. And I guess I've been living in a fairly limited view of how all this had to work for me and now I just feel freer . . . I can actually love who I love, rather than be limited to: 'Are you positive or not?' Yeah, that's big . . . In the past I probably would have just, 'Don't do it!' And now I would say 'The world has changed. The landscape has changed . . . Don't let [serodiscordance] be an obstacle. Don't let it be an issue. There's treatments. There's pathways. There's ways forward. And it gives space for, you know, relationships to happen, to evolve that I guess we once thought weren't possible'.

The idea that TasP is changing the landscape is echoed by US-based political blogger Andrew Sullivan (2014) who poses the question: 'Is the HIV divide now over?' That was certainly the message that many participants in this study wanted to get across. While those who entered their serodiscordant relationship pre-TasP had had to work through their own fears and preconceptions, they hoped that increased community awareness of TasP would make that process redundant. The potential for TasP to uncouple serodiscordance from 'risk' was so powerful that, for one negative partner, it held true even in the absence of treatment. After hearing about the PARTNER Study, 32-year old Jasper felt convinced that the condomless sex he and his female partner were having was safe, even though she had recently stopped taking treatment:

It's obviously that small, that tiny of a risk. Fuck, you've got more of a risk walking out in front of a bus . . . So I've just sort of gone with that and . . . we've spoken about it a lot and, at the end of the day, that's where I stand on that . . . Yeah, that's what they were saying, that [the transmission risk] just kept going down. And it's just amazing to see how much, you know, like you think five, six years ago how much they were talking about it and how, you know, 'you've gotta watch this, gotta watch that'. And it's all different now, you know. Very different.

Although this quote suggests some gaps in community understandings of TasP, what it also points to is a potential reframing of serodiscordance away from risk and stigma towards an eligible sexuality facilitated through pharmaceutical citizenship. That is, beyond enabling an expansion of sexual repertoires among couples, the discourse and practice of TasP might work to gradually normalise and legitimise intimate serodiscordant relationships as something that can be 'worked through' and then enjoyed, instead of being problematised as an anomaly in need of continuous sexual risk management. This quote by Charlie speaks to this idea:

You're dealing with the biggest issue that gay couples think about. You've suddenly got it. [But we've] dealt with it. Moved on. Which is really good . . . And all we have to worry

about is me staying negative, and so we can do that. And that's not as difficult as people think. It's not as though we're restricted to head jobs only or, you know, extreme vanilla sex and things like that. We do whatever we want. And it's good. And we can do it without guilt and without fear, and everything like that. And no, it's not easy, and no, it didn't happen like that straight away. It's taken us a good couple of months and it's taken, you know, a lot of consideration.

A possible trajectory of these emerging re-imaginings is that TasP will, largely unintentionally perhaps, un-discipline serodiscordant sexuality by shifting the focus of HIV prevention away from sexual practices toward treatment uptake and adherence, away even from sex altogether toward pharmaceutical citizenship and undetectability. Giami and Perrey (2012: 354) have flagged this scenario, arguing that with the consolidation of TasP 'the obligation to engage in sexual behavior change' to prevent HIV infection will no longer be seen as necessary 'thanks to the use of pharmacological medication'. These rudimentary signs of re-inscription appeared as potentialities rather than certainties in the interviews. Interestingly, however, they were more noticeable among: couples who had met after diagnosis; among more recent couples who met in the era of biomedical HIV prevention and who therefore were not already invested in condom use as a way to manage their serodiscordance; and among heterosexual couples who have generally had much less exposure to safe sex messages and cultures than gay men in Australia.

## Concluding reflections

Sexuality and medicine have a long entangled history, with medicine shaping how we understand and intervene in sex, based on typologies of normative and pathological sexualities (Foucault 1976). This history partly drives concerns that the global TasP agenda represents a return to the early medicalisation of people with HIV, which threatens to again elide the complex social dynamics of the epidemic (Nguyen *et al.* 2011) and perpetuate naive expectations that biomedicine will normalise HIV (Moyer and Hardon 2014). These are entirely valid concerns, which I do not intend to discount. But what I have attempted to show is that biomedicalisation has multiple effects, including the power to optimise life and counter stigma by restoring a sense of social and sexual belonging among people with HIV, as signified in the concept 'pharmaceutical citizenship' (Ecks 2005). Although this concept has primarily been critically analysed in terms of its limitations and the disciplinary obligations it can place on citizens, the stories explored here suggest that TasP holds potentiality to reframe serodiscordant sexuality as safe and legitimate, even render it immaterial in terms of future HIV prevention. In that sense, pharmaceutical citizenship in the context of TasP does not fit easily within common critiques that the proliferation of sexual medicine or 'pharmasex' only shores up cultural and gendered norms and expectations around sexuality (Marshall 2009, Tiefer 2006).

However, TasP is different from pharmasex in that the public health objective behind TasP is the prevention of HIV, not the sexual liberation and enhancement of people or couples living with HIV. But as my analysis suggests, one could argue that TasP becomes 'repurposed' by experience, by being situated in the midst of everyday life and relationships, which opens up new imaginaries and opportunities (Davis 2015). This 'afterlife of therapies' (Meyers 2013) not only remakes the medical therapy in question but also the illness or condition for which it is taken. In counterpoint to critiques that biomedicalisation only gives rise to new modes of governmentality and control, Biehl and Moran-Thomas (2009: 280) argue that biomedical technology 'does not determine or even necessarily constrain human lives; in fact, if often

liberates them'. New biomedical technologies make possible new experiences and practices, allowing 'people to imagine and articulate different desires and possibilities for themselves and others' (Biehl and Moran-Thomas 2009: 271). And so it seems in these stories of TasP, where we find perceptions and practices of serodiscordant sexuality that break away from its traditional positioning as 'risky' and problematic, hinting at its possible reinscription and re-embodiment as an eligible and, if you like, 'undetectable' sexuality.

To return to critiques of pharmaceutical citizenship; even as TasP holds the potential to un-discipline and de-stigmatise serodiscordant sexuality by unshackling it from the territory of 'risk', it remains to be seen whether the focus of disciplinary conduct will shift from sexual risk reduction to biomedical compliance instead (Giami and Perrey, 2012). As I show elsewhere (Persson *et al.* forthcoming), there is a risk that, in the new HIV treatment era, people feel pressured to take medication and maintain an undetectable viral load to be deemed responsible HIV citizens. Another potential upshot is that TasP leads to unwanted pressures within serodiscordant relationships to have condomless sex. TasP might also engender further scenarios in other cultural and epidemiological contexts where serodiscordance is shaped by different dynamics around HIV, medicine, sex and gender and where access to government-subsidised HIV treatment and resources are not as readily available as they are in Australia. These are all critical considerations to pursue in future research. In conclusion, TasP makes possible new ways to experience and imagine serodiscordant sexuality. But in this process, as Biehl and Moran-Thomas (2009: 280) caution, 'technology itself becomes a complex intersubjective actor, with transformative potential that must be negotiated with and even cared for to actualize its fragile chance for a new beginning'. In short, vigilance is required in the new HIV treatment era to ensure that as TasP opens new possibilities, others do not close.

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