THE SOCIAL AND POLITICAL DIMENSIONS OF THE ETHICS OF PREP FOR HIV PREVENTION AMONG MSM

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ABSTRACT

For many men who have sex with men (MSM), the risks, treatment, and prevention of HIV are central and unavoidable aspects of their experiences of sex and romance. This constant vigilance around HIV complicates their lives in medical as well as interpersonal and socio-political ways. Pre-exposure prophylaxis (PrEP) is a relatively new method of HIV prevention that is already revolutionizing the lives of MSM by lessening the need for this ongoing vigilance. However, the wide-ranging effects of PrEP on MSM are as of yet unclear. Therefore, the ethics of using PrEP among MSM is a timely issue that demands philosophical engagement. As MSM in North America face decisions of whether or not to use PrEP and the consequences of those decisions, philosophy has an important role to play in helping us think more clearly about the situation today by moving away from a strictly medical conception of the ethics of PrEP.

In my first chapter, I motivate my investigation into the social and political dimensions of the ethics of PrEP by providing a critical history of HIV and HIV prevention. In my second chapter, I challenge the prevalent risk assessment approach to the ethics of PrEP, arguing that it has a distorting effect, overblowing some risks while overlooking others. The second half of my dissertation demonstrates how a relational approach, focused on the conditions for trust and solidarity, better reveals the ethical terrain facing MSM with decisions about PrEP. In my third chapter, I examine the role of trust in sexual and romantic relationships between MSM as well as relationships between MSM and healthcare providers. In my final chapter, I argue that PrEP complicates relationships of solidarity within gay communities, focusing in particular on intergenerational differences in perspectives on HIV and HIV prevention.

Overall, my dissertation helps move us towards a more socially and politically informed conception of the ethics of PrEP, which helps us understand how MSM can live ethically within communities whose sexual and romantic lives continue to be medicalized, both internally by members of gay communities and externally by a broader culture and public health establishment.

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TABLE OF CONTENTS

INTRODUCTION

When the coronavirus disease 2019 (COVID-19) started to spread across North America and the rest of the world in 2020, it reignited difficult conversations about not only the medical and public health dimensions of pandemics, but also the broader ethical and political questions of risk and responsibility, stigma and exclusion, and equity and compassion, that surround them. The medical uncertainty about the COVID-19 pandemic and its effects on our health and our healthcare systems was rivaled by the uncertainty of its effects on our relationships, our communities, and our societies. We started having to assess the risk of not only contracting the virus, but also transmitting it to others - especially vulnerable older or immunocompromised people, whenever we went shopping at the grocery store, walking in our neighbourhood or visiting family and friends. We had to start using methods of prevention to reduce the spread of coronavirus in order to save lives and prevent further suffering: staying at home, staying two metres apart, and wearing face masks. Our response to the pandemic also importantly involved learning to trust ourselves and others in society to actually use these preventative measures consistently and correctly - especially people close to us, like our families, friends, co-workers, roommates, and other community members - and learning to advocate for these preventative measures throughout society, establishing shared scientific understandings and encouraging a sense of community solidarity. Unfortunately, these measures are sometimes controversial, counterintuitive, inconvenient, awkward, and uncomfortable for us and people are still navigating the many changes to our lives. COVID-19 is radically changing the ways in which we interact with each other and think about ourselves as part of communities in many ethically salient ways.

Nothing about this is new for gay, bisexual, and queer men in North America and around the world. Men who have sex with men (MSM) have been living with the reality of the HIV/AIDS pandemic, HIV prevention, and many of these same complicated and difficult ethical issues for decades.[1] They have had to assess the risk of HIV transmission whenever they have sex and they

[1] The group MSM includes self-identifying gay, bisexual, and queer men, but it also includes men who do not identify as either gay, bisexual or queer because group membership, in this case, is based on sexual behaviour and not self-identification. Gay men experience romantic and sexual attraction to other men, and bisexual men experience romantic and sexual attraction to people of the same gender and to people of different genders. ‘Queer’ is an umbrella term that covers individuals who do not identify as straight and/or cisgender. The group MSM,

have had to use various treatment and prevention strategies to reduce its spread in their communities and society more broadly. Using these HIV prevention strategies has also involved being able to trust each other in their sexual and romantic relationships and being able to rely on the political solidarity of gay communities in the face of cultures and public health establishments which have displayed neglect to active hostility, and were shockingly slow to respond to the AIDS crisis in the 1980s and 1990s.[2]

Today, MSM must still use multiple HIV prevention strategies and navigate the medical, social, and political effects of these on their lives, relationships, and communities. Condoms have been the primary strategy for HIV prevention for decades, but the recent advent of pre-exposure prophylaxis (PrEP) is changing the ways that MSM navigate these effects, including the assessment of HIV risk, the dynamics of trust in their relationships, and the political solidarity among different generations of gay, bisexual, and queer men who have experienced the HIV/AIDS pandemic in very different ways. These nuanced effects on the lives of MSM are not well captured by the approach to the ethics of PrEP as HIV prevention in either the academic literature or society more broadly, even in gay communities themselves, because of a focus on the clinical dimensions over the broader socio-political implications and community ethics. In this thesis, I argue that this is a mistake because the ethics of pandemics, whether HIV/AIDS or COVID-19, should not be viewed simply as a clinical issue, but one with important and inherent relational and cultural effects on different social and political groups in society. We cannot appreciate the risks and responsibilities brought on by HIV, or COVID-19, without this broader, relational lens. In particular, this approach directs our attention away from an individualistic assessment of risk and personal responsibility and towards the collective responsibility to create social conditions where responsible personal choice is possible (e.g. conditions of trust and solidarity, where stigma is minimized and diverse sexual norms are embraced).

I argue that the ethics of PrEP as HIV prevention is actually unintelligible without this broader social and political context because it shapes the debate in many important ways. While PrEP has the possibility of becoming an integral part of the fight against HIV, there are also many

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however, includes straight-identifying men who have sex with men as well as other men who do not take themselves to be part of the queer community for whatever reasons.

[2] Queer women as well as transgender and non-binary people more broadly have also been dealing with these issues, but they tend to be overlooked in the early politics, and even the current histories, of the AIDS crisis. See Shotwell, A. (2014). 'Women Don't Get AIDS, They Just Die From It': Memory, Classification, and the Campaign to Change the Definition of AIDS. *Hypatia*, 29(2), 509-525.

continuing political concerns about its use as HIV prevention, especially among gay, bisexual, and queer men.[3] The existing literature, however, focuses overwhelmingly on clinical concerns about PrEP: its effects on physical health, the seriousness and severity of its side-effects, the possibility of any drug resistance, the adherence and accessibility of PrEP, and the interest of pharmaceutical companies in its uptake among other concerns. My work goes beyond the clinic door by drawing attention to the significance of the wider history and social and political context of this relatively new HIV prevention strategy and its effects on the lives of MSM, including the physical as well as the mental and emotional health of MSM, the sexual and romantic relationships of MSM, and the perceptions of MSM and gay communities in society. I find that the debate about PrEP involves three distinct subjects of moral concern: the individual health of PrEP users, the relationships between individuals who are using PrEP, and their communities more broadly.

I also consider several relevant parallels to other preventative strategies, including the relatively uncontroversial use of malaria prophylaxis and the use of the birth control pill among women, in order to demonstrate that many different kinds of medical technologies often involve myriad social and political concerns as well. The problem with a strictly medical conception of the ethics of medical technologies like PrEP is that it simply does not account for the many relational and cultural consequences of using them on the lives of those who do use them. I call this the *medicalization fallacy* and it is especially important to resist this fallacy when the population using a certain medical technology is an oppressed social or political group, as in this case. The choices of MSM are more likely to be medicalized because of the history of pathologizing their behaviours and identities: first the demonization of homosexuality by religion, then its criminalization and its classification as a mental disorder, and finally, its connection to HIV/AIDS. Overall, my guiding research question is this: what does it mean to live ethically and to make ethical choices about using PrEP as HIV prevention within communities whose sexual and romantic lives continue to be medicalized, both internally by members of these communities and externally by a broader culture and public health establishment. The conclusions of this thesis present a framework that is also

[3] Although I sometimes use battle imagery to describe the experience of HIV/AIDS for gay, bisexual, and queer men, I acknowledge that there are positive and negative aspects of using this terminology. Thinking of dealing with a pandemic as a 'fight' against a virus can help inspire individuals and galvanize communities to action, but it can also make individuals feel like failures or communities feel fear, anxiety or panic. See Khullar, D. (2014). The Trouble With Medicine's Metaphors. *The Atlantic*. and Serhan, Y. (2020). The Case Against Waging 'War' on the Coronavirus. *The Atlantic*.

relevant and helpful for understanding the wider effects of other new developments in HIV prevention among MSM as well as other new medical technologies.

Before I continue, I want to briefly situate myself as the author of this project. Since I will be focusing on the social and political dimensions of the use of PrEP as HIV prevention among MSM, it is important to understand how my personal identity and experience interact with the issues that I will be considering in this thesis. First, my sexual behaviour is consistent with membership in the behavioural group MSM. Although not all MSM identify as gay, bisexual or queer because they might be straight, closeted or on the down-low, I am a self-identifying, openly gay man. I am also a white, cisgender, urban, educated millennial whose experience of the AIDS epidemic is one generation removed from the tragedy and who is privileged in many ways.[4] Insofar as I am a member of several gay communities, including those in Winnipeg and Toronto, I am a member of a distinct social and political group. Gay, bisexual, and queer men experience social and political challenges and opportunities that are unique among social and political groups in North America. For example, gay, bisexual, and queer men still face challenges when we want to get married and when we want to have children, but we also have the opportunities to create thriving gay cultures, build our own chosen families, and innovate new kinds of sexual and romantic relationship structures. As a gay man, I am a member of broader LGBTQ2S+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, etc.) communities. I understand myself, my life, and my experiences today in the context of a resilient LGBTQ2S+ history, which unfortunately involves the complicated history and legacy of HIV/AIDS, especially among gay, bisexual, and queer men, as well as the broader medicalization of homosexuality in North America.

Second, as a sexually active gay man, I am at high-risk for HIV when I have sex. Therefore, I go for regular HIV testing, I have to consider the risk of HIV when I have sex and when I build sexual or romantic relationships, and I have to use HIV prevention strategies. This is a consistent source of anxiety and stress for me which I have learned to accept and deal with as a part of the reality of building sexual and romantic relationships as a gay man. I am used to navigating HIV risk, learning to trust myself, my partner, and other casual sexual partners with HIV prevention, and discussing PrEP with my gay, bisexual, and queer friends and other members

[4] For example, the experience of Black MSM with HIV prevention is especially complicated because of pervasive racism in society as well as in gay communities. See Arnold, E.A., Rebchook, G.M., & Kegeles, S.M. (2014) 'Triply cursed': racism, homophobia and HIV-related stigma are barriers to regular HIV testing, treatment adherence and disclosure among young Black gay men. *Culture, Health & Sexuality*, 16(6), 710-722.

of gay communities. I am presently in a loving, long-term, open relationship. Both my partner and I are HIV-negative, so we are in a serosame relationship, which is a relationship where all partners have the same HIV status, or serostatus. When I have sex with either my partner or other sexual partners, I always have to consider the risk of HIV to me and my partners, and my strategies for HIV prevention. My present strategies for HIV prevention include limiting my sexual activity with others, choosing other sexual partners selectively, engaging in low-risk sexual behaviour, using condoms during sex with casual sexual partners, and using PrEP as HIV prevention. I started using PrEP as one of my HIV prevention strategies a year ago and my partner is also using PrEP among other HIV prevention strategies. All of this personal information is important in order to understand my situation in relation to other MSM, HIV, and PrEP and my perspective of the many ethical issues involved in PrEP use. Since my personal identity and my personal experience with sex, sexual and romantic relationships, HIV, and HIV prevention is relevant to my analysis, I will draw on it when it is appropriate throughout my thesis and I will refer to MSM, gay, bisexual, and queer men, especially those who are HIV-negative and who are using PrEP, and gay communities as "we", "us", "our", etc.

Following a chapter that critically and historically contextualizes the debate about the use of PrEP as HIV prevention among MSM (Chapter 1), this thesis investigates the social and political dimensions of the ethics of PrEP by focusing on three moral concepts: risk, trust, and solidarity. The present approach to the ethics of PrEP is one of medical risk assessment which I argue distorts the effects of PrEP on the lives of MSM (Chapter 2). Trust allows me to consider the effects of PrEP on the relationships of MSM, including sexual and romantic relationships as well as relationships with healthcare providers (Chapter 3). Solidarity allows me to consider the effects of PrEP on gay communities and intergenerational differences in views on HIV and HIV prevention (Chapter 4). I conclude that together these moral concepts demonstrate the nuance that is necessary to understand the ethics of PrEP in a way that actually helps MSM develop the skills that are needed for us to meet the ongoing challenges that HIV brings to our personal healthcare decisions, our interpersonal relationships, and our broader communities. I provide greater detail for each of these chapters below.

In Chapter 1, "Against a Strictly Medical Conception of the Ethics of PrEP", I present the background information about the ethics of PrEP, including the history of the AIDS epidemic, the development of HIV treatment and prevention strategies, and objections to PrEP use among MSM,

which focus on medical and behavioural concerns. HIV/AIDS has always been more than just a medical issue, especially for gay, bisexual, and queer men, and the social, political, relational, and cultural dimensions of the ethics of HIV and HIV prevention is obvious in the long-lived history as well as the medical, bioethical, and philosophical literature. However, the tendency to conceive of the ethics of PrEP as strictly a medical issue is a problem because it obscures the effects of this medical technology on the lives, relationships, and communities of MSM. I draw parallels between PrEP use among MSM and the use of the birth control pill among women in order to highlight the kinds of social and political effects that I think are missing from the strictly medical conception of the ethics of PrEP. If views of the birth control pill did not evolve to consider its effects on the sexual and romantic relationships of women who have sex with men and the changing perceptions of women in society, it would have missed some of its most important social and political effects. Therefore, I gesture towards a kind of socially and politically informed ethics of PrEP which I formulate more clearly over the course of the thesis, building from one moral concept to the next in the following chapters.

In Chapter 2, "Challenging the Risk Assessment Approach to the Ethics of PrEP", I consider the moral concept of risk and its privileged place in the debate about PrEP use among MSM. The present medical risk assessment approach to ethics of PrEP is insufficient because it is too narrow to capture all of the risks of using PrEP as HIV prevention or the lived experiences of MSM using PrEP. I demonstrate that this approach actually distorts the kinds of risks involved in using PrEP by overblowing certain medical risks, including the risks of sex between men, the risks of anal sex, the risks of condomless sex, the risks of anonymous sex, and the risks of having multiple sexual partners, and minimizes or overlooks other equally salient risks, including the risks of the stigmas associated with PrEP, the risks of PrEP reinforcing homophobic, biphobic, and serophobic stereotypes, the risks of PrEP emphasizing deep divisions in gay communities, and the risks of PrEP cultivating an ethics of disclosure. Since MSM have to weigh the risks and benefits of using PrEP ourselves, it is crucial to consider the entirety of our lived experiences with sex, HIV, and HIV prevention, because they affect our decisions. Unfortunately, these experiences are often outside the scope of the present medical risk assessment approach to the ethics of PrEP. Therefore, I argue that we have to broaden the ethical framework that we use to understand the risks of PrEP and resituate the concept of risk as just one of the many important aspects of the

ethics of PrEP in order to more fully consider other moral concepts like trust and solidarity, which allow us to discuss the effects of PrEP on our relationships and communities.

In Chapter 3, "Understanding the Effects of PrEP on Trust among MSM", I use the moral concept of trust to demonstrate how PrEP affects the relationships of MSM and how MSM can create the conditions for trust around HIV prevention in our relationships. I demonstrate the connection between the concepts of risk and trust by reviewing the literature on the philosophy of trust and explaining that trusting others necessarily involves accepting the risk of betrayal. Despite this risk, trust is valuable in many ways because it makes interpersonal relationships possible. However, different philosophical views of interpersonal, or relational, trust explain the motivation for being trustworthy differently, basing it on either self-interest, goodwill or virtue. I use risk assessment views of trust based on self-interest to explain trust in primarily sexual relationships between MSM, which I take to be more short-term or casual relationships, and will-based views and virtue views based on goodwill and virtue respectively to explain trust in romantic relationships between MSM, which I take to be more long-term or caring relationships. PrEP removes one barrier to trusting relationships between MSM because it reduces our risk for HIV, but it requires MSM to communicate about our sexual practices and desires within various relationship structures, including monogamous, polyamorous, and open relationships, and create the conditions for trust in these relationships. It is also important for MSM to be able to communicate with our healthcare providers because we have to trust them to actually prescribe us PrEP. Therefore, finally, I turn to institutional trust in order to analyze the trust between MSM and our healthcare providers. Unfortunately, the history of medicalization of homosexuality makes it difficult for many MSM to trust healthcare institutions as well as individual healthcare providers with our HIV prevention. Therefore, although healthcare providers have an important responsibility for creating the conditions for trust with their patients, it is really up to MSM ourselves as well as our communities to create the conditions for trust around using PrEP as HIV prevention in order for us to promote our own health and wellbeing more broadly.

In Chapter 4, "Understanding the Effects of PrEP on Solidarity among MSM", I use the moral concept of solidarity to demonstrate how PrEP affects gay communities and how MSM can build solidarity around HIV prevention despite deep divisions in our communities. I review the literature on the philosophy of solidarity to demonstrate how qualities like mutual respect, support, and loyalty, in addition to trust, are important in order for members of gay communities to actually

feel connected to one another. I use empathetic solidarity, in particular, to analyze the affective and relational components of solidarity in order to demonstrate how gay, bisexual, and queer men can understand each other across differences in perspectives and experiences with HIV. Although gay communities developed a strong sense of solidarity around HIV prevention during the AIDS epidemic, recent changes in our communities, including the development of new HIV treatment and prevention strategies, the recent successes of the gay rights movements, and the greater fragmentation of society today, have started to weaken the previous foundations of this solidarity. PrEP, in particular, presents challenges to broader gay solidarity because it exacerbates differences in sexual moralities and differences in intergenerational views. Furthermore, these differences are affected by the unequal power relations between different members of gay communities based on social factors like age, race, gender identity, and geography, which create barriers to empathy. Gay, bisexual, and queer men who have privilege are responsible for removing these barriers in order for everyone in our communities to feel like they are part of our collective responses to the challenges we all face in connection to HIV and HIV prevention. Therefore, I argue that MSM have to engage in difficult conversations with each other as well as other actions that are supported by community-based initiatives and that are aimed at developing greater empathetic understanding of each other's differences in order to rebuild the solidarity around HIV prevention that is necessary for us to continue to advocate for our health and wellbeing during the ongoing HIV/AIDS pandemic, which is still disproportionately affecting our communities.

Finally, in the "Conclusion", I tie together my whole analysis of the social and political dimensions of the ethics of PrEP as HIV prevention among MSM. I conclude that although PrEP initially seems like a straightforward clinical issue, in order for it to really be a successful HIV prevention strategy for gay, bisexual, and queer men in North America, we have to attend to its effects on our personal decisions, our interpersonal relationships, and our political communities. I argue for a nuanced ethical framework that incorporates the moral concepts of risk, trust, and solidarity and which highlights some of the most important, but overlooked, ethical implications of PrEP use for MSM today. I end with reflections about the future of the ethics of PrEP, and HIV prevention more broadly, as well as some implications of my conclusions on other related issues involving new medical technologies, like the prevention of COVID-19 and the important roles that risk, trust, and solidarity continue to play in our decisions, our relationships, and our communities during this new pandemic.

CHAPTER 1

Against a Strictly Medical Conception of the Ethics of PrEP

For many men who have sex with men (MSM), HIV, its risks, and its treatment and prevention strategies are a central and unavoidable aspect of our experiences of sex and romance. This constant vigilance around HIV complicates our lives in medical, social, and political ways. Pre-exposure prophylaxis (PrEP) is a relatively new method of HIV prevention and its apparent effectiveness has lessened the perceived need for vigilance around active sexual behaviour for MSM. However, the wide-ranging effects of PrEP on HIV prevention and MSM are as of yet unclear. Therefore, the ethics of using PrEP as an HIV prevention strategy among MSM is a complicated and timely issue that demands philosophical engagement. As MSM in both Canada and the United States face decisions of whether or not to use PrEP and the consequences of those decisions, this project provides new ways of approaching these decisions by broadening the ethics of PrEP beyond the traditional risk assessment in medical ethics and focusing instead on the relational and socio-political dimensions of using PrEP, particularly as they affect the lives, relationships, and communities of MSM in North America.[5]

In this initial chapter, I motivate and contextualize my discussion of the broader social and political issues around PrEP by providing a critical history and analysis of the background information that is relevant for understanding the present situation, including the history of HIV and its treatment and prevention as well as the experiences of MSM with sex, HIV, and HIV treatment and prevention. This critical history is intended to demonstrate why the social and political dimensions of PrEP use among MSM are so crucial for an adequate understanding of the debates over its use within and beyond gay communities. HIV and HIV treatment and prevention strategies have never been *merely* medical, especially when it comes to North American gay communities, and so philosophical discussions of them cannot be either. In order to understand the effect of PrEP on the lives, relationships, and communities of MSM, we first have to understand

[5] When I refer to North America, I am referring specifically to Canada and the United States. I focus on both Canada and the United States because they have similar rates of HIV, similar HIV prevention strategies, and the experience of MSM in both countries is similar as well. I focus on the North American context because I am most familiar with the experience of MSM with HIV in this context and the academic literature surrounding this experience.

what characterizes them and, in particular, the enormous medical, social, and political impact of HIV on them.

This chapter proceeds as follows. In the first half of this chapter, I present a brief history of HIV/AIDS, focusing on its impact on MSM and gay communities in Canada and the United States and the subsequent political awakening that accompanied AIDS activism. I then turn to the medical history of HIV treatment and prevention, from early treatment strategies to the development of ART and, most recently, the advent of HIV prevention via PrEP. Again, given my focus, I will cover both advances in treatment and prevention and the conversations and controversies that followed each advance. This double history provides appropriate context for the ethical debates about PrEP in academia. In the second half of this chapter, I critically examine those academic debates. I discuss the medical literature, which focuses on whether PrEP is safe and effective, as well as the non-medical literature, which focuses on how PrEP use affects the health, practices, and relationships of MSM. I use the non-medical literature in particular to highlight the social and political dimensions of the ethics of PrEP. Finally, I lay out some of the broader effects of using PrEP as HIV prevention for MSM. Particularly useful for my account are analyses of PrEP that draw on other controversial developments in reproductive and sexual medicine, such as the birth control pill, because these highlight how social and cultural anxieties around sex and sexuality complicate clinical assessments of medical risk. Ultimately, I conclude that careful analysis of the history and contemporary culture of HIV, MSM, and PrEP gives us significant reasons to doubt that a medicalized approach to the ethics of PrEP as HIV prevention among MSM can sufficiently capture the ethical issues involved in its use today because focusing solely on such an approach prevents us from recognizing several of these important ethical issues.

1.1. The Background Information on PrEP: Contextualizing the Present Situation

1.1.1. The History of MSM and HIV: The AIDS Epidemic

In order to understand the complexity of the ethics of PrEP, it is important to consider the relevant background information about HIV, HIV treatment, and HIV prevention. The complicated history of the AIDS epidemic continues to affect our understanding of the connections between HIV, MSM, and PrEP as HIV prevention today. The human immunodeficiency virus (HIV) and

acquired immunodeficiency syndrome (AIDS) are an ongoing pandemic. When HIV progresses to AIDS, it weakens the immune system and leaves the body susceptible to other opportunistic infections. Approximately 32 million people have already died of HIV/AIDS and 37.9 million people are living with HIV/AIDS today (UNAIDS, 2019). A total of 24.5 million people living with HIV have access to antiretroviral treatment (ART), which controls the infection, today. ART has almost eliminated the threat of death from HIV/AIDS in North America and HIV is no longer a death sentence. However, HIV is still a lifelong infection that complicates the lives of people living with it. People living with HIV require treatment for their infection and this treatment can be challenging, expensive, and inaccessible.

While advances in ART have dramatically reduced the spread of HIV worldwide, in both Canada and the United States rates of HIV infection are actually increasing among vulnerable populations like MSM. HIV is one of the most serious health problems facing MSM in North America. The most serious health problems facing men, in general, are cardiovascular or heart disease and cancer in both Canada and the United States (CDC 2016; Statistics Canada 2019). However, MSM have much higher rates of HIV and other STIs than other men as well as higher rates of distress, anxiety, and depression, higher rates of attempted suicide, higher rates of smoking and drug use, higher rates of partner violence, and higher rates of body dissatisfaction and eating disorders (Tooley, 2011). All of these factors demonstrate that MSM require a different approach to healthcare than other men, especially for HIV/AIDS because only 66% of gay, bisexual, queer, and men “who report being HIV positive are currently on HIV treatment” (CATIE, 2018). Unfortunately, the experiences and challenges that MSM face with HIV today stem from the tragic history of HIV/AIDS in North America.

AIDS was first identified in North America in 1981. The initial cases of AIDS were gay men in New York City and Los Angeles who contracted HIV through sex. In Canada, the first cases of AIDS were reported later in 1982 (CATIE, 2019). Initially, AIDS was thought to be a gay disease, a gay cancer or even a gay plague, and it was officially called Gay-Related Immune Deficiency (GRID) at the time (Herek & Capitano, 1999, p. 1130). The effects of AIDS were disproportionate within gay communities in North America. Although it is difficult to determine exactly how many of the AIDS diagnoses and related deaths were gay, bisexual, and queer men, given the relatively small size of this population in North America, the numbers of men who contracted HIV and died from AIDS were devastating to these communities. In the 1980s,

HIV/AIDS was closely associated with homosexuality and bisexuality and prevalent negative attitudes towards both. Not only was homosexual and bisexual activity equated with HIV/AIDS, but more blame was also assigned to gay, bisexual, and queer men who contracted it sexually than to, for example, heterosexual men as well as more anger fostered and less sympathy encouraged towards them, which led "to an unwillingness to help gay and bisexual people living with HIV/AIDS" (Herek & Capitanio, 1999, p. 1144). These negative attitudes meant that many hospitals and healthcare providers would refuse to treat people living with HIV, other people would refuse to touch them, and they would even sometimes be abandoned by their families and friends. For example, the experience of Ruth Coker Burks, who cared for hundreds of gay, bisexual, and queer men living with HIV and dying of AIDS in Arkansas during this time, demonstrates the effects of these negative attitudes (Koon, 2015). Burks witnessed nurses drawing straws to determine who would enter the hospital rooms of HIV/AIDS patients. When Burks learned that the families of these men had abandoned them, she would try to contact their families again and she would stand in as their family as necessary. She would hold the hands of these men, help them write their own death certificates, and even bury them because their "families would not even claim their ashes" (Koon, 2015). Not all of these negative effects were the result of actually living with HIV/AIDS, they were also the result of deeply rooted homophobia and biphobia in North America. Many religious and conservative people at the time believed that HIV/AIDS, the gay plague, was some kind of divine punishment for the immoral sexual behaviour of gay, bisexual, and queer men (Herek & Capitanio, 1999, p. 1131).

After the initial diagnoses of gay, bisexual, and queer men, HIV/AIDS became more widespread in North America, affecting populations like intravenous drug users, hemophiliacs, and blood transfusion recipients. However, the deaths of actor Rock Hudson in 1986 and singer Freddie Mercury in 1991 were high profile examples of the lasting effects of HIV/AIDS on communities of gay, bisexual, and queer men. These deaths reinforced the common perception that HIV/AIDS was primarily an epidemic among gay, bisexual, and queer men, associating the disease with their particular activities and practices, and appeared to demonstrate that this association was at least partially true. As early as 1984, bathhouses and sex clubs frequented by gay, bisexual, and queer men in San Francisco, Los Angeles, and New York City were closed due to high-risk sexual activity and growing prejudice even though these spaces were central to gay culture and gay communities at the time (Avert, 2018). Gay Men's Health Crisis (GMHC), an organization in New

York City that helped people living with HIV in the 1980s, was founded by men who believed that HIV/AIDS and its effects on gay, bisexual, and queer men were not being taken seriously by governments and health organizations (GMHC, 2016). GMHC demonstrated the need for community-based organizations to advocate on behalf of gay communities for an appropriate response to the AIDS crisis.

Across North America, community-based activist groups like AIDS Coalition to Unleash Power (ACT UP) in New York City, AIDS ACTION NOW! (AAN!) in Toronto, and Reaction SIDA in Montreal advocated even more strongly for the health of gay, bisexual, and queer men during the early years of the AIDS epidemic. These groups engaged in direct action to help people living with HIV and end the broader health crisis, including the discrimination faced by people living with HIV and other members of gay communities. This AIDS activism was very influential for gay communities and it connected the fight against HIV/AIDS with the fight for gay rights. The political abandonment, apathy, and hostility that gay, bisexual, and queer men faced during the epidemic were directly connected to the stigma and stereotypes around being gay, bisexual, queer or living with HIV. The cultural legacy of the AIDS epidemic and AIDS activism within gay communities in North America, and North American society more broadly, demonstrates the importance of this moment in history (Crimp, 1988). This includes representation in popular media like film, theatre, and television. The 1993 film *Philadelphia,* the 1996 musical *Rent,* and the 2003 television miniseries *Angels in America* are some of the most prominent examples of this moment in history being represented in popular culture. *The Normal Heart*, both the 1985 play and the 2014 film, even details the beginning of AIDS activism in the United States by presenting a fictional history of GMHC and the fight for HIV/AIDS research funding.

The 2018 television show *Pose* deals directly with the AIDS epidemic and its effects on primarily transgender women and gay, bisexual, and queer men who are part of the ball culture in New York City in the 1980s and 1990s. Several of the main characters are living with HIV, including Blanca Rodriguez and Pray Tell, and the show details their transition from being devastated and isolated by their diagnoses to their activism on behalf of their community. When Judy Kubrak, a nurse who works with people living with HIV, introduces Blanca and Pray Tell to ACT UP, they are inspired to fight not only for their own lives, but also for the lives of their friends and chosen families. They take part in the “Stop The Church” protest at St. Patrick’s Cathedral against the Catholic Church’s stances on HIV/AIDS, condoms, and homosexuality and they

continue to inspire others to take part in ACT UP actions and AIDS activism in general. Today, there are AIDS organizations, AIDS memorials, and AIDS walks in cities across North America because the AIDS epidemic and AIDS activism have continued to be part of the experience of gay, bisexual, and queer men, and LGBTQ2S+ communities, in North America for decades. This HIV/AIDS history and activism have not only affected how gay, bisexual, and queer men see ourselves and our communities, but it has also affected how the rest of society sees our communities and their association with HIV/AIDS.

Although the public perceptions of the association between HIV and homosexuality and bisexuality in North America have decreased since the 1980s, the actual numbers of gay, bisexual, and queer men affected by HIV today are still disproportionate. In fact, MSM are still the most high-risk group for HIV infection in North America today (CDC, 2017). In Canada, MSM are 131 times more likely to get HIV than men who do not have sex with men (CATIE, 2018). This means that more than half of all new HIV infections in Canada are among MSM each year and the number of new HIV infections among MSM has continued to increase since 2014 (CATIE, 2018). Although MSM are one of the most vulnerable groups for HIV infection, it is important to remember that MSM are a broad and diverse group. Some of the most vulnerable people in the group, those who are often even more disproportionately affected by HIV, include Black men, Indigenous men, Latino men, sex workers, and injection drug users. These groups tend to experience even more exclusion, stigma, and ostracization in society and even in gay communities because of a lack of integration. In Canada, for example, gay, bisexual, queer, and Two Spirit Indigenous men experience a confluence of factors, including the legacy of colonization, which leads to highly disproportionate rates of HIV (CATIE, 2018). Although Indigenous people make up 4.9% of the Canadian population, they represent 11.3% of new HIV infections (Public Health Agency of Canada, 2018). In the United States, Black men are the most disproportionately affected by HIV among MSM and Black MSM also account for the most new cases of HIV infection today (CDC, 2017; CDC 2019). Finally, although they are sometimes misidentified as MSM because of transphobia and ignorance about transgender and non-binary people, transgender women are obviously not part of the group MSM, but they are also a high-risk group for HIV infection in North America, especially given the prejudice they face in society. Although it is very important to study the experience of HIV and HIV treatment and prevention among both transgender and

cisgender women as well as non-binary people, I focus specifically on the HIV prevention challenges for MSM.[6]

MSM face several uniquely difficult HIV prevention challenges today, compared to the broader North American population. First, there is a large percentage of MSM, especially gay and bisexual men, living with HIV today.[7] Although gay, bisexual, and queer men only account for a very small percentage of the population of the United States, we account for over half of the HIV-positive population as well as 70% of new HIV diagnoses (CDC, 2019). In fact, 14.5% of gay, bisexual, and queer men are actually living with HIV today in the United States (UNAIDS, 2019, p. 453). The statistics are similar in Canada. Gay, bisexual, and queer men represent 2% to 3% of the population, but we account for 52% of the HIV-positive population and approximately 16% of gay, bisexual, and queer men are living with HIV today in Canada (CATIE, 2018). Therefore, the probability of being exposed to HIV is greatly increased for gay, bisexual, and queer men. Many gay, bisexual, and queer men are also in serodifferent relationships. Serodifferent relationships are relationships in which at least one partner is HIV-positive and another partner is HIV-negative. In these relationships, there is the risk of HIV transmission from an HIV-positive partner to an HIV-negative partner. Gay and bisexual men in serosame relationships, or relationships in which all partners are HIV-negative, do not have the same risk. However, different relationship structures among gay, bisexual, and queer men, including monogamy, polyamory, and open relationships, almost all involve some risk of HIV from sexual partners either within or outside the relationships, except monogamous serosame relationships. Furthermore, "gay, bisexual, and other men who have sex with men on average have a greater number of lifetime sexual partners", according to the CDC (2016). Therefore, even serially monogamous gay, bisexual, and queer men have increased risk for HIV in their lifetimes.

Second, many gay, bisexual, and queer men engage in what medical communities identify as high-risk sexual behaviour for HIV. HIV is a sexually transmitted infection (STI) and the probability of transmission is increased with high-risk sexual behaviour, such as anal sex if any of

[6] Again, for a critical explanation of how women were involved and affected by the AIDS epidemic, see Shotwell, A. (2014). 'Women Don't Get AIDS, They Just Die From It': Memory, Classification, and the Campaign to Change the Definition of AIDS. *Hypatia*, 29(2), 509-525 and for more information on HIV and transgender women, see Poteat, T., German, D., & Flynn, C. (2016). The conflation of gender and sex: Gaps and opportunities in HIV data among transgender women and MSM. *Global Public Health*, 11(7-8), 835-848.

[7] I try to use 'MSM' when I refer to the group in general and I try use 'gay or bisexual men' when I refer to the group who is affected by the special social issues that arise from their sexual orientation and identity. However, the statistics about HIV among MSM alternate between identifying the population as 'MSM' and 'gay and bisexual men' and I do so too.

the partners is HIV-positive (CDC, 2018). In fact, anal sex is the highest risk sexual behaviour for contracting HIV. Vaginal sex is lower risk and oral sex and other sexual activities like touching and kissing have very low or no risk for contracting HIV (CDC, 2018). HIV is transmitted in sex by bodily fluids, including blood, semen, pre-seminal fluid, and vaginal fluid as well as rectal fluids. The lining of the vagina and cervix and the lining of the rectum are more likely to allow HIV to enter the body during sex for the receptive partner than the insertive partner because HIV can only enter the body through the urethra, the foreskin or any abrasions on the penis (CDC, 2018). The difference between vaginal sex and anal sex in terms of HIV risk is characterized by the fact that the lining of the rectum is much thinner than the lining of the vagina and cervix. Therefore, receptive anal sex, or bottoming, is much higher risk than insertive anal sex, or topping. The receptive partner, or bottom, is actually 13 times more likely to contract HIV than the insertive partner, or top (CDC, 2018).

According to the CDC (2018), "most gay and bisexual men get HIV through having anal sex without condoms or medicines to prevent or treat HIV". Although using condoms or HIV prevention medicines, like PrEP, reduces this risk for HIV, gay, bisexual, and queer men still have an especially high risk of contracting HIV through typical partnered sexual behaviour.[8] Furthermore, neither condoms nor HIV prevention medicines are 100% effective at preventing HIV transmission. PrEP, for example, is approximately 99% effective at preventing HIV transmission among MSM (Grant et al., 2014). It is difficult to measure optimal condom use during sex, but consistent condom use during sex among MSM is only 63% effective at preventing HIV transmission for insertive anal sex and only 72% effective at preventing HIV for receptive anal sex (Smith et al., 2015). "Condom effectiveness is also likely to be higher when condoms are used correctly every time during sex", but it is difficult to account for this in studies based on self-reported condom use (CDC, 2019).

Third, 1 in 6 gay and bisexual men living with HIV are unaware of their serostatus (CDC, 2018). Serostatus refers to "the state of either having or not having detectable antibodies against a specific antigen" (AIDSinfo, 2018, p. 158). In this context, serostatus refers to whether a person has detectable antibodies to HIV. Testing seropositive, or HIV-positive, means that someone has

[8] I use the phrase "sexual behavior" in this chapter to go along with the way that the literature usually discusses it, but in subsequent chapters, I will favor describing these activities as "sexual practices" because I find that they are practices more akin to practices of faith or family than mere behaviours as it is sometimes implied in standard academic treatments of sexual health.

detectable antibodies to HIV, which determines that they have HIV. Testing seronegative, or HIV-negative, means that someone does not have detectable antibodies to HIV, which determines that they do not have HIV. If gay, bisexual, and queer men are unaware of their serostatus, then we cannot get the right HIV treatment and we can unknowingly transmit HIV to our sexual partners. People living with HIV who are unaware of their serostatus and who are not seeking treatment are actually more likely to transmit HIV than people who are aware and who are seeking treatment. HIV treatment can greatly reduce, or even often eliminate, the likelihood of HIV transmission among sexual partners (Prevention Access Campaign, 2019).

These three prevention challenges demonstrate the risks that gay, bisexual, and queer men face with HIV and the importance of effective HIV prevention strategies in order to minimize those risks. However, the CDC (2018) also adds that other prevention challenges that gay, bisexual, and queer men face include homophobia, biphobia, stigma, discrimination, and socio-economic factors, "such as having limited access to quality health care, lower income and educational levels, and higher rates of unemployment and incarceration". I think it is important to acknowledge these further HIV prevention challenges because it is not only medical and physical prevention challenges that affect gay, bisexual, and queer men. Social and political prevention challenges also include the closet, shame, embarrassment, internalized homophobia and biphobia, difficulties maintaining consistent condom use or adherence to HIV prevention medicines as well as distrust of medical communities, especially after the muted response to the AIDS epidemic and the previous medicalization of homosexuality and bisexuality as mental disorders in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).

I also want to draw special attention to how the closet complicates the experiences of MSM with HIV and presents a fourth HIV prevention challenge for MSM. The closet determines how MSM navigate the world; we always have to either hide or disclose aspects of our personal lives to others. The closet is a central experience for MSM and it has long shaped the development of queer culture, but it is also a complicated aspect of queer life. The legacy of the closet for MSM is one of secretiveness and deception because of the need to conceal our identities in order to protect our relationships and our lives in an often hostile society. In order to overcome this legacy, it is important to identify how the closet affects the ongoing experiences and decisions of MSM in society today. For example, there are goods associated with being out of the closet (MacLachlan, 2012) and there is also the phenomenon of passing as privileged, which MSM can often use to our

advantage (Silvermint, 2018). It is clear that the closet represents a major social and political dimension of the ethics of PrEP, but there also exists a sero-closet for people living with HIV. People living with HIV often have to hide their serostatus from others or they have to disclose it depending on the situation. It is even more complicated for MSM living with HIV because they have to contend with two different closets and the disclosure of two different identities. Therefore, being in the closet and coming out of the closet in terms of either sexual orientation or serostatus constitutes a fourth HIV prevention challenge for MSM. Overall, the history of HIV/AIDS exclusion, neglect, stigma, and shame demonstrates that the pandemic, and the experience of MSM with it, has always been a socio-political struggle as well as a biomedical issue. This social and political history extends to MSM, and particularly gay, bisexual, and queer, today as we explore our options for HIV treatment and prevention strategies and the effects of these strategies on our lives, relationships, and communities.

1.1.2. HIV Treatment and Prevention Strategies: From AZT to PrEP

The advent of ART has had a serious impact on both the treatment and prevention of HIV for MSM and other people either living with HIV or at high risk for HIV. As HIV testing methods and ART improved, people were diagnosed with HIV sooner and started living with HIV longer. The first antiretroviral drug, zidovudine or AZT, was approved for HIV treatment by the United States Food and Drug Administration (FDA) in 1987 (Avert, 2018). AZT was the focus of much of the early AIDS activism by gay communities, including ACT UP, AAN!, Reaction SIDA, and other groups. By 1995 though, the FDA approved highly active antiretroviral treatment (HAART) which started to greatly reduce the rates of AIDS-related deaths in the United States and around the world for people who had access to it (Avert, 2018). Governments and public health organizations have often responded slowly to new developments in HIV treatment and prevention though, which has led to the increased stigmatization and discrimination of people living with HIV as well as ongoing issues with access to these treatment and prevention strategies for marginalized groups. Stigmatizing attitudes towards people living with HIV and moral judgments about them still persist today (Pitasi et al., 2018). Without greater access to treatment and prevention strategies, HIV rates continue to increase among MSM in North America, especially in Black, Latino, and Indigenous communities. Nevertheless, the life expectancy for people living with HIV is approaching that of

the general population because of ART (Samji, Cescon, Hogg, et al., 2013). One of the most interesting developments in ART was a drug that can actually be used to help either treat or prevent HIV infection. In 2004, Gilead Sciences developed an orally administered drug called Truvada, which is a combination of two antiretroviral drugs: tenofovir and emtricitabine (Jay & Gostin, 2012, p. 867). Tenofovir and emtricitabine were first used as part of HIV treatment, but it was discovered that this combination was also effective as HIV prevention. Truvada, and more recently a generic version of the drug, is now being prescribed as both treatment as prevention (TasP) and pre-exposure prophylaxis (PrEP) around the world.[9]

First, TasP is the treatment of people living with HIV in order to help prevent them from transmitting HIV to others. Truvada, in combination with other antiretroviral drugs, reduces the risk of HIV transmission because it reduces the viral load in the bodily fluids of people living with HIV. If their HIV viral load level is very low, then it is deemed undetectable and there is negligible risk of transmission. The recent undetectable equals untransmittable (U=U) informational campaign is an attempt to disseminate, and contextualize, the scientific research that has concluded that an undetectable HIV viral load is actually untransmittable (Prevention Access Campaign, 2019). According to several studies, if people living with HIV use TasP to effectively maintain an undetectable HIV viral load, then they are incapable of transmitting HIV to their sexual partners (Cohen, Chen, McCauley, et al., 2016; Rodger, Cambiano, Bruun, et al., 2016). Therefore, TasP is a form of both HIV treatment and prevention because it not only treats people living with HIV, but it also prevents HIV transmission to their sexual partners.

Second, PrEP is the use of Truvada by people who are not living with HIV before an exposure to it in order to help prevent infection. Truvada is taken daily and if taken consistently, it significantly reduces the risk for HIV infection because maintaining a certain level of antiretroviral drugs in the body helps prevent the contraction of the virus even with exposure. Truvada, and its generic version, is a blue pill that contains 200 mg of tenofovir and 300 mg of emtricitabine. The regime for the pill is almost always the same; the pill is supposed to be taken at the same time every day to maintain the right level of tenofovir and emtricitabine in the body. If a dose is missed by

[9] In addition to TasP and PrEP, a similar combination of antiretroviral drugs can also be used as post-exposure prophylaxis (PEP). PEP is the use of antiretroviral drugs by people who are not living with HIV who have recently had an exposure or possible exposure to HIV. This can be from having sex, being sexually assaulted, sharing needles for injection drugs or even occupational transmission among healthcare workers (CDC, 2019). The ethical issues involved in the use of PEP are very different than TasP and PrEP since it is only used in emergency situations and its use never planned far in advance. Therefore, I will set aside further discussion of PEP in order to focus on TasP and PrEP and the ethical issues that are involved specifically among MSM.

more than 12 hours, then the pill is supposed to be taken the next day at the same time. It takes about 1 week of daily doses for the levels of tenofovir and emtricitabine to reach a level in the body that effectively prevents HIV upon exposure (PrEP Facts, 2014). Therefore, missing a dose, or missing several doses, might eventually compromise the effectiveness of PrEP. The effectiveness of PrEP depends on adherence, how consistently the drugs are taken and how many doses of the drugs are taken weekly, but the effectiveness of PrEP for reducing the risk of HIV transmission is still approximately 99% (Anderson et al., 2012, p. 1).

The use of PrEP as an HIV prevention strategy requires both self-trust and relational trust or trust in others. Self-trust is required in order for individuals to trust themselves to take PrEP consistently and correctly and relational trust is required in order for either HIV-negative or HIV-positive partners of individuals taking PrEP to trust that they are actually taking it consistently and correctly and that they have the right levels of the drugs in their body in order to actually prevent HIV transmission. Trust is one of the concepts that demonstrates the social and political dimensions of the ethics of PrEP for MSM that are often overlooked in literature, where the focus is usually on the medical dimension. This point about the trust involved in PrEP use, especially among MSM, will be important in Chapter 3, and I will go into further detail about interpersonal trust as well as institutional trust between MSM and our healthcare providers, who are the ones who consult with us and prescribe us PrEP as HIV prevention.

Truvada has already had a significant impact in North America for both the treatment and prevention of HIV in Canada and the United States. Canada approved Truvada as TasP in 2004 and it approved Truvada as PrEP in 2016. The United States approved the use of Truvada as TasP in 2004 and it approved the use of Truvada as PrEP in 2012. Therefore, PrEP is a relatively new HIV prevention strategy in both Canada and the United States. Since MSM are one of the highest risk groups for HIV and one of the groups who would benefit most from alternative HIV prevention strategies, PrEP was targeted to gay, bisexual, and queer men and it continues to be targeted to us in both Canada and the United States. In the United States, for example, the CDC identifies the following people who are at high risk of HIV and who are candidates for PrEP: "those in a relationship with an HIV-positive partner" regardless of their gender or the gender of their partners, "men who don't use condoms when having sex with men", and "men who have been diagnosed with a sexually transmitted infection (STI) in the past six months and who are not in a mutually monogamous relationship with an HIV-negative partner" (2019). Therefore,

according to the CDC, MSM who have an HIV-positive partner, who have recently had an STI, who have a high number of sexual partners, who have a history of inconsistent or no condom use, and who do commercial sex work are all designated as high-risk for HIV and candidates for PrEP. This captures many MSM and explains why PrEP is being targeted to us.

When MSM decide to start using PrEP there are three steps in the process. First, MSM who are interested in using PrEP have to go for PrEP counselling. We meet with a doctor, nurse or other healthcare provider and we discuss our sexual behaviour with them. If they decide that we could benefit from using PrEP, then we receive a three-month prescription after testing negative for HIV. Second, every three months we return for regular HIV and other STI testing because we have to be HIV-negative to use PrEP and it does not prevent any other sexually transmitted infections besides HIV. Since only people who are not living with HIV can use PrEP, PrEP users have to always know their serostatus and maintain a negative status. However, it is sometimes difficult to get tested for HIV and actually know your serostatus because different methods of HIV testing are able to identify HIV at different stages of infection. For example, some tests can detect HIV after 1 month of infection, but others can only detect HIV after three months of infection. It also takes different amounts of time for different bodies to develop the relevant antibodies. In other words, there is a period of time, a window period, in which people can test negative for HIV when they are actually HIV-positive, depending on the kind of tests and their bodies. Therefore, it is especially difficult to know your serostatus because the different window periods in HIV infection make HIV testing imprecise. This difficulty in knowing your serostatus contributes to the complexity of the ethics of PrEP as HIV prevention.

Third, PrEP is not usually recommended outside of a combination strategy for HIV prevention that includes condoms and other safer sex practices. Condoms and other safer sex practices protect against other STIs besides HIV, including chlamydia, gonorrhea, and syphilis. If PrEP is used as an HIV prevention strategy instead of condoms, then the risk for these other STIs remains high for MSM.[10] Therefore, doctors, nurses, and other healthcare providers usually recommend PrEP as part of a combination HIV prevention strategy. However, there are problems with condoms and other safer sex practices as methods of HIV prevention, especially for MSM. For example, condoms are less effective for HIV prevention than it was initially thought because

[10] There is evidence that tenofovir, one of the component drugs of PrEP, is modestly effective as protection against genital herpes (Abdool Karim et al., 2015).

many MSM do not always use them consistently or correctly during sex (Green et al., 2012). Condoms are actually only 70% effective as HIV prevention during all sex between men. MSM are also using condoms less and less, which is a phenomenon called condom fatigue (Smith et al., 2015). Given the problems with condoms as HIV prevention among MSM and the high rates of HIV infection among MSM in North America today, there is clearly a need for alternative HIV prevention strategies, especially since HIV rates remain so high at a time when condoms are the primary HIV prevention strategy among MSM. PrEP is occasionally recommended outside of a combination strategy for HIV prevention because some healthcare providers admit that if MSM do not use condoms during sex, then using PrEP is still beneficial as HIV prevention even if it does not prevent other STIs. Regardless, alternative methods of HIV prevention, like PrEP, are increasingly necessary in order to either complement HIV prevention or supplement HIV prevention for MSM in North America.

1.1.3. Objections to PrEP: Explaining the Controversy

Despite their clinical efficacy, the development of both PrEP and TasP has caused controversy in North America. The increasingly widespread use of both TasP and PrEP inadvertently undermines the principles that, until now, seemed to be the only way to keep communities safe: use condoms, limit your number of sexual partners, and avoid sex with people living with HIV. The controversy stems from the double role of these drugs as both treatment and prevention because their use communicates the possibility of safe sex with people living with HIV. Refraining from having sex with people living with HIV was the most basic tenant of the fight against the spread of HIV starting in the 1980s until very recently; the possibility of safe sex with people living with HIV was previously unthinkable. Today, both PrEP and TasP are challenging these deeply established principles. First, although TasP, and by extension U=U, demonstrates a significant advance in both the treatment and prevention of HIV, the conversations around these advances clearly challenge the aforementioned principles. The social and political implications of people living with HIV being incapable of transmitting HIV to their partners change the dynamics of sexual and romantic relationships among MSM and combats the stigma around living with HIV. For example, do the sexual partners of people living with HIV who have an undetectable viral load even need to use an HIV prevention strategy, like condoms or PrEP, if transmission is impossible?

The challenge is for people to acknowledge these scientific advances and the ways that they affect their sexual behaviour and their perceptions of both HIV and people living with HIV. Again, every advance in HIV treatment and prevention has medical as well as social, cultural, and political implications, especially for MSM whose lives, relationships, and communities are still so intimately affected by HIV and HIV treatment and prevention.

Second, although PrEP is safe and effective as HIV prevention, it also challenges the traditional principles of the fight against the spread of HIV and this challenge has medical, social, and political aspects too. As PrEP becomes more widely available in North America, several objections to its widespread use have shaped the conversations that MSM, healthcare providers, and others are having about it. The medical objections to PrEP include questions about the severity of its side-effects, the effect of PrEP use on the rates of other STIs among MSM, and the possibility that widespread PrEP use might lead to drug-resistant strains of HIV. These objections deal with the kinds of risks that are justified for certain kinds of behaviours or practices. How we identify the sexual behaviour in question and how valuable we think it is affects how reasonable it is for MSM to take some of these risks. Nevertheless, the responses to these objections in the academic literature and the medical data on the side-effects, STI rates, and HIV drug resistance associated with PrEP demonstrate that these risks are minimal and the related questions are mostly settled within at least a clinical context.

However, the social and political objections are much more complex and contentious in both academic and public sources; the controversies surrounding PrEP go far beyond its effectiveness as HIV prevention. First, the social objections include questions about the possibility that taking PrEP will lead to risk compensation behaviour among MSM. In other words, if MSM take PrEP and subsequently engage in more risky sexual behaviour, then we might actually increase our risk for HIV and other STIs. The worry here is that PrEP is a "party drug" and that it might actually make its users sexually irresponsible. PrEP users are even sometimes derogatively called "Truvada whores" because of this worry (Calabrese & Underhill, 2015). Unfortunately, this worry misrepresents the debate about risk within the ethics PrEP. The risks and rewards involved in using PrEP as HIV prevention are broader than the risks of sexual behaviour, HIV, and other STIs. I will take up this discussion of risk in the ethics of PrEP in Chapter 2 because there are also social and political risks and rewards for MSM, our relationships, and our communities. Second, the social objections also include questions about the kinds of relationships the PrEP encourages

MSM to build. MSM who use PrEP as HIV prevention can build sexual and romantic relationships with each other regardless of serostatus. However, after decades of serophobia and the ongoing threat of HIV, these relationships can be difficult for MSM to maintain. If PrEP is only viewed in terms of sexual behaviour and risk mitigation, then we miss the opportunity to evaluate its impact on the trust and cohesion of sexual and romantic relationships. I will take up this discussion of trust in the relationships of MSM in Chapter 3. Third, the political objections include questions about how PrEP will affect gay communities more broadly. The worry is that the division between older and younger generations on the issues of HIV and HIV prevention might be exacerbated by the widespread use of PrEP. PrEP might just be another way for MSM to manage our fear of HIV and people living with HIV and it might just further reinforce the stigma (McCelland, 2019). Solidarity around HIV is also important for gay communities and if PrEP jeopardizes this solidarity, then it might actually weaken communities that have already had to work so hard to survive the AIDS epidemic. I will take up this discussion of solidarity among MSM in Chapter 4. Since MSM are increasingly using PrEP as HIV prevention today, it is important to respond to all of these medical, social, and political questions in order to determine how PrEP use is actually going to affect MSM in North America.

1.2. The Literature on PrEP: More than Medicine

Given the significance of PrEP as a development in HIV treatment and prevention and the controversies attending its acceptance, it is not surprising that there exists a literature examining the medical dimensions of PrEP use, focusing on clinical and public health issues. Since PrEP is a relatively new HIV prevention strategy, the literature is still dealing with some of the foundational medical issues about its safety and efficacy. This literature is also not always focused specifically on the use of PrEP by MSM. However, clinical studies of PrEP, like the iPrEx trial and others, demonstrated its effectiveness as HIV prevention among MSM in particular (Grant et al., 2010). The public health policy recommendations that MSM use PrEP as HIV prevention have led to its increasingly widespread use among MSM and research about this use and its effects on the health of MSM. Therefore, a growing literature is taking into consideration the experiences of MSM with HIV and broadening its focus to include several social and political issues involved in PrEP use. I

will summarize the arguments and issues in both the medical and non-medical literature on PrEP use among MSM in order to situate my own approach to the ethics of PrEP.

The medical literature on PrEP in journals specializing in medicine, public health, and bioethics often focuses on medical issues like the safety and efficacy of PrEP, the side-effects of PrEP, the possibility of drug-resistant strains of HIV, and the cost-effectiveness of PrEP as HIV prevention. Sugarman and Mayer (2013) identify issues of wellbeing and issues of justice as the most relevant ethical dimensions of PrEP use. They identify the ethical issues related to wellbeing as issues of safety, risk behaviours, drug resistance, and stigma among others. In terms of safety, the discussion in the literature usually focuses on PrEP adherence and the severity of its side-effects. If PrEP users do not use it consistently, then HIV transmission and the occurrence of drug-resistant strains of HIV are both possible. Even when PrEP is used consistently, breakthrough HIV infection is still possible (Knox et al., 2016). Although side-effects are usually limited to nausea, they can also include kidney impairment and bone density loss (Jay & Gostin, 2012, p. 867). If the widespread use of PrEP ended up having negative long-term side-effects on its users or resulted in drug-resistant strains of HIV, then it would not likely be ethically justified as an HIV prevention strategy. The occurrence of drug-resistant strains of HIV would have especially serious implications for people living with HIV who rely on ART to manage the infection because those drugs would no longer be as effective. However, the consensus in the literature and public health organizations in both Canada and the United States today is that these considerations are not justified by the scientific data and, therefore, they are not serious enough to call into question the approval of PrEP as HIV prevention.

In terms of risk behaviours, the worry is that PrEP use might lead to an increase in so-called risky sexual behaviour, including “unprotected sex, having additional sexual partners, or engaging in riskier behaviors such as unprotected receptive anal intercourse” (Sugarman & Mayer, 2013, p. 236). “If unsafe sex were to increase with PrEP, it could theoretically offset effectiveness in practice”, according to Jonathan Jay and Lawrence Gostin (2012, p. 867). This worry about risk behaviour, however, is closely tied to stigma. In terms of stigma, PrEP users might be associated with the stigma that people living with HIV face as well as stigma arising “from moral or cultural attitudes and beliefs about risk behaviors and the character of those who engage in them”, which includes homophobia, biphobia, and negative attitudes towards promiscuity, polyamory, and sex in general (Sugarman & Mayer, 2013, p. 136). This is particularly challenging for MSM because we

already face stigma because of our sexual practices and relationships. PrEP users are sometimes even thought of as irresponsible because of their perceived sexuality, promiscuity or polyamory, "despite the responsibility inherent to taking preventive measures" like using PrEP as HIV prevention (p. 136).

Sugarman and Mayer (2013) identify the ethical issues related to justice as issues of access and competing priorities. In terms of access and competing priorities, it is helpful to consider the cost-effectiveness of PrEP. Although "PrEP use in MSM has the potential to prevent a considerable number of new HIV infections", especially among high-risk MSM, it is still very expensive and inaccessible (Juusola et al., 2012, 8). Nevertheless, PrEP is certainly cost-effective when compared to the lifelong treatment of HIV (Jay & Gostin, 2012, p. 867). PrEP is also comparable to other cost-effective interventions, but it competes with other priorities, such as TasP and HIV testing, for funding. This raises the ethical question of whether it is better to fund and promote TasP or PrEP. In other words, since it involves using the same drugs, it is better to treat people living with HIV or people who are at risk for HIV. The answer in the literature is that in a situation "where there are limited opportunities to access care" TasP is preferable, but PrEP is otherwise ethically justified because it helps to redistribute the burden of responsibility between those who are HIV-positive and those who are HIV-negative and "harnessing its preventative potential now will ultimately reduce demand on treatment resources" (Haire & Kaldor, 2013, p. 69). The high cost of PrEP and the intensity of its medical monitoring, however, might "exclude individuals with low income, unstable housing, drug dependence, or mental illness" (Jay & Gostin, 2012, p. 867). It is also possible that PrEP might "reframe responsibility, erode beneficial sexual norms and waste resources" (Haire & Kaldor, 2013, p. 63). These might not be reasons to object to its widespread use though. Instead, "its risks and benefits are likely to be weighed differently by individuals according to complex psychological rationale" (Haire & Kaldor, 2013, p. 69). This is certainly the case for MSM, given our complex experiences with sex, HIV, and HIV treatment and prevention. Overall, the medical literature supports PrEP as an acceptable HIV prevention strategy because it meets accepted standards for safety and effectiveness, but it also points to some of the relevant ethical issues involving wellbeing and justice.

Since the medical concerns about PrEP are already being addressed by researchers, policymakers, and activists, I focus on some of the social and political concerns about PrEP that are either presently being overlooked or do not really have a place in the medical literature. I find that

the focus on the medical concerns about PrEP is actually distracting us from many of the other important concerns about PrEP use among MSM, which are often connected to the medical concerns in ways that negatively influence the discourse around PrEP by limiting its scope to issues of adherence, side-effects, risk behaviours, drug resistance, and cost-effectiveness. Therefore, I look to the non-medical literature on PrEP in order to build my argument against a strictly medical conception of the ethics of PrEP. The non-medical literature on PrEP in HIV/AIDS research, sexuality studies, and LGBTQ2S+ health focuses more specifically on the use of PrEP among MSM and it situates PrEP in the broader context of the experiences of MSM regarding sex, HIV, and HIV treatment and prevention. Although this literature also largely supports PrEP as an acceptable HIV prevention strategy because of its safety and efficacy, it points to further objections, misperceptions, and problems that revolve around PrEP use among MSM. Notably, these discussions shift beyond medical issues to discuss social, relational, and even political concerns. Some of these concerns include the perceptions of PrEP among MSM in North America, a more detailed discussion of the role that stigma plays in PrEP use, including the negative sexual stereotypes surrounding MSM, and the complicated dynamics of the sexual and romantic relationships of MSM using PrEP as HIV prevention. I address each of these concerns and demonstrate how the non-medical literature on PrEP expands on the medical literature to focus specifically on the experiences of MSM.

First, the literature on the acceptability of PrEP as an HIV prevention strategy has so far focused primarily on its use among MSM (Young & McDaid, 2014, p. 213). Awareness and willingness to use PrEP is increasing among MSM in North America, especially compared to other populations, but it remains lower than expected (Leonardi & Tan, 2011, p. 740). It also “remains unclear how socio-cultural norms (e.g., attitudes towards HIV; social understandings regarding HIV risk practices) may influence the scalability of future PrEP interventions” (Knight, Small, Carson, & Shoveller, 2016, p. 1). In one study on the community perspectives on PrEP in Vancouver, some participants thought of PrEP as an acceptable form of HIV prevention similar to women using the birth control pill. Other participants, however, “cast PrEP as a means to facilitate ‘socially unacceptable’ behaviour (e.g., promiscuity)” (Knight, Small, Carson, & Shoveller, 2016, p. 1). Gay, bisexual, and queer men, in particular, expressed concerns about PrEP based on “stereotypes that link promiscuity and condomless sex with a ‘gay lifestyle’ and used those prejudices to underpin their negative opinions about PrEP” (p. 6). These negative opinions of PrEP

were also “often juxtaposed against more conventional approaches to HIV prevention (condom use; limiting numbers of sex partners)” (p. 6). These MSM seem to be worried that others will only further target them with gay stereotypes on the basis of hearing about the details of PrEP as an HIV prevention strategy. This study demonstrates some of the tensions in the perceptions of PrEP among MSM and the significance of stigma as well as the perceptions of both condoms and relationships in the literature.

Second, it is important that there is a significant literature on stigma related to PrEP use, given the negative perceptions of PrEP of at least some MSM. Stigma resulting from the “sex negative messaging and moral appeals - as exemplified by the “Truvada whore” stereotype” can actually act as a barrier to PrEP access in several ways (Calabrese & Underhill, 2015, p. 1960). This stigma can reduce the willingness of providers to prescribe PrEP to MSM, reduce the motivation for MSM to use PrEP as HIV prevention, and change the perception of PrEP among MSM to include these negative associations (Calabrese & Underhill, 2015, p. 1961). Given the worries about risk compensation behaviour among MSM because of PrEP, we face three different kinds of social stigma: anticipated stigma, internalized stigma, and experienced stigma (Herron, 2016). First, the worry about risk compensation behaviour is based on anticipated stigma, especially since studies confirm that MSM do not actually change our sexual behaviour when we start using PrEP as HIV prevention (Herron, 2016, p. 104). Second, internalized stigma is “the internalization of negative societal attitudes toward a stigmatized group” (Feinstein et al., 2018, p. 3847). For MSM, internalized stigma can result from the desire to not be homosexual, bisexual or queer, the fear of coming out, or the fear of stereotypical perception (3848). The stigma surrounding PrEP certainly risks increasing the fear of stereotypical perception among MSM because using PrEP might reinforce the stereotypes of gay, bisexual, and queer men as promiscuous. Finally, “assumptions regarding MSM and sexual health behaviors reinforce and at times exacerbate feelings of social stigma, which can manifest as either anticipated or experienced” (Herron, 2016, p. 106). Experienced stigma for MSM includes being rejected by family or friends, being threatened or physically attacked, being unfairly treated by employers, and being treated poorly by healthcare professionals (p. 106). Therefore, in terms of PrEP use, stigma can actually be a social determinant of health for MSM.

Third, since PrEP is usually recommended for use by MSM who are in serodifferent relationships, it is important to understand what it is like for MSM to be in these relationships and

how PrEP affects them. PrEP allows MSM to build sexual and romantic relationships regardless of serostatus, but this new sexual freedom also affects the resulting relationships. In serodifferent relationships, the risk of HIV transmission is higher early in the relationship and these relationships have higher break-up rates (Bavinton et al., 2015). Most MSM in serodifferent relationships were serodifferent when they met and in these relationships, serodifference has little impact on sexual and relational satisfaction. However, MSM who "did not meet discordant felt it had a greater impact, reporting sexual frustration and anxiety over seroconverting" (Beougher et al., 2013, p. 379). MSM in both serodifferent relationships and negative serosame relationships also tend to use seroadaptive strategies within and outside of our relationships in order to avoid seroconversion. These strategies include serosorting, which "refers to when an individual chooses to have anal sex with someone who has the same HIV status" as well as seropositioning, which "refers to when HIV status differs between the two men, such that the HIV-positive male takes on the receptive role (i.e., bottom) while the HIV-negative male takes on the insertive role (i.e., top)" (Mitchell, 2013, p. 2). The experience of sex, therefore, differs for seronegative and seropositive partners. Risk-taking behaviour in sex negatively affects "reports of relationship intimacy, autonomy, and sexual satisfaction" for seronegative partners whereas risk-taking behaviour in sex positively affects reports of sexual satisfaction for seropositive partners (Starks et al., 2018, p. 1). Therefore, it is clear that "aspects of relational quality may be differentially associated with sexual decision making for same-sex male couples in serodiscordant relationships" (p. 1). The fact that PrEP is another HIV prevention strategy that MSM can use while either building or maintaining different kinds of sexual or romantic relationships helps ease some of these difficulties. Although the literature on serodifferent relationships is helpful for beginning to understand the effects of PrEP on the relationships of MSM, the literature needs to go further in addressing other aspects of these relationships and the broader trends in the relationships of MSM that result from an uptake in using PrEP as HIV prevention.

Finally, since PrEP is usually compared to condoms as a strategy for HIV prevention, it is important to understand how MSM use condoms and how we feel about them. Again, condoms are only 70% effective as HIV prevention during sex for MSM and only 16% of MSM report actually using condoms consistently and correctly during sex (Smith et al., 2015). Nevertheless, "the ethics of safe sex in the gay community has, for many years, been focused on debates surrounding the responsibility (or lack thereof) regarding the use of condoms to prevent HIV

transmission", since condoms were the only HIV prevention strategy for decades (Brisson, Ravitsky, & Williams-Jones, 2018, p. 1). The fact that PrEP, even without condoms, constitutes part of a safe sex framework for MSM is controversial given the status of condoms as the primary HIV prevention strategy. Integrating PrEP into a safe sex framework for MSM, therefore, involves both ethical and political discussions (Brisson, Ravitsky, & Williams-Jones, 2018). Gay, bisexual, and queer men who lived through the AIDS epidemic and experienced losing their lovers, friends, and members of their chosen families have good reasons for questioning the merits of an alternative HIV prevention strategy, especially one that allows for condomless sex. Many gay, bisexual, and queer men who did not live through the AIDS epidemic, however, have very different views of condoms, which is demonstrated by condom fatigue. Young gay, bisexual, and queer men today do not use condoms for several reasons, including "the desire to achieve emotional intimacy", "the perception of being in a monogamous relationship", and "the difficulties associated with accessing and/or using condoms" (Greene et al., 2014, p. 1). In addition to intimacy and monogamy, problems with condoms also include the difficulty of using them in the heat of the moment during sex. MSM have implicit and explicit condom decision-making processes that sometimes involve different relationship dynamics and structures (Campbell et al., 2014). However, these condom decision-making processes increasingly involve PrEP for MSM today. The intergenerational differences in views and experiences in gay communities today present a political challenge for MSM as part of the broader LGBTQ2S+ rights movement because broader access to PrEP as HIV prevention depends on how these communities are able to address these intergenerational differences in order to advocate for their collective health and wellbeing.

Overall, most of the research on the ethics of PrEP is being done in journals that specialize in medicine, public health, HIV/AIDS, sexuality, and LGBTQ2S+ health, but it is crucial that more research on PrEP is done in philosophy, ethics, and bioethics in order to bring the medical and non-medical literature together. A more comprehensive literature on PrEP will help us to more fully understand how PrEP really affects the lives, relationships, and communities of MSM. A literature on PrEP that focuses on its effects on sexual and romantic relationships and LGBTQ2S+ political movements is especially crucial for understanding its broader effects on MSM. Both the medical and non-medical literature on PrEP demonstrates that this new HIV prevention strategy is already affecting the broader discourse around HIV, HIV treatment and prevention, and MSM today. As PrEP use becomes even more prevalent among MSM across North America, it is the

substantial effects on the lives of MSM that demand that we take the relational, cultural, social, and political dimensions of the ethics of PrEP more seriously.

1.3. PrEP and Its Precedents: Lessons from the Birth Control Pill

As a new and controversial prevention strategy for a widespread and socially complex infection, PrEP has the potential to radically change sexual practices and relationships, but it is not the first preventative medication that has changed sexual practices and relationships. So, what can we learn from relevantly similar medical technologies? Francois Venter, Lucy Allais, and Marlise Richter (2014) compare PrEP to both malaria prophylaxis and the birth control pill in order to learn from its precedents. First, they compare PrEP to malaria prophylaxis. They explain that malaria prophylaxis is relatively uncontroversial. When people are traveling to malaria areas, doctors prescribe malaria prophylaxis and they do not seem to worry about risk compensation behaviour in their patients or the broader ethical implications of their prescription. Malaria prophylaxis is seen as a medical issue in which doctors have a responsibility to help prevent malaria in their patients. Doctors do not usually make value judgments about their patients' behaviour even though "travel to a malaria area for vacation is a voluntary activity undertaken for pleasure" (Venter, Allais, & Richter, 2014, p. 272). Unfortunately, this is not the case for the prescription and perception of PrEP use among MSM. Doctors and ethicists often worry about risk compensation, whether MSM will engage in higher risk sexual behaviour because they are using PrEP as HIV prevention. Venter, Allais, and Richter (2014) suggest that the "reasons pre-exposure prophylaxis is viewed differently from malaria prophylaxis are likely to include the fact that sex is involved" (p. 272). Unfortunately, people often moralize about sex and sexuality in ways that they do not about travel and tourism. The comparison between PrEP and malaria prophylaxis is important because it establishes that PrEP is often perceived differently than other drugs or medical technologies that are used as preventative medication in other contexts.

Second, Venter, Allais, and Richter (2014) compare PrEP to the birth control pill because both PrEP and the birth control pill involve sex. They explain that safe and effective contraception, including the "morning-after" pill, condoms, and abortion, plausibly leads to an increase in risky sexual behaviour for women, especially those who do not use the medication properly (Venter, Allais, & Richter, 2014, p. 272). This increased risky sexual behaviour among women involves the

increased risk of STIs, as well as pregnancy and abortion. However, “the possibility of increasing risk-taking behaviour with respect to sexually transmitted infections is not regarded as a reason to prohibit access to contraceptives”, even though social and political objections to their use continue today (Venter, Allais, & Richter, 2014, p. 272). Unfortunately, this particular risk compensation objection persists against PrEP use, especially among MSM. Venter, Allais, and Richter (2014) argue that this is “an example of inappropriate [moralizing] about sex” (p. 272). Although malaria prophylaxis, contraception, and PrEP are all preventive medical technologies, it is the fact that sex is involved in contraception and PrEP that makes these medications so much more controversial than malaria prophylaxis. The ethics of contraception and PrEP also both raise questions about gender and sexuality. Therefore, sexual morality objections, in particular, have a disproportionate impact on both the acceptability and accessibility of medical technologies that are used by oppressed social groups, like women and MSM.

In discussing oppressed social groups here, I follow Iris Marion Young’s definitions of both social groups and oppression. Young (2001) argues that we need to evaluate inequality and injustice in terms of social groups, not just individuals. Social groups are typically thought of as groups differentiated by gender, race, class, age, ability, and sexual orientation among other social factors. Young (2001) explains that “what we refer to by group differentiations of gender, race, class, age, and so on, in the context of evaluating inequalities as unjust, are structural social relations that tend to privilege some more than others” (p. 2). Structural social injustice is what leads to oppression for certain social groups. Young (2004) also systemizes the concept of oppression as it is felt by diverse social groups, including both women and gay, bisexual, and queer men. Although “all oppressed people suffer some inhibition of their ability to develop and exercise their capacities and express their needs, thoughts, and feelings”, since each group experiences oppression differently, Young concludes that oppression is actually a family of concepts (Young, 2004, p. 40). Therefore, she identifies five faces of oppression: exploitation, marginalization, powerlessness, cultural imperialism, and violence. The presence of any of these five conditions is sufficient for calling a group oppressed, but different groups and different individuals experience different combinations of these conditions. Young (2004) specifically identifies women as experiencing exploitation, powerlessness, cultural imperialism, and violence, whereas she identifies gay men as primarily experiencing cultural imperialism and violence (p. 64). This understanding of

oppression and social groups helps explain both the similarities and the differences between PrEP and the birth control pill.

PrEP and the birth control pill, or the combined oral contraception pill (COCP), are similar in several ways. First, both are forms of orally administered preventative medication. PrEP and COCP are both pills that are taken daily in order to be effective as medical prevention for different outcomes and both are preventative medications that involve sex. PrEP is involved in sex between men and COCP is involved in sex between men and women. Both PrEP and COCP are used as medical prevention for unwanted outcomes of sex: MSM use PrEP as prevention for HIV transmission and women use COCP as prevention for pregnancy. PrEP and COCP are also both used predominantly by oppressed social groups. Whereas women as a group are oppressed because of their sex and gender, MSM are oppressed because of their sexual orientation and sexual behaviour. Therefore, both PrEP and COCP are embedded in social movements (Hardin, 1966). COCP is embedded in the women's movement, or the feminist movement, and PrEP is embedded in the broader LGBTQ2S+ movement. COCP certainly had an important effect on women's rights and the lives of women in North America and PrEP is already having an effect on LGBTQ2S+ rights and the lives of gay, bisexual, and queer men in North America. Furthermore, both have the possibility of increasing sexual freedom for their users. It is this sexual freedom that improved women's lives and empowered them to control their own sexual and reproductive health. Likewise, PrEP increases the sexual freedom of MSM and empowers us to be able to control our own sexual health as well. Finally, both face medical objections about their safety and efficacy and social and political objections about increased risky sexual behaviour and sexual morality. Overall, PrEP and COCP are both methods of preventing unwanted outcomes of sex used by oppressed social groups with the possibility of increasing their sexual freedom that face medical, social, and political objections to their use.

PrEP use among MSM and COCP use among women are also different in several ways. COCP was originally developed for infertility while PrEP was originally developed for HIV treatment (Myers & Sepkowitz, 2013). Although both were originally developed for treatment, they both started being used as prevention. The medical history of each of these medical technologies is obviously very different as well. COCP was approved for use as contraception in the 1960s while PrEP was only approved for use as HIV prevention in the 2010s (Myers & Sepkowitz, 2013). The social and political conditions for women in the 1960s were very different

from the social and political conditions for MSM today; the views of women and MSM in society have changed a lot over the decades in North America, but both groups still face oppression. Women and MSM are oppressed social groups who face very different challenges when it comes to sexual health and sexual freedom. Sexual morality objections to COCP usually involve sexism, while objections to PrEP usually involve heterosexism. Moreover, the history of the AIDS epidemic in the 1980s uniquely contributes to the stigma around the use of PrEP by MSM today (Herek & Capitano, 1999). Serophobia, in particular, has become a very difficult problem for MSM, especially MSM living with HIV. Negative views of the sexual identity and sexual behaviour of MSM specifically, including views related to promiscuity and polyamory, are the basis for sexual morality objections to PrEP. This is a very different basis than the sexual morality objections against COCP, which involves stereotypes about the sexual identity and sexual behaviour of women. Overall, PrEP and the birth control pill certainly have different histories as methods of prevention and objections to PrEP are unique because they involve specific biases surrounding HIV, sex, and sexuality. Nevertheless, we can learn from both the differences and the similarities between PrEP and the birth control pill in order to better understand how to conceive of the ethics of PrEP and other similar medical technologies.

What does an analysis of the history of the birth control pill reveal for PrEP? Ultimately, an analysis of the medical and clinical effects of the birth control pill, including its side-effects, increases in risky sexual behaviour, and pregnancy prevention rates, would have ignored the most important consequences of its widespread use in society. I argue that the same is true of PrEP and that the history of the birth control pill is a cautionary tale that sets up a framework for analyzing the social and political dimensions of PrEP and other similar medical technologies. The birth control pill empowered women by increasing their welfare through economic gains, employment opportunities, and increased rights (Chiappori & Oreffice, 2008). This kind of empowerment increases a "person's control over the determinants of her quality of life, through (necessarily) an increase in either health […] or knowledge or freedom […]" (Tengland, 2008). Women were empowered by the birth control pill because it allowed them to better control not only their risk of pregnancy, but also their reproductive and sexual health as well as their sexual and romantic relationships. This control over their sexual health, sexual freedom, and sexual lives also seemed to eventually outweigh the harms predicted by the initial objections to its use for many women who use it today. Even if it increased risky sexual behaviour among women, the related social and

political benefits offered reasons for them to use it regardless. An increase in risky sexual behaviour is usually no longer viewed as a good reason to prohibit women's access to the birth control pill or condemn its use. Nevertheless, debates continue in North America about the moral acceptability of the birth control pill as well as its accessibility due to the persistent stigma that women who use it face. For example, Rush Limbaugh publicly slut-shamed Sandra Fluke, a law student at Georgetown University, because she was advocating for access to the pill in 2012 (Johnson, 2012). In the United States, some institutions, in particular religious institutions, like Catholic colleges, still want to be able to deny women birth control coverage (Grady, 2012). Moreover, some healthcare providers "refuse to prescribe or dispense it on grounds of personal conscience, whether for religious reasons or not" (Anderson et al., 2006). The widespread use of the birth control pill today offers lessons for responding to similar issues as well as specific objections about increased risky sexual behaviour among MSM using PrEP and anticipating similar social and political changes and stigmas (Myers & Sepkowitz, 2013).

Furthermore, the history of the birth control pill demonstrates that the social and political dimensions of such medical technologies are inherent in their use by different social groups. The birth control pill highlights the ways in which certain medical technologies affect personal relationships as well as the political standing and opportunity of certain social groups. If the use of the birth control pill among women was discussed as simply a medical issue, then many of its important social and political effects would be missed. Women were able to increase their rights, gain sexual and economic freedom, enter the workplace, and balance the power in heterosexual relationships in part because of their use of the birth control pill (Chiappori & Oreffice, 2008; Goldin & Katz, 2000; Goldin & Katz, 2012). A strictly medical conception of the ethics of the birth control pill would be unable to account for these revolutionary effects. Even many of the objections to both the birth control pill and PrEP seem to actually be social and political objections. For example, objections to the birth control pill and PrEP that focus on increased promiscuity among its users worry about the non-medical ethical aspects of their use. In order to respond to these largely behavioural concerns, it is crucial to take a broader approach to the ethics of these kinds of medical technologies. Although it is understandable that the ethics of a new medical technology would begin with a focus on the medical issues involved in its use, it is impossible to isolate the medical issues from the social and political ones, especially when a new medical technology is being used by a particular social group because of its members' identities,

behaviours, practices or relationships. Therefore, like the birth control pill, a medicalized approach to the ethics of PrEP does not capture the full range of its effects on MSM. In order to understand how the use of PrEP as HIV prevention will affect the lives of MSM, and the rest of society, and how MSM can live ethically while using PrEP, it is important to start moving away from a strictly medical conception of the ethics of PrEP.

1.4. Conclusion: Towards a Social and Political Ethics of PrEP

My aim in this chapter has been to contextualize the ethical debate surrounding PrEP use among MSM as HIV prevention. I did this by providing a brief synoptical history of the AIDS epidemic, ART treatment, and the development of PrEP, and by highlighting the key challenges surrounding the use of PrEP by MSM, in particular, in the first half of the chapter. In the second half of the chapter, I shifted the focus to the academic literature on PrEP and the precedents set by relevantly similar medical technologies. In summarizing the recent academic literature on PrEP, I identified the perspectives of gay communities on PrEP, the stigma associated with PrEP, the effects of PrEP on sexual and romantic relationships, and the different views and experiences of PrEP and condoms as important foci in the debate. Crucial for my purposes is what the literature does not conclude or fully address, namely, the particular challenges I began to identify in my historical narrative of the connection between HIV, HIV treatment and prevention, and MSM – for example, the ethical implications of PrEP on the relationships of MSM and the political effects of PrEP on LGBTQ2S+ communities. More important, however, are broader ethical discussions of PrEP and related medical technologies. Therefore, I concluded with a discussion of the analogy between PrEP and the birth control pill, focusing on an analysis of these medical technologies that addresses the social and political dimensions of their use. After demonstrating the limits of a strictly medicalized conception of the ethics of PrEP in this chapter, I will now turn to my positive project: articulating a broadly social and political ethics of PrEP in the following chapters via three key concepts: risk, trust, and solidarity. Together these concepts demonstrate that a socially and politically informed conception of the ethics of PrEP as HIV prevention better captures how this new medical technology will really affect the lives, relationships, and communities of MSM in North America.

CHAPTER 2

Challenging the Risk Assessment Approach to the Ethics of PrEP

In this chapter, I focus on - and challenge - the concept of risk as it applies to the ethics of PrEP as HIV prevention among MSM. At first glance, it might seem that risk is centrally and uncontroversially part of any ethical discussion of medical treatment and prevention regimes. Whether you want to personally take, medically prescribe, or legally approve a particular drug, you have to consider not only the nature and severity of any side-effects, contraindications, or other possible harms, but also the likelihood of such harms actually taking place. In other words, you have to assess the medical risks associated with its use. Much of the biomedical literature on the ethics of PrEP focuses on exactly this kind of risk assessment. My discussion in this chapter, however, challenges this narrow focus. Given the ongoing association between MSM and HIV as well as the history of AIDS injustice and activism detailed in the previous chapter, the ethics of HIV treatment and prevention strategies, like PrEP, cannot be limited to biomedical ethics, nor its risks understood only in terms of traditional risk assessment. My argument for this expansion involves critiquing the present risk assessment approach to the ethics of PrEP today and gesturing towards what the discussion of the ethics of PrEP might look like if we start recognizing the social and political risks of the situation MSM face when deciding whether or not to embrace PrEP as an HIV prevention strategy. It is time to start broadening the kinds of risks that we consider in this discussion and the ways that we address the personal experiences of MSM in relation to PrEP. Furthermore, I explain how the ethics of PrEP can actually be framed as the much broader issue of living ethically in a social and political community uniquely affected by HIV. Therefore, instead of always prioritizing the concept of risk in the discussion of the ethics of PrEP as HIV prevention, I conclude by suggesting that there are other important ethical questions about PrEP which revolve around what it means for MSM to live ethically within a community whose sexual and romantic lives continue to be medicalized, both internally by members of the community and externally by a broader culture and public health establishment.

This chapter proceeds as follows. In §2.1, I present some of the most relevant background information on PrEP and risk assessment. I focus on its previous risk assessment and its remaining medical objections, which centre on so-called risky sexual behaviour as well as the risk for other STIs. In §2.2, I explain why the discussion of the ethics of PrEP seems to be framed around the concept of risk and why this is problematic by responding to the remaining medical objections, recontextualizing risk within the history of HIV, and reevaluating the questions being asked about the ethics of PrEP. It is clear that the present framing of the ethics of PrEP around medicalized risk is affecting the discussion in two ways: it is distorting the relevant risks of using PrEP and it is ignoring the lived experiences of MSM, which informs the acceptability of these risks for both individuals and communities. I focus on the first point about the distortion of risks in §2.3 by demonstrating that the medical risks, including the risks of condomless sex, are presently being overblown and the social and political risks, including the risks of the stigmas associated with PrEP, are being overlooked. Since the discussion of the ethics of PrEP is a topic that is being examined in several different academic disciplines, including both medicine and philosophy, as well as popular media, I incorporate all of these perspectives into my analysis. I focus on the second point about the lived experiences of MSM in §2.4 by acknowledging how the experiences of MSM regarding sex, HIV, and HIV prevention complicate a traditional, biomedical risk assessment of PrEP. This further demonstrates how PrEP affects MSM in myriad social and political ways and how the present risk assessment framework is lacking. Therefore, in §2.5, I propose that we rethink the ethics of PrEP in order to better situate the concept of risk in the discussion by adopting a more socially and politically informed approach to the ethics of PrEP in order to better account for the lived experiences of MSM. Although the concept of risk is important in the ethics of PrEP, and bioethics more broadly, I conclude in §2.6 that we have to situate risk in a much broader approach to the ethics of PrEP that is responsive to the medical, social, and political dimensions of the situation MSM face with PrEP as a relatively new HIV prevention strategy in the long and complicated history of HIV in North America.

2.1. The Background on PrEP Risk Assessment: Contextualizing Risk

2.1.1. The Risk Assessment of PrEP: Traditional Risk Assessment

Given its high effectiveness as HIV prevention and the capacity to prescribe it widely among high-risk populations, PrEP seems to be a powerful new tool for public health efforts to curb the spread of HIV in North America. Unfortunately, the number of new HIV infections seems to have been increasing slightly in Canada across all populations up until 2016 (CATIE, 2018). According to the CDC (2020), after years of decreasing numbers of new HIV infections in the United States, the number of new HIV infections seems to have plateaued starting in 2013, including among MSM. Although HIV diagnoses remain stable in the United States among MSM in general, HIV diagnoses are increasing among specific groups according to age and race or ethnicity (CDC, 2019). For example, the number of new HIV infections is increasing among gay, bisexual, and queer men aged 25-34 as well as gay, bisexual, and queer Latino men. Therefore, an alternative HIV prevention strategy like PrEP seems welcome in North America. However, according to governments and other kinds of regulatory bodies, any new drug, regardless of its effectiveness, has to be assessed for its associated pharmaceutical risks, including the possibility of serious medical side-effects of its use and the likelihood of even more severe, drug-resistant, strains of a virus emerging as a result of its widespread use, as the first step in the process of its official approval for broader use and distribution in society (Jay & Gostin, 2012; Knox et al., 2016; Sugarman & Mayer, 2013).

In the case of PrEP, these concerns about side-effects and drug resistance were addressed by the risk assessment performed by Health Canada and the United States Food and Drug Administration (FDA) before PrEP became widely available in either Canada or the United States. For example, when Health Canada approved PrEP as HIV prevention in 2016, in combination with safer sex practices, “to reduce the risk of sexually acquired [HIV] in adults at high risk”, it did so only after a drug review process. In Canada, this process involves scientists from Health Canada, and occasionally outside experts, assessing and evaluating “the safety, efficacy and quality data to assess the potential benefits and risks of the drug” (Health Canada, 2016). If the medical benefits of using a particular drug outweigh the medical risks of using it or if the risks of using it can be mitigated in order to secure its benefits, then the drug is officially approved for widespread use. A similar kind of risk assessment process is conducted in the United States and most other jurisdictions that approve new medications like PrEP. This risk assessment process for PrEP focused almost exclusively on its physical side-effects and the possibility of drug-resistant strains of HIV, which are usually the main topics of discussion in the medical literature, as well as its effects

on other medications and contraindications (Sugarman & Mayer, 2013). Again, the long-term physical side-effects of PrEP include bone density loss and decreased kidney function, both of which are minimal without underlying conditions (Jay & Gostin, 2012, p. 867). Testosterone increases bone density, so many MSM are not affected by the bone density loss, and kidney function is closely monitored in those using PrEP. The occurrence of any drug-resistant strains of HIV would be a severe risk involved in widespread PrEP use for MSM and the rest of society, but this risk was clearly not substantiated by the traditional risk assessment completed in Canada and the United States based on its approval as well as ongoing research (Gibas et al., 2019; Parikh & Mellors, 2016).[11] Unfortunately, this risk assessment and approval did not include any consideration of the potential social and political effects of these medications on the target populations or society more broadly. Therefore, any further risks and benefits to MSM of using PrEP besides strictly medical risks or benefits to either our health or public health were not considered in this risk assessment and approval, which leaves some uncertainty for us as to whether or not to actually use it as HIV prevention.

Traditional risk assessment is based on reliable scientific data and involves two distinct components: risk estimation and risk evaluation. First, risk estimation involves describing and measuring "the magnitude of the harm involved in the event a hazard occurs, multiplied by the probability of its occurrence, both thought to be purely empirical and mathematical problems" (Brunk et al., 1991, p. 4). This would map onto the stage of PrEP risk assessment in which clinical trials were conducted in order to estimate the safety and efficacy of the drug, with a focus on possible side-effects and drug resistance. Second, risk evaluation involves normative judgments about the estimated risk; in other words, this second component asks what is the acceptability of the risk identified in the first stage. This would map onto the stage of PrEP risk assessment in which the risks of side-effects and drug resistance were weighed against the benefits of effectively preventing HIV infection.

Whether a risk is acceptable, however, depends on the values of those evaluating the risk. In the risk assessment of medical technologies like PrEP by medical professionals, the predominant value system is one that weighs the risks and benefits of using them in relation to the health of individuals, populations or society more broadly. This would map onto the stage of PrEP risk

[11] In fact, most drug resistance will actually arise because of HIV treatment using emtricitabine and tenofovir not HIV prevention unless someone who is HIV-positive is using PrEP without knowing their serostatus, which is monitored by healthcare providers when they prescribe it (Gibas et al., 2019; Parikh & Mellors, 2016).

assessment where an authority like Health Canada or the FDA would determine the acceptability of the risks and benefits identified in the clinical trials and it would seem to import its particular institutional values to bear on its assessment of PrEP. The clinical trials for PrEP included iPrEx, IPERGAY, and PROUD among others, some of which are ongoing and each of which studied its effects on MSM in particular (Grant et al., 2010; Molina et al., 2015; Dolling et al., 2016). Risk evaluation involves both objective risk, which is "established by careful use of scientific risk assessment methodology", and subjective risk, which is "the perceptions of risk held by different persons" (Brunk et al., 1991, p. 4). Therefore, risk assessment seems to always involve the values of the assessors of new technologies; depending on which kinds of risks are included in the assessment and how these risks are weighted according to the kinds of values that are assumed by the assessors, the risk of a particular medical technology can be estimated and evaluated very differently. The fact that risk assessment involves both estimation and evaluation demonstrates that it has both a descriptive and a normative component. It also seems that the normative component is ignored in favour of the descriptive component in traditional risk assessment. However, any shift from descriptive to normative means that values are being introduced into the process. Nevertheless, traditional risk assessment maintains that, together, estimating and evaluating risk is a simply descriptive process and, therefore, it ignores the obviously normative ways that values affect risk assessment (Lowance, 1976; Rowe, 1977).

Risk assessment also often involves a further stage: risk management (Brunk et al., 1991; Cranor, 1997; Waring & Lemmons, 2005). Risk management involves drawing on the risk estimations and evaluations in order "to develop policy options that aim to prevent, minimize, or mitigate the risks and evaluate their health, economic, social, and political implications" (Waring & Lemmons, 2005, p. 254). The risks of PrEP have to be managed by healthcare providers, policymakers, communities, and individuals via recommendations, policies, guidelines, and personal decisions. Again, this risk mitigation involves the values of the different parties. Since different parties might consider different kinds of risks and weight them differently, they might also approach their management differently. Whereas healthcare professionals might focus their risk mitigation on medical concerns about adherence, policymakers might focus on economic concerns about distribution, and communities and individuals might focus on social and political concerns about sexual practices, sexual and romantic relationships, and the perceptions of these in society more broadly. Regardless, the ongoing risk mitigation of PrEP continues today and it involves

responding to several lingering medical objections to PrEP use among MSM, which focus specifically on the sexual behaviour of MSM.

2.1.2. The Medical Risk Objections to PrEP: Risk Compensation Behaviour

Most of the early academic work on the ethics of PrEP, including Venter, Allais, and Richter (2014), Jay and Gostin (2012), Caceres et al. (2014), Grant et al. (2010), and Wheelock et al. (2012) among others, explicitly addresses a particular worry about a change in the sexual behaviour of MSM as a result of using PrEP as HIV prevention. The worry is that MSM who use PrEP might stop using condoms or start engaging in more so-called high-risk sexual behaviour, like condomless anal sex. Since MSM who use PrEP might feel safe from HIV during sex, we might feel like we can take more risks or engage in condomless anal sex more often. This is called risk compensation behaviour and it involves people taking more risks when they feel that they are protected against the relevant risks. Risk compensation behaviour in this instance might even counter the protective effects of PrEP, according to Venter, Allais, & Richter (2014, p. 271). Jay and Gostin (2012) even admit that "if unsafe sex were to increase with PrEP, it could theoretically offset effectiveness in practice" (p. 867).

However, the risk compensation behaviour objection was based on early efficacy figures from scientific studies that were not as high as they are today because of poor PrEP adherence among the participants in those particular studies (Haire, 2015). This worry was largely discredited by later clinical PrEP trials in which participants had good adherence, which demonstrated that PrEP actually has efficacy similar to the birth control pill, and further research on PrEP use among MSM in particular (Grant et al., 2010; Molina et al., 2015; Dolling et al., 2016). Unfortunately, this growing body of counterevidence has failed to sway judgments of "riskiness" among researchers, public health officials, MSM, and others in society more broadly. The worry that PrEP will lead to other kinds of risky, or dangerous, behaviour remains popular, despite being undermined by all of the presently available evidence. Although the broader behavioural worry about risk compensation behaviour is out of date, there are related worries that are still relevant here, including medical objections that focus specifically on PrEP adherence among MSM and the risk of other STIs associated with PrEP use.[12]

[12] See Montess, M. (2020). Demedicalizing the Ethics of PrEP for HIV Prevention: The Social Effects on MSM. *Public Health Ethics* for a discussion of these in greater length.

Therefore, I consider these two relevant medical objections which continue to centre on the sexual behaviour of MSM and the behavioural risks associated with the widespread use of PrEP. The first objection states that PrEP use might increase the risk of HIV because of poor adherence and the second objection states that PrEP use might increase the risk of other STIs for MSM. Both objections expand on the worry about risk compensation behaviour by imagining ways in which risk compensation could negatively affect the physical health of MSM. First, there are worries about the risks associated with poor or imperfect adherence to PrEP. Even though PrEP is up to 99% effective with good adherence, it is possible that many MSM will not have perfect adherence (Anderson et al., 2012, p. 1). Therefore, adherence is actually "one of the great challenges of effective PrEP implementation" (Haire, 2015, p. 242). It is possible that many MSM using PrEP will have poor or imperfect adherence, and thus, if we will still engage in sexual behaviour that is riskier than we realize, like sex with people we don't know, sex with more people, and sex without condoms, then it might actually counter the effectiveness of PrEP as HIV prevention. Sugarman and Mayer (2013) explain that "it is conceivable that increased risk behaviors might overwhelm the ability of PrEP to prevent HIV infection itself, particularly if adherence is sub-optimal, and/or amplifying factors [...] are present" (p. 136). Overall, adherence clearly plays a crucial role in the effectiveness of PrEP as HIV prevention and worries connected to adherence and risk compensation behaviour are based on evidence. Although there is ongoing research on adherence among MSM, whether or not we are actually more likely than others to have good adherence or engage in so-called risky behaviour, these worries might still be based on generalizations about gay, bisexual, and queer men, which I will discuss later in this chapter.

Second, there are worries about an increase in the risk for other STIs associated with PrEP use. PrEP is an HIV prevention strategy that does not protect against most STIs other than HIV (Jenness, 2017; Montaño, 2017). So, MSM using PrEP who continue to engage in so-called risky behaviour, specifically condomless anal sex, might actually be at increased risk for other STIs, including chlamydia, gonorrhea, syphilis, and herpes as well as the human papillomavirus (HPV). Together, the recently documented decrease in condom use and the increase in STI rates among MSM using PrEP seem to substantiate this worry (Traeger et al., 2018). Leonardi, Lee, and Tan (2011) explain that "there is concern that new HIV prevention technologies may result in increased sexual risk-taking ('risk compensation'), resulting in higher rates of sexually transmitted infections" (p. 740). If MSM use PrEP as a replacement for condoms, which protect against HIV as well as

other STIs, then it means that rates of other STIs could increase because of changes in our sexual behaviour (Sugarman & Meyer, 2013, p. 136). Unfortunately, the rates of other STIs, including chlamydia, gonorrhea, and syphilis, are actually increasing in both Canada and the United States among MSM today. It is not likely that this is due to widespread PrEP use among MSM because PrEP was only approved a few years ago and the rates of STIs among MSM, and the general population, were already increasing before PrEP was widely available. In fact, the increasing rates of STIs might actually be due to decreasing rates of condom use among MSM, which might even highlight a greater need for alternative HIV prevention strategies, such as PrEP (Greene et al., 2014; Wheelock, 2012). Nevertheless, these kinds of medical objections based on behavioural worries continue to influence the discussion about PrEP use among both medical professionals and gay communities.

2.2. Problems with the Risk Assessment Framing of the Ethics of PrEP

2.2.1. Responding to the Medical Objections

The medical objections that I considered in the previous section demonstrate problems with the scope and appropriateness of the risk assessment framing of the ethics of PrEP. Framing the ethics of PrEP around risk assessment presents the issues involved in its use as a set of medical concerns, but this framing actually involves descriptions and generalizations about the behaviour, practices, relationships, and sexuality of MSM as well as a series of normative judgments about the risk and acceptability of that risk which depend on the values of the different parties. It is not only that the risk assessment framework focuses the discussion on the medical concerns over the social and political concerns, which already ignores many of the salient ethical issues facing MSM using PrEP as HIV prevention besides simply issues of adherence and the risk of other STIs, but also that it seems to unnecessarily limit the discussion to the medical concerns. However, even the medical concerns identified by the objections actually seem to be behavioural concerns about PrEP rather than physical or pharmaceutical concerns, which point towards the very kinds of social and political concerns that are actually relevant to MSM.

Risk assessment, or the point at which a drug is declared safe for public use, is not the end of the story, especially when it comes to the individuals and communities for whom it is intended

and who will continue using it for years or decades while it shapes their health and their lives in myriad ways. In the case of PrEP, which aims at preventing HIV among a population already targeted by sexual stigma, the risks associated with its use cannot necessarily be separated from our sexual behaviours, relationships, and identities as well as widespread assumptions about them. Thus, the objections, which focus on the sexual behaviour of MSM, are also tied to assumptions about our sexual relationships and identities, which are not usually within the scope of traditional risk assessment because it tends to narrowly focus on medical concerns, which it considers quantifiable scientific data, not social and political concerns that arise from the lived experiences of individuals and communities. Careces et al. (2015) note that much of the "moral panic" about "a potential loss of sexual restraints" uniquely affects MSM as well as gay communities more broadly (p. 4). They state that "even within the gay community, this concern has created a certain stigma affecting PrEP" and that "with the current media focus on PrEP and MSM, many assume that MSM should ''be responsible and just use condoms,'' which provide sufficient protection to them" (Careces et al., 2015, p. 4). However, the empirical worries about things like adherence and the risk for other STIs among MSM because of PrEP use are not supported by the present literature; the negative patterns that people predicted were unsupported, but they continued to predict them regardless of the evidence to the contrary. Therefore, the way that risk is being centred in the medical and bioethical literature on PrEP, and in the wider media coverage of PrEP, already seems to involve problematic assumptions about MSM and our sexual behaviours, practices, relationships, and identities.

What does it really mean to assess the risks associated with the widespread use of PrEP as HIV prevention among MSM? To some extent, what the risks are depends on who is asking the question. From a regulatory perspective, the risks of a drug typically amount to at least some of the following: the side-effects, the effects on other medication, and the effects on public health, like the likelihood of creating new strains of a virus. Even a broader view that takes into consideration the likely effects of a drug on the behaviours of the target population is, in some sense too narrow, insofar as it isolates the behaviours of individuals and communities from their broader social and political context. However, as I demonstrated in the previous chapter, the history of HIV and the identification of gay, bisexual, and queer men as a high-risk population and condomless anal sex as a high-risk behaviour are inseparable from the highly politicized history of HIV in North America. We cannot understand gay communities and our sexual practices and relationships in North

America today without reference to the devastating history of HIV and the powerful mobilizing powers of AIDS activism. Similarly, we cannot make sense of our decisions and feelings related to HIV risk and prevention apart from this same history. Any discussion of the risk assessment of a medical technology has a normative dimension in the process of risk evaluation and this process is insufficient if it fails to account for the relevant cultural, social, and political history as well as its effects on the values of the people either assessing or using the medical technology. Therefore, I aim to recontextualize risk within the history of HIV in order to highlight its effects on the lives of MSM and I consider how this history has shaped perceptions of sex among gay, bisexual, and queer men today as well as the risks associated with gay sex and the perceptions of gay, bisexual, and queer men as well as our sexual practices, relationships, and identities in society more broadly in order to move away from the risk assessment framing of the ethics of PrEP.[13]

2.2.2. Recontextualizing Risk within the History of HIV

Recontextualizing risk within the devastating history of HIV in North America and its effects on MSM highlights the significance of self-identification, emotions, a sense of safety, sexual and romantic relationships, and communities of MSM in the discussion of the ethics of PrEP. The ways in which MSM identify, especially when we identify as gay, bisexual or queer, demonstrates the significance of self-identity. Self-identity, however, is affected by the history of HIV in North America because of the association between homosexuality and HIV. Some MSM do not identify as gay, bisexual or queer in part because of this history, and the related negative stereotypes, while others take on this history as an important part of our self-identity. MSM, and gay, bisexual, and queer men in particular, therefore, often have strong emotions towards HIV and the AIDS epidemic because HIV/AIDS has fundamentally changed how many of us feel about sex. Many of us feel anxiety, embarrassment, anger, and stress around sex because of the constant threat and fear of HIV since the AIDS epidemic in the 1980s. These emotions determine our sense of safety around sex. We have to use HIV prevention strategies, like condoms or PrEP, in order to create a sense of safety for ourselves and our partners in order to have sex comfortably. We also have to

[13] Although I use both 'MSM' and 'gay, bisexual, and queer men' to refer to refer to the target population, I often use the term 'MSM' because it most accurately captures all of the different kinds of people that belong to the group. It is a behavioural term that is sometimes medicalized, but I certainly do not mean to endorse a medicalized approach to the issues I am discussing.

trust ourselves and our partners to use these HIV prevention strategies correctly and consistently. Therefore, our sexual and romantic relationships are affected by HIV as well because using HIV prevention immediately tests the trust that we place in ourselves and our partners and raises the stakes of trusting ourselves and each other. Since relationships are built on trust, the ways that HIV complicates that trust can often affect the structure and success of our relationships. Finally, communities of gay, bisexual, and queer men across North America are affected by the history of HIV too. During the AIDS epidemic, our communities demonstrated incredible solidarity and established sexual and romantic norms in response to HIV, which focused on condoms as the primary strategy for HIV prevention and the symbol of sexual safety and responsibility (Chambers, 1994). Today, new developments in HIV prevention, like PrEP, are starting to challenge these norms and this past solidarity among MSM around HIV.

The history of HIV, and the AIDS epidemic in particular, has shaped perceptions of sex among gay, bisexual, and queer men, and the risks associated with this kind of sex in society more broadly. Since the AIDS epidemic disproportionally affected gay, bisexual, and queer men, gay sex has become associated with HIV and the fear of HIV in society. The stigmas and prejudicial attitudes towards the value of gay sex as well as gay relationships are, therefore, playing a role in how PrEP is being perceived by a wider audience today. For example, PrEP is being seen as facilitating open or polyamorous gay relationships as well as hookups, which are often devalued in society because they are all kinds of non-traditional sexual and romantic relationships. Many MSM, however, choose to pursue these kinds of non-traditional relationships with or without PrEP. Therefore, the negative perceptions of PrEP seem to be based on negative perceptions of gay sex and gay relationships. Gay sex, in particular, is most closely associated with HIV and it has come to be viewed as inherently risky since the AIDS epidemic, especially within the risk assessment framing of the ethics of PrEP, which consistently asks whether it is risky and whether its risks are acceptable. By continuing to discuss condomless gay sex as "'risky', even in the context of PrEP use or other biomedical prevention strategies", researchers and healthcare providers might "inadvertently undermine [some of the] indirect but highly desired benefits of PrEP for sexual and psychological health" among MSM (Marcus & Snowden, 2020). If this riskiness is accepted as a descriptive fact, then we again miss its normative dimension. The widespread perceptions of gay sex and its risks influence the kinds of values that assessors, whether medical professionals or gay, bisexual, and queer men ourselves, bring to bear on decisions to either approve, prescribe or use

PrEP as HIV prevention. Unfortunately, the influence of these different values in our decision making around PrEP is further downplayed in traditional risk assessment because it again seems to map the normative onto the descriptive.

In *Value Assumptions in Risk Assessment: A Case Study of the Alachlor Controversy*, Conrad Brunk, Lawrence Haworth, and Brenda Lee (1991) argue for the importance of incorporating values and value assumptions in risk assessment in order to actually account for the values of different parties. They focus on the alachlor controversy in which Agriculture Canada decided to cancel the registration of a herbicide manufactured by Monsanto Canada, Inc. in 1985 because of its carcinogenicity. The Alachlor Review Board process exposed the values of the different parties involved in the issue, including the government, Monsanto as well as various farming organizations, environmentalist groups, and private citizens and demonstrated that the values and value assumptions of the different parties affected each of their assessments of alachlor's risk. For example, the Alachlor Review Board only considered the risk of cancer posed by alachlor to humans and certain economic risks and benefits to Monsanto, in particular, and Canadian farmers, more generally, including yields and price effects (Brunk et al., 1991, p. 131). The specific values that they considered were those of public health and economic freedom because of the central role of the government and Monsanto in the process. However, other values, risks, and benefits could have easily been considered by the Alachlor Review Board, including the value of the environment, the risk of cancer to non-human animals, and even other, perhaps unexpected, economic benefits to Canadians. These were some of the values, risks, and benefits mentioned to the Alachlor Review Board by various farming organizations, environmentalist groups, and private citizens, but which were largely ignored because of the relatively weak position of these groups in the overall process. Therefore, Brunk, Hayworth, and Lee (1991) present an alternative risk assessment framework that attempts to broaden the kinds of values, risks, and benefits that are considered in the process and I follow their lead by applying this same kind of strategy to the risk assessment of PrEP.

In the case of PrEP, MSM might have different values and value assumptions about sex, sexual and romantic relationships, and HIV prevention than others in society, including medical professionals, especially when it comes to non-traditional sexual behaviour and non-traditional sexual and romantic relationships. Non-normative sexuality is often treated differently in situations of risk assessment, especially in public health. For example, during the early period of the

COVID-19 pandemic, the government of Quebec suggested that people be monogamous, or that they have only one sexual or romantic partner, in order to reduce the risk of coronavirus transmission (Moore, 2020). Although this recommendation is based on social or physical distancing, the practice of maintaining fewer physical relationships, it also assumes that polyamorous partners are not already sharing the same COVID-19 infection circles, which are typically considered to be all of the people living in the same house. These people could be monogamous partners or nuclear families, but they could also be polyamorous partners, roommates or even chosen families. Nevertheless, the Quebec government demonstrated by this recommendation that it seems to value monogamous relationships more than others. It is these kinds of values and value assumptions in public health issues, whether COVID-19 or HIV prevention, that can unnecessarily narrow the scope of risk assessment. Therefore, in the case of PrEP, we need to start re-evaluating the kinds of questions that we ask about risk in ways that account for these kinds of differences in values between different parties.

2.2.3. Re-evaluating Questions about the Ethics of PrEP

Although it is clear that we need to start being more attentive to the social and political history of HIV/AIDS, so far the discussion of the ethics of PrEP has mostly focused on its medical dimensions and the present risk assessment framing of the discussion contributes to this problem. Therefore, I want to re-evaluate the kinds of questions that we ask about the ethics of PrEP and I identify two main problems with these questions and the ways that we are thinking about them. First, the discussion of the ethics of PrEP has typically focused almost exclusively on questions of medical risk. One of the main questions behind the medical objections seems to be the following: are the benefits of using PrEP as HIV prevention enough to counterbalance the risks, or potential harms, associated with an increase in so-called risky sexual behaviour among MSM because of risk compensation behaviour and the feeling of safety from HIV that PrEP provides us? As a distinct social and political group, however, there are many different kinds of risks and benefits associated with PrEP that are ethically salient for MSM beyond simply the effects of PrEP on our sexual behaviour and physical health, especially given the long, complicated history of HIV in gay communities across North America. Therefore, a broader framing of the discussion of risk in the ethics of PrEP seems necessary in order to address all of the social and political risks of MSM

using PrEP as HIV prevention together with the medical risks. This broader framing also needs to consider the social and political benefits of PrEP, some of which I discussed in the previous chapter, including access to sexual and romantic relationships as well as sexual freedom, beyond just the medical benefits of preventing HIV transmission in order to properly weigh them against the relevant risks. By asking whether the benefits of using PrEP are enough to counterbalance the risks associated with its use without preempting a discussion about so-called risky sexual behaviour, we can address the more nuanced issues facing different individuals and communities when they are deciding on their HIV prevention strategies depending on how PrEP will affect their health and their lives more broadly.

Second, the questions of medical risk are also typically treated as settled questions in North America because PrEP was officially approved as HIV prevention in both Canada and the United States. Its risk assessment by Health Canada and the FDA concluded that it was not too risky to be approved as HIV prevention and, therefore, it seems that the medical benefits of using PrEP as HIV prevention clearly outweigh the medical risks. However, if we realize that questions of medical risk are not the only ethically relevant questions about PrEP, then we also realize that thinking about questions of risk more broadly as settled questions because of its official approval is also a mistake. Although the questions about medical risk seem to be settled in the literature by the relevant medical research, despite the lingering objections, there remain questions about the social and political risks and benefits involved in PrEP use. It is not yet clear what the broader, long-term social and political effects of widespread PrEP use among MSM will be. Since the present framing of the ethics of PrEP primarily around risk does not seem like the best way to understand all of the ethical issues involved, I challenge the idea that the ethics of PrEP should be thought of as primarily a question of risk and in the following chapters, I highlight questions about trust and solidarity. In the following sections, I explain how the present medicalized framing of risk in the ethics of PrEP distorts the ethical discussion in two important ways: it distorts the relevant risks of using PrEP and it ignores the lived experiences of MSM and the effects of those experiences on our decisions about HIV prevention. I deal with the first point about the kinds of risks that are involved in PrEP use in §2.3 and I return to the ways in which we can incorporate the experiences of MSM into the ethics of PrEP in §2.4.

2.3. The Kinds of Risks Involved with PrEP: Overblown and Overlooked Risks

The overly medicalized risk assessment framing of the ethics of PrEP affects the ethical decisions of MSM by distorting our understanding of the risks and benefits involved in those decisions by overblowing some risks while overlooking others. Since PrEP is a medical technology that is presently being targeted towards a specific group in society, it is important to take the perspective of that group in order to determine the relevant risks of using it as HIV prevention. Different medical technologies target different groups in society depending on their healthcare needs. For example, the birth control pill is targeted towards women who have sex with men in order to prevent pregnancy even though women can take it for other reasons as well. Insofar as different groups are targets for different medical technologies, these groups have to make decisions about whether or not to actually use them. The lived experiences of members of these groups are, therefore, crucial for understanding these decisions. Drawing on media, public conversations, memoirs, and personal writings from self-identified gay, bisexual, and queer men, as well as my own experiences, I focus on how different risks and benefits are distorted in the present risk assessment approach to the ethics of PrEP, either because they are overblown or because they are overlooked, and how this affects our risk assessment and decision making around using PrEP as HIV prevention. Unpacking the distorting effects of medicalization and the language of risk surrounding PrEP draws our attention to several ethically salient aspects of its use among MSM beyond simply the medical risks and benefits.

2.3.1. The Overblown Risks of PrEP: Risky Sexual Behaviour

I find that several kinds of risks are presently being overblown by the risk assessment approach to the ethics of PrEP: these include the risks of sex between men, the risks of anal sex, the risks of condomless sex, the risks of anonymous sex, and the risks of having multiple sexual partners. As I mentioned previously, the medical risk objections to PrEP question each of these non-normative sexual behaviours. Sex between men and anal sex violate heteronormativity, condomless sex and anonymous sex violate norms of sexual prudence, and having multiple sexual partners violates norms of monogamy. The objections worry that MSM who use PrEP are going to engage in risk compensation behaviour, including having more sex, more risky sex, more

condomless sex, more anonymous sex, and sex with more partners. Whether the fact that PrEP effectively prevents HIV transmission actually outweighs any of the risks of this possible increase in so-called risky sexual behaviour seems to be the most important ethical question, according to the objections and the present risk assessment framing of the ethics of PrEP. Therefore, the only relevant risks of using PrEP seem to be behavioural risks, which are intimately tied to the sexual practices and relationships of MSM. Risk assessment involves determining which risks are relevant and whether the relevant risks are acceptable, but this process is also influenced by the norms and values of different assessors. Whether a risk is acceptable depends on whether it is outweighed by the relevant benefits. However, different risk assessors will identify and weigh different risks and benefits in a specific situation differently based on their experiences. For example, different medical professionals, policymakers, researchers, and community members might under-weigh the benefits of condomless sex, anonymous sex or sex with multiple partners because they are more focused on the risks of HIV and other STIs, but MSM who find these sexual practices and relationships meaningful might weigh these risks and benefits differently and we might even find that the benefits outweigh the risks. Risk assessment can sometimes fail to take this kind of meaningfulness into account when the norms and values of the people accepting the risks are not fully considered in the process.

However, it is important to acknowledge that considering the norms and values of the people accepting the risks in a specific situation is complicated by problems with granting epistemic authority to different social and political groups. Although some MSM might value our sexual freedom over their sexual safety, I agree with the present risk assessment approach to the ethics of PrEP that safety is the most important consideration in any decision about HIV prevention. However, freedom is another important consideration in such decisions and it is being undervalued because of the emphasis on the medical risks today. This tension between safety and freedom in risk assessment is evident in the examples of the recent protests across North America, including at Queen's Park in Toronto, where people rallied against social distancing measures and other lockdown restrictions during the early COVID-19 pandemic (Draaisma, 2020). The protesters argued that public health experts should not be able to override their assessment of the relevant risks or their values. The difference between the COVID-19 protesters, anti-vaccination activists or even religious groups and MSM involves an asymmetry between these different groups. Unlike the other groups, MSM are a marginalized group in society and there are existing biases

against taking the viewpoints of such marginalized groups (Fricker, 2007). Since our viewpoints and values are systematically discounted and ignored, MSM are sometimes skeptical of strictly medicalized approaches to our healthcare decisions (Dotson, 2011). Instead of granting MSM epistemic authority in the risk assessment of PrEP, it is simply important to remember that since our concerns and experiences are often discounted or ignored because of epistemic injustice, including both testimonial injustice and hermeneutical injustice according to Miranda Fricker (2007), medical professionals, policymakers, and researchers need to consider our norms and values and take into account the meaningfulness of our sexual practices and relationships.

The risks and benefits for MSM involved in using PrEP as HIV prevention not only include how it affects our sexual practices and relationships, but also how it affects our communities and our standing in society, which are things that are sometimes more obvious to us than the others assessing the risks. The present focus on the overblown medical risks reduces our decisions about PrEP to decisions about our sexual health and our sexual behaviour, instead of decisions about our sexual practices, sexual relationships, sexualities, and even communities. Sex is inherently risky when it comes to HIV transmission, regardless of who is having it with whom. However, since MSM have an especially high risk for HIV for several historical, behavioural, and biological reasons, sex between men seems to be even more risky. Although it is necessary to respond to this high risk for HIV among MSM with widely available prevention strategies, like PrEP, the language of risk surrounding gay sex is stigmatizing and the present discussion of the ethics of PrEP reinforces this stigma (Marcus & Snowden, 2020). Even though sex is inherently risky, thinking, talking, and writing about sex between men in this way is detrimental to MSM and our uptake of PrEP because we are a group that is already characterized and judged by its sexuality and its association with HIV. If the discussion of the ethics of PrEP continues to focus primarily on so-called risky sexual behaviour, then it will continue to stigmatize gay sex as especially risky and this stigma can “hinder both the seeking of sexual health care by those who need it and the provision of sexual health care by providers” (Marcus & Snowden, 2020).

The problem here is that in the risk assessment of PrEP use among MSM, the benefits of being able to have sex and build sexual and romantic relationships free from the anxiety around HIV are not being fully acknowledged and properly weighed against the risks for HIV and other STIs. These benefits are really valuable to many MSM, but they are often ignored or undervalued by risk assessors, whether medical professionals, policymakers, researchers or MSM who have

worries about PrEP. Sex and sexual and romantic relationships are meaningful parts of healthy and fulfilling lives for many people and even sexual health is "defined not only by the absence of disease, but also by a holistic state of physical, emotional, mental, and social wellbeing in relation to sexuality" (Marcus & Snowden, 2020). By not always fully acknowledging the meaning of sex and sexual and romantic relationships for MSM because of its focus on the medical risks and benefits, the present risk assessment approach to the ethics of PrEP seems to be missing key benefits to weigh against the risks and it seems to not always be weighing the risks and benefits properly in a way that acknowledges the values of MSM. Overall, the present risk assessment approach is so narrow that it contributes to further stigmatization of our sexual practices and relationships, which in turn can have negative consequences on our physical, mental, and emotional health as well as the health of our communities.

Furthermore, the same problem applies to thinking about anal sex, condomless sex, anonymous sex, and sex with multiple partners as risky. Each of these sexual practices can be meaningful for the people engaging in them, but this is not usually reflected in the risk assessment of PrEP. Safe access to these kinds of sexual practices because of PrEP is not considered among its benefits because of the lingering worries about the risk of HIV and other STIs. Many gay, bisexual, and queer men, in particular, engage in these sexual practices and relationships as a way of expressing ourselves sexually and defying the sexual norms that stigmatize us. MSM who engage in anal sex often view it as the "highest in a hierarchy of sexual activities", including oral sex, sex toys, and masturbation, and even "a symbol of the most powerful emotional union between men and a symbol of gay men's hard-fought battle for sexual freedom" (Chambers, 1994, p. 359). Condomless sex, or bareback sex, can hold similar meaning for MSM because condoms can feel restrictive both physically and emotionally, as both a physical barrier and a barrier to intimacy. Even though most MSM know the risks of HIV and other STIs involved in bareback sex, we still sometimes engage in this practice because "sexual satisfaction, adventure, intimacy, and love overpower health concerns and condom use recommendations" (Carballo-Diéguez et al., 2011). In the context of the history of HIV, sex without condoms can also demonstrate the progress that we have made since the AIDS epidemic, especially for those of us who use PrEP as HIV prevention instead of condoms. As effective treatment and prevention "transformed the meaning of HIV/AIDS from a lethal illness to a chronic, manageable condition", the norms around using condoms shifted for MSM and increased access to condomless sex and it's associated benefits of

greater pleasure and intimacy (Hammack, Toolis, Wilson, Clark, & Frost, 2019). The fact that many MSM accept the risks of condomless sex in order to access these benefits again demonstrates that the risk assessment of PrEP does not always account for all the relevant risks and benefits or weigh them properly.

Likewise, the benefits of anonymous sex and sex with multiple partners are being missed in the risk assessment of PrEP even though they are meaningful for many MSM. These sexual practices were discouraged during the AIDS epidemic in order to reduce the spread of HIV in North America, but these practices are meaningful to many MSM today despite the fact that they are risky and stigmatized from within gay communities because of the history of HIV and by the rest of society because they do not conform to traditional sexual practices, like monogamy. However, bathhouses have been an important part of gay culture since the 1950s as places where gay, bisexual, and queer men engage in anonymous sex and sex with multiple partners and popular hookup apps like Grindr and Scruff demonstrate the continuing importance and prevalence of these sexual practices today (Box, 2019). In particular, anonymous sex, including cruising and public sex, has a long history among gay, bisexual, and queer men. It was necessary at first because of discrimination, but it has become a part of our sexual culture in the form of sex parties, for example, which require a high level of trust and respect among participants (Abrams, 2017; Khan, 2020). Many gay, bisexual, and queer men remain interested in anonymous sex today with over half of us reporting we have visited a public sex venue recently (Klein, 2019, p. 2). Instead of being merely risky, anonymous sex can be a healthy, meaningful, and even traditional part of gay, bisexual, and queer men's sexual lives.

Finally, sex with multiple partners might be a part of open or polyamorous relationships among gay, bisexual, and queer men.[14] In fact, some gay, bisexual, and queer men in these kinds of relationships credit their high relationship satisfaction and good communication skills to their consensual non-monogamy despite the stigma that these relationships are "lesser than" other, especially monogamous, relationships (Macnaughton, 2016; Stults, 2019). Therefore, thinking about these kinds of sexual practices and relationships as risky only further stigmatizes them in a society that already devalues non-traditional sexual practices and relationships. Since their value

[14] Open relationships, and other forms of consensual non-monogamy like polyamory, seem to be more widespread among gay, bisexual, and queer men than among heterosexual men and women or queer women, which further demonstrates the relevance and importance of these kinds of relationships in the risk assessment of PrEP and the discussion of the ethics of PrEP among MSM more broadly (Levine et al., 2018).

and their associated benefits for MSM are not being factored into the present risk assessment of PrEP because of its narrow focus on medical risks, this approach to the ethics of PrEP is lacking. Instead of simply being risky, these non-traditional kinds of sexual practices and relationships can contribute to a sense of community, connection, solidarity, trust, and intimacy for gay, bisexual, and queer men. Unfortunately, the present risk assessment framing casts many of the sexual practices and relationships of MSM as merely risky, which reinforces stigmatizing narratives about MSM being sexually irresponsible. If we continue to think of sex between men, anal sex, condomless sex, anonymous sex, and sex with multiple partners as merely risky, then these narratives will continue to negatively impact the broader health and wellbeing of MSM and limit the utility of PrEP as effective HIV prevention by generalizing and misunderstanding the sexualities, sexual practices, and sexual relationships of MSM as well as ignoring the lived experiences of MSM regarding sex, HIV, and HIV prevention, which could inform a more comprehensive risk assessment framework. In many instances, we might be coming to the wrong conclusions when assessing the risks of PrEP because we are assigning too little weight to the value to the different kinds of sexual practices and relationships that are meaningful to MSM. Therefore, we have to broaden the kinds of risks and benefits that we consider when assessing the risk of PrEP to include those that are being overlooked today.

2.3.2. The Overlooked Risks of PrEP: Stigma, Stereotypes, Etc.

Several risks are presently being overlooked by the risk assessment approach to the ethics of PrEP, including the risks of the stigmas associated with PrEP, the risks of PrEP reinforcing homophobic, biphobic, and serophobic stereotypes, the risks of PrEP emphasizing deep divisions in the gay communities, and the risks of PrEP cultivating an ethics of disclosure. There are actually several stigmas associated with PrEP, which are closely related to the behavioural risks discussed earlier. Unfortunately, people who take PrEP are often thought of as being promiscuous or interested in engaging in so-called risky sexual beahviour, like condomless sex, anonymous sex or sex with multiple partners. MSM who use PrEP as HIV prevention are even sometimes negatively referred to as “Truvada whores” by those who disapprove of their decision and infer that they are using it to engage in so-called risky sex (Calabrese & Underhill, 2015). One opinion piece about PrEP even suggests that “for men who engage in unsafe sex with other men, this is just an excuse

to continue to be irresponsible" (Duran, 2012). Unfavourable associations with so-called risky sexual behaviour have led to several PrEP-related stigmas, including the "the stigma of being related to HIV" and "the stigma of PrEP being an alternative to condoms (as condom use is associated with responsible sexual activity)" (Haire, 2015, p. 241). The prevalence of the term "Truvada whore", or "PrEP whore", to refer to MSM who use it as HIV prevention is an example that demonstrates the popularity of these kinds of stigmas around PrEP. These stigmas are also reminiscent of the stigmas, like slut-shaming, that women who use the birth control pill, or who advocate for its use like Sandra Fluke, still face in society even though it has become more acceptable as a form of contraception (Johnson, 2012). The stigmas around non-monogamy, open relationships, polyamory, and promiscuity associated with PrEP might even influence MSM to decide against using it as HIV prevention and these stigmas affect those of us who decide to use PrEP anyway. Therefore, those of us who decide to use PrEP might even assume the risk of experiencing the negative effects of these stigmas. For example, if a potential sexual partner finds out that you are using PrEP, they might not consider hooking up with you because they might think that your PrEP use signifies something about your sexual practices and desires, regardless of whether or not you engage in these practices or have these desires.

Second, there is a risk that the stigmas associated with PrEP will reinforce homophobic, biphobic, and serophobic stereotypes. Serophobia is the fear of people living with HIV and it has serious negative effects on people living with HIV and people who are at high risk for HIV because negative things are inferred about their sexual practices. Likewise, homophobia and biphobia lead to stereotypes about gay, bisexual, and queer men being promiscuous or not having meaningful sexual and romantic relationships, which demonstrates the lasting influence of the AIDS epidemic. These kinds of stereotypes not only affect individuals, but they also affect gay communities. The AIDS epidemic created negative stereotypes about gay, bisexual, and queer men being sexually irresponsible and threatening public health. It is possible that widespread PrEP use risks reinforcing these stereotypes by continuing the association between MSM and HIV even if it is in the interest of public health for MSM to use PrEP in order to help reduce rates of HIV in North America. This might also influence the decisions of MSM about whether or not to use PrEP because many of us do not want to live up to the negative stereotypes about us. Nevertheless, some of us do live up to the stereotypes and this demonstrates that the underlying sexual practices, desires, and relationships are things that are valuable to some of us. Those of us who decide to use

PrEP might have to deal with the negative consequences of these stereotypes regardless. For example, some of your families and friends might not understand why you are using PrEP and they might make false or moralizing judgments about the kinds of sex you might be having and the kinds of relationships you might be pursuing. Some people living with HIV might even think that your PrEP use demonstrates serophobia and they might even be deterred from hooking up with you or building a relationship with you (McCelland, 2019).

Third, the widespread use of PrEP as HIV prevention risks emphasizing deep divisions in gay communities based on different responses to these stereotypes. Members of gay communities across North America obviously have differing views on PrEP for several reasons, including how members of these communities view sex, sexual, and romantic relationships, HIV, HIV prevention, and LGBTQ2S+ politics in general. Although there are several reasons for these differing views on PrEP, they sometimes fall importantly along generational lines; gay, bisexual, and queer men who lived through the AIDS epidemic sometimes view PrEP more negatively because of their losses, while those who grew up during the AIDS epidemic and those who grew up afterwards sometimes view PrEP more positively because they are not always aware of the history of HIV and how it affected the ways in which others view sex, HIV, and HIV prevention and the ways in which the rest of society views gay communities. These younger generations of gay, bisexual, and queer men, therefore, seem to be more willing to use PrEP as HIV prevention than older generations (Hammack, Meyer, Krueger, Lightfoot, & Frost, 2018). However, those who grew up during the AIDS epidemic, including Generation X and Millennials, are actually the most familiar with PrEP, possibly because we were “saturated with information about AIDS during [our] childhood and adolescence in the 1980s and 1990s” (Hammack, Meyer, Krueger, Lightfoot, & Frost, 2018). Generation Z are growing up well after the AIDS epidemic and at a telling forum on PrEP at the LGBT Center in San Francisco, this younger generation of gay, bisexual, and queer men clashed with the older generation who lived through the epidemic. When the younger men admitted to infrequent condom use, the older men said, “every time you do that, you are asking to die” and the younger men responded, “we can’t keep being afraid of sex because you were” and “we can’t carry the burden of everyone who died before us” (Hammack, Frost, Meyer, & Pletta, 2018). Therefore, PrEP is sometimes a particular flashpoint for political conflict surrounding HIV prevention between different generations of gay, bisexual, and queer men.

Although the AIDS epidemic fostered solidarity among gay, bisexual, and queer men, PrEP challenges that solidarity by changing the norms around sexual responsibility. Gay communities adopted moral norms around sex that focused specifically on the responsibility for using condoms during sex because they were the primary strategy for HIV prevention for decades. Even AIDS activist Larry Kramer, who founded both Gay Men's Health Crisis (GMHC) and AIDS Coalition to Unleash Power (ACT UP) in the 1980s and who supports PrEP as HIV prevention today, previously said, "there's something to me cowardly about taking Truvada instead of using a condom" and he worried that it "lessened your energy to fight, to get involved, to do anything" (Brathwaite, 2015). He seemed to be explicitly worried about the effects of PrEP on AIDS activism, including a sense of complacency among MSM using it as HIV prevention instead of condoms. Since the AIDS epidemic, using condoms meant that you were having "safe" or "protected" sex, which is responsible sex, and not using condoms meant you were having "unsafe" or "unprotected" sex, which is irresponsible sex (Berer 2006; Weinmeyer, 2013). Today, PrEP allows for "safe" or "protected" condomless sex and different individuals, communities, and generations will view this change either positively or negatively depending on their experiences with HIV/AIDS and this will certainly affect the decisions of different MSM about whether to use it as HIV prevention.

Finally, the widespread use of PrEP as HIV prevention among MSM risks cultivating an ethics of disclosure. Although this is already starting to happen today with initiatives like online hookup and dating profiles including sections on HIV prevention strategies, the broader effects of an ethics of disclosure surrounding PrEP as an HIV prevention strategy are not yet established in society or in the literature. During the AIDS epidemic, disclosure of one's serostatus was recommended by public health institutions, but these "decisions about disclosure of HIV status involve anxiety, stigma, and shame" and "divulging to sexual partners may lead to isolation or even physical injury" (Stein, Freedburg, & Sullivan et al., 1998). An ethics of disclosure around PrEP might not necessarily have negative effects on the lives of MSM today because of shifting attitudes towards HIV and it even might help further normalize conversations about HIV prevention, which is an important aspect of the sexual and romantic lives of all sexually active gay, bisexual, and queer men in North America, but it is still important to understand the possibly strict new ethical demands on MSM because of the increasingly widespread use of PrEP. For example, disclosing your PrEP use on hookup or dating apps might expose you to the negative consequences of the

stigmas associated with PrEP, the negative homophobic, biphobic, and serophobic stereotypes or the intergenerational, political conflict detailed above.

If disclosure becomes the norm, however, MSM will have to deal with issues of privacy, vulnerability, and accusations of deception. MSM might not want to disclose our HIV status or our HIV prevention strategies because we might want to keep our sexual practices private and only decide to disclose when we feel safe and comfortable to do so. This is especially important because some of our practices can make us vulnerable to negative judgments from others, which could affect our safety and our relationships with friends, family members, and even colleagues and coworkers. The norm of disclosing this kind of information to sexual and romantic partners in particular means that we have to share something that is very personal with them or else we might be deceiving them. If we don't share information that is important for them to consider before having sex or building a relationship with us, then we can actually be deceptive by not disclosing (Dougherty, 2013). Already some MSM are being accused of lying about their PrEP use or serostatus in order to avoid difficult conversations with potential partners (Kelser, 2015; Smith, 2017). Overall, the presence of each of these risks for MSM demonstrates that medical risks are certainly not the only kinds of risks involved in PrEP use. The present focus on the medical risks in the discussion of the ethics of PrEP not only distracts from these other social and political risks, but it also contributes to them. However, if we give these risks proper weight in PrEP risk assessment, it might actually change the verdict on whether someone should use PrEP or when someone should use PrEP depending on their values and their experiences with sex, HIV, and HIV prevention. Therefore, in order to really understand the medical, social, and political risks involved in PrEP use together, it is crucial to determine how exactly the lived experiences of MSM regarding sex, HIV, and HIV prevention shape our risk assessment of PrEP and our decisions about whether and when to use PrEP as HIV prevention. Although the importance of these lived experiences are often being missed in the present risk assessment of PrEP, they should inform its risk assessment as well as the broader discussion about the ethics of PrEP as HIV prevention among MSM today.

2.4. The Experiences of MSM: Sex, HIV, and HIV Prevention

What seems to be missing in the present discussion, especially when thinking about the kinds of risks and benefits that are involved in PrEP use, are the unique experiences of MSM and the ways that they affect the risk assessment of PrEP because these experiences determine what kinds of risks are acceptable to us. Since the experiences of the population using a particular medical technology for their own unique healthcare needs are important to consider if we really want to be attentive to the most pressing ethical issues involved for them and the effects of using these medical technologies on their lives, then we need to understand how these experiences inform PrEP risk assessment. The present risk assessment approach to the ethics of PrEP is insufficient because it is too narrow, focusing on the medical risks and benefits and ignoring many of lived experiences of MSM, which determine the acceptability of the various risks and the value of the various benefits for those of us who use PrEP as HIV prevention. Instead, we have to understand how the lived experiences of MSM regarding sex, HIV, and HIV prevention inform the present discussion in order to first improve the risk assessment approach by including more kinds of risks and benefits in the analysis and then explore what other concepts besides risk are important to consider in order to really understand the broader social and political effects of its use. I already mentioned some of these lived experiences by discussing the overblown and overlooked risks in the previous section, but in this section, I discuss other relevant experiences, including whether MSM are HIV-positive, whether MSM are in serodifferent relationships, whether MSM are in monogamous relationships, and whether MSM are out to their family and friends. Each of these lived experiences further influences whether or not MSM decide to use PrEP as HIV prevention, how we weigh the risks and benefits involved in its use, and how our lives as well as our communities might be affected by our decisions about HIV prevention.

First, whether MSM are HIV-positive affects how we view PrEP and how it affects our lives because being HIV-negative is necessary in order to use PrEP. Whether MSM decide to use PrEP does not only depend on being HIV-negative, but it also depends on how we view HIV and how it influences our subsequent sexual practices and relationships. If we are afraid of HIV, then it might lead to stress and anxiety around sex and sexual and romantic relationships. We might decide to use PrEP to reduce this stress and anxiety and feel more comfortable around sex and our sexual and romantic partners (Whitfield et al., 2019). However, PrEP use might signify different things to different people. It might even signify that people using PrEP are not only afraid of HIV, but also afraid of people living with HIV. Therefore, people who are living with HIV might have

complicated views about what PrEP use means. The fact that people are using PrEP might indicate to some people living with HIV that they are afraid of them (McClelland, 2019). This might affect the possibility of building meaningful relationships between MSM who are HIV-positive and MSM who are HIV-negative. Nevertheless, MSM who are HIV-negative and who are using PrEP might be afraid of HIV even if we are not afraid of people living with HIV. Although some people might make negative judgments about our sexual practices and relationships because of our PrEP use, others, including those living with HIV, might make positive judgments. For example, PrEP use might signify to some people living with HIV that we are informed about the science of HIV transmission and that we are taking responsibility for our own HIV prevention, not burdening them with awkward disclosures, conversations or judgments about their serostatus, sexual practices or relationships.

Second, whether MSM are in serodifferent relationships affects how we make decisions about whether or not to use PrEP as HIV prevention because it changes our relationship dynamics. PrEP is usually considered especially beneficial for MSM who are in a serodifferent relationship, a relationship in which at least one partner is HIV-positive and at least one is HIV-negative, because it helps reduce the risk of HIV transmission. HIV-negative partners can use PrEP as HIV prevention and HIV-positive partners can use treatment as prevention (TasP) strategies to reduce their viral load to undetectable levels. If HIV-positive partners have an undetectable viral load, then it actually eliminates the risk of HIV transmission. However, since this places the control of HIV transmission risk in the hands of HIV-positive partners, HIV-negative partners might want to use PrEP in order to also assert their own sexual agency in their relationships. By sexual agency, I mean an individual's ability to make autonomous choices about their sexual behavior, practices, and relationships, and to feel in control of their own sexual desires, needs, security, and safety. Therefore, PrEP can reduce any added stress, anxiety, mistrust, and worry in serodifferent relationships because of HIV and increase relational trust by giving agency to HIV-negative partners. PrEP use in serosame relationships, relationships where all partners are HIV-negative, however, can take on different meanings and affect relationship dynamics in different ways. Although it can demonstrate that partners using PrEP care about the sexual health and wellbeing of their partners, it can also indicate to their partners that they are planning on cheating or engaging in sexual practices that might not be part of either their implicit or explicit relationship structures, including whether their relationships are closed or open.

Therefore, third, whether MSM are in monogamous relationships also affects our decisions about PrEP. In a monogamous relationship, PrEP use could indicate to the partners, and even friends and families, of MSM that they are planning on cheating, having multiple sexual partners, or engaging in sexual practices that are not a part of the relationship structure that they agreed to with their partners. This perception of their PrEP use might not reflect their intentions or behaviours, but it might negatively affect the trust in their relationships regardless. However, MSM structure our relationships in many different ways and we have many different kinds of sexual and romantic relationships, including long-term, casual, monogamous, polyamorous, and open relationships as well as friends with benefits among others. Depending on the structure of our relationships, deciding to use PrEP as HIV prevention might either cause problems for us or solve problems. For example, in open or polyamorous relationships, using PrEP might help partners protect not only our own sexual health, but also the sexual health of our partners. If MSM in these relationships are hooking up with other guys, especially without using condoms, then both our partners and ourselves are at higher risk for HIV and other STIs. Using PrEP might actually give reasons for our partners, and even our friends and families, to praise our decisions to protect our partners and ourselves. Our decisions might even help alleviate persistent worries around HIV transmission that cause stress and anxiety in our relationships and help us facilitate happier and healthier relationships.

Finally, whether we are out to our families and friends affects our decisions to use PrEP as HIV prevention and it colours the other experiences I consider here as well.[15] Being out changes whether we want our families and friends to know that we are using PrEP as HIV prevention depending on what we think PrEP signifies to them. If our families and friends know that we are using PrEP, then this might actually signify to them that we are gay, bisexual or queer even if we are not out to them. Since PrEP use might out us to our families and friends, which can still be a very difficult experience for gay, bisexual, and queer men in North America, we might decide to not use PrEP as HIV prevention. Even if we are out to our families and friends, they might mistakenly think that using PrEP means we are living with HIV or that we are engaging in so-called risky sexual behaviour, which might lead them to think that we are irresponsible, despite the fact that using HIV prevention is inherently responsible. Although we might be engaging in

[15] It is also relevant for our decisions about PrEP to consider whether we are out to our healthcare providers, including our doctors, nurses, and pharmacists, because they are the ones who actually prescribe us PrEP as HIV prevention. Since this is very important for the ethics of PrEP, I will consider it in more detail in the Chapter 3.

condomless sex, the negative judgments of our families and friends about our sexual practices and relationships might discourage us from using PrEP or disclosing our PrEP use and this might in turn endanger our sexual health. Nevertheless, our families and friends might be supportive of our PrEP use and its positive effects on our sexual health and this might further encourage us to use it as HIV prevention or think more carefully about our HIV prevention options. Overall, all of these experiences demonstrate ethically salient dimensions of PrEP use that are involved in the decisions of MSM about HIV prevention. If we take these experiences into consideration, then we can start rethinking the ethics of PrEP in ways that can really benefit the lives, relationships, and communities of MSM, the population using this particular medical technology today, by including a broader set of social and political risks and benefits in PrEP risk assessment instead of limiting the discussion to the weighing of medical risks and benefits.

2.5. Rethinking Risk in the Ethics of PrEP: A Broader Framework

Rethinking the ethics of PrEP with the experiences of MSM regarding sex, HIV, and HIV prevention in mind, enables us to better situate the concept of risk in the discussion by adopting a more socially and politically informed approach to the ethics of PrEP. This involves considering the effects of the present risk assessment framing on the decisions of MSM as well as the benefits of using PrEP as HIV prevention. Risk assessment should provide a framework for weighing the relevant risks and benefits of a medical technology, but in the case of PrEP, many of these are being missed in the assessment because the process is so focused on the medical risks and benefits. Since the present risk assessment framework has a problem accounting for the values and the lived experiences of MSM, it does not seem to be the best framework for approaching the ethics of PrEP. Although it is clear that the ethical decisions of MSM are informed by our experiences, our decisions are also often influenced by healthcare providers and policymakers who continue to frame decisions about PrEP primarily as an assessment of risk. For example, when MSM go to doctors to be prescribed PrEP as HIV prevention, they usually focus on questions about medical risk, including how many partners do you have? How often do you use condoms during sex? What kind of sex are you having? Doctors do not tend to ask about other relevant information about our lives, like how we structure our relationships, how we feel about HIV, how we feel about condoms, etc. This leaves MSM largely unprepared for the other kinds of risks and benefits

that we might face while using PrEP depending on our personal experiences and our situations in life. It also obscures the fact the PrEP has medical as well as social and political dimensions. Even if it is not the role of doctors to prepare MSM to navigate the related social and political issues, it is still important for us to be prepared for all of the kinds of risks that we might face because of using PrEP as well as the kinds of benefits that PrEP might have on our lives, relationships, and communities. Therefore, we need to move away from the present risk assessment framework and towards a more socially and politically informed risk assessment framework that is more responsive to these kinds of considerations and better prepares us for the kinds of risks that we might face using PrEP as HIV prevention.

I have already detailed some of the social and political benefits of using PrEP as HIV prevention in both this chapter and the previous chapter, but they are also being obscured by the present risk assessment framework. Again, in traditional risk assessment, the risks of a medical technology are weighed against its benefits and deemed acceptable when they are outweighed by the benefits. The main medical benefit of using PrEP is that it greatly reduces the risk of HIV for MSM and this seems to outweigh any of its medical risks. However, these medical risks and benefits also need to be weighed against the social and political risks and benefits. In order to understand how PrEP is actually going to affect MSM socially and politically, it is necessary to investigate the ways in which its use will affect our relationships as well as our communities and this will require going beyond the risk assessment approach to the ethics of PrEP and appealing to moral concepts other than risk. Therefore, in the following chapters, I will use the concept of trust to understand how PrEP affects our relationships and the concept of solidarity to understand how PrEP affects our communities. Together, risk, trust, and solidarity among other moral concepts help us appreciate the complexity of the ethics of using PrEP as HIV prevention among MSM. Thus, although the concept of risk is important in the ethics of PrEP and the decisions of MSM about PrEP, the discussion of the ethics of PrEP should be framed as the much broader issue of living ethically in a social and political community uniquely affected by HIV. Instead of thinking about the ethics of PrEP as merely an assessment of risk, we should think about it as an interlocking matrix of values and considerations, which change according to the context of different individuals and communities. This more sophisticated framework, which still includes risk assessment, will give us more accurate normative guidance when it comes to making judgments about the ethics of PrEP and assessing these judgments.

2.6. Conclusion: Towards an Analysis of Relationships and Communities

In conclusion, I not only critique the risk assessment approach to the ethics of PrEP in this chapter in order to improve it, but I also imagine what the ethics of PrEP might look like if we broaden the discussion beyond just the concept of risk, especially medical risk, and start to more fully recognize the social and political dimensions of the situation MSM face when deciding whether or not to use PrEP as HIV prevention. Unfortunately, the present risk assessment approach to the ethics of PrEP is distorting the kinds of risks that we think are involved in using PrEP and obscuring the importance of the lived experiences of MSM regarding sex, HIV, and HIV prevention, which are crucial to understanding the broader effects of PrEP on MSM as a social and political group in society. The case study of PrEP is analogous to other situations where social and political groups use particular medical technologies, but if we simply focus on the medical dimensions of these situations and the physical health of the social and political groups using these technologies, then we miss how much these technologies can really affect their lives, relationships, and communities. Therefore, we have to expand our understanding of these kinds of situations in order to acknowledge that these social and political issues can profoundly affect the health and wellbeing of these groups. As one of these groups, MSM are profoundly affected by the social and political issues involved in using PrEP as HIV prevention, especially with the history of HIV and the AIDS epidemic bearing on our decisions and affecting our personal lives, relationships, and communities in myriad ways. By first broadening the risk assessment of PrEP to include medical, social, and political risks and then by resituating the concept of risk as just one of the many important aspects of the ethics of PrEP as HIV prevention among MSM, we are able to more fully consider other important moral concepts like trust and solidarity, which I discuss in more detail in the following chapters.

CHAPTER 3

Understanding the Effects of PrEP on Trust among MSM

In this chapter, I focus specifically on the concept of trust in the discussion of the ethics of PrEP as HIV prevention among MSM in order to explore how using PrEP affects the personal relationships of MSM, especially the personal relationships of gay, bisexual, and queer men, in North America. Although PrEP allows MSM to more safely and easily build and maintain sexual and romantic relationships with each other, it is important to attend to the resulting relationship dynamics because they vary with partners' serostatuses and different relationship structures. MSM have to place trust in our partners in order to build and maintain sexual and romantic relationships and, therefore, the ways in which using PrEP affects this interpersonal, or relational, trust between us are important for the ethics of our relationships, the responsibility for creating the conditions of trust in our relationships, and the success of PrEP as a relatively new HIV prevention strategy. However, it is not only interpersonal trust that is relevant here, but also institutional trust in healthcare and healthcare providers. Using PrEP means that we have to trust our healthcare providers to understand not only the medical technology and its critical and historical context, but also our experiences with sex, sexual and romantic relationships, HIV, and HIV prevention. Our relationships with healthcare providers, including doctors, nurses, and pharmacists, are complicated by a long history of discrimination and medicalization, which affects our trust in healthcare institutions. If we think about PrEP through the lens of trust, then we realize that its use as HIV prevention affects the social and political lives of MSM in myriad subtle ways beyond just our sexual health, starting with some of our most intimate and important relationships. We also realize just how important relational concepts like trust are in bioethics in order to enhance the analysis of new medical technologies by analyzing some of their less obvious, but more pervasive effects on different social and political groups.

This chapter proceeds as follows. In §3.1, I detail the philosophy of trust, focusing on interpersonal, or relational, trust as the dominant paradigm of trust. I start by highlighting the necessary connection between trust and risk, building on the discussion in the previous chapter.

Then, I present a definition of trust and several different kinds of views of trust that can help inform our discussion in this chapter, including risk-assessment views of trust, like the social contract view and the encapsulated interest view, will-based views, and virtue views. I also explain the intrinsic and instrumental values of trust by discussing the "goods of trust" and I return to the analogy between PrEP and the birth control pill in order to set up my relational analysis of PrEP as HIV prevention. In §3.2, I focus specifically on interpersonal trust by exploring how PrEP affects trust, and the conditions for trust, in the relationships between MSM, including first sexual relationships and then romantic relationships. I consider relationships where partners have different serostatuses and different relationship structures in order to ensure that I capture the range of experiences MSM have with using PrEP as HIV prevention. In §3.3, I shift my focus from interpersonal trust to institutional trust and I consider the trust as well as the conditions for trust between MSM and our healthcare providers. The relationships between MSM and our doctors, nurses, and pharmacists are crucial in terms of access to PrEP, but the history of the medicalization of homosexuality weighs on these relationships and complicates them in ways that jeopardize our access to PrEP. I conclude in §3.4 that thinking about how PrEP affects trust in the relationships of MSM helps us better understand the conditions under which the appropriate kinds of trust around HIV prevention can flourish between different parties and how we ought to allocate the responsibility for creating these conditions between both sexual and romantic partners and seropositive and seronegative individuals as well as between MSM and community organizations, healthcare providers, governments, and the rest of society.

3.1. The Philosophy of Trust: Trusting Relationships

There is an extensive literature on the philosophy of trust that engages with the metaphysics, epistemology, and ethics of trust (McLeod, 2015). Philosophers are interested in understanding what trust is, how it is that we trust others, whether we should trust others, and why we should trust others. I will draw on this literature in order to provide the background information on trust as a relational concept that is necessary for my discussion of trust in the context of PrEP. Although the philosophical literature engages with several different kinds of trust, including institutional trust, trust in government, and self-trust, the dominant paradigm of trust in philosophy seems to be interpersonal, or relational, trust and other kinds of trust seem to be modeled on this

kind of trust (McLeod, 2015, p. 2). This is actually helpful in the context of PrEP because some of the most obvious and important effects of using different kinds of HIV prevention on trust for MSM are in our interpersonal relationships with our sexual and romantic partners. Therefore, I will focus on interpersonal trust in this section and throughout the chapter, but I will return to institutional trust in particular in §3.3 in order to consider some of the other effects of PrEP on the MSM and our trusting relationships.

3.1.1. The Connection between Risk and Trust

There is an especially strong connection between the topic of the previous chapter and the present chapter because trust necessarily involves risk. Whenever we accept certain risks we do so in order to receive certain benefits. When we trust others, we do so because we want or need them to do something for us, but we risk that they will not always do these sometimes important things. If it was guaranteed that they would do the things that we trusted them to do, then we would not have to actually trust them (McLeod, 2015, p. 1). Therefore, trust is inherently risky; we risk a lot when we trust, including our self-respect, our physical safety, and our emotional stability among other things. In the case of PrEP, the risks of trusting your sexual or romantic partners include the risk for HIV among other social and political risks. However, the reason we risk so much in order to trust others is that trust is the foundation for any collaboration with others, including building and maintaining interpersonal relationships. Although we can build trusting relationships with healthcare providers, financial experts, and government officials, it is our relationships with family, friends, and partners that often involve the most risk for us. Whenever you trust someone you not only accept some level of risk that they will not do what you trust them to do, but you also become vulnerable to them (Becker, 1996). We are often uniquely vulnerable to our loved ones, emotionally, financially, even physically, because we trust them more often than others and we often trust them to do more important things for us. For example, when you trust a sexual or romantic partner to not cheat on you, you are accepting the risk that they might in fact do so and you might suffer the harm of them cheating on you, so you are especially vulnerable to them emotionally.

To be vulnerable to another person when trusting them is also always to make yourself vulnerable to betrayal. Betrayal involves the ones you trust having the freedom to not do what you

trust them to do. We typically give others this freedom by not monitoring them out of respect for them as autonomous individuals, especially when it comes to our loved ones (Baier, 1986; Dasgupta, 1988). Again, for example, we usually give our sexual and romantic partners the freedom to cheat on us because we do not monitor their every movement and correspondence in order to check for anything suspicious, but if monogamy, or at least not having sex with partners outside of the relationship, is part of our agreed-upon relationship structure, then their fidelity demonstrates their strong commitment to us as our partners and their infidelity constitutes a devastating emotional betrayal. However, the possibility of betrayal is only one of the necessary conditions for interpersonal trust, so it is important to ask what the other conditions are for trusting others and when exactly trust is warranted (McLeod, 2015, p. 4).

3.1.2. The Different Views of Trust

According to Carolyn McLeod (2015), in order for trust to be warranted, it seems to require that we "be vulnerable to others (vulnerable to betrayal in particular)", "think well of others, at least in certain domains", and be optimistic about their competence to do the things that we trust them to do (p. 3). Trust also seems to require that we be optimistic that others will be motivated to do the things that we trust them to do, but this condition is more controversial than the others, according to McLeod (2015). Depending on how we understand each of these conditions, especially the optimism about the motivations of others for being trustworthy, we can adopt different kinds of views of trust that are proposed by different philosophers, which each describe trust differently and help us understand the trust between MSM in different kinds of relationships, especially different kinds of sexual and romantic relationships affected by PrEP. These views include risk-assessment views, will-based views, and virtue views

First, risk-assessment views of trust hold that we trust others when we assume that the risk of them not doing the things that we trust them to do is low because it is in their self-interest to do them (Jones, 1999; McLeod, 2015). Therefore, the motivation for others to do what we trust them to do is their own self-interest. Thus, the risk-assessment views seem to describe trust in short-term relationships or relationships where individuals are not motivated by others to be trustworthy. I will use these views in particular to describe the trust between MSM in sexual relationships, especially those relationships that are more casual or short-term. One example of a risk-assessment view of

trust is the social contract view. According to the social contract view, certain social constraints can motivate others to be trustworthy. People can either subject themselves to social constraints in an effort to be trustworthy or they can be subjected to social constraints by others (McLeod, 2015, p. 7). For example, people can actually sign a contract stating that they will do what they are being trusted to do. Another example of a risk-assessment view of trust is the encapsulated interest view. According to this view, people are motivated to be trustworthy because they are interested in maintaining their relationships with others who trust them. They encapsulate the interests of others in their own interests in an effort to be trustworthy (Hardin, 2002). The problem with risk-assessment views of trust, however, is that they do not require that the people who trust each other actually care about each other (McLeod, 2015, p. 9). If people do not care about each other, then we might say that they are only relying on each other, not really trusting each other. Trust is different than mere reliance because it seems to be based on our attitudes towards others, such as goodwill or virtue, as opposed to self-interest, ill will or indifference on the part of trustees towards trustors (McLeod, 2015, p. 9).

Will-based views of trust attempt to solve this particular problem with risk-assessment views by motivating trustworthiness with goodwill (Baier, 1986; Jones, 1999; Potter, 2002). According to these views, which are based on the work on Annette Baier (1986), trustees act out of goodwill towards trustors if they are really trustworthy; in other words, the people we trust have to actually care about us. This helps explain why betrayal is such a crucial part of trusting others because if we trust someone to act out of goodwill towards us, as opposed to ill will, selfishness or indifference, and they did not do what we trust them to do, then betrayal seems like the appropriate response (Baier, 1986). Since individuals are motivated by their attitudes towards others to be trustworthy according to will-based views, these views seem to describe trust in long-term relationships or relationships where individuals really care about each other. Therefore, I will use these views to describe trust between MSM in romantic relationships, especially those relationships that are more caring or long-term. Although there are several criticisms of will-based views of trust, one of the main criticisms is that these views are too narrow. Certainly, we can sometimes trust strangers or others who do not have goodwill towards us; even if someone has ill will towards us or even if they are indifferent towards us, we might still be able to trust them to do some things. For example, we might trust ex-partners to co-parent children or estranged siblings to care for elderly

parents even if we have ill-will towards them and we might trust strangers because of their commitment to social norms, not goodwill towards us (Mullin, 2005)

Finally, virtue views of trust understand trustworthiness as a virtue or disposition to be trustworthy, so the motivation to be trustworthy is part of the motivation to be virtuous. We trust others because we think that they have the virtue of trustworthiness or that they are a trustworthy person. According to Nancy Nyquist Potter (2002), using an Aristotlean conception of virtue, a trustworthy person is "one who can be counted on, as a matter of the sort of person he or she is, to take care of those things that others entrust to one and (following the Doctrine of the Mean) whose ways of caring are neither excessive nor deficient" (p. 16). When thinking of trustworthiness as a virtue it is helpful to think about why people are motivated to act virtuously, not just why they are motivated to be trustworthy. Again, our loved ones are often motivated to be virtuous towards us, including being trustworthy, because of their love for us or the importance of our relationships to them. If we think of someone as virtuous insofar as they possess the virtue of trustworthiness, then we will trust them. Since individuals are motivated to be trustworthy because of their attitudes towards others, according to the virtue views, they seem to describe trust in long-term or caring relationships. Therefore, I will use these views, along with the will-based views, to describe the trust between MSM in more caring and long-term romantic relationships. Overall, it seems like people can be motivated by either self-interest, goodwill or virtue in order to be trustworthy, according to the different views of trust. Although each of these views describes whether and how people are motivated to be trustworthy differently, vulnerability on the part of the trustor and competence on the part of the trustee are especially important for each of them in order for both of them to benefit from the resulting trusting relationship.

3.1.3. The Value of Trust

Therefore, finally, it is important to understand why we try to determine when trust is warranted and why we trust despite the inherent risk of betrayal: we trust because it is valuable. Trust seems to have both instrumental and intrinsic value. The instrumental value, in particular, includes "opportunities for cooperative activity, meaningful relationships, knowledge, autonomy, self-respect, and overall moral maturity" (McLeod, 2015). Although the instrumental value of trust is often different for the trustor and the trustee, the "goods of trust" are both individual goods and

social goods because they might benefit both parties of a trusting relationship, the trustor and the trustee, as well as society more broadly (McLeod, 2015). For example, trust greatly enhances cooperation because it gives reasons for the parties of a trusting relationship to not have to monitor each other; trust, therefore, actually makes their cooperation less complicated. This cooperation brings with it other practical social benefits, like coordination, specialization, and the division of physical as well as epistemic labour. Trust, however, also allows us to make meaningful relationships with others beyond just relationships of cooperation (Hardin, 2011). The trust between sexual and romantic partners, friends, and family members facilitates cooperation, but it also allows for meaningful connections based on mutual love, support, and belonging. Furthermore, it is the relationality of trust that allows for knowledge and autonomy. We have to trust others in order to know many things, including scientific facts, and we can only assert our autonomy "in social environments where we can trust people to support it" (McLeod, 2015). Similarly, when others trust us, it can improve our self-respect and moral maturity by encouraging us to internalize the respect that them trusting us demonstrates. The intrinsic value of trust, therefore, seems to stem from the fact that trusting others is a sign of respect. When we trust others, we demonstrate that we respect them and this sign of respect is intrinsically valuable for both the trustor and trustee (McLeod, 2015). The fact that trust is so valuable to us explains why it is relevant and important in ethical discussions and why I use the concept of trust to help us understand the social and political effects of PrEP on MSM.

3.1.4. Trust and the Birth Control Pill

Before I analyze PrEP in terms of trust, it is helpful to consider how the birth control pill affects trust in the relationships of women who use it as contraception. The birth control pill affects the trust between women and the men who are their sexual or romantic partners (Myers & Sepkowitz, 2013). With the pill, men lose control over contraception and must trust that their partners are actually taking the birth control pill and that they are taking it consistently and correctly. Previously, it was these men who were in control of contraception by using condoms as the primary birth control strategy. However, this disempowered women from being in control of their own sexual and reproductive health in a situation where their health and wellbeing were at much higher risk with pregnancy than their partners and where they were more likely to face

coerced sex. In fact, men have no direct health risks when their partners are pregnant, so the relative risks of pregnancy are completely asymmetrical for men and women. Before the advent of the pill, women had to trust their sexual and romantic partners in a situation where they were particularly vulnerable, which raised the stakes for trust in their relationships. They had to trust that their partners were actually using condoms and that they were using them consistently and correctly. Using the birth control pill changes these dynamics by rebalancing vulnerabilities and redirecting the flow of trust between partners; women are empowered by the pill to be in control of their own sexual and reproductive health and the dynamics in their sexual and romantic relationships with men change because they are now in control of contraception (Chiappori & Oreffice, 2008). Furthermore, women have to trust the doctors, nurses, pharmacists, and other healthcare providers who help them decide on their birth control strategy, whether it is the birth control pill, an intrauterine device (IUD), or condoms, and actually access these strategies. Although the use of the birth control pill among women involves issues that are relevantly different than those involved when MSM use PrEP as HIV prevention, especially the gendered dynamics between heterosexual partners, the birth control pill still sets a precedent for how new medical technologies can redirect the flow of trust in sexual and romantic relationships and rebalance vulnerabilities between different kinds of partners.

3.2. Trust Between MSM: Sex and Relationships

MSM place trust in each other when we have sex and when we build sexual and romantic relationships with each other because these relationships involve intimacy and, therefore, various forms of physical, emotional, and personal vulnerability to harm. This trust often involves the kinds of HIV prevention strategies we use, including either PrEP or condoms. PrEP, in particular, affects the trust in our sexual and romantic relationships by allowing us to use an HIV prevention strategy other than condoms, which were the primary HIV prevention strategy for decades, and by allowing us to build and maintain relationships with each other regardless of our serostatus or the serostatus of our partners. Since MSM who are HIV-negative and who use PrEP as HIV prevention can have sex, including condomless or bareback sex, with partners who are HIV-positive, HIV-negative or who don’t even know their serostatus relatively safely and easily, we have to trust ourselves and our partners to actually use PrEP and to use it consistently and

correctly.[16] The dominant paradigm of trust helps us understand how MSM trust each other, especially in terms of sex and HIV prevention, how using PrEP as HIV prevention affects this trust between us, and why it is important to consider trust when thinking about the effectiveness of PrEP as HIV prevention among MSM in relationships today.

MSM actually face various barriers to trust in our relationships that have been created by histories of both homophobia and HIV/AIDS in North America, including practices of secrecy, lying, anonymity, closets, and fears of disclosure. We have had to hide our sexualities and our serostatuses from family, friends, healthcare providers, and governments in order to avoid violence and discrimination. This has negatively affected the kinds of trust that we place in others and the kinds of trust that they place in us, which sometimes creates a culture of distrust between MSM and others in society. However, MSM have also developed strong practices of trust, honesty, and solidarity among ourselves, which emerged in MSM sexual and romantic communities because of these threats to our safety and security. For example, trust is involved in cruising or having sex in public bathrooms, parks, and clubs, sharing secret codes and signs with each other, like the hanky code which uses different colours of handkerchiefs or bandanas to indicate sexual preferences and fetishes, knowing the locations of gay bars and bathhouses, arranging private parties when there are no bars or bathhouses, and recognizing when to publicly display affection, especially when the risks of doing these things involve death, violence, arrest, infamy, or shame. Although PrEP changes the dynamics of trust around HIV prevention for MSM, these histories of trust and distrust already affect our sexual and romantic relationships in many ways.

I consider trust in sexual and romantic relationships separately in this chapter. First, I consider trust in sexual relationships, which I mean to refer to any relationships that are primarily sexual, including hookups, one night stands, friends with benefits, sex buddies, boyfriends, partners, etc.[17] The trust in these relationships often centres on sexual health and intimacy and includes physical vulnerabilities like HIV transmission as well as other emotional vulnerabilities

[16] Since I focus on a relational analysis of the ethics of PrEP centreing on the interpersonal relationships of MSM, I will not explicitly consider self-trust here. Nevertheless, MSM have to trust ourselves that we are actually going to use PrEP correctly and consistently. Self-trust is modelled on interpersonal, or relational, trust and it has interesting effects on self-perception and self-identity, especially when it comes to MSM trusting ourselves with different HIV prevention strategies and within different kinds of relationships (Govier, 1993; Lehrer, 1997; Foley, 2001; McLeod, 2002; Goering, 2009; Jones 2012; Potter, 2013).

[17] I do not address paid sexual relationships, male sex workers or transactional sex here because many of the specific issues involved in PrEP use in these circumstances and by these individuals and communities are beyond the scope of this project. However, there is a growing body of literature in these areas of PrEP research that takes into account these specific issues (Beillo et al., 2016; Underhill et al., 2018; MacGibbon et al., 2020).

related to intimacy. Second, I consider trust in romantic relationships, which I mean to refer to relationships that not only involve sex, but also involve qualities like commitment, honesty, love, mutual care, attention, and affection, regardless of whether the relationships are long-term, short-term, open, closed, dyadic, non-dyadic, monogamous, non-monogamous or polyamorous or whether or not partners use labels like boyfriends or partners. The trust in these broadly romantic relationships centres on things like relationship satisfaction, relationship quality or functioning as well as open communication in addition to things like sexual health and intimacy, including vulnerabilities around HIV and emotional vulnerabilities like infidelity.

3.2.1. Trust in Sexual Relationships: Self-Interest

When MSM have sex or when we build primarily sexual relationships with each other, we have to trust each other and we are vulnerable to each other in various ways, but unlike the vulnerability inherent in any experience sex, ours always involves at least some risk of HIV. Therefore, the kinds of HIV prevention strategies that we use determine how exactly we trust each other and how exactly we are vulnerable to each other. For example, monogamy can actually be a kind of HIV prevention strategy, one in which trust is very important and partners are especially vulnerable to each other because they often have no backup strategies, like PrEP or condoms. In monogamous relationships, both partners can go for HIV testing and if they are both HIV-negative and they only have sex with each other, then their relationship structure acts as a perfectly effective HIV prevention strategy. However, this strategy relies entirely on each partner's promises to the other and their accounts of their own behaviour; they have to trust each other completely, especially if they have no backup strategies. I compare and contrast the use of condoms and PrEP here because, besides abstinence, they are the two most effective and most prevalent HIV prevention strategies used by MSM today, including MSM in monogamous relationships, and I consider how each of them affects the trust in our relationships.

First, when we use condoms, receptive partners or bottoms have to trust insertive partners or tops to use them correctly and consistently. This is analogous to the asymmetrical situations that women face when having sex with men if condoms are the preferred method of birth control. In a similar way, condoms disempower bottoms because tops are in control for using them. Although responsibility for condom use is shared by tops and bottoms because both are usually interested in

HIV prevention, since tops actually control condom use, they have greater responsibility for providing them, initiating their use, monitoring them, and disposing of them, especially since bottoms are more vulnerable during sex. Bottoms are at much higher risk for HIV than tops because of the relative opportunities for infection; again, bottoms are actually 13 times more likely to contract HIV through sex than tops (CDC, 2019). When bottoms trust tops to use condoms, they are in a much more vulnerable position and it is a position in which they have even less control over their sexual health. They are not only physically or physiologically vulnerable though. Many cultural histories and practices are tied to insertive and receptive roles for all different kinds of partners, including MSM and heterosexual partners, which play a role in how partners trust each other. Insertive partners culturally have more power, so receptive partners often face other social and identity-based vulnerabilities before, during, and after sex. Since condomless sex is still very popular and prevalent among MSM in North America today, there are also reasons for us to not always trust that our partners will use condoms consistently and correctly during sex (Paz-Bailey et al., 2016; MacGibbon et al., 2020).

Again, condoms are only 70% effective as HIV prevention for MSM and only 16% of MSM actually use them correctly and consistently during sex (Greene et al., 2014; Smith et al., 2015). This decrease in condom use stems from the fact the condoms decrease pleasure and intimacy, they are coitally dependent, and they are sometimes a source of shame for some MSM as I mentioned previously in Chapter 1. However, the fact that condoms are coitally dependent is especially important when discussing trust and vulnerability because using condoms as HIV prevention during sex is the moment when our sexual partners might not do the thing that we trust them to do. Although it is sometimes difficult to initiate condom use during sex because sexual partners are in the heat of the moment and our judgment is not always clear, we still have to trust either ourselves or our partners to use condoms if it is clear that any of the parties are not interested in having condomless sex. While some MSM simply forget to use condoms, others actively avoid using condoms in order to not ruin the moment or in order to fulfill their desires for condomless sex and this can lead to a betrayal of trust between sexual partners even if the motivation is not clear or it is not clear that our sexual partners are intentionally betraying us.

Another serious problem with bareback sex when it comes to trusting our sexual partners is that many MSM do not actually know our serostatuses accurately (CDC, 2019). Even if we go for HIV testing regularly in either the recommended 3 or 6-month intervals, depending on the kinds of

tests that are administered by our healthcare providers, their accuracy, and window periods in infection, it is possible that we could be HIV-positive for a while without knowing it. Whether we can reasonably expect even relatively trustworthy people to be so diligent with HIV testing given all of its uncertainty is a difficult question and reminiscent of the uncertainty around COVID-19 testing that is so prevalent today. During this time of uncertainty, people could be putting their sexual partners at risk for HIV, especially if they have bareback sex, so we not only have to trust that our sexual partners are going for HIV testing, but we also have to trust that they are using appropriate HIV prevention strategies with their other sexual partners given the information they have about their serostatus. This seriously complicates the trust we place in them because it is sometimes unclear whether we have good reasons to trust them since they might not even know certain information about themselves. So, even when sexual partners who believe that they are HIV-negative have bareback sex, there is still some risk of HIV transmission. Therefore, MSM often use HIV prevention strategies besides condoms, including limiting our sexual partners to those we trust the most and practicing seropositioning or strategically positioning ourselves as tops instead of bottoms as well as other strategies for reducing our risk of HIV like pulling out before ejaculating, opting for oral sex instead of anal sex, and not swallowing semen during oral sex among others (Chambers, 1994; Paz-Bailey et al., 2016).

When we are deciding whether to have sex with someone, MSM have to ask ourselves the following kinds of questions: Do I have sex with this person based on their serostatus? Do I trust this person to disclose their serostatus and sexual history? Do I trust this person to use HIV treatment or go for HIV testing? Do I think this person is trustworthy? What kind of sex do I have with this person? What kind of relationship do I have with this person? What kind of HIV prevention strategies do I use with this person? Do I trust this person to have the initiative to use a condom during sex? If this person says they are using PrEP, do I trust that they are using it consistently and correctly? Although it is important to ask ourselves these self-reflective questions about our sexual partners and our assessments of their trustworthiness, we also have to actually ask our sexual partners questions before, during, and after sex about their serostatus, their sexual history, their sexual practices, preferences, and relationships, their HIV testing habits, and their HIV prevention strategies. The conversations that we have with our sexual partners can be awkward because they are about intimate details that we are not used to sharing with others, but

these conversations are necessary for building trust; interpersonal trust is built through our conversations with others and our actions towards each other.

Second, PrEP is the most recent alternative HIV prevention strategy to condoms and it is also the most effective at preventing HIV transmission for MSM when adherence is high (Hodson, 2018). When we use PrEP as HIV prevention instead of condoms, however, the dynamics in our sexual relationships change when it comes to trust and vulnerability. For example, if bottoms use PrEP as HIV prevention, then they become less vulnerable and more in control of their sexual health, like women do, vis a vis pregnancy, when they use the birth control pill as contraception. Bottoms do not have to trust tops to be responsible for their HIV prevention and tops do not have to be held responsible for it either. If bottoms are using PrEP as HIV prevention, then they can actually be responsible for their sexual health as well as the sexual health of their partners. In the same way that the responsibility for contraception switched from men to women in heterosexual relationships with the introduction of the birth control pill, PrEP changes who is responsible for HIV prevention among MSM. However, unlike the asymmetric power dynamics between heterosexual men and women because of the pill, where partners are forced to trust each other, PrEP allows for symmetric power dynamics between MSM because either tops or bottoms can use it and either of them can be responsible for HIV prevention without having to be forced to trust each other. This means that MSM have a unique opportunity for trusting sexual relationships where partners have relatively equal power when it comes to practicing safe sex and where partners have to create the same kinds of conditions for trust for each other: conditions that do not have to specifically address an imbalance of power, which can sometimes be a barrier to trusting relationships.

Another example of a similar kind of prevention strategy is the practice of using face masks during the present COVID-19 pandemic. Whether or not someone actually has the coronavirus, if we all wear face masks, then we don't have to worry as much about its transmission because we are preventing its spread through respiratory droplets in the air. The crucial fact that PrEP is not coitally dependent means that MSM do not face a specific moment where we have to trust our sexual partners. Instead, we have to trust that our partners are taking PrEP and that they are taking it consistently and correctly because adherence is important for its effectiveness (Haire, 2015, p. 242). Since we do not usually see each other taking PrEP, trusting each other to take it is very different than trusting each other to use condoms because instead of determining whether our

partners will take initiative during sex in the heat of the moment, we have to determine whether our partners will keep to the daily PrEP schedule, which requires different kinds of character traits and skills, like punctuality and consistency.

Furthermore, although some MSM see PrEP use as allowing them to have bareback sex, others use both PrEP and condoms because of the meaning of bareback sex for many of us. For example, when Matt Cain (2017) started using PrEP, he also started having bareback sex, but one of his sexual partners refused saying, "it would feel as if we were rushing into the intimate stages of a trusting relationship to have condom-less sex straightaway". This example demonstrates that bareback sex has come to culturally and historically represent a particular kind of intimacy for MSM, especially after the AIDS epidemic. Since bareback sex involves a very high risk of HIV, MSM really have to trust our sexual partners in order to safely engage in the practice today. PrEP, however, changes the conditions for this trust because it allows us to more easily have bareback sex with each other, which is something that used to happen primarily within trusted, long-term relationships for many MSM. Instead, PrEP allows for a kind of trust and intimacy that used to, and still usually does, take a much longer time to build with our sexual partners. Therefore, depending on how sexual partners view PrEP, it will actually allow for different kinds of sexual practices and relationships.

It is helpful here to consider three different kinds of sexual relationships where PrEP use as HIV prevention is possible and where it changes the dynamics of trust in relationships. First, in serosame relationships where HIV-negative partners are all using PrEP, sexual partners share the responsibility for HIV prevention.[18] Instead of the asymmetrical responsibility involved in condom use, this kind of sexual relationship is symmetrical and all of the partners are trusting each other to do the same thing, which is to take PrEP consistently and correctly. This kind of shared responsibility might also have benefits for partners in these relationships because not only are they all equally vulnerable to betrayal, but they also have greater protection from HIV as long as some partners are using PrEP consistently and correctly even if others have poor adherence. Second, in serosame relationships where only some HIV-negative partners are using PrEP, they are simply

[18] Although the literature usually refers to relationships in which all partners are HIV-positive as "seroconcordant" relationships and relationships in which at least one partner is HIV-positive and at least one partner is HIV-negative as "serodiscordant" relationships, I refer to these relationships as "serosame" relationships and "serodifferent" relationships". I find that the terms "seroconcordant" and "serodiscordant" suggest that these relationships are either harmonious or not and imply that "seroconcordant" relationships are better then "serodiscordant" relationships, whereas the terms "serosame" and "serodifferent" are more neutral because they suggest that these relationships are simply different and do not imply that either is better.

replicating the kind of asymmetrical responsibility involved in condom use. Although any PrEP use in a relationship allows partners to have bareback sex more safely and easily, those using PrEP are now responsible for HIV prevention unless they are also using condoms. If partners are having bareback sex, then those who are not using PrEP have to trust that the partners who are using it to do so consistently and correctly. Third, PrEP is usually thought to be especially beneficial in serodifferent relationships, but if HIV-positive partners in a serodifferent relationship use treatment as prevention (TasP), then it is actually sufficient to eliminate the risk of HIV transmission. However, this places the responsibility for HIV prevention in the hands of HIV-positive partners and results in another asymmetrical relationship in terms of both risk and trust since HIV-negative partners are not only vulnerable to HIV transmission, but they also have to trust HIV-positive partners to maintain an undetectable and untransmittable viral load. Although HIV-negative partners are more physically or physiologically vulnerable in this particular situation, HIV-positive partners are often more vulnerable in the relationship and society more broadly, given the widespread stigma and prejudice around HIV. The trust in serodifferent relationships may be affected by all of these different kinds of vulnerabilities. In order to share the responsibility for HIV prevention in these relationships and balance some of these vulnerabilities, HIV-negative partners can take PrEP to not only help reduce the risk of HIV transmission, but also establish a more symmetrical trusting relationship in terms of HIV prevention, stigma, and prejudice.

According to the different views of trust, the kind of trust that sexual partners place in each other when using PrEP as HIV prevention are explained differently. Overall, sexual partners are certainly vulnerable to each other in terms of their sexual health, especially in terms of HIV, but also in terms of other STIs as well as sexual intimacy. Ideally, sexual partners respect and think well of each other, at least in some domains, and they are probably optimistic about each other's competence to do the things that they trust each other to do, like use different HIV prevention strategies, given that they are already agreeing to have sex with each other. However, it is not always clear what the motivation is for sexual partners to actually be trustworthy and each philosophical view of trust, the risk-assessment views, the will-based views, and the virtue views, explains this motivation differently.

The risk-assessment views focus on self-interest as the motivation for trustworthiness, but it's not clear that using an HIV prevention strategy is always in one's self-interest. For example, tops who are responsible for using condoms might not do so because they have less risk for HIV

than bottoms or they might be more interested in having bareback sex than protecting their sexual health or the sexual health of their partners. However, using PrEP seems to be precisely in your self-interest regardless of whether you are a top or bottom because it reduces your risk for HIV, unless you are relying on your partners to be responsible for sexual health. Since MSM have varying attitudes towards the risks involved in sex, assessments of risk really depend on how you value the goods associated with barebacking. Depending on whether or not you think that the benefits of barebacking outweigh the harms, you will assess the risk of HIV differently and make different decisions about PrEP as HIV prevention. Moreover, MSM sometimes use something precisely like a social contract to motivate trustworthiness by displaying our HIV prevention strategies and sexual preferences on hookup apps or by discussing them with partners before sex. If MSM are interested in maintaining a relationship with a particular sexual partner, then the encapsulated interest view seems to explain the motivation for trustworthiness, but some sexual relationships, like hookups and one-night stands, are not usually the beginning of either long-term sexual or romantic relationships. Risk-assessment views seem to be especially well-suited to describe trust in casual sexual relationships because they do not rely on partners having long-term relationships or caring about each other in order to motivate their trustworthiness. Although some sexual relationships are caring, long-term relationships, I take the main difference between sexual and romantic relationships to be that qualities of commitment, honesty, love, mutual care, attention, and affection are usually more common in romantic relationships. Therefore, self-interest is a really good motivation to be trustworthy if these qualities are not present in a relationship because self-interest is not based on our attitudes towards others.

The will-based views and the virtue views, however, describe the motivation for trustworthiness very differently because they are both based precisely on our attitudes towards others. The will-based views focus on goodwill as the motivation for trustworthiness, but some of our sexual partners are strangers with neither goodwill nor ill will towards us, so these views seem to have limited explanatory power for how PrEP use effects trust in primarily sexual relationships, especially those relationships that do not develop into more long-term or committed romantic relationships. These views seem to better describe trust between romantic partners or partners who have more long-term or caring relationships because they seem to say that short-term relationships that do not involve goodwill are simply not trusting relationships. Although we usually refer to trust in even short-term or casual relationships, the will-based views seem to reserve trust for more

well-developed relationships. Nevertheless, many sexual partners seem to have at least some goodwill towards each other because they have decided to at least have an intimate and vulnerable experience with each other. Whether or not sexual partners have goodwill towards each other, will-based views do not seem like the best views to describe the motivation for finding sexual partners trustworthy because they do not account for different kinds of, especially casual or short-term, sexual relationships.

Likewise, the virtue views, which focus on trustworthiness as a virtue, also do not really explain the motivation for being trustworthy towards our sexual partners, especially casual sexual partners, either. Although being virtuous is motivated by the desire to be a good person, virtue ethics frameworks often focus on the power of personal relationships to motivate us to be virtuous, including being trustworthy. In sexual relationships, however, especially casual sexual relationships, partners might not be properly motivated to be virtuous without a strong connection to each other. Therefore, virtue views also seem to better describe trust between romantic partners because they tend to have more caring, long-term relationships. According to virtue views, more casual, short-term relationships are probably not trusting relationships, even though we usually refer to trust between even casual sexual partners in terms of safe sex. Thus, thinking of trustworthiness as a virtue in this particular context is not especially helpful for understanding how MSM are actually motivated to be trustworthy or how PrEP really affects the trust of MSM in especially casual sexual relationships because it does not seem to highlight the specific dynamics of primarily sexual relationships beyond a broader framework of virtue ethics. Overall, the risk-assessment views seem to better describe trust between primarily sexual partners than either the will-based views or the virtues views because self-interest as the motivation for trustworthiness is especially helpful for understanding sexual relationships.

Finally, in order to demonstrate the importance of viewing the ethics of PrEP through the lens of trust, it is important to consider the value of trust in sexual relationships and how using PrEP not only affects that value, but also illuminates moral demands, like responsibilities for actually creating conditions for trust between partners. Although trusting each other in sexual relationships involves several vulnerabilities for MSM, the resulting trusting relationships are really valuable to us because they make sex possible and sex is an important social good for many of us. We have to trust our sexual partners in order to have sex with them relatively safely and comfortably even if it means risking HIV transmission, but PrEP reduces the risk of HIV

transmission and it also reduces stress and anxiety around sex for many MSM, even if it does not always increase sexual esteem or satisfaction (Whitfield et al., 2019). This reduced risk for HIV and this reduced sexual anxiety because of PrEP might even have other positive effects on our sexual relationships by lowering the stakes for trusting our sexual partners; if we don't have to worry that their betrayal will result in HIV transmission, then maybe we can think more positively about our sexual partners and be more comfortable engaging in various kinds of sexual practices and relationships with them. Although we are all responsible for creating the conditions for trust in our relationships in many different ways, PrEP helps MSM establish such conditions in our sexual relationships by first and foremost preventing HIV, which removes an important barrier to more trusting relationships for us. It is by focusing on the concept of trust that we come to realize how much PrEP really affects the sexual lives of MSM; PrEP not only reduces our risk for HIV and protects our sexual health, but it also allows us to cultivate more trusting relationships with our sexual partners. Most importantly, PrEP changes the trust in our sexual relationships by shifting HIV prevention away from coitally dependent condoms and by balancing the responsibility for HIV prevention between tops and bottoms as well as different configurations of sexual partners based on serostatus and preferences in sexual practices and HIV prevention strategies. Therefore, despite the risks and vulnerabilities that we face in our sexual relationships, PrEP actually facilitates trust and allows us to more safely and easily build sexual relationships with each other. Sexual relationships are clearly very important for many of us because they are a significant source of fun, intimacy, satisfaction, and sometimes even love and support when they develop into either friendships or romantic relationships. Romantic relationships, however, are relevantly different than sexual relationships when it comes to PrEP and trust because they involve different kinds of vulnerabilities and values.

3.2.2. Trust in Romantic Relationships: Goodwill and Virtue

When MSM build and maintain romantic relationships with each other, we have to carefully and deliberately cultivate trust around HIV prevention, whether it is PrEP or condoms. Since I refer to romantic relationships as relationships that are also sexual relationships because of my focus on HIV prevention, the dynamics of trust and vulnerability that I discussed in the previous section apply here as well. Nevertheless, it is important to consider some of the

differences in trust and vulnerability that arise when sexual partners commit to building and maintaining romantic relationships or friendships and how these differences change our perceptions of PrEP. These differences depend crucially on the kinds of relationship structures that MSM choose for ourselves, including whether our relationships are closed or open and whether our relationships are dyadic or non-dyadic. First, I refer to closed relationships as relationships where main partners only have sex with each other and open relationships as relationships where main partners in either monogamous or polyamorous relationships not only have sex with each other, but also have sex with other partners, including casual partners. Since having sex with multiple casual partners involves more chances for HIV transmission than having sex with only main partners, open relationships often involve a higher risk for HIV than closed relationships and, therefore, PrEP is often especially important for MSM in open relationships. PrEP use actually makes open relationships more realistic because it reduces the risk of HIV when partners have sex with casual sexual partners and it alleviates stress and anxiety around having sex with casual partners. Since open relationships are often more trusting relationships because partners are already navigating sex with others, the foundations of trust that are necessary for PrEP use are also often already there. Although partners in open relationships do not have to trust that their partners will exercise good judgment in choosing casual partners or deciding on various sexual practices as much if they are using PrEP, they still have to trust that their partners are actually using PrEP correctly and consistently and operating responsibly under their new shared paradigm of safe sex.

Nevertheless, PrEP is also an option in closed relationships because they always involve the risk of infidelity, including at least some risk for HIV if a partner cheats. PrEP use in closed relationships takes on a very different meaning than in open relationships though. For example, it might actually indicate infidelity or mistrust in a relationship by communicating to main partners that you are either interested in having sex with other partners or that you do not trust your main partners to not cheat on you (Bosco et al., 2019, p. 8). Although closed relationships are seemingly the norm in North America with the widespread popularity of monogamy, open relationships remain very popular among MSM, which is one of the reasons that HIV prevention continues to be so important for us today (Levine, 2018; Stults, 2019). In fact, monogamy is more than just popular in North America, it is actually the norm for romantic relationships, (Shotwell, 2017; Jenkins, 2017), including the romantic relationships among MSM, and it is enforced along the same lines of compulsory heterosexuality (Rich, 1980). Therefore, even though MSM are more likely to be in

open relationships, many of us still experience judgment, stigma, and shaming from others in society because of our non-monogamy, which in turn affects our attitudes towards how open we are with our relationships, whether we disclose our relationship structures to others, and our capacity for trust in our relationships.

Second, whether relationships are dyadic or non-dyadic is another important distinction to consider with respect to PrEP. Dyadic relationships are relationships between only two people whereas non-dyadic relationships are relationships between more than two people. Despite the prevalence of monogamous relationships in North America, I do not assume that any sexual or romantic relationships are monogamous, closed or dyadic. Therefore, it is important to consider the relative risks and vulnerabilities of dyadic and non-dyadic relationships. In dyadic relationships, since there are only two partners, the risk of HIV for MSM is often lower than non-dyadic relationships because there are simply fewer opportunities for HIV transmission, even if the dyadic relationship is open or one of the partners cheats in a closed relationship. Since there are more than two partners in non-dyadic relationships, there are also sometimes more opportunities for HIV transmission, especially if the relationship is open or any of the partners cheats in a closed relationship. Nevertheless, non-dyadic relationships can be structured in many different ways, including having different numbers of partners in the relationships (e.g. triads or thruples), having different hierarchies among partners (i.e. primary partners and secondary partners), and involving partners of different genders or sexual orientations. Since non-dyadic relationships, as well as dyadic relationships, can be either open or closed relationships, the risk of HIV for MSM in these relationships depends much more on whether they are open or closed relationships because of the opportunities for HIV transmission involved in having sex with partners outside the relationships. Overall, both open and closed relationships as well as non-dyadic and dyadic relationships can be structured in different ways depending on the interests, preferences, and desires of the partners; the partners in any of these different kinds of relationships have to communicate with each other and develop their own rules for their relationships, including rules around sex and HIV prevention both inside and outside the relationships. It is precisely these rules that establish how PrEP affects the trust between partners in romantic relationships.

Therefore, it is helpful to consider two more kinds of romantic relationships where PrEP use as HIV prevention is possible and where it changes the dynamics of trust in the relationships: monogamous or closed polyamorous relationships and open dyadic or polyamorous relationships.

First, monogamous relationships, which are both closed and dyadic, seem to be the most widespread romantic relationships in North America. Monogamous relationships are contrasted with non-monogamous relationships, including open relationships and polyamorous relationships, which involve multiple partners and many different kinds of specific relationship agreements (Brunning, 2016; Jenkins, 2015; Jenkins, 2017). Closed polyamorous relationships, in particular, are relevantly similar to monogamous relationships in terms of vulnerabilities for HIV among MSM. If all partners in a relationship are either HIV-positive or HIV-negative and they only have sex with each other, then there is no risk of HIV transmission even without the use of any HIV prevention strategies. Monogamous relationships are even sometimes specifically encouraged as a strategy for HIV prevention for MSM because having only one partner often means there are even fewer opportunities for HIV transmission (CDC, 2020).

Although PrEP is usually recommended specifically for MSM in serodifferent relationships and open relationships because of their higher risk for HIV, 35% to 68% of HIV transmissions among MSM actually happen in the context of different kinds of long-term romantic relationships, so even romantic partners in monogamous and closed polyamorous relationships would sometimes seem to benefit from using PrEP as HIV prevention (Bosco et al., 2019, p. 1). However, MSM in monogamous relationships, for example, often "avoid initiating a PrEP-related conversation with their partner as it might incite negative connotations related to betrayal, infidelity, mistrust, and sexual promiscuity" (Bosco et al., 2019, p. 3). They might worry that PrEP use will negatively affect the functioning of their relationships, including the trust in their relationships, by signaling to their partners that they are interested in either breaking or changing the rules of their relationship in order to have sex with casual partners. Nevertheless, discussing PrEP, and using it as HIV prevention, might actually enhance both their sexual health and their sexual satisfaction by reducing anxiety around HIV transmission through sex, enhancing the effectiveness of their HIV prevention, and allowing for different kinds of sexual practices with their partners (Bosco et al., 2019, p. 9). The challenge for MSM in monogamous and closed polyamorous relationships is to be able to discuss PrEP without seeing its use as a trade-off between relationship quality and sexual safety. This involves establishing the conditions for trust in our relationships, including open communication about sex and HIV prevention that challenges stigmas like serophobia and allows MSM to discuss our sexual and romantic desires and practices more openly with our partners. Partners need to be able to trust each other enough and feel comfortable enough with each other to

express their desires and describe their practices in order for PrEP to be effective as an HIV prevention strategy and the opportunity that PrEP presents for these kinds of conversations actually enables us to continue building greater trust in our sexual and romantic relationships.

Second, although MSM in open dyadic relationships obviously benefit from using PrEP as HIV prevention, we also often find it difficult to discuss it with our partners for the same reasons as MSM in monogamous and closed polyamorous relationships (Bosco et al., 2019, p. 7). The perception of a trade-off between relationship quality and sexual safety sometimes deters even MSM in open relationships from having conversations about PrEP despite its benefits. This clearly demonstrates the high value that we place on trust in our romantic relationships because it seems as though we are sometimes willing to sacrifice our sexual health in order to be, or at least appear to be, trustworthy. However, MSM in open dyadic relationships also have a greater incentive to discuss PrEP with our partners because we have more opportunities for HIV transmission and, therefore, a seemingly greater need for effective HIV prevention. Open dyadic relationships can be structured very differently though. Sometimes partners in open relationships only have sex with casual partners together, sometimes only one partner has casual sexual partners, and sometimes both partners have different casual sexual partners.

MSM also often use different HIV prevention strategies with main partners than we do with casual partners. For example, many MSM do not use condoms with main partners, but they do so with casual partners (MacGibbon et al., 2020, p. 1390). In this case, main partners have to trust each other that they are actually using condoms with casual partners. Since there are several problems with MSM using condoms as HIV prevention, including the facts that they are less effective for MSM and MSM are less likely to use them (Smith et al., 2015; (Greene et al., 2014), and many MSM engage in bareback sex regardless, PrEP is an important alternative for many of us. MSM in open dyadic relationships already have to trust each other enough to allow each other to have sex with casual partners, so PrEP is just another way to have sex safely, especially since MSM sometimes have bareback sex with casual partners regardless of their sexual agreements with their main partners (MacGibbon et al., 2020, p. 1395). Although many MSM worry about the impact of discussing PrEP on the quality of our relationships, it is still less difficult to discuss PrEP in open dyadic relationships because there is already a foundation of trust around having sex with casual partners, which requires difficult conversations between main partners about things like commitment, jealousy, and safety. This kind of open communication about difficult topics helps

create the conditions for even greater trust in these kinds of relationships. MSM in “monogamish” relationships, for example, are actually the most likely to be able to discuss PrEP with their partners and convince their partners to use it as HIV prevention, demonstrating the potential for open communication around both sex and HIV prevention to help improve the effectiveness of widespread PrEP use among MSM in North America (John et al., 2018).

Finally, the main difference between open dyadic relationships and open polyamorous relationships is the number of partners involved in the relationships and the increased risk for HIV when there are more main partners having sex with casual partners. Since there are even more opportunities for HIV transmission in open polyamorous relationships than in open dyadic relationships, partners in open polyamorous relationships have an even greater incentive to discuss PrEP with each other and an even greater need for effective HIV prevention. Such partners usually also have a strong foundation of trust because their relationships require conversations about having sex and using HIV prevention strategies with each other as well as casual partners. Whether or not this foundation actually helps MSM in open polyamorous relationships more easily discuss PrEP, it remains an example of the kind of conversations that are necessary in order to create the conditions for greater trust in romantic relationships and actually build greater trust between romantic partners around HIV prevention. MSM in open relationships have to be able to have difficult conversations with their romantic partners about what kind of sex they want to have with whom and what kind of HIV prevention strategies they want to use with different partners, weighing the risks and benefits of both condoms and PrEP. However, if PrEP is actually going to be effective as HIV prevention, then MSM really need to learn how to discuss it more openly with romantic partners, including both main partners and casual partners.

Although the previous HIV prevention paradigm, where main partners might not use condoms with each other but use condoms with casual partners, seems to be changing with the simultaneous increase in PrEP use and decrease in condom use, MSM need to be able to discuss our relationship agreements involving both casual sex and condomless sex with our romantic partners (MacGibbon, 2020). Even if MSM do not have specific relationship agreements or even if we violate our relationship agreements by having condomless sex with casual partners, using PrEP as HIV prevention still protects our sexual health and the sexual health of our partners. Normalizing conversations about PrEP between romantic partners and creating the conditions for trust that are necessary for these kinds of conversations are two important ways of ensuring that

PrEP is actually successful as effective and widespread HIV prevention among MSM in North America and that MSM are attentive to its broader social and political effects on our relationships (John et al., 2018). In fact, “one study found that men in relationships thought that PrEP might enable more open communication about risk, which may lead to sexual agreements that foster safety as well as sexual and emotional needs more clearly”, demonstrating some of its possibilities for actually improving our sexual and romantic relationships in other ways (MacGibbon, 2020, p. 1390; Malone et al., 2018).

MSM need several things to be in place, however, in order to help normalize conversations about PrEP, including social scripts that make these conversations easier between partners and encouragement from partners, friends, and healthcare providers to actually engage in these kinds of conversations. Although there are already public service advertisements and posters in gay bars, bathhouses, community centres, and clinics about PrEP, we need these resources to go further and focus on the communication skills necessary for effective PrEP use among MSM in different kinds of sexual and romantic relationships. Furthermore, role models in gay communities need to speak out to help foster a culture of open communication around PrEP. Even memes, hashtags, and storylines in film and television could help MSM become more familiar with these kinds of conversations and the skills necessary for having them successfully. Many of these same factors have helped conversations about sexual consent evolve over the last few decades from “no means no” to “yes means yes” and we have the skills to discuss consent more accurately today (Mettler, 2018). In order for MSM to enter conversations about PrEP more comfortably, we need a shared background of trust with our partners, friends, and even healthcare providers. This requires addressing homophobia in society more broadly and serophobia within gay communities in order to create new attitudes and cultures of openness around not only sex, HIV, and HIV prevention, but also PrEP as an HIV prevention strategy with unique social and political dimensions for MSM in North America.

Again, each of the different views of trust explains the kind of trust that romantic partners place in each other with PrEP differently. Romantic partners are as vulnerable to each other in terms of their sexual health and sexual intimacy as sexual partners, but they are also vulnerable to each other in terms of emotional health and wellbeing. Romantic partners usually already think very well of each other and they are certainly optimistic about each other’s competence to do the things that they trust each other to do or else they would probably not be in an intimate and

important relationship with each other. However, it is not always clear what the motivation is for romantic partners to be trustworthy according to the different views of trust. The risk-assessment views of trust focus on self-interest as the motivation for trustworthiness, which depends on either the social contract between romantic partners or whether each of their self-interest encapsulates the interests of their partners, but both of these options seem likely in the context of loving and trusting romantic relationships. Nevertheless, the risk-assessment views do not seem to offer a more nuanced explanation of trust between romantic partners that addresses the unique qualities of these relationships, like commitment, honesty or love, beyond the explanation based on self-interest that they provide for trust between sexual partners.

Both the will-based views and the virtue views, however, address these unique qualities of romantic relationships because instead of self-interest, these views are based on our attitudes towards others. Our positive attitudes towards our romantic partners are usually why we actually trust them with more than others in the first place. The will-based views of trust seem to work well for capturing trust in romantic relationships around PrEP because partners usually have goodwill towards each other and that goodwill would seem to easily motivate trustworthiness around safe sex. In especially long-term, caring relationships, mutual goodwill between romantic partners would seem to motivate them to protect each other's sexual health by using PrEP as HIV prevention. Likewise, the virtue views of trust would seem to capture the motivation for being trustworthy in romantic relationships around PrEP because romantic partners are often interested in improving themselves for the sake of their partners; romantic partners usually strive to be virtuous precisely in order to be a good partner and being trustworthy, including being trustworthy around safe sex practices like PrEP, is certainly one of the relevant virtues in striving to be a good partner. Therefore, both the will-based views and the virtue views of trust seem to offer more nuanced explanations of trust is romantic relationships that locate the motivation for trustworthiness in the typically positive attitudes of romantic partners towards each other.

Unfortunately, all of these explanations of the motivation for trustworthiness in romantic relationships fail if they are not really trusting or caring relationships. In caring relationships, romantic partners are attentive to each other's needs and they are concerned about each other and whether each other are accessing different kinds of goods, expressing their own agency, and living safely among other things. If romantic partners are abusive, or deceptive, or if the relationship is dysfunctional or unhealthy in other ways, then self-interest, goodwill or virtue might not be

motivating enough for partners to actually be trustworthy; according to all the different theories of trust, these kinds of partners are just not trustworthy. Baier (1986) even argues that "when the trust relationship itself is corrupt and perpetuates brutality, tyranny, or injustice, trusting may be silly self-exposure, and disappointing and betraying trust [...] may be not merely morally permissible but morally praiseworthy" (p. 253). This kind of misplaced trust might even explain why so many cases of HIV transmission among MSM happen in long-term romantic relationships: particular romantic partners are not always trustworthy or the trust romantic partners place in each other is not always warranted under the circumstances of their particular relationship. Since romantic partners are supposed to be trustworthy in at least certain domains relevant to such relationships and our trust in them is supposed to be warranted, according to the ways that romantic relationships are often presented in society as functional and healthy, MSM might sometimes be misplacing trust in our romantic partners around HIV prevention. Nevertheless, the importance of being able to trust our romantic partners demonstrates the broader value of trust in romantic relationships and how PrEP affects that value. Romantic relationships are important sources of love, support, intimacy, fun, and satisfaction and PrEP not only allows MSM to maintain our romantic relationships more safely and easily, but it also encourages us to communicate with each other about our sexual desires, sexual practices, relationship structures, relationship agreements, and HIV prevention strategies. This communication, which can be inspired by PrEP, is not only necessary in order for PrEP to actually be effective as widespread HIV prevention, but it is also beneficial for the broader sexual health and emotional wellbeing of MSM in relationships.

Trust in both sexual and romantic relationships among MSM also involves broader trust in gay communities beyond just interpersonal relationships between individual MSM. Since our sexual and romantic partners are actually members of our broader social and political communities, we also have to trust that our communities are open and safe places for us to discuss PrEP as HIV prevention and its effects on our lives. We have to trust that gay community members will support, or at least understand, our sexual desires and practices as well as our relationship structures and HIV prevention strategy preferences. It is this kind of support, and understanding, that can really help us establish the conditions for trust in our intimate relationships. Many gay community members are involved in MSM sexual health education and counselling either professionally as counsellors at gay community centers and healthcare providers at gay clinics or personally as friends and family members. This education and counselling has to go further than just including

PrEP as another possible HIV prevention strategy though. It has to acknowledge both the challenges and opportunities involved in having conversations about PrEP, by addressing stigmas like homophobia and serophobia and creating the conditions for trust in gay communities more broadly. MSM can more easily build trusting sexual and romantic relationships with each other if open and honest communication is encouraged by our communities. This especially includes healthcare providers, whether or not they are community members, because they are often the first people to discuss PrEP with us and they often give us our first impression of PrEP as an HIV prevention strategy. Therefore, in the following section, I focus specifically on trust between MSM and our healthcare providers in order to demonstrate how important it is to trust people with whom we discuss such intimate decisions about our health and wellbeing.

3.3. Trust Between MSM and Healthcare Providers: A History of Medicalization

Finally, MSM place trust in healthcare providers, including doctors, nurses, and pharmacists, when we consult them about PrEP and when they prescribe it to us because we have to disclose our sexual behaviour and sexual orientation to them in order to qualify for it. In order for there to be widespread uptake of PrEP among MSM and in order for it to actually be effective as HIV prevention for us, we have to be able to trust our doctors, nurses, and pharmacists. These healthcare providers have to not only understand PrEP as a relatively new medical technology and HIV prevention strategy, including its regimes, contraindications, and side-effects, but also understand our sexual practices and our sexual relationships in order to know whether PrEP is appropriate for us and how PrEP can actually be effective as HIV prevention for us in terms of our adherence and our relationship agreements with our partners. However, it is often difficult for us to trust healthcare providers with the intimate details of our sexual and emotional lives because they have not always historically treated us fairly in medical settings or respected our identities as gay, bisexual, and queer men. Although some healthcare providers might not respect our identities, many other healthcare providers are simply ignorant of, or know very little about, our sexual practices and relationships. Therefore, even well-intentioned healthcare providers who respect our identities might be uncomfortable with our disclosures and miss important information about which practices are being performed regularly with or without HIV prevention or which relationships entail certain practices. It is not only individual healthcare providers and our relationships with

them that are important here, but also our relationships with healthcare institutions themselves, which involve structural features like official forms, contact details, social categories, background histories, and testing methods that do not always fit the model for the practices, relationships, and lives of MSM.

Trust is important in all kinds of relationships between healthcare providers and their patients (Onora O'Neill, 2002), but there are special reasons to worry about the status of this trust for MSM. Trust between MSM and healthcare providers is specifically complicated by the history of the medicalization of homosexuality, first as a mental disorder and then in connection to HIV/AIDS. This medicalization of homosexuality followed its demonization by religion, especially Christianity in North America, and its criminalization in both Canadian and American law. Homosexuality was criminalized in North America until 1969 in Canada and 2003 in the United States nationally and it was even defined as a medical disorder in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) until 1973 (Carol, 2016; Spitzer, 1981). This long history of medicalizing homosexuality, including the ongoing practice of gay conversion therapy, already cultivated mistrust of healthcare providers among gay, bisexual, and queer men in North America (HRC, 2020). Although homosexuality was medicalized for a long time, there was a period when it was actually being demedicalized in the 1970s before the AIDS epidemic forced MSM, in particular, back into the clinic because we needed to regularly go for either HIV testing, HIV treatment or HIV prevention (Conrad & Angell, 2004; Wahlert, 2012). This return to the clinic, especially in terms of HIV prevention, demonstrates the wider medicalization of our sexuality as well as the ongoing emphasis on medicine in gay, bisexual, and queer men's lives (Giami & Perrey, 2012; Garry, 2001; Purdy, 2006). During the AIDS epidemic, MSM had to trust healthcare providers with their lives at a time when governments and other organizations were slow to respond to the crisis because of widespread homophobia, biphobia, and serophobia. Homophobia, biphobia, and serophobia remain widespread in society today and these prejudices are also certainly present in healthcare institutions. For example, Canadian Blood Services used to completely ban MSM from donating blood because of the lasting stigma from the AIDS epidemic and we are still only able to donate blood if we have not had sex with another man in the last 3 months (CBS, 2020a; CBS, 2020b). Healthcare institutions were also slow to approve research on HIV treatments in the 1980s and 1990s and they are slow at addressing problems of accessibility to HIV treatment and prevention

even today. Therefore, MSM are used to a fraught relationship with healthcare institutions as well as healthcare providers and this affects how we access PrEP and how effective it can really be for us as HIV prevention.

Institutional trust helps us understand how exactly MSM trust healthcare providers and healthcare institutions more broadly, especially given the history of medicalization. Although the dominant paradigm of trust is interpersonal, institutional trust refers to the ways in which individuals or communities trust the institutions that serve them. This trust in institutions is a kind of social trust, or public trust, that is affected by things like the present political climate or the present systems of oppression in a particular society (McLeod, 2015; Govier, 1997; Townley & Garfield, 2013). For example, "societies that are oppressive make it irrational in general for the people who are oppressed to trust those who oppress them" (Potter, 2015). Since healthcare institutions have contributed to the oppression of gay, bisexual, and queer men in the past, it is sometimes difficult for us to trust them now. Black, Indigenous, and Latino MSM might feel particularly mistrustful of healthcare institutions, which have also promoted racism and other forms of oppression that intersect with homophobia, biphobia, and serophobia. Although we are certainly vulnerable in our interactions with healthcare institutions, we also have to rely on them for things like access to PrEP as HIV prevention, which usually involves us either coming out as gay, bisexual, or queer or disclosing other intimate information to healthcare providers, opening up the possibility of experiencing homophobia, biphobia, or serophobia. If healthcare institutions want to restore our trust in them, then they have to indicate that they are actually trustworthy by demonstrating that they understand us, our sexual practices, and sexual and romantic relationships. However, the success of things like marketing campaigns and outreach programs geared towards MSM by healthcare institutions will not always be successful because many MSM, especially Black, Indigenous, and Latino men, face several forms of oppression in medical settings. Therefore, depending on the political climate in Canada and the United States, it might not even be prudent for MSM to always trust healthcare institutions (McLeod, 2015). For MSM who have already experienced homophobia, biphobia, serophobia, transphobia or racism in healthcare, it might be even more difficult to trust healthcare institutions.

Whether or not MSM really trust healthcare institutions, we still have to trust individual healthcare providers who are influenced by the histories of these institutions, having learned from them and worked in them. It is crucial that we feel like we can trust our doctors, nurses, and

pharmacists with PrEP in order for it to be effective as HIV prevention. For example, if your doctor recommends PrEP but you do not trust them, then you might not decide to start using it as HIV prevention even though it might be beneficial for you. However, it is more likely that MSM have to trust our doctors enough to either ask them for PrEP ourselves or disclose intimate information about our sexual practices and relationships to them. Asking your family doctor to prescribe PrEP, for example, might be difficult because you might not be out as gay, bisexual or queer to them or you might not feel comfortable disclosing information about your preference for bareback sex or your open relationship. Disclosing this kind of information makes you even more vulnerable in a situation where you are already vulnerable to HIV transmission and related stigmas. Your doctor might also not even know about PrEP or they might even object to its use as HIV prevention and refuse to prescribe it to you. These are all obstacles to accessing PrEP for MSM, but they are also some of the reasons for the advent of special PrEP clinics in cities across North America and healthcare organizations and pharmacies that specifically serve gay communities, like the PrEP Clinic in Ontario which operates across the province and provides free consultations and prescriptions (The PrEP Clinic, 2020). Nevertheless, MSM still have to trust the individual healthcare providers at these new institutions, who we consult about PrEP, who prescribe us PrEP, and who do our HIV testing, enough to share intimate information during our appointments with them. Therefore, interpersonal trust remains important even in institutional settings. MSM have to ask ourselves the following kind of questions during these appointments: do I trust this healthcare professional to not discriminate against me or judge my sexual practices and relationships? Do I feel comfortable disclosing my sexual orientation? Do I feel comfortable sharing my sexual history and relationship agreements? Do I trust this healthcare professional to know enough about PrEP and the experience of MSM with HIV prevention to understand my healthcare needs? We also have to actually ask our healthcare providers questions and answer their questions when we have conversations with them about PrEP, but this can be especially difficult given the imbalance of power dynamics between providers and patients in the clinic.

The fact that MSM sometimes have no choice but to trust healthcare providers is what leads to this kind of power imbalance between them. According to the will-based views of trust, for example, MSM have to rely on the goodwill of our healthcare providers because we need them to prescribe us PrEP, but they do not have to rely on our goodwill because they do not really need anything from us. Moreover, it is especially difficult for some MSM to trust healthcare providers

because we have an attitude of mistrust towards healthcare institutions more broadly because of their history of homophobia, biphobia, serophobia, transphobia, and racism. In many cases, MSM have to trust healthcare providers when we should not trust them, when we do not find them to be trustworthy or when we do not find them to behave in trustworthy ways. Nevertheless, Baier (1986) explains that even in situations where we trust people whom we should not trust, "trusting can continue to be rational, even when there are such unwelcome suspicions, as long as the truster is confident that in the conflict of motives within the trusted the subversive motives will lose to the conformist motive" (p. 254). In other words, MSM have to be confident that even though healthcare providers might be homophobic, biphobic, serophobic, transphobic or racist, these prejudices will be overcome by their dedication to being good doctors, nurses, and pharmacists. According to the virtue views of trust, it is precisely their dedication to being good healthcare providers that motivates them to be trustworthy, especially towards their patients. Baier (2007), writing about virtues, highlights what she calls Aesculapian virtues, or the virtues that we expect from trustworthy healthcare providers, which include "due awareness of the power discrepancy that the doctor-patient relationship involves, the will to communicate appropriately with the patient, and to take timely action of various sorts" (p. 135). If healthcare providers actually espoused these virtues, then MSM would not have to worry about misplaced trust, but this is still not always the case in North America today.

Access to PrEP from healthcare providers is also a problem for many MSM in North America, but since stigma and shame are present in medical settings, they actually amplify the problem of accessibility, echoing the kinds of stigma and shame that MSM feel from within gay communities and from society more broadly and the effects they have on the uptake and use of PrEP as HIV prevention. MSM worry that healthcare providers will stigmatize or shame us for our sexual practices and relationships when we ask for PrEP and we also worry about actually finding healthcare providers who are knowledgeable about PrEP as well as our experiences as gay, bisexual, and queer men (Bosco et al., 2019, p. 10). There are healthcare guidelines on PrEP as HIV prevention for doctors, nurses, and pharmacists, but many still do not know these guidelines well because of either prejudice, ignorance or hesitance to engage in difficult conversations about sexual practices and relationships with their patients (Planned Parenthood, 2020; CDC, 2015). Healthcare providers need to know enough about PrEP medically, socially, and politically in order to be able to help MSM with our HIV prevention strategy decisions. Since PrEP is a prescription,

healthcare providers are necessarily inserted into the romantic relationships of MSM, which raises the stakes for us trusting them because our romantic relationships are usually very important to us and they are one of the things that make us especially vulnerable in society because of homophobia and biphobia. Again, this dynamic where MSM rely on prescriptions from healthcare providers for safe sex is similar to women who have sex with men because they rely on prescriptions for the birth control pill. If healthcare providers are in control of our access to safe sex, then they have a distinct responsibility for not only providing safe sex strategies like PrEP to MSM or the birth control pill to women, but also creating the conditions for us to trust them and equipping us with the basic skills to discuss these strategies with our partners.

Ideally, this would include supporting "open, non-judgemental communication between partnered men to facilitate agreements that accommodate PrEP, the discussion of acceptable sexual practices, and whether condomless sex with casual partners is expected or allowed" (MacGibbon, 2020, p. 1398). Although it might seem like this is outside the role that healthcare providers typically play in the lives of MSM, it is necessary that MSM are able to have difficult conversations with both our sexual and romantic partners as well as our doctors, nurses, pharmacists, and even receptionists and other supporting clinical staff members. Since healthcare providers are interested in improving our sexual health, they have to understand how social and political factors, like the dynamics of trust between sexual and romantic partners, affect our sexual practices and relationships, our risk for HIV, and our decisions about HIV prevention strategies. Therefore, their role involves "providing support to gay and bisexual men who navigate non-monogamous relationships (consensual or otherwise), including facilitating trust, open communication and disclosure about sexual behaviours" and familiarizing "themselves with gay and bisexual men's changing sexual practices in the PrEP era", including both the physiological and social effects of PrEP on pleasure, intimacy, disclosure, and trust in our relationships (MacGibbon et al., 2020, p. 1398). If MSM can trust healthcare providers and if they are knowledgeable about both PrEP and our experiences related to sex and HIV, then they can help us navigate difficult conversations about PrEP and its effects on the trust in our relationships and our communities, which will ultimately determine whether PrEP is successful as a widespread HIV prevention strategy among MSM in North America.

3.4. Conclusion: From Trusting Relationships to Solidary Communities

In conclusion, thinking about the effects of using PrEP on the trusting relationships of MSM actually helps us better understand the conditions under which the right kinds of trust can be established between partners, healthcare providers, and patients and how we should allocate the responsibility for creating these conditions. Once we realize the necessary connection between trust and safe sex, the responsibility for safe sex becomes a responsibility for creating trust-enabling and trust-enhancing conditions in our interpersonal relationships. Therefore, engaging in conversations about PrEP as HIV prevention among MSM is as much about learning how to communicate and destigmatize different sexual practices and relationships and different HIV prevention strategies and learning how to understand the experiences and perspectives of different people as it is about deciding to use PrEP or remembering to take pills. Sexual and romantic partners have to establish open lines of communication about their sexual desires and preferences with respect to relationship structures and HIV prevention strategies in order for PrEP to really present an opportunity for more healthy relationships, both in terms of trust and HIV. Furthermore, seropositive and seronegative partners have to appreciate the different kinds of physical, emotional, and broadly social vulnerabilities involved in serosame and serodifferent relationships and take responsibility for addressing related stigmas and prejudices, like serophobia. Likewise, healthcare providers have to take responsibility for not only helping MSM access PrEP, but also helping us develop the skills to discuss PrEP with them as well as with our sexual and romantic partners. In fact, we all have some responsibility for creating the conditions for broader trust around HIV prevention in society, including community organizations, and even governments, public health institutions, and the rest of society in terms of lowering stigma, in which MSM are able to make decisions and have conversations about PrEP in ways that are responsive to its social and political effects on our lives. In the following chapter, I consider how this responsibility for creating the conditions for trust in our relationships plays out in our communities and how widespread PrEP use among MSM affects solidarity within gay communities more broadly.

CHAPTER 4

Understanding the Effects of PrEP on Political Solidarity among MSM

In this chapter, I expand my focus, shifting from questions of individual risk and interpersonal trust involved in using PrEP as HIV prevention among MSM, to broader questions of solidarity within communities, exploring how PrEP affects communities of gay, bisexual, and queer men in North America. In the previous chapter, I highlighted that MSM, along with our healthcare providers and institutions as well as the rest of society, have a responsibility for creating the conditions for trust around HIV prevention in our relationships, our broader communities, and even our societies. Besides creating the conditions for trust, MSM also have an interest in building solidarity around HIV prevention in our communities in order to better advocate for our health and wellbeing. Although the AIDS epidemic and early AIDS activism necessitated a strong sense of solidarity among gay, bisexual, and queer men, this solidarity is changing given new developments in HIV treatment and prevention and new developments in society, including the successes of the gay rights movement and increasing fragmentation. Therefore, I establish some of the ways in which PrEP challenges solidarity among MSM in particular, given differences in sexual moralities and intergenerational views within gay communities, and how we can possibly respond to these new challenges. Although these challenges raise important questions and considerations about the use of PrEP as HIV prevention among MSM today because of the specific critical and historical context of its use in North America, I demonstrate how responding to these challenges within gay communities might actually help us build - or rebuild - solidarity around our ongoing responses to HIV and our ongoing use of HIV prevention.

This chapter proceeds as follows. In §4.1, I define the concept of political solidarity and I provide a critical analysis of some recent accounts. I argue in favour of *empathetic* solidarity and I highlight the importance of the affective and relational aspects of solidarity in my particular analysis because they capture the problem and point to a solution. I also focus specifically on solidarity in bioethics and the influence of feminist ethics on the inclusion of relational concepts in the analysis of issues in healthcare. In §4.2, I detail the history of solidarity within gay communities

and the present state of this solidarity today through the lens of a broadly empathetic, affective, and relational solidarity. I explain how exactly the AIDS epidemic necessitated solidarity within gay communities and how recent changes in gay communities are affecting that solidarity. I present two of the main ways in which PrEP, in particular, challenges solidarity among MSM, in §4.3, by exposing differences in sexual moralities and intergenerational views within gay communities. PrEP highlights differences in sexual moralities among MSM through several objections to its widespread use, which are based on its effects on safe sex, promiscuity, and the stereotyping of gay, bisexual, and queer men in society. PrEP also highlights differences in intergenerational views among MSM by exposing how the legacy of the AIDS epidemic continues to affect the views of HIV, HIV treatment and prevention, sex, and sexual and romantic relationships among gay, bisexual, and queer men from different generations. Finally, in §4.4, by responding to these challenges, I consider the kinds of opportunities that PrEP provides MSM for rebuilding broader solidarity within gay communities around new understandings of non-traditional sexual practices, non-traditional sexual and romantic relationships, intergenerational perspectives, power relations, and even different conceptions of solidarity. I conclude in §4.5 that thinking about how PrEP affects the solidarity of MSM really helps us understand the relevance and importance of the broader social and political dimensions of the ethics of PrEP as HIV prevention and the long-lasting and wide-ranging effects of PrEP on both individuals as well as communities of gay, bisexual, and queer men in North America.

4.1. The Philosophy of Solidarity

Although solidarity is often thought of as humanistic, directed towards all humans because of our shared identity as human beings (Wiggins, 2008), or altruistic, aimed at selflessly helping others, I use a different notion of solidarity, according to which solidarity describes a group-based attitude or relationship, often associated with contexts of group struggle, among members of a particular group who share some relevant feature - or sometimes among people who are not members of a pre-existing group, but who come together in order to respond to some form of oppression. Since MSM share common experiences, and many or most share an identity as gay, bisexual or queer, and we often come together to respond to forms of oppression that we all face because of our shared identity, we demonstrate solidarity within our communities across North

America. We can recognize and empathize with other members of our group because we can all understand our shared experiences of oppression and we are often willing to help each other because of this understanding (Bartky, 2002). This kind of political solidarity, however, is explained in different ways according to different philosophical accounts of solidarity and each account emphasizes different features. First, empathetic solidarity grounds the concept in empathy for others by which we transcend our own perspectives in order to understand their experiences; this kind of empathetic understanding is what really allows us to act in solidarity with others, according to this account (Bartky, 2002; Harvey, 2007; Thomas, 1998). Second, expressive solidarity grounds the concept in the expressions of its essential features, including joint interest, group identification, a disposition to empathy, and mutual trust, and the normative relations of these expressions (Taylor, 2015). When these normative relations are expressed reciprocally by members of a particular group, then they are acting in solidarity. Third, rational solidarity grounds the concept in the reasons individuals have to act in solidarity with others (Kolers, 2012; Kolers 2016). Therefore, even if individuals disagree with the goals of their particular group, they act accordingly in order to be in solidarity with others. Overall, I favour empathetic solidarity because I focus specifically on how MSM can develop greater understanding of each other's different perspectives on, and experiences with, HIV and HIV prevention whether or not we actually express this solidarity or have reasons for it, although we often do both. I highlight some more detailed views of solidarity in §4.1.1 in order to expand on my broadly empathetic account of solidarity and I contextualize solidarity in bioethics specifically in §4.1.2 in order to use it to help us understand how PrEP really affects solidarity among MSM as an issue related to healthcare in the rest of the chapter.

4.1.1. Defining Solidarity: Unpacking Different Views

In several different articles, Barbara Prainsack and Alena Buyx (2011; 2012; 2016) review the philosophical literature on solidarity and provide a new definition for a concept that is often perceived as vague yet is increasingly being used in philosophy, and bioethics in particular. Prainsack and Buyx (2016) review the conceptual history of solidarity and highlight the different approaches to the concept in philosophy in Europe and North America. Although the concept of solidarity originated in continental Europe and has distinct socialist and Christian foundations,

many Anglo-American philosophers, including Richard Rorty, H. L. A. Hart, John Rawls, Charles Taylor, and Michael Sandel, have discussed the concept as well (2016, p. 492-493). Prainsack and Buyx (2012) build their definition of solidarity on these earlier discussions. Their definition states that "solidarity signifies shared practices reflecting a collective commitment to carry 'costs' (financial, social, emotional, or otherwise) to assist others" (2012, p. 346). They go on to clearly identify three tiers of solidarity: interpersonal, communal, and institutional solidarity. First, at the interpersonal, or individual, level "solidarity comprises manifestations of the willingness to carry costs to assist others with whom a person recognizes sameness or similarity in at least one relevant respect" (2012, p. 356). Second, at the communal, or group, level, which is the most prominent of the three tiers, "solidarity can be described as manifestations of a collective commitment to carry costs to assist others (who are all linked by means of a shared situation or cause)" (2012, p. 347). Third, the institutional, or contractual, level involves contractual or other legal norms or manifestations, such as the welfare state, public healthcare systems, etc. (2012, p. 347). These tiers have increasing levels of institutionalization and each higher tier depends on lower tiers to develop first, but they do not require them for maintenance. In the case of PrEP, the solidarity I focus on is at the communal level, especially because any solidarity at the institutional level around HIV was heavily influenced by AIDS activism that was driven by gay communities.

Prainsack and Burx (2012) understand solidarity as a practice, not a sentiment or value, and "as such, it requires actions – motivations, feelings such as empathy etc. are not sufficient to satisfy this understanding of solidarity, unless they manifest themselves in acts" (p. 346). Therefore, the fact that solidarity involves an active component is one of its distinguishing features, according to their definition, and they seem to endorse a kind of expressive solidarity. Solidarity around HIV within gay communities certainly demonstrates this active, expressive component through the work of gay community organizations, many of which focus on HIV in particular like the Gay Men's Health Crisis (GHMC) in New York City and similar organizations across North America, and the ongoing commemoration of the lasting effects of the AIDS epidemic through permanent AIDS memorials and annual AIDS walks. Furthermore, Prainsack and Buyx (2011) specifically distinguish solidarity from other related concepts, including responsibility, charity, dignity, reciprocity, social capital, and even trust. Since they find that solidarity is often perceived as a vague concept in the literature because of its similarity to these other concepts, they work to establish the relevant differences between solidarity and these other concepts. For example, they

explain that solidarity and responsibility differ in terms of contexts of accountability. Individuals face consequences or sanctions for not acting responsibly, but individuals are not usually penalized for being unsolidary. They also explain that solidarity and charity differ in terms of symmetry between parties. Whereas charity assumes asymmetry between parties, solidarity assumes symmetry (Prainsack & Buyx, 2011, p. xii-xiii). By reviewing the conceptual history of solidarity, identifying three tiers of solidarity, and distinguishing solidarity from other related concepts, Prainsack and Buyx present their definition of solidarity as a promising contribution to philosophical and bioethical analysis.

Others, however, critique their definition of solidarity and use it in order to build their own definitions in order to help improve the utility of its application to bioethics, and specifically public health ethics. In "The Place of Solidarity in Public Health Ethics", Angus Dawson and Bruce Jennings (2012) critique two aspects of Prainsack and Buyx's definition: "the idea that solidarity is built up from the individual level and that 'costs' are a necessary condition for solidarity" (p. 72). First, Dawson and Jennings determine that the communal level of their definition is what most people really think of as solidarity. Since the interpersonal level simply involves a commitment between one individual and another, it is unclear that this is really solidarity and not altruism or beneficence because it does not involve a broader community (Dawson & Jennings, 2012, p. 73). This aligns with my analysis of solidarity in the case of PrEP because it is individuals acting together in communities that reveals the kinds of unexpected social and political effects that are my focus. Therefore, I situate my analysis at the communal level because I agree with Dawson and Jennings that the interpersonal level of solidarity outlined by Prainsack and Buyx is not clearly solidarity and it is not particularly helpful for my analysis of communities instead of individuals. Likewise, although the institutional level of solidarity outlined by Prainsack and Buyx is an interesting scaling up communal solidarity, my focus is on gay communities, not governments or healthcare institutions, especially given the troubling history of their responses to HIV/AIDS and the ongoing problems with their responses today.

Second, Dawson and Jennings (2012) agree that solidarity involves action, but they disagree that costs are necessary for such actions. Their definition of solidarity involves the fundamental idea of 'standing up beside', "a positive identification with another and their position, whether individual or group, driven by sympathy and understanding" (p. 74). Although they admit that the action of 'standing up beside' someone "may increase one's vulnerability to negative

outcomes (criticism, arrest, violence)", costs are simply not necessary for such actions to demonstrate solidarity (Dawson & Jennings, 2012, p. 74). They go on to emphasize the relational nature of solidarity by explaining the solidary actions of "standing up for", "standing up with", and "standing up as" that demonstrate increasingly strong degrees of affiliation with other individuals and groups (Dawson & Jennings, 2012, p. 75). Although I focus on empathetic solidarity in order to understand how MSM can actually build greater solidarity in our communities, I agree with Dawson and Jennings that solidarity needs to eventually lead to action, but that action does not necessarily have to involve costs. For example, MSM can act in solidarity with each other by marching in protests, volunteering at events, or donating to charities, all of which might involve costs, but we can also act in solidarity by simply not judging each other's HIV prevention strategies, sexual practices or sexual and romantic relationships, which does not cost us anything. Since I am interested in how members of the same group actually build solidarity and then eventually act it out, group members already have a strong degree of affiliation with other members of the group in terms of identity. However, differences in sexual practices, relationship structures, and political strategies within gay communities, which I will describe in more detail later, determine how closely different gay, bisexual, and queer men identify with each other and each of these differences has consequences for the strength of our solidarity.

In "Political Solidarity, Justice and Public Health", Meena Krishnamurthy (2013) also critiques two aspects of Prainsack and Buyx's definition of solidarity. First, Krishnamurthy finds that Prainsack and Buyx's definition fails to account for the necessary affective component of solidarity. Solidarity seems to be primarily driven by our feelings for each other as individuals, members of groups, and citizens, which is especially helpful for my analysis of solidarity within gay communities because of our strong feelings around HIV and HIV prevention. Second, Krishnamurthy explains that "their view fails to give an account of how those individual citizens, who are characterized by political solidarity, ought to interact with one another outside of acting in ways that express a willingness to take costs on to help one another" (2013, p. 130). Therefore, she goes on to develop her own definition of solidarity by incorporating an active component that is emphasized by Prainsack and Buyx as well as Avery Kohlers (2012), a cognitive component that is emphasized by Sally Schulz (2008) as well as an important affective component. She also adds several relational components to her definition of political solidarity. According to her definition, solidarity is specifically characterized by attitudes of collective identification, mutual respect,

mutual trust, loyalty, and mutual support among citizens. Furthermore, solidarity is important for justice in society, according to her definition, because "relations of political solidarity help us to develop attitudes that are necessary for a firm commitment to justice" (Krishnamurthy, 2013, p. 138). Krishnamurthy even applies her definition of political solidarity specifically in the context of pandemic responses in public health, which applies to both HIV/AIDS and COVID-19 today, in order to demonstrate this connection to justice. Rudd ter Meulen (2013) agrees that solidarity is important for justice in healthcare because he argues that it emphasizes the social and political aspects of healthcare, like "the importance of recognition of identities and the promotion of dignity in the context of personal relationships", which analyses of justice often overlook in favour of focusing on the distribution of goods (p. 18).

Together, each of these emerging definitions of solidarity is useful for rethinking our approach to issues that affect public health and the health and wellbeing of specific social and political groups, such as MSM and gay communities in North America, in discussions about the ethics of PrEP as HIV prevention. Although I start with Prainsack and Buyx's definition of solidarity at the communal level and I agree with Dawson and Jennings critiques, I consider Krishnamurthy's comprehensive definition of solidarity, especially her emphasis on its affective and relational components, to be the best definition for my analysis of solidarity among MSM around HIV prevention. Since PrEP is such a personal thing for MSM, involving sex, sexual and romantic relationships, and persistent anxiety and stigma around HIV, the way we feel about each other having different kinds of sex, building different kinds of relationships while using PrEP, and advocating for safe sex in different ways and the way we actually relate to different members of our communities who have different views about PrEP are crucial for understanding solidarity among MSM, identifying challenges to that solidarity, and responding to those challenges. Finally, the connection that Krishnamurthy and ter Meulen draw between solidarity and justice, especially during pandemics, demonstrates just how important it is to analyze solidarity in issues related to healthcare in order for philosophy to have a practical impact in the world. For example, solidarity among MSM around HIV and HIV prevention might actually teach us lessons for dealing with other pandemics, like the present COVID-19 pandemic, and help us continue to develop attitudes of justice in society more broadly that we can apply in other cases of controversy around new treatment and prevention strategies (Montess, 2020).

4.1.2. Solidarity in Bioethics: The Influence of Feminist Ethics

In the bioethics literature, there is actually an increasing focus in the last decade on relational concepts like solidarity and how they help us better approach different issues related to healthcare. Although relational concepts like solidarity are often absent in more traditional bioethical analyses, I think we need to use solidarity in order for these kinds of analyses to really grasp the nuances of issues that involve life, health, and wellbeing more broadly, including the ethical issues involved in HIV treatment and prevention. Therefore, I follow Susan Sherwin's lead in approaching bioethical issues through a decidedly relational lens. In "Whither Bioethics? How Feminism Can Help Reorient Bioethics", Susan Sherwin (2008) explains how feminist ethics and relational concepts like solidarity are necessary in order to address the large-scale problems that we are facing in society today, including climate change, war, and infectious diseases. Sherwin states that "if we hope to avert the crises facing us, we must look beyond the moral responsibilities of individuals and consider the ways in which social organizations of all sorts (including community groups, corporations, governments, and international bodies) also must alter their behaviours" (p. 9). Sherwin argues that these large-scale existential threats require a new approach to both ethics and bioethics, as the branch of ethics that focuses on life in particular, that draws specifically on feminist bioethics and feminist relational theory. While traditional ethics tends to focus on the responsibilities of individuals, Sherwin proposes a new kind of "public ethics", a collective ethics based on the idea of public health that focuses on the responsibilities of individuals as well as the responsibilities of groups, communities, and institutions. Sherwin (2008) explains that "the moral obligations of individuals are inextricably intertwined with the moral actions and duties of their societies (locally, nationally, and globally)" and that "this fact means that we need an ethics that can address the multiple and complex ways in which moral responsibilities must be coordinated across different types of social groups" (p. 11). Feminist work on relational concepts in ethics, like autonomy and personhood, is particularly helpful because these concepts enable us to understand how individuals relate to each other, how individuals build communities with one another, and how individuals and communities interact with institutions by paying special attention to the necessary interconnectedness of different individuals, communities, and institutions.

Sherwin (2008) even considers the example of HIV prevention and how a public ethics approach would target not only individuals, but also communities and institutions, and seek to

understand the relationships between the parties involved in order to really improve the situation for everyone. For example, she states that “programs that promote safer sex on the part of individuals also require local institutions (schools, health clinics, even rock concerts) to provide cheap (or free) condoms, while research institutions investigate better treatments for HIV/AIDS, and governments find ways of providing healthcare resources to meet the needs of people who become infected in order to limit further spread of the disease” (Sherwin, 2008, p. 11). Regularly scheduled HIV testing in bathhouses is one way in which gay communities are already following Sherwin’s suggestion that local institutions become more involved in HIV prevention and public health more broadly (Johnson, 2019).

In “Whither Bioethics Now? The Promise of Relational Theory”, Susan Sherwin and Katie Stockdale (2017) review how feminist bioethicists have actually helped reorient bioethics in the last decade. They explain that feminist bioethicists have used relational theory, and the relational concepts of equality, justice, solidarity, and especially autonomy, to contribute to bioethics by incorporating social justice and discussions of privilege and oppression in their analyses. In fact, “bioethicists, in both feminist and mainstream circles, have become increasingly attentive to the ways in which interpersonal relationships, social, political, and economic circumstances, and embodied features of the self affect the people we are and the decisions we make”, according to Sherwin and Stockdale (2017, p. 11). They highlight solidarity as a particularly important relational concept in public ethics and they use the concept of “relational solidarity” as proposed by Francoise Baylis, Nuala Kenny, and Susan Sherwin (2008) in their approach to public health issues. Since bioethics often focuses on individual rights-based approaches and individual autonomy, especially in public health issues, they suggest that relational solidarity can help us understand the issues on local and global levels, which “can help to reorient the focus from an individual to a collective ethics that can better inform public responses to pandemics and other public health issues” (Sherwin & Stockdale, 2017, p. 12). Solidarity specifically addresses how individuals relate to each other in various ways and how the resulting relationships affect the decisions, health, behaviour, and trust of individuals. Therefore, Sherwin and Stockdale (2017) implore us to understand solidarity “as a central value in public health that works in tandem with social justice and other related values to provide the core motivations and justifications for the very enterprise of public health” (p. 14).

Sherwin and Stockdale (2017) use two examples of Indigenous health crises in Canada, the lack of safe drinking water on reserves and missing and murdered Indigenous women, in order to demonstrate the potential of using feminist relational approaches to responsibility, solidarity, and social justice in ethical analyses. They demonstrate that these two examples involve multiple systems of oppression, including poverty, racism, sexism, and colonialism, and require responses from individuals as well as groups, communities, and institutions, including the Government of Canada. In terms of the second example, Sherwin and Stockdale state that "responsibility for addressing the problems that contribute to widespread missing and murdered Indigenous women must be understood through feminist relational theory as requiring a coordinated effort across all levels of human organization to dismantle the interrelated systems of oppression determining their fates" (p. 22). Different individuals, groups, communities, and institutions have different responsibilities for this situation and different ways of cultivating solidarity because "solidarity arises through responsible action" (p. 23). Unfortunately, the same systems of oppression that are involved in these examples are also faced by Indigenous Two-Spirit, gay, bisexual, and queer men in Canada and the United States in terms of HIV prevention. All gay, bisexual, and queer men face systems of oppression based on their sexual orientation and gender identity in society today, but some face several systems of oppression, which only makes things like accessing PrEP as HIV prevention even more difficult for them. Overall, although Sherwin and Stockdale (2017) do not always work with empathetic solidarity, I agree with them that "feminist relational theory makes visible the ways in which patterns of privilege and oppression are at work in creating, maintaining, and often worsening public health problems" (p. 17). Therefore, I follow their unique approach of applying feminist relational theory and relational concepts to bioethics by using solidarity, and in this case specifically empathetic solidarity, in my analysis of the ethics of PrEP in order to better understand the ethical issues involved in its use by MSM and its broader effects on communities of gay, bisexual, and queer men in North America.

4.2. Gay Communities: Building Solidarity

In order to analyze the ethics of PrEP use among MSM in terms of solidarity, it is important to understand the role of solidarity among MSM and within gay communities. Gay, bisexual, and queer men form communities across North America and these communities are often referred to

collectively as the “gay community”. However, it is difficult to discuss such a large and diverse social and political group in society. For example, MSM who do not identify as gay, bisexual or queer might not form communities like other self-identified gay, bisexual or queer men because they are primarily defined by their sexual behaviour, or sexual practices, not their sexual orientation, their gender identity or their social and political position in society. Although many MSM and gay, bisexual, and queer men in North America share similar experiences surrounding sex, sexual and romantic relationships, HIV, and HIV treatment and prevention, these shared experiences are not enough to describe a homogeneous community. Instead of one “gay community”, there are actually many different gay communities in Canada and the United States who experience similar oppression, marginalization, and stigmatization because of the history of HIV as well as our sexual orientations and gender identities, but who also have many different experiences depending on other factors.

Gay, bisexual, and queer men have very different experiences with HIV and HIV prevention based on our age, race, gender identity, education, geography, serostatus, and many other factors that determine our social and political positions in society. For example, long-standing racism within gay communities means that Black MSM in particular often face racism from within gay communities in addition to homophobia and biphobia from the rest of society and, therefore, they face barriers to identifying as gay, bisexual or queer from both sides. As a result, Black MSM have higher rates of HIV and less access to HIV treatment and prevention, including PrEP (Kanny, Jeffries, Chapin-Bardales et. al, 2019; Arnold, Rebchook, & Kegeles, 2014). Likewise, many queer people identify with different genders or as non-binary, genderqueer or gender non-conforming and they are not always understood by either gay communities or the rest of society. Again, as a result of greater stigma, transgender and gender non-binary people not only have less access to PrEP, but they are also seriously understudied in the research on PrEP, which compounds the problem of accessibility (CDC, 2019; Reisner, 2019). Furthermore, research is limited on the attitudes towards PrEP in rural areas as opposed to urban areas; less access to PrEP and high levels of stigma around its use, however, seem to be more prevalent in rural areas than urban areas (Sarno et al., 2020; Hubach et al., 2017). Therefore, depending on each of these different kinds of social positions, even our shared experiences can be very different from one another. Nevertheless, I focus on gay communities more broadly in order to demonstrate how the social and political effects of PrEP affect all MSM insofar as we belong to different communities of

gay, bisexual, and queer men whose solidarity is nevertheless greatly impacted by our experiences with HIV and HIV treatment and prevention. First, I explain how the history of the AIDS epidemic and HIV treatment and prevention necessitated solidarity among MSM in North America in the first place and, second, I explain how recent changes in gay communities, and in society more broadly, including the advent of PrEP as a new HIV prevention strategy, are affecting solidarity among MSM with consequences on the lives and relationships of MSM and the rates and experiences of HIV in our communities.

4.2.1. The AIDS Epidemic and HIV Prevention

Communities of MSM, and communities of gay, bisexual, and queer men in particular, developed a strong sense of solidarity in the 1980s and 1990s during the AIDS epidemic out of necessity. The slow response to the epidemic by governments and public health organizations necessitated AIDS activism by MSM and their allies in order to fight the spread of HIV/AIDS in North America, especially in large urban areas. Gay Men's Health Crisis (GMHC), AIDS Coalition to Unleash Power (ACT UP), AIDS ACTION NOW! (AAN!), Reaction SIDA, and other gay community organizations demonstrated how gay, bisexual, and queer men worked together during the epidemic to advocate for our communities by calling for HIV research, funding, treatment, and prevention. Since this advocacy was led by gay community organizations and focused largely on gay communities, many gay, bisexual, and queer men developed a kind of solidarity with their communities in the face of this tragedy. Martin Holt (2011) explains that "the concept of 'gay community', and gay men's attachment to and involvement in gay community activities, has held both a symbolic and practical role in understanding and guiding responses to HIV in developed world contexts" (857).[19] Gay community attachment and involvement actually predicted safe sex practices among MSM during the AIDS epidemic because associating with each other increased access to education and outreach about HIV and safe sex. Therefore, several strategies were used to promote HIV prevention, and safe sex in particular, among MSM, including "community intervention strategies and attachment strategies" (Holt, 2011, p. 858). Community intervention strategies "used gay events, venues and gay media to promote safe sex" and

[19] Martin Holt (2011) focuses on gay community attachment, the AIDS epidemic, and HIV prevention in Australia, but the context of developed world countries is often relevantly similar, especially in this case because of the similar experiences of MSM in Canada, the United States, and Australia.

attachment strategies “utilised peer education and outreach to engage men less connected to gay life, promoting safe sex outside of gay venues and events or encouraging men to learn about safe sex, HIV and gay life in peer groups” (Holt, 2011, p. 858). These strategies not only helped reduce the spread of HIV among MSM, but they also fostered solidarity within gay communities across North America. Overall, this history sets a precedent for solidarity among MSM and within gay communities in response to HIV and its success in helping to reduce the spread of HIV in these communities and society more broadly.

Nevertheless, there was pushback to this kind of approach towards HIV prevention within gay communities which presented challenges to solidarity even during the early AIDS epidemic. Some MSM felt that the promotion of safe sex was actually an attempt to restrict their autonomy and further stigmatize gay sex. After the sexual revolution of the 1960s and 1970s, gay, bisexual, and queer men resisted the idea of safe sex, and using condoms, as antithetical to their recent liberation and the progress that their communities had made recently. Many MSM, therefore, did not use condoms even though AIDS activist groups, like ACT UP, were heavily promoting their use in gay communities around the world. Larry Kramer, for example, was especially angry and frustrated with other gay, bisexual, and queer men who would not use condoms in the 1980s and 1990s because he viewed this as going against the interests of gay communities (Leland, 2017). Likewise, these gay, bisexual, and queer men probably thought that it was Kramer and ACT UP who were betraying the progress that they had made recently by forcing gay, bisexual, and queer men into restrictive sexual practices and relationships all over again. This early controversy around condoms and safe sex and this early division within gay communities are examples of the same kind of controversy and division that are reappearing today with PrEP as a new kind of HIV prevention strategy. While some activists are promoting PrEP today as an innovative way to continue the fight against HIV/AIDS, others want to continue using condoms in order to stick to the status quo, which sometimes involves the different kinds of stigmas around HIV as well as sex and sexual and romantic relationships. Although these kinds of tensions around HIV and HIV prevention continue to play out today, a lot has also changed in gay communities during the last few decades, which makes building solidarity today uniquely challenging.

4.2.2. Recent Changes in Gay Communities

Solidarity around HIV seems to have decreased within gay communities since the early days of the AIDS epidemic because of recent developments in HIV treatment and prevention, the recent successes of the gay rights movement, and the increasing fragmentation of society in North America since the 1980s and 1990s because of social, political, and especially technological developments. Nathaniel Lewis et al. (2015) explain that "changes in gay and bisexual men's connectedness to the gay community are related to the declining public visibility of HIV/AIDS and greater acceptance for homosexuality and bisexuality in mainstream society" (p. 1201). The declining public visibility of HIV/AIDS is partially a result of recent developments in HIV treatment and prevention, like PrEP. These developments have not only dramatically reduced the risk of HIV for MSM, but they have also dramatically improved the life expectancy of people living with HIV. Since people living with HIV can live long healthy lives with HIV treatment, there is less urgency around HIV prevention today. Therefore, these developments seem to have weakened one of the foundations of the solidarity that was fostered during the AIDS epidemic: the urgent threat of dying from HIV/AIDS. Furthermore, the recent successes of the gay rights movement, including the legalization of same-sex marriage in Canada in 2005 and in the United States in 2015 among other legal developments, demonstrate increased acceptance of gay, bisexual, and queer men in society. This acceptance has "changed the structure of community (e.g. fewer bars and organizations) and disproportionately benefited certain groups, such as a 'homonormative' gay, coupled middle class", while other groups continue to be marginalized in their communities based on race among other factors (Lewis et al., 2015, p. 1203). Regardless, both of these changes in gay communities in North America seem to be threatening some of the traditional foundations of solidarity within these communities.

Society in North America has also experienced increasing fragmentation because of rapid technological developments in the past few decades, which also seems to threaten solidarity in society more broadly by further dividing us into smaller communities. We use technology more than ever in society and recent developments like the internet and social media allow us to find others who share our identities, ideas or interests and divide ourselves into smaller communities based on these shared identities, ideas, and interests. This fragmentation affects gay communities, in particular, by breaking them up into alternative personal communities. Wilkinson et al. (2012) investigate what kind of solidarity exists between gay, bisexual, and queer men today in a society that is increasingly experiencing social fragmentation (p. 1161). They note that lower interest in

public sex venues, like bathhouses, and higher interest in using even hookup apps to find gay friendships, demonstrates that sexuality might no longer be the basis for solidarity among MSM (p. 1169). Instead of basing solidarity on sexuality in gay communities, Wilkinson et al. (2012) base it on friendships, chosen families, and personal communities. Therefore, alternatives to gay communities, especially personal communities, might be a better way of understanding how gay, bisexual, and queer men relate to each other and how HIV prevention strategies are actually being taken up by MSM today (Holt, 2011; Lewis et al., 2015; Wilkinson et al., 2012).[20] Although increasing fragmentation in North American society does seem to threaten solidarity, it also demonstrates how the foundations of solidarity can change over time from larger groups with only some things in common, to smaller groups who have found each other using new technologies precisely because of what they have in common.

Overall, I think that there are three main factors that affect solidarity among MSM that emerge from the history of the AIDS epidemic and HIV prevention and the recent changes in gay communities, which reveal how our attitudes towards HIV, and each other, affect the ethics and politics of the situation that we are facing with PrEP today. First, solidarity seems to depend on the urgency of external threats. Since the AIDS epidemic, both HIV/AIDS and homophobia and biphobia have become less threatening to MSM in North America. Since these threats have diminished over time because of both medical as well as social advancements, solidarity among MSM seems increasingly less necessary today. Second, solidarity also seems to depend on the divisions as well as the diversity within gay communities. Many MSM increasingly prefer to be a part of smaller personal communities over larger gay communities, lessening our feelings of solidarity with other gay, bisexual, and queer men more broadly. Furthermore, the dominance of some MSM over others, especially along the lines of age, race, gender identity, geography, and serostatus that I mentioned above, also seems to lessen solidarity by leaving stigma unchecked in gay communities, which discourages some members of the community from feeling like they really belong or feeling like they want to even follow the advice of a gay establishment that excludes them. Finally, solidarity seems to depend on the actual controversies and disagreements about different HIV treatment and prevention strategies. In the same way that gay, bisexual, and queer men felt differently about the advent of safe sex, many of us feel differently about PrEP and the

[20] Although I continue to refer to gay communities in this chapter, I mean to also include the personal communities of gay, bisexual, and queer men in my analysis in order to address some of the recent changes in solidarity because of greater fragmentation in North America today.

context of its use today. These acute differences only seem to further lessen solidarity among gay communities around HIV. Again, stigma plays an important role here in shaping our views of PrEP as well as our sexual partners, practices, and relationships because serophobia is still prevalent in gay communities and contributes to the continued othering of people living with HIV. Together, these causes of lessened solidarity will be difficult for gay communities to overcome when deciding whether or not to embrace PrEP as an HIV prevention strategy, but they also demonstrate what kinds of attitudes we have to cultivate in order to build solidarity. Therefore, in the next section, I explore how exactly developments in HIV prevention, and PrEP in particular, threaten solidarity among MSM and within gay communities and whether it can still help to foster solidarity within gay communities in new ways. Overall, I hope to demonstrate the continued importance of solidarity for understanding the ethics of PrEP use among MSM as well as bioethical issues involving health and wellbeing among social and political groups more broadly.

4.3. Challenges to Solidarity from PrEP: Sexual Moralities and Intergenerational Views

The AIDS epidemic and HIV treatment and prevention fostered solidarity within gay communities in the past, but the widespread use of PrEP as HIV prevention among MSM along with other recent medical developments seems to present challenges to solidarity within our communities today. Although it might seem like the advent of PrEP is simply an example of the third main factor affecting our solidarity because there is controversy and disagreement about it as an HIV prevention strategy, it also contributes to the decreased urgency of the threat of HIV because it is so effective as HIV prevention as well as the divisions within gay communities because of the ways that gay, bisexual, and queer men react differently to these new developments. I focus specifically on the ways that PrEP contributes to the divisions within gay communities because these present the greatest challenge to our solidarity. Since HIV prevention was one of the foundations of solidarity among MSM, many gay, bisexual, and queer men as well as gay communities in North America adopted norms around sex as well as sexual and romantic relationships that reflect the context of the AIDS epidemic (Weeks, 1998). These norms include engaging in safe sex, which involves not only using HIV prevention strategies, but also deciding on and engaging in sexual practices that reduce the risks of STIs, especially HIV, as well as seeking closed or monogamous relationships, and integrating gay, bisexual, and queer men and

whole gay communities into mainstream society. However, PrEP seems to allow MSM to ignore or undermine some of these previous sexual and romantic norms because of its safety and efficacy as HIV prevention. PrEP allows MSM to more safely and easily engage in condomless sex and build open or polyamorous relationships with multiple partners, which are not always widely accepted in either gay communities or mainstream society today. Several of the social and political objections to PrEP from gay, bisexual, and queer men ourselves that I discuss in the following sections are actually based on its effects on these very sexual and romantic norms. These objections from within gay communities present distinct challenges to solidarity among MSM because they highlight divisions based on differences in our views. Furthermore, it is also not just that we are sometimes divided in our communities, but that there are often power differences between those of us who have different attitudes, depending on our age, race, gender identity, geography, and serostatus among other factors, which all affect our broader solidarity. I will return to these kinds of power relations in more detail later in this section and in the following section. Overall, I identify two main differences in views that are the basis of these challenges to solidarity: differences in sexual moralities and differences in intergenerational views. First, I consider how PrEP reinforces differences in sexual moralities among MSM, focusing on safe sex, promiscuity, and stereotypes of gay, bisexual and queer men in society, and, second, I consider how PrEP reinforces differences in intergenerational views because of the history and legacy of the AIDS epidemic. I explain how both of these differences in views challenge solidarity within gay communities in North America by emphasizing deep divisions, which prevents us from developing the empathetic understanding of each other that is necessary for solidarity.

4.3.1. Sexual Moralities: Safe Sex, Promiscuity, and Stereotypes

Differences in sexual moralities among MSM and within gay communities challenge solidarity around HIV and HIV prevention because they demonstrate deep divisions within gay communities centring on different views of safe sex, promiscuity, and the stereotyping of gay, bisexual, and queer men in society. Although these divisions already exist within gay communities in North America, PrEP seems to exacerbate these divisions by changing how gay, bisexual, and queer men engage in sex, build sexual and romantic relationships, and relate to each other and the rest of society. Since gay, bisexual, and queer men subscribe to different sexual moralities, some

embrace PrEP as HIV prevention and others object to its widespread use in our communities. Therefore, I consider three of the lingering social and political objections to PrEP from within gay communities themselves, including the safe sex objection, the promiscuity objection, and the stereotyping objection, in order to demonstrate how each of them challenges solidarity in our communities by exposing ways in which we are different from each other. Although I already considered these objections in other contexts in previous chapters, especially Chapter 2 when considering the concept of risk in particular, they take on new meaning when analyzed in terms of solidarity. These objections to PrEP centre on the risks associated with condomless sex, the changes in sexual and romantic relationship structures, and the strategy of the gay rights movement respectively, but each one also demonstrates how such objections expose divisions within gay communities on these very issues, which present new challenges to our previous solidarity around HIV and HIV prevention.

4.3.1.A. Safe Sex: Condoms and Drug-Resistant STIs

First, the safe sex objection centres on the risks to MSM associated with condomless sex, especially the risk of STIs other than HIV, including chlamydia, gonorrhea, and syphilis. Some gay, bisexual, and queer men worry that those of us who decide to use PrEP will contribute to the increasing rates of STIs among MSM in North America more broadly, which would affect everyone in our communities (Traeger et al., 2018). If more gay, bisexual, and queer men have STIs or STIs are generally more prevalent within gay communities, then all gay, bisexual, and queer men are at increased risk for STIs whenever we have sex, especially with new partners or partners who are unaware of STI status. This makes hooking up more risky, even for those of us who do not use PrEP as HIV prevention. Therefore, some gay, bisexual, and queer men condemn the use of PrEP as HIV prevention because they believe that it encourages us to engage in more so-called risky sexual behaviour, especially condomless sex (Weinmeyer, 2014). The risk of other STIs has become even more serious recently due to the emergence of drug-resistant strains of certain STIs, like drug-resistant strains of gonorrhea. The Public Health Agency of Canada, for example, recently detailed the increasing rates of gonorrhea in Canada and admitted that the effects of drug-resistant strains of gonorrhea on public health are very serious (Bodie et al., 2019). According to the literature, the rates of STIs were already increasing and the rates of condom use

among MSM were already decreasing before PrEP became widely available, so it is not clear that PrEP is actually contributing directly to these phenomena. However, recent studies demonstrate that MSM who start using PrEP as HIV prevention do have higher rates of STIs, in part because of increased STI testing required when using PrEP and in part because of increased condomless sex (Montano et al., 2019; Werner, Gaskins, Nast, & Dressler, 2018).

Although this objection is only partially supported by the literature, it demonstrates that MSM have very different views of condomless sex and that these differences in sexual moralities among gay, bisexual, and queer men challenge solidarity within gay communities. Whether or not PrEP is really contributing to the increasing rates of STIs in our communities, gay, bisexual, and queer men seem to disagree about the acceptability of its risks. Whereas some gay, bisexual, and queer men see PrEP as undermining beneficial norms around safe sex by allowing MSM to engage in condomless sex, others see PrEP as establishing newer and freer sexual norms. The sexual norms established by PrEP involve either enhancing HIV prevention by using condoms as well as PrEP or using PrEP as an alternative to condoms in order to more safely engage in condomless or bareback sex, which is clearly very important for some gay, bisexual, and queer men. After starting to use PrEP, David Toussaint (2018) writes that "going bareback was the best sex decision I ever made" because of the increased sexual pleasure and freedom from the fear of HIV, but he admits, "I'm aware that PrEP doesn't prevent other STDs, and that's something I'm willing to accept". Some gay, bisexual, and queer men see PrEP as not only establishing new sexual norms, but encouraging non-traditional sexual behaviour that was previously less safe for us to engage in. Condomless or bareback sex is a non-traditional sexual practice for gay, bisexual, and queer men because of the longtime importance of condoms as HIV prevention during the AIDS epidemic (Brisson, Ravitsky, & Williams-Jones, 2018). It was previously condemned as irresponsible and dangerous because it greatly increased the risk of contracting HIV through sex for gay, bisexual, and queer men (Chambers, 1994; Berer, 2006). Today, however, many gay, bisexual, and queer men continue to condemn bareback sex because of the risks of other STIs, especially drug-resistant STIs. For example, when Matt Cain (2017) started taking PrEP he was met with disapproval or unease by other gay, bisexual, and queer men who said they "struggle with PrEP" and who shared articles about increasing STI rates. One man on the hookup app Grindr even explicitly rejected him because he believed Cain's PrEP use meant that he wanted to have bareback sex and that he had STIs. Cain (2017) started having condomless sex while on PrEP, but he struggled with it himself

because he “would be skipping over rules that have been strictly laid out since the onset of HIV/AIDS”. It is this kind of violation of previous norms that makes the discussion around safe sex so divisive for gay, bisexual, and queer men.

These changes and disagreements over norms are especially difficult, and even painful, for gay, bisexual, and queer men because unlike other sexual and romantic norms, which were imposed on us from the rest of society and which are often actively hostile to our existence, identity, and sexual and romantic practices and relationships, these rules were developed, and are still being developed, by gay communities in order to protect ourselves. During the AIDS epidemic, the development of these norms was a heroic effort by our communities when most of the rest of the world had abandoned us and allowed so many of us to die. It feels particularly disloyal and hurtful, like betraying or disrespecting the memories of those gay, bisexual, and queer men who died then, for many MSM to see some of us breaking those very important rules today. The fact that these rules were autonomous, in the sense of self-rule, because gay communities developed them ourselves is what makes it so difficult for many of us to let go of these rules and the painful memories tied to them. This is a conflict between different kinds of freedom: a kind of positive freedom or freedom as self-rule and a kind of negative freedom or freedom as license (Berlin, 1969). Freedom as self-rule involves the participation in developing, and actually following, the rules of your community, especially in circumstances like the AIDS epidemic where it was your community versus the government, the public health establishment, and the rest of society. Although the “us versus them” mentality was very effective during the early AIDS epidemic, it is increasingly more difficult to identify “them” today when the threat is less urgent and society is more accepting. Freedom as license involves the ability to choose what you want to do as an individual, including the excitement or fulfillment of having bareback sex or even just not following rules that do not make sense to you or restrict you in ways that you find unacceptable. This conflict between freedom as self-rule insofar as we are part of communities and freedom as license insofar as we are individuals clearly demonstrates the challenge of maintaining solidarity among groups like gay, bisexual, and queer men who have different views on the important struggles still facing us today.

The reason I favour a broadly empathetic account of solidarity is because it helps us understand why this conflict runs so deep for gay, bisexual, and queer men. MSM have to be able to transcend our individual perspectives in order to understand the broader experiences of others in

our communities, with whom we need to work together in order to effectively respond to our struggles with oppression. However, we sometimes lack empathetic understanding for each other because of the strong feelings attached to the norms around HIV prevention as well as other conflicts and resentments about our sexual practices and relationships, some of which are certainly well-grounded based on our experiences. While some MSM feel like others are being disloyal or hurtful towards them when they violate previous sexual and romantic norms, some MSM feel like others are being judgemental or overbearing towards them when they uphold those norms. Both of these situations impede the kind of fellow-feeling that is necessary for political solidarity (Bartky, 2002). Therefore, regardless of who is right about the status of these norms today, MSM need to engage in reconciliations, reach out to each other, and make adjustments to their practices and relationships in order to respond to the complexities of HIV prevention because these different perspectives can teach us valuable things about both learning from past experiences and adapting to new developments. Instead of seeing disagreements about HIV prevention as a conflict between individual freedom and community freedom, we need to develop greater empathy for each other in order to understand that our individual decisions regarding HIV prevention are not necessarily disloyal or hurtful and our reactions to others decisions are not necessarily judgmental or overbearing. The key here is not expressing normative relations or finding reasons for solidarity, but actually feeling a connection to others in our communities even when we are hurt by their decisions or their reactions to our actions. Krishnamurthy (2013) emphasizes the affective and relational aspects of solidarity because she finds that our feelings for each other as individuals and as members of communities and our attitudes of mutual respect, mutual trust, and loyalty towards each other are really what ground solidarity. Therefore, I continue to use Krishnamruthy's account of solidarity in the following subsections in order to describe why exactly these differences in views among MSM present such strong challenges to solidarity in our communities and how we might actually be able to respond to these challenges if we really pay attention to the affective and relational aspects of solidarity in order to develop greater understanding.

4.3.1.B. Promiscuity: Dating and Structuring Relationships

Second, the promiscuity objection centres on recent changes in sexual and romantic relationship structures, specifically the increasing prevalence of non-monogamous relationships

among gay, bisexual, and queer men in North America. Some gay, bisexual, and queer men worry that those who use PrEP will have more sexual and romantic partners because they are less worried about HIV and that this will contribute to the decreasing prevalence of monogamous relationships in our communities. If more gay, bisexual, and queer men have non-monogamous relationships and these relationships become more prevalent in our communities, then those of us who want monogamous relationships will have fewer options and this will make dating more difficult for them (Zane, 2018). The dating pool among gay, bisexual, and queer men is already much smaller than among heterosexual men and women and many gay, bisexual, and queer men already have non-monogamous relationships, which affects the dating pool further. Open relationships, and other forms of consensual non-monogamy like polyamory, seem to be more widespread among gay, bisexual, and queer men than among heterosexual men and women or queer women, even before PrEP was widely available as HIV prevention (Levine et al., 2018). However, some gay, bisexual, and queer men value monogamy and refuse to date others who are in non-monogamous relationships or who are open to non-monogamous relationships. Therefore, they condemn the use of PrEP because they believe that it encourages non-monogamy and that it has direct consequences for their own sexual and romantic relationships because their dating pool coincides with their community. Nevertheless, gay, bisexual, and queer men who worry about the effects of PrEP on changes in relationship structures seem to be mistaken about these particular effects of PrEP because, according to the literature, those who start using PrEP do not actually report having more sexual or romantic partners (Montano et al., 2019). These worries about promiscuity are another clash of norms around sex and relationships that demonstrates how differently gay, bisexual, and queer men view PrEP based on our interests, our perspectives, and our experiences with actually navigating sex and relationships.

Again, this objection demonstrates how differences in sexual moralities among gay, bisexual, and queer men challenge solidarity within gay communities. Whether or not PrEP is actually changing relationship structures among gay, bisexual, and queer men, many of us seem to disagree about the acceptability of its effects on our relationships and communities. Whereas some gay, bisexual, and queer men see PrEP as undermining beneficial sexual and romantic norms pertaining to relationship structures, others see PrEP as establishing newer, freer norms. These norms established by MSM using PrEP as HIV prevention involve using it in order to more safely and easily build non-monogamous relationships, which are very important for some gay, bisexual,

and queer men. Hugh McIntyre and Toph Allen, for example, credit having sex with other people and good communication for the success of their open relationship, saying, “we get to fulfill our desire of having sex with other people” and “we avoid cheating and the resentment that comes in monogamous relationships when you can’t pursue sexual urges” (Macnaughton, 2016). Some MSM see PrEP as actually encouraging non-traditional sexual and romantic relationships, like open relationships, which were not previously as safe for MSM because of the risk and fear of HIV, but which can be important sources of intimacy (Garamel & Golub, 2015). Nevertheless, monogamy, or the practice of limiting our number of sexual partners as a kind of HIV prevention strategy, was crucial for MSM during, and following, the AIDS epidemic. Non-monogamous relationships were condemned at the time because they increased the risk of contracting and spreading HIV through sex for gay, bisexual, and queer men. Today, however, many gay, bisexual, and queer men continue to condemn non-monogamous relationships because of their effects on dating and hookup culture. For example, Kyle Valenta (2018) tried dating men who were already in open relationships, but he could not achieve the level of intimacy that he wanted with these men knowing they already had partners. It is these kinds of interpersonal difficulties and conflicts that arise when partners have differing views on relationship structures and their meanings that can have a lasting impact on how gay, bisexual, and queer men view each other as potential partners and friends and how we view ourselves as members of our broader communities.

There are several reasons that differing views on relationship structures and their meanings can have such a lasting impact on how we view each other and our communities. Again, these views are tied up with the norms that we developed in our communities during the AIDS epidemic. Feelings of disloyalty and hurt for breaking these norms by pursuing relationships or relationship structures that used to be dangerous for the whole community reappear as yet another challenge to solidarity. Different kinds of normative relationships, especially monogamous relationships, used to clearly signify whether MSM were seen to be acting in their own interests or in the interests of their communities. Many MSM today feel something distinctive about our communities is being lost because the norms we developed in the past are changing and some of us are acting in ways that they interpret as selfish. Many other MSM feel that judgments about their open or polyamorous relationships are overbearing and even hurtful because they are not abandoning those norms carelessly, they are pursuing meaningful relationships. Although it is no longer the case that open and polyamorous relationships represent selfishness or a danger to our communities, especially

since PrEP drastically reduces the risk of HIV, feelings of disrespect, betrayal, judgment, and hurt continue to divide MSM by preventing us from having empathy and understanding for each other's relationship decisions, regardless of the reasons for our preferences. If we feel a disconnection with other members of our communities, then we are not going to be able to continue to build solidarity in our communities around broader HIV prevention strategies. Instead, we need to find ways of validating well-grounded concerns about changing relationship structures and their effects on longstanding sexual and romantic norms while also accepting the resulting relationships as new ways for MSM to safely express themselves sexually and romantically in communities where this is made much more difficult because of society that often disapproves of, and sometimes even legislates against, our relationships.

Again, we do not always have to actually express our solidarity or evaluate the reasons for our solidarity, but we do have to feel mutual respect, trust, and support as well as a sense of loyalty to and from our communities (Krishnamurthy, 2013). Furthermore, views about relationships, in particular, are incredibly personal because of the emotional dimensions of relationships themselves; our sexual and romantic relationships reflect our most intimate desires and vulnerabilities. We risk more than just our sexual health when we trust our partners, we risk emotional betrayal when we build sexual and romantic relationships with others in order to access the benefits of trusting relationships, including cooperation around shared goals and a sense of belonging. Therefore, when MSM perceive others' actions as either affecting the possibilities of fulfilling our desires for sexual or romantic relationships or threatening the actual structures and qualities of our relationships, we can take it personally because these relationships are usually very important to us. It is these personal stakes that are what make this particular challenge to our solidarity so difficult; solidarity depends precisely on how you view your community and how you view yourself in relation to your community. If MSM view our communities as a threat to our relationships instead of a place where we can find support for them, especially in a society that often misunderstands or undervalues our relationships, then we will not feel like our communities are really there for us or that we really want to be there for our communities.

4.3.1.C. Stereotypes: The Same-Sex Marriage Analogy

Finally, the stereotyping objection centres on the strategy for the gay rights movement, especially the worry that PrEP use among MSM will reinforce negative stereotypes of gay, bisexual, and queer men, in particular, as being promiscuous. Some gay, bisexual, and queer men worry that by reinforcing these kinds of stereotypes, PrEP will either reverse some of the progress of the gay rights movement, especially following the recent successes like the legalization of same-sex marriage, or hinder further progress. The analogy between the debate about same-sex marriage and the debate about PrEP is actually really helpful in order to understand this objection because this is not the first time that views about normative relationships have divided gay communities. In the debate about same-sex marriage, gay individuals and communities were divided on whether to embrace or reject certain stereotypes and relationship structures (Warner, 2000; Mayo & Gunderson, 2002; McCormick, 2018). Some gay individuals and communities argued for same-sex marriage because it would help integrate gay, bisexual, and queer people into mainstream society by adopting traditional relationship structures, focusing particularly on monogamous relationships. Others argued against same-sex marriage because it would not recognize the diversity of relationships and relationship structures among LGBTQ2S+ people. Judith Butler (2004) even suggested that maybe instead of marriage equality, "the task at hand is to rework and revise the social organization of friendship, sexual contracts, and community to produce non-state-centered forms of support and alliance" (p. 109). Therefore, the same-sex marriage debate seemed to involve a balance between achieving political objectives of equality and defending the diversity of individual relationship choices. The debate about PrEP seems to involve a very similar balance for gay, bisexual, and queer men between maintaining good political standing in society and embracing the diversity of sexual practices and sexual and romantic relationships found in gay communities across North America.

Both of these debates focus on the changing perceptions of gay individuals and communities and our acceptance in mainstream society. The legalization of same-sex marriage had the possibility of countering previous stereotypes about promiscuity, or non-monogamy more broadly, in gay communities, especially among gay, bisexual, and queer men, but widespread PrEP use has the possibility of actually reinforcing these sometimes negative stereotypes because of the widespread perceptions of PrEP users as being promiscuous, or having multiple partners. In fact, the stereotypes of gay, bisexual, and queer men being promiscuous seem to really have a negative effect on the acceptance of gay rights, according to David Pinof and Martie Hazelton (2017). Pinof

and Hazelton (2017) demonstrated that "representations of gay men as promiscuous interact with mating strategies to predict opposition to gay rights" by showing different individuals articles that either refuted or confirmed the stereotype. They found that individuals who were more averse to casual sex "exhibited more support for gay rights when assigned to read the stereotype-refuting article compared to the stereotype-confirming article" (2017). If PrEP does reinforce negative stereotypes about gay, bisexual, and queer men, then it really could have a negative effect on gay rights. Nevertheless, promiscuity, or having sex and building sexual or romantic relationships with multiple partners, is already prevalent within gay communities. The prevalence and importance of these practices and relationships are demonstrated by how just many gay, bisexual, and queer men actually have open relationships, engage in casual sex, and visit public sex venues like bathhouses (Levine et al., 2018; Klein, 2019; Stults, 2019). Therefore, depending on our views of these practices and relationships and how we think the stereotypes associated with them might affect the gay rights movement, some gay, bisexual, and queer men embrace PrEP and others reject it, leading to yet another challenge to our solidarity.

This particular challenge to our solidarity again demonstrates how divisions and diversity within gay communities affect how we feel about each other and our communities. Whereas divisions based specifically on sexual and romantic norms stir feelings about our collective responses to the AIDS epidemic, the political divisions based on how we want to be perceived as individuals and communities in society highlight even broader differences within our communities. The diversity in terms of age, race, gender identity, geography, serostatus, and even politics within gay communities, especially in a time of greater fragmentation, means that there are more opportunities for disagreement about how our communities should be represented in society because we have different visions of what queer communities, queer relationships, and queer sexualities really are. Some of these visions, however, are dominant over others because members of gay communities who are white, cisgender or privileged in other ways often have the power to determine which visions are accepted by the rest of society and, therefore, how our queerness is represented in society, which often excludes the representation of further marginalized queer people. The same-sex marriage debate also involved different visions of what queerness really was as well as the conflict between individual and community freedom. While some queer people see marriage equality as another example of self-rule, others see it as replicating the restrictive norms imposed on us by the rest of society, norms that have often hurt queer individuals, relationships,

and communities. Although the PrEP debate involves a similar conflict between different kinds of freedom as previous debates about safe sex and HIV prevention, it also replicates the political divisions of the same-sex marriage debate because it affects how MSM in particular see ourselves and our communities and how the rest of society sees us. If we disagree about what we take to be important aspects of our shared identity that are affected by certain stereotypes, then we weaken our overall sense of fellow-feeling, community, and solidarity.

Nevertheless, diversity in our communities and disagreements and changes within them do not necessarily threaten solidarity; they might even strengthen solidarity because they demonstrate the thoughtful debates and confluence of perspectives that are necessary in order for groups to actually build solidarity and respond effectively to the particular kind of oppression that they face. Of course, many MSM face internal oppression from within our communities because of the imbalance in power relations between different members, which makes building solidarity difficult because of the ongoing exclusion of their valuable perspectives and experiences. For example, recommendations about PrEP from a gay establishment made up of predominantly middle-aged, wealthy, urban, white, gay men can alienate young, poor, rural, Black, bisexual men, especially given the discrepancies in the awareness and uptake of PrEP among many Black men (Cahill et al., 2017; Mutchler et al., 2015). Therefore, in order for us to effectively build solidarity, gay, bisexual, and queer men, especially those with power and privilege, need to take on the responsibility for making all of us feel welcome in our communities and encouraging us to develop the kind of empathy and understanding that is necessary for broader solidarity that includes all MSM. Since there are several structural and emotional impediments to empathy across generations, racial identities, and other differences, addressing racism and other forms of oppression and ignorance in our communities and responding to the needs of MSM who are further marginalized in concrete ways would go a long way to facilitating this kind of empathetic understanding. Thus, although PrEP seems to present real challenges to solidarity within gay communities by highlighting previous divisions based on our differences in views of sexual morality that only seem to be further exacerbated by conversations about the ethics of PrEP as HIV prevention, our different experiences with HIV and HIV prevention are really valuable if we can learn to develop greater empathy and understanding for each other in ways that actually allow us to improve each other's health and wellbeing.

4.3.2. Intergenerational Views: The Legacy of the AIDS Epidemic

Although I addressed the risk of PrEP emphasizing divisions within gay communities based on our different experiences of HIV and HIV prevention, and the AIDS epidemic in particular, in Chapter 2, I return to it here because this overlooked risk also has consequences for solidarity within gay communities. Many older gay, bisexual, and queer men who lived through the AIDS epidemic in the 1980s and 1990s view sex and sexual and romantic relationships very differently than many younger gay, bisexual, and queer men because of their experiences. The worry here is that the use of PrEP among MSM, especially if it encourages condomless sex and promiscuity, or sex and sexual and romantic relationships with multiple partners, is disrespectful to the losses of the AIDS epidemic, the activists who helped make so much progress, and the norms established in the past regarding sex and sexual and romantic relationships. Upholding these norms is one way in which we can continue to honour these past sacrifices. Again, prominent AIDS activist Larry Kramer, who founded GMHC and ACT UP in New York City in the 1980s and advocated against the practices and relationships that violated these norms, worried that PrEP use among MSM would increase the risk for HIV and threaten AIDS activism and solidarity among gay, bisexual, and queer men (Brathwaite, 2015). It was previously very important to engage in safe sex and limit your number of sexual and romantic partners in order to reduce the risk of HIV among MSM in North America. Although developments in HIV treatment and prevention, like PrEP, have greatly reduced this risk for MSM, many older gay, bisexual, and queer men still view condomless sex, casual sex, and open or polyamorous relationships negatively because of their traumatic experience with HIV and the AIDS epidemic. Since these practices and relationships contributed to the deaths of many gay, bisexual, and queer men, it is understandable that many us who lived through the epidemic would view them negatively because they lost loved ones and our communities lost generations (Johnson & Styker, 1993). Since we often think of the dead as having dignity and deserving respect, some philosophers argue that the living actually have responsibilities to the dead, that we can maintain relationships with the dead, and that the dead are actually still part of our living communities (De Baets, 2004; Norlock, 2017). Therefore, honouring AIDS losses might make sense for gay communities and this might involve upholding previous, more traditional norms against particular sexual and romantic practices and relationships. Thus, if PrEP really does encourage these kinds of practices and relationships and dishonours these AIDS losses, then it is

understandable that at least some gay, bisexual, and queer men would object to its widespread use as HIV prevention.

However, many younger gay, bisexual, and queer men who did not live through the AIDS epidemic, do not understand the significance, and the tragedy, of the epidemic for gay communities, and especially the generations who experienced it in the 1980s and 1990s. There seem to be three relevant generations, or birth cohorts, of gay, bisexual, and queer men when it comes to our views about PrEP as HIV prevention: men over 50 who represent a first AIDS generation and who experienced the terrible losses of the AIDS epidemic, men in their 30s and 40s who represent a second AIDS generation and who grew up during the epidemic when the connection between sex and HIV as a death sentence was the strongest, and men in their 20s who represent a post-AIDS generation to whom HIV was always a manageable chronic condition (Hammack, Meyer, Krueger, Lightfoot, & Frost, 2018; Hammack, Toolis, Wilson, Clark, & Frost, 2019). The AIDS epidemic had a huge impact on sex education in the 1980s and 1990s and this effected the gay, bisexual, and queer men growing up then (Rothman, 2014). It is this middle generation that is also sometimes most likely to view PrEP negatively in part because "the sexual culture into which many were socialized in the 1990s was one in which condoms and monogamy were privileged, and condomless, multi-partner sex was taboo" (Hammack, Toolis, Wilson, Clark, & Frost, 2019). Although the two older generations experienced the AIDS epidemic very differently, both of them experienced its effects on sexual norms and negative perceptions of gay, bisexual, and queer men as well as gay communities in society and it had a lasting impact on both them and their views, fears, and anxieties about sex, HIV, and HIV prevention.

The post-AIDS generation of gay, bisexual, and queer men who are entering gay adult life today sometimes view PrEP, condomless sex, casual sex, and open or polyamorous relationships outside of the critical and historical context of the AIDS epidemic and they sometimes seem to be more willing to use PrEP as HIV prevention than the older generations (Hammack, Meyer, Krueger, Lightfoot, & Frost, 2018). Again, Hammack, Frost, Meyer, and Pletta (2018) describe the telling forum on PrEP at the LGBT Center in San Francisco where these three distinct generations demonstrated their differing views of sex, HIV, and HIV prevention. While a group of younger men in their 20s admitted to infrequent condom use because they view condoms are barriers to intimacy and a relic of the AIDS epidemic, a group of older men in their 50s condemned their actions as dangerous and irresponsible because of the ongoing risk of HIV, and even death, to

themselves and their communities. Men in their 30s and 40s, however, seemed to be able to relate to both generations, "having developed their sexual lives as gay men with condom use as a strong community norm but having lost few to AIDS" (Hammack, Frost, Meyer, & Pletta, 2018). This particular scene demonstrates that it is sometimes difficult for different generations of gay, bisexual, and queer men to understand each other's views of HIV treatment and prevention as well as sex, and sexual and romantic relationships more broadly because of the differing, but lasting effects of the AIDS epidemic on all generations of gay, bisexual, and queer men alive today. These differences, which are exposed, and exacerbated, by the ways in which PrEP changes sex and sexual and romantic relationships for gay, bisexual, and queer men, seem to divide us clearly along generational lines, threatening intergenerational solidarity within gay communities, which is still important as HIV rates remain relatively high among MSM today.

What seems to be another fight over sexual and romantic norms within gay communities is actually a series of conflicting claims about what it is to demonstrate solidarity with queerness because these different claims enact different visions of what queer communities, relationships, and sexualities really are. In the case of conflicts in intergenerational views, in particular, these visions of queerness are shaped by different generations' experiences with the AIDS epidemic. While older generations might see queerness as honouring the norms we developed ourselves during the epidemic in order to respect past fights and losses, younger generations might see queerness as developing new norms that are responsive to technological, social, and political changes, like PrEP. Therefore, it is not that PrEP itself is a threat to solidarity, it is that fights over the acceptability of PrEP as HIV prevention and its effects on our lives, relationships, and communities reveal just how important solidarity really is for us. It is conflicting views of solidarity based on whether MSM feel that their communities are respectful, trustworthy, supportive, and loyal that are actually dividing gay communities. The philosophical work on solidarity, especially empathetic, affective, and relational accounts of solidarity, helps explain why these challenges exist in the first place, but also helps contribute to settling or easing these challenges. It is not always clear how to actually build solidarity in the face of such challenges, but MSM can at least aim to develop an understanding of the different perspectives and experiences of different members of our communities and work to build, or strengthen, the kind of respect, trust, support, and loyalty that is necessary for solidarity and that often already exists between us regardless of our sometimes differing views. The real challenge, however, is how deeply held some of these different views are and how difficult it really

is to develop empathetic understanding of others' perspectives and experiences when the issues are so personal for members of gay communities.

Overall, the challenge to solidarity that stems from these differences in intergenerational views is quite different from the challenge to solidarity that stems from differences in sexual moralities. Although both challenges are similar insofar as they centre on differences in the views of gay, bisexual, and queer men of sex and sexual and romantic relationships, those involving sexual morality do not seem to divide us along any clearly defined social and political lines, like our age, our membership in a certain generation or our experience of the AIDS epidemic. Gay, bisexual, and queer men clearly have many different kinds of sexual moralities and these divide us in various ways, but these divisions often seem to be based on misunderstandings or assumptions about the effects of PrEP on sexual practices and sexual and romantic relationships or the dominance of some MSM over others, leading to greater stigma and less access to PrEP for many. Solidarity among MSM and within gay communities is certainly threatened by these kinds of divisions, but the understanding that is required for us to understand each other can more easily make use of the data on PrEP. For example, if PrEP does not actually increase rates of other STIs within gay communities, then MSM who condemn condomless sex might have good reasons for changing their sexual moralities because of this data. Likewise, according to the data, MSM who do not use PrEP might be doing so because they face greater stigma or have less access to PrEP based on either their race or whether they live in urban or rural areas.

The challenge to solidarity involving differences in intergenerational views, however, divides gay, bisexual, and queer men along clearly defined generational lines. Older gay, bisexual, and queer men have very good, especially affective, reasons for objecting to PrEP and worrying about its effects on sexual and romantic norms in our communities. From the point of view of older generations, things like casual sex and open relationships might demonstrate that younger generations are freeriding on their significant past sacrifices. Losses during the AIDS epidemic were especially painful for MSM because of how many of us died in such a short period of time in the 1980s and 1990s; some MSM lost not only their lovers, but also many of their friends and members of their chosen families. Those who died in hospitals during this time were also often not visited because of serophobia or denied visitors because hospitals did not recognize their lovers, friends, or chosen family members. MSM had to fight for their survival and their basic rights during the AIDS epidemic at a time when governments, public health establishments, and most of

the rest of society had abandoned them, but their achievements have had long-lasting effects on access to HIV treatment and prevention for MSM and the rights of gay, bisexual, and queer men more broadly. “I want people to understand why they’re able to take this right now”, says one man, who lived through the AIDS epidemic and lost many loved ones, about PrEP in an interview with *New York Magazine*, “it’s on the backs of people who have died and suffered. All that needs to be learned and honored” (Murphy, 2014). Even some younger gay, bisexual, and queer men who use PrEP as HIV prevention acknowledge this history, including Leo Herrera who says, “I feel very proud because a lot of men have died for me to be able to do this” (Murphy 2014). Understandably, the terrible losses that older generations suffered during the AIDS epidemic affected their views of sexual and romantic norms in our communities and their feelings about those who violate these norms, but now we all have to work together to better understand how the lessons of this history can be incorporated into our ongoing responses to HIV today. Again, Krishnamurthy (2013) stresses the importance of the affective component of solidarity, which involves how we feel about each other, because these feelings are what actually ground solidarity. It is, therefore, sometimes especially difficult for gay, bisexual, and queer men to understand each other across generational divides because they arise precisely from our very different experiences of the history and legacy of the AIDS epidemic depending on our age. Overall, these challenges to solidarity within gay communities, differences in sexual moralities and intergenerational views, which are exacerbated by MSM increasingly using PrEP as HIV prevention, are serious for gay, bisexual, and queer men and they demonstrate how widespread PrEP use has far-reaching social and political consequences for gay communities in North America.

4.4. Responding to the Challenges: Rebuilding Solidarity

Although PrEP seems to present challenges to solidarity within gay communities, it also seems to presents opportunities to build, or rebuild, solidarity around HIV and HIV prevention as well as the personal relationships between gay, bisexual, and queer men and our communities. Each of the divisions that I detailed in the previous section seems to stem from a lack of empathy and understanding of different perspectives and experiences, whether it’s differences in sexual moralities or differences in intergenerational views. This lack of empathy and understanding, in turn, stems from communities, and a wider society, where individuals often take their perspectives

and experiences to be the norm without realizing that others think, feel, and act differently for sometimes very good reasons. Since sex, sexual and romantic relationships, and especially HIV and HIV prevention are such personal and emotional subjects for MSM because of the history of the AIDS epidemic and the ongoing vigilance around HIV prevention that is necessary for both individuals and communities, we need to find a way to develop empathetic understanding for others in our communities even when we have different views that bring up painful memories or difficult emotions. Addressing these challenges to our solidarity, demonstrates the kinds of actions, conversations, and collaborative projects that MSM would need to engage in to understand each other's differing views about PrEP as well as each other's differing views of sex, sexual and romantic relationships, and even HIV and HIV prevention more broadly. In Chapter 3, I explained that individual gay, bisexual, and queer men have the responsibility for creating the conditions for trust in our personal relationships and that members of gay communities have a responsibility for creating broader conditions for trust in our communities themselves. However, trust is only one of the relational qualities that is necessary for solidarity, according to Krishnamurthy (2013) and others (Taylor, 2015; Prainsack & Buyx, 2011; Sherwin & Stockdale, 2017). Respect, support, and a sense of loyalty are also important in order for members of a group to really feel solidarity with each other. The best way to foster all of these relational qualities, then, is to focus on the affective component of solidarity, the way MSM actually feel about each other despite the deep divisions in our communities. It is these feelings that eventually lead to, and motivate, the kinds of solidary actions that actually constitute respectful treatment of each other, support for each other's decisions, practices, and relationships, and loyalty to our broader communities.

Therefore, again, it is not that MSM need to start expressing those actions to one another or finding reasons for acting in solidarity with each other, it is that MSM need to start developing empathy for one another. We can actually do this in some of the same ways that gay communities fostered solidarity around HIV prevention during the AIDS epidemic, including community intervention and attachment strategies, like outreach and education at gay events, venues, and peer groups as well as on gay media platforms. We also have to actually spend time with gay, bisexual, and queer men who have different views than us in order to see ourselves in them, whether it is identifying shared experiences with them or learning about the experiences that they have which we do not because of differences in age, race, gender identity, geography or serostatus among other factors. Unfortunately, the power differences between gay, bisexual, and queer men due to these

factors create barriers to empathy in gay communities because those with power and privilege are often ignorant of, or even prejudiced against, those who are further marginalized. Thus, MSM who have power and privilege in our communities, and in our wider society, because of these factors, especially if we are healthcare providers, community organizers, or academic researchers, have greater responsibility for removing, or at least alleviating, these barriers to create the conditions for broader solidarity. In order for even substantive disagreements and changes within a community, like the advent of using PrEP as HIV prevention and the subsequent debate about its widespread use among MSM, to strengthen instead of hurt solidarity, members of the community need to have strategies in place for developing empathetic understanding for one another. It is necessary to first think well of each other, understand each other's perspectives and experiences, and establish more just relationships with each other across power differences in order for us to actually be there for each other in concrete ways and act in solidarity with each other more broadly. In the rest of this section, I consider how even simple conversations between MSM with differing views can be an effective strategy for bridging divisions and rebuilding solidarity by allowing MSM to share what we think it is to actually be in solidarity with our communities.

First, gay, bisexual, and queer men need to engage in conversations around the sexual and romantic norms that seem to belong to, or emerge out of, our communities. Gay, bisexual, and queer men clearly have different sexual moralities based on different norms for different reasons, but PrEP presents opportunities for us to discuss the bases of these sexual moralities and norms with each other, regardless of whether gay communities continue to embrace PrEP or not. If non-traditional sexual practices, like condomless sex, and non-traditional sexual and romantic relationships, like non-monogamous relationships, are safer because PrEP reduces the associated risks of HIV, then gay, bisexual, and queer men who have sexual moralities that are wary of these practices and relationships might change their views by becoming more comfortable or familiar with them. This might even increase the acceptance of non-traditional sexual practices and non-traditional sexual and romantic relationships among MSM and within gay communities more broadly. Likewise, if some MSM are using PrEP incorrectly or inconsistently, then discussions about the reasons for certain sexual and romantic norms might be helpful for promoting greater diligence around HIV prevention. Since many gay, bisexual, and queer men already engage in condomless sex, casual sex, and sex with multiple partners and build open, non-monogamous, and polyamorous relationships, this greater diligence around HIV prevention and increased acceptance

of different sexual practices and relationships might actually help strengthen different members' connections to others in our communities, whether they were previously judging others or being judged by others themselves. Feeling connected to the other members of your community is crucial for solidarity, but since MSM see the norms that we developed ourselves in response to HIV very differently, we can often feel disconnected from our communities. Therefore, instead of us seeing the traditional norms around HIV and sexual practices and relationships as restrictive or the new norms as disrespectful, we need to understand that they actually represent different ways of conceiving of solidarity. The traditional norms are a way of honouring the past for many MSM and maintaining diligence around HIV prevention and the new norms are a way of promoting sexual and relational freedom and diversity for many others. Both of these conceptions of solidarity centre on the goods of the community and the responses to the oppression that all gay, bisexual, and queer men face because of our shared identity in society, but each of them leaves the impression that the other one actually undermines solidarity. One of the values of solidarity, however, is people coming together regardless of what outcome they come together around, in this case, whether or not one conception of solidarity or the role of sexual and romantic norms in gay communities is widely adopted over the other. Thus, having conversations with each other that reveal we often simply have different conceptions of solidarity might help us realize that we can still build solidarity in our communities even though we sometimes have different views of sexual and romantic norms, practices, and relationships.

This approach to understanding each other might also strengthen solidarity within gay communities by actually breaking down divisions created by differences in sexual moralities. Solidarity is threatened when individuals with a shared identity focus on what makes them different from each other and it is strengthened when individuals recognize their shared identities with others regardless of the differences between them. Sherwin (2008) and Sherwin and Stockdale (2017) explain that solidarity involves how individuals think about, and relate to, each other and how the resulting relationships affect their decisions, their health, their behaviour, and their trust of others who are relevantly similar to themselves. Therefore, if we try to work through our differences and improve our understanding of each other's different views of sexual practices and relationships, then maybe we can start to rebuild our solidarity by developing greater empathy. Furthermore, although many gay communities are very accepting of different sexual practices and relationships, if every corner – and particular dominant, "homonormative" corners – of gay communities become

more accepting of both non-traditional sexual practices and non-traditional sexual and romantic relationships, then it is possible that the rest of society might become more accepting of them too, which could strengthen broader solidarity around HIV prevention beyond gay communities. MSM are disproportionately affected by HIV, but heterosexual cisgender and transgender men and women as well as non-binary people are also affected by HIV and they might have less experience with, or less support for, dealing with the effects of serophobia or relying on solidarity with other individuals and communities affected by HIV in order to access treatment, prevention or other resources. Although PrEP is increasingly being studied as HIV prevention in these other groups, the solidarity that MSM are able to build around PrEP, HIV, and HIV prevention despite our divisions might help others overcome similar challenges by setting an example for them.

Second, gay, bisexual, and queer men would also need to engage in conversations around the history and legacy of HIV/AIDS in order to further develop empathetic understanding for each other across generations. Again, different generations often have different views of PrEP as HIV prevention because of differences in our experiences of the AIDS epidemic or its lasting effects in society and differences in our views of sex and sexual and romantic relationships because these views are directly shaped by our experiences, and our perspectives, of the AIDS epidemic and its effects on our communities in particular. PrEP also presents opportunities for us to discuss these experiences and perspectives with each other, especially when we have sex or build relationships with gay, bisexual, and queer men from different generations because we usually have to discuss HIV prevention with each other before, during or after sex anyway. Although Larry Kramer was initially opposed to PrEP because of his personal experience with the AIDS epidemic and his dedication to AIDS activism, especially his advocacy for practicing safe sex by using condoms, he eventually endorsed PrEP as HIV prevention, along with other intergenerational activists, because of the evidence of its effectiveness and he even called out Gilead, the pharmaceutical company that manufactures Truvada, for its “abusive pricing of its near monopolies in drugs that treat and prevent HIV” (Bratwaithe, 2015). It is the prohibitive cost of PrEP that contributes to the problem of accessibility, especially in rural places and among Black, Indigenous, and Latino MSM in North America. Kramer was acutely aware of the problem of accessible HIV treatment and prevention because of his personal experience fighting for access to experimental medication for gay, bisexual,

and queer men during the AIDS epidemic with ACT UP.[21] It is these kinds of historically informed perspectives on PrEP, and changes in perspectives, that are incredibly valuable for gay communities because they highlight the oppression that we face as gay, bisexual, and queer men and the power of solidarity, advocacy, and intergenerational collaboration. Younger generations need to both understand that older generations are burdened with the history of HIV/AIDS, either because of the losses they suffered or their sex education, and learn from them in order to more fully understand the social and political context of PrEP today. Likewise, older generations need to understand that younger generations are not always aware of the complicated history of HIV/AIDS and share the lessons they learned then with them now. Again, older generations sometimes understandably view things like safe sex and monogamy as crucial for HIV prevention and younger generations need to be able to discuss emerging medical technologies and changing sexual and romantic norms with them too. The PrEP forum at the LGBT Center in San Francisco could have presented an opportunity for this kind of intergenerational learning and empathetic understanding if the importance of solidarity and its connection to successful HIV prevention was a more prominent part of the broader discussion of the ethics of PrEP in both the academic literature and gay communities themselves (Hammack, Frost, Meyer, & Pletta, 2018).

If different generations of gay, bisexual, and queer men more fully understand each other's views of HIV and HIV prevention and approach this understanding with empathy for the difficult memories and anxieties around HIV that we all share, then we might be able to strengthen our connections to each other and thereby strengthen the solidarity within our communities by breaking down intergenerational barriers. Krishnamurthy (2013) emphasizes the importance of the affective, active, cognitive, and relational components of solidarity and all of these components are necessary for solidarity, but it is the affective and relational components that are especially helpful for addressing this particular challenge to solidarity surrounding HIV prevention for MSM. Although solidarity seems to be driven by our actions, thoughts, feelings, and relationships, it is our feelings and the ways they affect our actions, thoughts, and especially our relationships that are crucial for MSM to pay attention to regarding HIV and HIV prevention. The AIDS epidemic affected how different generations of gay, bisexual, and queer men feel about HIV and HIV prevention in

[21] Nevertheless, Larry Kramer's identity as a white, cisgender, gay man certainly contributed to his role as the face of ACT UP and his approach to activism, despite his work on HIV treatment accessibility. See Schroeder, D. (2020). Larry Kramer and ACT UP. *Outward*. <https://slate.com/ podcasts/outward/ 2020/06/act-up-larry-kramer>. Last accessed October 7, 2020.

different ways, but PrEP is affecting how we feel about our sexual practices and relationships in relation to HIV all over again. This presents a unique opportunity for MSM to rebuild solidarity in our communities because we can establish, or re-establish, sexual and romantic norms in response to PrEP together based on mutual respect, trust, and support, which foster broad solidarity by incorporating lessons from our different intergenerational experiences and perspectives of HIV and HIV prevention. The first step is for gay, bisexual, and queer men of different generations to cultivate attitudes of collective identification with each other despite our differences by engaging in difficult conversations about our shared identity and our shared experiences with HIV in order to use the resulting solidarity to actually advocate for our communities, especially in a society that still does not always take our concerns seriously.

Finally, if gay communities are able to rebuild solidarity around PrEP, then we can use our solidarity to not only advocate for ourselves, but also set an example for other communities, or even the rest of society, to use solidarity in order to respond to issues involving public health and wellbeing that inevitably have social and political dimensions. The COVID-19 pandemic, for example, demonstrates how even a public health crisis that affects everyone in society has social and political dimensions when it comes to government responses, norms around social or physical distancing and wearing masks, and feelings of shame, anger, and frustration over the loss of life and restrictions of freedom. Both Krishnamurthy (2013) and ter Meulen (2013) highlight the importance of solidarity specifically in terms of justice; building political solidarity helps us to commit ourselves to justice because we learn to understand and empathize with other people's struggles. In the case of justice in healthcare, political solidarity also helps us realize that the issue is never just about distributing, debating, accessing, or even taking a medication like PrEP. Justice involves attending to how a medication interacts with the identities and relationships of the individuals and communities who are using them. If gay communities have a strong sense of how we understand our identities, our relationships, and our conceptions of solidarity, then our concerns regarding access to PrEP and other ethical issues involved in PrEP use might be taken more seriously by the governments and healthcare institutions that control things like access because of our advocacy. This is what is at stake for MSM with PrEP and why HIV treatment and prevention was one of the foundations of solidarity among MSM and gay, bisexual, and queer men in North America starting during the AIDS epidemic and continuing until today. Therefore, although PrEP seems to challenge this solidarity by exposing deep divisions within gay communities, if we do the

necessary work of having difficult conversations with each other about our shared identities and our experiences with HIV and HIV prevention among other actions and adjustments aimed at reconciliations, then PrEP actually has the possibility of helping us rebuild solidarity within our communities by increasing the empathetic understanding between gay, bisexual, and queer men who have different views, but who have similar interests when it comes to the health and wellbeing of our communities.

4.5. Conclusion: Social and Political Challenges and Opportunities

In conclusion, focusing on the concept of solidarity reveals some of the most important social and political dimensions of the ethics of PrEP by highlighting both the challenges and opportunities that using PrEP as HIV prevention presents to MSM and gay communities across North America. The first challenge involves highlighting differences in sexual moralities among MSM, including different views of safe sex, promiscuity, and stereotypes, and the second challenge involves differences in intergenerational views. Although both of these challenges expose, and exacerbate, differences in views about HIV prevention within gay communities, they also present opportunities for gay, bisexual, and queer men to develop greater empathy and understanding for each other across several divisions within our communities by engaging in important conversations about how we view ourselves as part of gay communities, how we view each other as community members, and how our communities are viewed by the rest of society. We all have a responsibility to create the conditions for empathy in our communities, but gay, bisexual, and queer men who have power and privilege in society have a particular responsibility to remove barriers to empathy that further marginalize many in our communities and prevent different groups from feeling solidarity with each other. The affective and relational aspects of solidarity are particularly important to attend to here because HIV and HIV prevention are so personal for gay, bisexual, and queer men and we need each other in order to be able to advocate for our collective health and wellbeing.

Since HIV continues to be a central part of the sexual and romantic lives of MSM, it is crucial to acknowledge that PrEP will continue to affect us in myriad social and political ways because it is more than just a medicine with risks and benefits for our health and wellbeing, it affects the trust in our most intimate relationships and the solidarity in our communities that is

necessary for further advocacy. The lessons that MSM are learning about the importance of the social and political dimensions of the ethics of PrEP are especially relevant today as we face the COVID-19 pandemic and adjust to medical treatment and prevention strategies that are challenging trust and solidarity in society in new ways. As we increasingly use relational moral concepts, like solidarity and trust, in addition to more traditional concepts, like risk, in order to analyze the social and political dimensions of issues in bioethics related to healthcare, the ethics of PrEP offers an example where the concepts of risk, trust, and solidarity work together to clearly demonstrate the wide-ranging and long-lasting effects of medical technologies on individuals, their relationships, and their communities.

CONCLUSION

When many of us think about the ethics of PrEP, our first questions are about its clinical safety and efficacy as HIV prevention. If it passed the risk assessments of Health Canada and the FDA and it is safe and effective as HIV prevention, without the risks of serious physical side-effects or the risks of creating drug-resistant strains of HIV, then we conclude that its widespread availability and use among MSM, and other groups, is certainly morally acceptable and worthy of even sustained public advocacy, especially given the ongoing HIV/AIDS pandemic. However, in this thesis, I hope to have demonstrated that beyond this preliminary ethical analysis, questions about the broader social and political effects of PrEP on its users, specifically gay, bisexual, and queer men, are necessary for not only better understanding the ethical issues involved in its use, but also optimizing its success as a relatively new and promising HIV prevention strategy. This is true because of both the history and the ongoing legacy of HIV as a biomedical and *political* phenomenon in North America.

In Chapter 1, I provided the critical and historical context for the ethical debate about PrEP as HIV prevention, which showed that the ethics of HIV and HIV prevention have always had social and political dimensions for gay, bisexual, and queer men. Although there is a tendency to conceive of the ethics of PrEP and other ethical issues related to healthcare as strictly medical issues, the use of new medical technologies is always embedded in a social, political, and historical context that interacts with the lives, relationships, and communities of different social groups in myriad ways. I considered the most obvious precedent for PrEP, the use of the birth control pill among women, to highlight its effects on the power dynamics between partners in sexual and romantic relationships as well as the wider perceptions of its users in society. In order to more closely investigate these social and political dimensions of the ethics of PrEP, I turned to the moral concepts of risk, trust, and solidarity in the following chapters to provide an ethical analysis that builds up from the decisions of individuals to their relationships with others.

In Chapter 2, I argued that the present risk assessment approach to the ethics of PrEP was distorting the kinds of risks that we often think are involved in PrEP use among MSM and obscuring the importance of the lived experiences of MSM with sex, HIV, and HIV prevention. Although risk is certainly an important concept when discussing the use of medical technologies,

like PrEP, it needs to be contextualized within particular histories, like the history of HIV, which shapes our perceptions of what is risky when it comes to the sexual practices and relationships of MSM as well as our HIV prevention strategies. Since it is MSM who actually weigh the risks and benefits of using PrEP ourselves, the ways in which the academic literature, the government, and the public health establishment approach the ethics of PrEP is important because it affects whether MSM decide to use it, how we view its wider use, and how it ends up affecting our sexual and romantic relationships and our broader political communities. Therefore, I encouraged a broader approach to the ethics of PrEP that analyzes its effects on the trust in our relationships and the solidarity in our communities in order to better understand these particular effects.

In Chapter 3, I explained that it is important for MSM to trust each other around HIV prevention in order for PrEP to actually be a successful HIV prevention strategy for us. MSM need to be able to trust our sexual and romantic partners to use PrEP correctly and consistently in order for it to be effective as HIV prevention. We also need to be able to trust our healthcare providers, especially given the history of medicalizing homosexuality in healthcare institutions, because they are the ones who actually prescribe us PrEP. Therefore, I considered both interpersonal trust and institutional trust in order to understand how MSM can create the conditions for trust in both our relationships with sexual and romantic partners and our relationships with healthcare providers. I argued that this involves MSM establishing open communication with our partners, healthcare providers learning more about the experiences of MSM with HIV, and gay communities supporting these initiatives by offering resources for both MSM and healthcare providers to actually develop these skills through community-based counselling, education, and advocacy.

In Chapter 4, I explained the importance of solidarity within gay communities in order for them to successfully advocate for access to PrEP as HIV prevention as well as the broader health and wellbeing of MSM in terms of HIV/AIDS. Although PrEP presents challenges to previous solidarity in gay communities, which was established in response to the AIDS epidemic, by exacerbating differences in sexual moralities as well as intergenerational differences, it also presents opportunities for rebuilding the foundations of that solidarity. I argued that if gay, bisexual, and queer men are able to develop greater empathy and understanding for each other's perspectives and experiences across these divisions within our communities by engaging in difficult conversations with each other, among other community-based actions, then we might be able to reconcile our different views of sexual practices and relationships and HIV prevention strategies.

This reconciliation is necessary in order for us to rebuild solidarity around HIV prevention in our communities, which is important for further advocacy, but gay, bisexual, and queer men have very different responsibilities in this process because of unequal power relations in our communities depending on social factors like age, race, gender identity, geography, and serostatus.

It is precisely because these questions of responsibility are so nuanced, and the kind of trust, solidarity, and inclusion required to create conditions for responsibility are presently quite fragile, that this thesis is not – and cannot be – a straightforward argument for or against the widespread use of PrEP among MSM. If anything, I have argued that we cannot yet even ask the simple question, "should MSM embrace PrEP?", until we more fully recognize the role that the socio-political context plays in how that question is articulated, asked, and answered by those in various corners of gay communities and until we have worked to make it a question that can be reasonably asked and answered in the affirmative. Gay, bisexual, and queer men need resources that many of us do not currently have in order to be able to make better decisions about when and whether to use PrEP ourselves and develop the skills to discuss it with our sexual and romantic partners, our healthcare providers, and other members of our communities. If PrEP is going to be a successful alternative HIV prevention strategy to condoms for MSM, then we have to be prepared for how to assess its risks ourselves, including weighing its risks against its benefits, how using it is going to affect our trusting relationships with our sexual and romantic partners, and how its use presents challenges as well as opportunities for rebuilding solidarity in our communities. First, the academic literature needs to move away from a strictly medicalized conception of the ethics of PrEP based on traditional risk assessment and towards a more socially and politically informed ethics of PrEP in order for policy analysts, government officials, healthcare providers, and gay, bisexual, and queer men ourselves to start paying closer attention to the social and political dimensions of PrEP use today. Then, by creating the conditions for trust in our relationships and by developing empathetic understanding for members of our communities who have different views than us, we can better integrate PrEP into our lives as yet another safe, effective, and promising HIV prevention strategy for a social and political group whose sexual and romantic lives continue to depend on our broader responses to HIV/AIDS.

Overall, drawing on recent feminist philosophical work on the moral risks and rewards of trust and the complexities of community solidarity, I argued that the ethical implications of PrEP cannot be grasped on an individualist model and must instead be situated in a much broader social

and relational understanding of the lives of gay, bisexual, and queer men and the politics of the LGBTQ2S+ rights movement. Therefore, my conceptual analysis not only helps to address the ethics of PrEP in particular, but it also helps further develop the theoretical foundations of risk in bioethics, interpersonal and institutional trust, and political solidarity within communities whose members have different perspectives and experiences. My thesis also raises several further questions about the ethics of HIV more broadly: how will future developments in HIV treatment and prevention affect the lives of MSM and the philosophical theories and concepts that are used to understand them? Is HIV really an exceptional health issue, even for MSM and the rest of the LGBTQ2S+ community in North America whose experiences with the pandemic are uniquely complex? Does bioethics properly account for biases around sex and sexuality involved in the ethics of issues like PrEP and the birth control pill, which are often treated differently than other related issues in the research?

The conclusions of this thesis present a framework that is helpful for answering these questions, especially understanding the wider effects of future developments in HIV treatment and prevention among MSM, including undetectable equals untransmittable (U=U). Again, U=U is a new campaign to inform people about the new development in HIV treatment and prevention which asserts that an undetectable HIV viral load is actually untransmittable. People living with HIV face serophobia, the fear of HIV, and a prevention strategy like PrEP, which focuses on people who are HIV-negative, might actually reinforce this fear by continuing to stigmatize HIV and people living with it. However, the fact that it is now impossible for people living with HIV who have an undetectable viral load to transmit the virus to others recenters the discussion of HIV prevention on people who are HIV-positive and further changes the dynamics in the personal, sexual, and romantic relationships of MSM as well as the wider perceptions of gay communities in society. Since the medical risks of HIV transmission are eliminated by U=U, the social and political risks of reinforcing stigmas, stereotypes, and divisions within gay communities based on serostatus, especially for people living with HIV, become much more prominent as do the benefits of building serodifferent relationships with each other. When we have sex or build sexual and romantic relationships with each other, being HIV-positive is no longer a barrier to trusting our partners if they are undetectable. Solidarity based on empathetic understanding of the perspectives and experiences of others remains necessary in this case in order for MSM to combat serophobia in our

communities more broadly so that a development like U=U can really improve the lives of people living with HIV, their partners, and their communities.

Finally, my conclusions also have implications for other related issues involving new medical technologies, including new developments during the COVID-19 pandemic. Today, the prevention of the novel coronavirus involves simple methods of prevention like staying at home, staying two metres apart, and wearing face masks. However, each of these simple measures has social and political dimensions and affect our lives, our relationships, and our communities in myriad ways. We all have to navigate the medical risks of either contracting or transmitting the novel coronavirus whenever we decide to leave our home, but we also have to navigate the social and political risks involved in using certain prevention methods, like face masks, and the stigmas or stereotypes associated with either using them or not using them. Unfortunately, the controversies around these measures are already being taken up for political gain and it seems to be very difficult to provide even simple biomedical information that can be understood in the same way by various groups in society, especially when it comes to face masks and a possible coronavirus vaccine. Again, we have learned that scientific literacy is fragile and it is an early casualty in a politicized pandemic in the same way that false information about HIV and negative attitudes around sex and sexuality led to serophobia that seriously impacted the treatment of MSM in society. Furthermore, we have to ask ourselves if we really trust our friends, family members, co-workers, roommates, and other community members to actually follow the public health guidelines regarding these methods of coronavirus prevention and any new measures in the future. Although many of us have different perspectives of these measures and different experiences with the coronavirus, broad political solidarity is still very important for any successful response to this pandemic because the current prevention strategies require everyone to use them in order for them to be effective at reducing the spread of coronavirus in society. COVID-19 and HIV/AIDS are different in many ways, but my conclusions about the social and political dimensions of PrEP as HIV prevention among MSM and the important roles that the moral concepts of risk, trust, and solidarity play together in our healthcare decisions, our relationships, and our communities during a pandemic are just as timely and relevant for everyone during the COVID-19 pandemic as they are for MSM during the ongoing HIV/AIDS pandemic.

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