

# Biopolitics, citizenship, and inequalities in HIV assemblages

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## Abstract

Di Felicianantonio and Brown offer an important overview of key research areas for the geographies of PrEP, TasP, and undetectability, and they consider what matters for the lives of gay and bisexual men. I offer two areas of further consideration. Firstly, I suggest that rather than setting the biopolitical critiques of PrEP and TasP as at odds with grassroots activism, sexual pleasure, and subjectivities, that these particular forms of biosexual activism are indeed central to subject formation and sexual practices and are constitutive of the other within HIV assemblages. Secondly, I highlight the need to consider inequalities more directly both within the context of national borders in relation to jurisdictional health policy, implementation, and access, and within gay communities themselves in relation to intersectional and embodied identities.

## Keywords

Biosexual citizenship, activism, intersectional inequalities, UK, HIV, PrEP, TasP

Di Felicianantonio and Brown (2022) offer a distinctly geographical contribution to analysing the radically changing biomedical HIV technologies and their capacity to reorganise social and material worlds, in particular for gay and bisexual men in high-income or minority world contexts. They provide a comprehensive overview of the contributions geography has made to HIV research, and sketch out important areas for further work for the field. I am impressed by how the authors cover such a vast – and nebulous – field, both in terms of the materiality of the virus and its biotechnological apparatus, and more widely in relation to the reconfiguration of social and sexual practices, the heterogeneous transformation of its delivery and the wider HIV context. Their attempts to craft TasP and PrEP assemblages is indeed what a number of us in sibling disciplines have been

discussing – and attempting – for some time (e.g. Keogh and Dodds, 2015). I welcome this contribution, indeed provocation, from medical geography which has long contributed essential critical thinking to social science research in health and illness in general, and HIV in particular, as the authors outline. While there is much with which to engage, I would like to pick up on two areas raised throughout the article and push the authors – and other social scientists – to think through some of the implications of these orientations and/or absences in the work.

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## Biopolitics, activism, and citizenship

In the section on ‘Biomedical surveillance and biopolitics’, Di Feliciano and Brown sketch out the academic debates over PrEP, biopolitics, and pharmacopower. Although they suggest that a focus on these biopolitical debates will identify important concerns in relation to PrEP, they note that ‘these approaches limit researchers’ capacity to rethink negotiations between sexual practices, medical technologies, desire, pleasure and subject formation’. I do not necessarily disagree with the sentiment of this statement and the ways in which pleasure, amongst other things, is often excluded from biopolitical explorations. However, I do suggest that rather than seeing this topic as limiting, we ought to pay closer attention to how, where, when, and for whom the biopolitical, pleasure, and ‘community’ identities are constitutive of these biotechnologies, and each other.

In my research on PrEP, and to a lesser extent TasP, I pay attention to how biomedicalization and enactments of bisexual citizenship (Epstein, 2018) allow us to examine how biopolitics are indeed critical to forms of community activism as well as identity and sexual practices (Jones et al., 2020). That is, considering not (only) if and how people are ‘responsible’ or ‘compliant’ in relation to biotechnologies, but how they understand and respond to the imperatives to act as biological (Petryna, 2002; Rose, 2007) and/or sexual (Richardson, 2018) citizens in this new biotechnological era. This means paying attention to how the wider scientific, health, regulatory, and social structures affect and shape the make-up of these new biotechnologies *and* the communities who are expected to – or prevented from – taking up these new tools.

Where the authors note the concerns of Preciado and Dean in relation to PrEP and the pharmaceuticalisation of HIV and gay and bisexual men’s bodies, in contrast to Florêncio and others’ analyses of the increased ‘democratic biopolitics of PrEP’, I suggest that we need to pay more attention to the complexities which fall between and across these biopolitical poles. When I first began my research on PrEP, I too had similar concerns about the increasing

biomedicalization of HIV prevention through intensified surveillance and pharmaceutical control which came with PrEP and TasP, and in particular the implications for those most affected by HIV (not only gay and bisexual men, but other communities deemed epidemiologically vulnerable in the UK such as people from countries where HIV is endemic). As a sociologist of health and illness with an interest in history, I have been trained to be suspicious of magic bullet responses to biosocial phenomena (Brandt, 1987; Kippax and Stephenson, 2012). But, as I engaged with community *and* clinical partners in early research, I was taken aback by how health practitioners were also highly dismissive of PrEP on the basis that these communities would not be able to ‘comply with’ the heightened demands of this new intervention. Similar claims were made in relation to TasP and not ‘trusting’ that people living with HIV would actually adhere to strict treatment regimes to maintain an undetectable viral load that might offer protection to a sexual partner. Although health paternalism is certainly not a new phenomenon, this mistrust of community capacity to use new HIV prevention technologies effectively seemed at odds with the longstanding historical narratives and practices of collective and creative harm reduction responses to crises (Crimp, 1987). As such, I sought to understand if and how communities might actually engage with these new technologies and what we could, in fact, *learn from* these communities (Young et al., 2016, 2019). I raise this point not (only) to reflect on my own PrEP and TasP journey over the past ten years, but to think through the historical and contemporary biopolitical factors at play in this emergent treatment as prevention field.

In addition – or perhaps as an alternative – to concerns about narrow biopolitical determinism, the authors point to its ‘opposition’ through the grassroots activism as collective agents of change, especially in relation to PrEP. Arguing that ‘gay men have been active agents in bringing the PrEP assemblage into being, thus challenging the crudest biopolitical readings of PrEP’, the authors rightly point to how grassroots advocacy groups foster a ‘knowledge commons’ around PrEP and its effective use, thus enabling even more effective awareness, access, and use than the established public health apparatus. While I agree

that particular forms of community activism have and will continue to play a critical role, I suggest that these particular forms of biosexual activism are also central to subject formation for communities. The re-invigorated figure of the gay man as HIV activist, which is central to contemporary PrEP (and to a lesser degree, TasP) activism, purposefully draws on AIDS activist histories that have been and continue to be central to community identities and sexual practices. Moreover, this grassroots activism is highly intertwined with the biomedical establishment and clinical services; much of the work of getting PrEP into UK NHS services involved collaborations with clinical partners, using NHS services, enlisting clinical practitioners into community activist activities, and mobilizing clinical research for advocacy (Jones et al., 2020; Young, 2021). Indeed, sex-positive PrEP activism is inherently tied to the formation and re-inscription of gay subjectivities, enabling pleasure in sexual pleasure, and the wider regulatory and clinical biotechnological apparatus of HIV.

### De-centring inequalities

I was particularly interested in how inequalities were examined in Di Feliciano and Brown (2022) article. The authors are explicit in their focus on gay men, a group disproportionately affected by HIV in a Global North/minority world context, but who, as of late, are often portrayed as a highly privileged if diverse community. While the transnational flow of PrEP, TasP, and HIV activism is of particular importance to how messages are shaped and how the biotechnologies themselves are constituted, the dominant orientation of the article was not 'global' but very much focused on particular communities within high-income countries. I recognize that there is much to be said on HIV assemblages globally and this was not the aim of the authors, so this is not a criticism of their focus otherwise. Rather, I suggest that more could have been made of geographical and jurisdictional inequalities *within* the national contexts on which they largely focused. The regulatory case of PrEP in the UK is a good example of how federal/national and provincial/state/local authority jurisdictions and health policy play a key role in not only facilitating access to particular biotechnologies and services,

but also in how these new biotechnologies are cast through national and regional organisational policy and practice. These shape the orientation of provision and the constitution of what these biotechnologies are and who they might be for. That the provision of PrEP through NHS services in the UK was facilitated through a government sexual health and blood borne virus framework (Scotland), a public health 'trial' (Wales), a pilot sexual health community programme enabled by Westminster funding (Northern Ireland) and a protracted court battle, a highly criticized community trial and high profile advocacy (England) between 2017 and 2020 provides some insight into how heterogeneous health systems, health policy, and implementation can contribute to significant inequalities within national borders. Moreover, the particular forms of PrEP activism within these borders highlight the role of metropolitan gay community identities and the mobilisation of social capital in enabling successful if unequal access to HIV prevention.

In addition, I was surprised that there was little reference to heterogeneity *within* the gay and bisexual communities in the article. Trans and non-binary experiences, race, disability, and socio-economic inequalities have already been identified as significant factors which exacerbate existing inequalities in relation to PrEP awareness and access (e.g. Witzel et al., 2019). I suggest that it is not only about *adding* these characteristics to the list for consideration, but *rethinking* and *repositioning* whose bodies, practices, and needs are imagined and centred within these communities and their subsequent implications for provision and access. For instance, early on in the Impact Trial (run by Public Health England in lieu of provision of PrEP through NHS services, see Dodds, 2021) and in early discussions around the BHIVA PrEP guidelines, 'non-MSM' was temporarily deployed as a concrete category for clinical consideration, in opposition to the assumed majority MSM users. Where gender identity and race were going to be addressed directly in the 'other' category, the MSM category subsumed all intersectional experiences. Although the (problematic) 'catch-all' category was eventually discarded, this binary orientation highlights how the essentialising of identity (and bodily) categories in relation to biotechnologies not only masks inequalities of access, but also centres whiteness, cis-normative ablebodiedness

of gay men within the structures that deliver these biotechnologies. As such, we need to interrogate not only the repurposing of HIV treatment as prevention, but how the health, regulatory, and social systems are oriented towards particular imagined ‘bodies’ of PrEP users and people living with HIV, and how this shapes equity, wellbeing, and pleasure.

## Interdisciplinary collaborations

Di Feliciano and Brown make an important contribution to the study of PrEP, TasP, and HIV more broadly. They sketch out a series of fascinating and important areas of study through the notion of HIV assemblages and challenge the field of geography to take up questions that other disciplines have only begun to address. From the materiality of the virus, the body, and reconfigurations of sexual practice to the unequal distribution of biotechnologies and their accompanying surveillance, there is much potential for exploration both within geography and across disciplinary borders. I suggest that in addition to these areas of exploration, social scientists also consider how the biopolitical apparatus and gay community activism (and identities) are not at odds with each other, but constitutive of the other within HIV assemblages. I also urge researchers (and communities) to consider more directly how inequalities *within* borders and communities shape and shift these HIV assemblages. Where Di Feliciano and Brown rightly point out the important work by early geographers who pay attention to the heterogeneity of gay communities and their creative approaches to early AIDS epidemics, we need to continue to examine the material, discursive, and biopolitical implications of community activism, service orientation, and intersectional inequalities for PrEP, TasP, and HIV assemblages.


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