



The Biomedical Closet? Undetectability among HIV-positive Gay Men in India

Cornelis J. Rijneveld

To cite this article: Cornelis J. Rijneveld (2021) The Biomedical Closet? Undetectability among HIV-positive Gay Men in India, *Medical Anthropology*, 40:8, 718-731, DOI: [10.1080/01459740.2021.1916741](https://doi.org/10.1080/01459740.2021.1916741)

To link to this article: <https://doi.org/10.1080/01459740.2021.1916741>



© 2021 The Author(s). Published with license by Taylor & Francis Group, LLC.



Published online: 06 May 2021.



Submit your article to this journal [↗](#)



Article views: 1729



View related articles [↗](#)



View Crossmark data [↗](#)

The Biomedical Closet? Undetectability among HIV-positive Gay Men in India

Cornelis J. Rijneveld

School of Oriental and African Studies London, London, United Kingdom of Great Britain and Northern Ireland

ABSTRACT

The discourse of Undetectability, referring to the effect of HIV viral suppression on forward sexual transmission, is at the heart of the current paradigm of Treatment-as-Prevention and is invested with hopes of eliminating stigma. But ethnographic examination of the way HIV-positive gay and bisexual men in four major Indian cities experience Undetectability reveals a more complicated picture. Rather than resolve the problem of HIV stigma, Undetectability enables new ways of managing it, including ethical non-disclosure in the face of social danger. This reveals three paradoxes inherent in the universalism of Treatment-as-Prevention and its reliance on biomedical solutions.

KEYWORDS

India; biomedicalization; gay; HIV/AIDS; treatment-as-prevention; undetectability

“Once I’m undetectable,” asked Santosh, a sales manager in his mid-twenties when we met over iced coffee in Bengaluru, “and I just want to hook up – because you do need to hook up from time to time – do I need to disclose I am [HIV-]positive and undetectable? Because there is so much stigma attached to it. Especially in India, the environment is not very friendly.”

My conversations with thirty HIV-positive gay and bisexual men in Mumbai, Bengaluru, Chennai and New Delhi kept circling back to this question. In the past decade, a scientific consensus has emerged around the fact that those with suppressed or undetectable viral loads cannot pass on HIV through sexual routes (Centers for Disease Control and Prevention 2020). The message that “Undetectable = Untransmittable” (U = U), popularized in a campaign launched in 2016 by the U.S. based Prevention Access Campaign, is invested with hopes of eliminating HIV stigma by decreasing fear of transmission (Prevention Access Campaign 2020). It is at the heart of the current paradigm of treatment-as-prevention (TasP) and attendant “end of AIDS” discourses, according to which the HIV epidemic can be ended by reducing forward transmission through biomedical means.

In this article, I offer an ethnographic examination of the way middle- to upper-class HIV-positive gay and bisexual men in urban India experience this biomedical discourse. I use capital-U Undetectability to refer to an emergent assemblage of discourses, ideologies and technologies, rather than simply a measure of viral load (undetectable). Challenging the assumption that Undetectability will dismantle HIV stigma, I argue it instead gives rise to novel ways of navigating the question of responsibility for risk management, including ethical non-disclosure in the face of perceived *social danger*. As such, Undetectability may contribute to the closeting of HIV rather than its de-stigmatization, shoring up a serological divide in terms of access to TasP discourses. But even if this barrier were to be overcome, it is doubtful that knowledge of Undetectability alone will end HIV

CONTACT Cornelis J. Rijneveld  cornerijneveld@gmail.com  SOAS, Anthropology and Sociology Department, 10 Thornhaugh Street, Russell Square, London WC10XG

Media teaser

U = U (Undetectable = Untransmittable) is invested with hopes of ending HIV stigma by reducing fear of forward transmission. I argue it’s not quite so straightforward.

© 2021 The Author(s). Published with license by Taylor & Francis Group, LLC.

This is an Open Access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/4.0/>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

stigma. I argue that these insights reveal three interrelated paradoxes inherent in the treatment-as-prevention paradigm.

Treatment-as-prevention

There is nothing new about undetectable viral loads, as Race's (2001) prescient analysis of the "power effects" of the medical technologies associated with HIV, particularly antibody testing, antiretroviral treatment (ART) and viral load testing, reminds us. As viral load tests measuring the rate of viral replication became more sensitive, doctors began using the phrase "undetectable" to describe viral loads below 500 RNA copies of the HIV virus per ml blood,¹ which signified patient compliance and was seen as a "fairly reliable, but not infallible, measure of infectivity" (Race 2001: 168). Over the past decade, the emergence of a scientific consensus regarding the effect of ART treatment on forward sexual transmission (Centers for Disease Control and Prevention 2020) and the diminishing problem of treatment toxicity has led to a re-conceptualization of viral suppression as a matter of epidemiological surveillance and control rather than merely individual patient care. In 2019, U.S. public health guru Dr Fauci declared that "the concept of U = U [Undetectable = Untransmittable] is the foundation of being able to end the epidemic" (U Equals U 2019).

At the risk of overstating its novelty, I use capital-U "Undetectability" in this article to refer to this contemporary yielding of what in more formal HIV jargon is known as Undetectable Viral Load (UVL) as a form of *treatment-as-prevention* (as opposed to treatment-as-treatment). Treatment-as-prevention (TasP) comprises a set of discourses, strategies, protocols and technologies that revolve around the notion that getting people to know their status and encouraging those who test positive for HIV to start treatment as early as possible will significantly reduce forward sexual transmission. It posits biomedical means of prevention, including taking antiretroviral treatments preventatively or after risk exposure in the form of Pre- and Post-Exposure Prophylaxis (PrEP/PEP) respectively and viral suppression through HIV treatment, as solutions to both the epidemic and the stigma that has accompanied it. In 2014, the UNAIDS enshrined this mode of managing the epidemic in its "90/90/90" goals, the three nineties referring to 90% coverage in diagnosis, treatment and viral suppression (UNAIDS 2014). The World Health Organization in 2016 introduced a strategy it summarized as "prevent HIV, test and treat all" (World Health Organization 2016; Guta et al. 2016), thereby solidifying the break with treatment protocols that relied on CD4 counts to prioritize those most at risk of falling ill for treatment in resource-scarce settings. By 2018, 84% of low- and middle-income countries had signed up to this test-and-treat policy, up from 40% in 2016 (AVERT 2019). Among them was India, whose National AIDS Control Organization (NACO) had announced its intentions to scale up treatment and viral load testing in line with its adoption of Test and Treat and the 90/90/90 targets (NACO 2017).

Anthropologists have been skeptical of the promissory discourse accompanying TasP since its first stirrings a decade ago, with Vinh-Kim Nguyen and colleagues expressing their concern at "bold claims of a 'paradigm shift' at the recent World AIDS Conference [that] signal a striking remedicalization of our approach to the HIV epidemic and a return to the early 1980s view of the epidemic as a medical problem best addressed by purely technical, biomedical solutions" (Nguyen et al. 2011: 1). Kenworthy et al. (2018) have contextualized this biomedical turn and the "End of AIDS" discourse it underwrites with reference to political and economic shifts and detailed some of its counterproductive effects. Others highlighted the continued (and unevenly distributed) forms of suffering these triumphalist discourses obscure (Sangaramoorthy 2018), and the claim that TasP will eliminate stigma has been dismissed as "a common justification for medicalizing the disease throughout its 30-year history" (Moyer & Hardon 2014: 267). These interventions notwithstanding, Marilou Gagnon is right to point out, in conversation with Sarah Schulman, that the shift to TasP has happened "very quickly", without the intellectual battles that typically attend a paradigm shift (Schulman 2016: 130). This leaves anthropologists the task of "link[ing] analysis of policy/discourse with realities in geopolitically specific places, revealing disjunctures and opportunities" (Kenworthy et al. 2018: 8).

I do this with reference to how relatively affluent gay and bisexual men in urban India navigate Undetectability. Scholars have mobilized the Foucauldian frame of biopolitics and governmentality to argue that the emphasis on viral suppression in TasP enables novel forms of subject-formation and surveillance (Guta et al. 2016; Persson 2013; Persson et al. 2016). Race's (2001, 2015) analysis regarding the way viral load testing places the onus of risk management on the HIV-positive person through a process of responsabilization is borne out by social scientific research on the impact of new biomedical prevention technologies on queer men. Drawing on Paul Rabinow's (1996) conceptualization of biosociality, researchers demonstrate that new biomedical prevention technologies are instead mediated by generational, serological and geographic positionings, and may give rise to new forms of marginalization (Girard et al. 2018; Grace et al. 2015; Young et al. 2019, 2016). Yet while this emerging queer-biosocialities scholarship illustrates the need for "focused examination of particular biomedicalization processes, situated in their specific – but globalised – contexts" (Young et al. 2016: 413), its scope is mostly limited to the context of queer communities in Euro-American contexts, with some exceptions (Tan et al. 2020).

India is home to the world's third largest HIV epidemic, one characterized as concentrated among key populations including MSM (men who have sex with men) (AVERT 2020). The role of the epidemic in shaping and solidifying sexual subjectivities and queer mobilizations in India is well-documented (Bhaskaran 2004; Boyce 2007; Cohen 2005; Dube 2015; Khanna 2016; Lakkimsetti 2020), particularly in the context of the lengthy struggle against Section 377, the anti-sodomy law that was read-down by India's Supreme Court in September 2018. Yet the voices of sexual and gender minorities *living* with HIV are largely absent in this body of scholarship. Conversely, most anthropological research on people with HIV in India focuses on women, reflecting the early construction of the epidemic as a heterosexual one (Bhaskaran 2004) and the heavily gendered nature of HIV surveillance and stigma in the Indian context (Nataraj 2020; Van Hollen 2013). Discussions about HIV stigma among sexual and gender minorities tend to feature the working-class communities that are seen as most acutely vulnerable to HIV (Manian 2019) and who comprise the constituency and staff of NGOs and community-based organizations (CBOs) carrying out targeted interventions on NACO's behalf (Lorway and Khan 2014).

As a result, little is known about the experiences of middle- to upper-class gay and bisexual men with HIV, who for the most part access HIV treatment privately rather than through NGOs, CBOs, or government ART centers. These men may be more likely to access the discourse of Undetectability than their less privileged counterparts because of their fluency in English, their consumption of global gay media, and their privileged access to viral load monitoring. Although NACO introduced biannual viral load testing into its treatment protocol in 2018, the agency stopped short of endorsing U = U, citing concerns around treatment literacy and adherence. The experiences of middle- to upper-class gay and bisexual men thus offer a unique window into the dissonances between transnational biomedical discourses and the situated lived experiences of a small and relatively privileged subset of people living with HIV in India.

Methods

This article is based on thirty loosely-structured interviews with HIV-positive men who self-identify as gay or bisexual in the cities of Bengaluru, Mumbai, Chennai, and New Delhi conducted between July 2019 and March 2020. It also includes one interview about PrEP, the preventative antiretroviral treatment that I have otherwise bracketed off for future discussion. The focus on socio-economically privileged men emerges from an obvious limitation related to my positionality as European visitor. My lack of fluency in Hindi, unfamiliarity with any of the South Indian languages, and concerns about the ethics of using a translator narrowed the parameters of my research to a minority of relatively well-to-do Indians who speak English as a first or second language.

Most interlocutors were recruited through Grindr, a dating app for gay men on which I made a profile inviting people to approach me if they wanted to speak about being HIV-positive for the

purposes of research. Grindr, though not the only digital platform used by men looking for sex with men in India, is a key site in the transnational flow of discourses around sexuality (Dasgupta 2017), including biomedical ones – particularly now that HIV status can be indicated as Negative; Negative, on PrEP; Positive; or Positive, Undetectable. In the interest of building trust, my profile revealed my own status. “HIV positive people will speak only to those they feel comfortable with, other positives only,” someone explained once during an interview. “We can also talk about it because you are positive.” Similarly, when I expressed reservations about being added to a peer support WhatsApp group to advertise my research, the administrator assured me that if I was gay and “poz”, there was no issue.

Other strands of my fieldwork included participant observation with a gender/sexual minorities’ rights NGO in Bengaluru and a series of informal and formal interviews with staff at HIV/Aids NGOs and CBOs and activists across India. Although I detail them elsewhere (Rijneveld 2020), these experts’ assessments of the way global TasP strategies play out on the ground frame the arguments presented below.

Navigating responsibility

Raj and Vinay messaged me on Grindr from separate accounts, both inviting me to their shared apartment in a leafy Bengaluru neighborhood for a conversation about my research. “Maybe don’t launch into the interview straight away,” Raj cautioned as he picked me up from outside the compound. He explained that though he is comfortable with his status, his partner Vinay only got diagnosed when the two of them started dating the previous year. After disclosing his status on their first date, Raj suggested they visit a diagnostics center together. Vinay, who was 26, had never been tested before.

But within minutes of my arrival, Raj and Vinay were locked in discussion about the ethics of non/disclosure, arguing in the playfully adversarial way of happy couples. Raj’s policy is to disclose his status straight away when speaking to potential sexual partners, not because he feels a moral obligation to do so, but to protect himself from the fall-out of non-disclosure. “They do so much emotional drama,” the thirty-year-old software professional explained. “Why didn’t you tell me before, why did it take so long?” Even though it’s not about you, it’s about *me* – I have to live with this!”

By way of illustration, Raj shared an experience he had on a dating app recently. After telling a match that he is HIV-positive, Raj was chastised for not putting his status on his profile. “I would have had a chance to weed you out,” the match explained. Raj replied that that is not his problem, and told me he suspects his match was just anxious about having had unprotected sex himself. “I understood him, his problem was, ‘Oh God! I did so many things.’ But if he’s not aware of his own status, that is *his* responsibility!”

Implicit in Raj’s explanation is a theory of HIV stigma as cycle of fear and avoidance. Writing with reference to gay male Latino communities in the U.S., Rafael Díaz (2006) used the phrase “displaced abjection” to refer to the way his interlocutors project their own disproportionate HIV risk – emerging from the intersections of poverty, homophobia, and racism – onto their peers, thereby giving themselves an illusion of safety. Raj opined that instead of “taking it out on someone who is just talking to you virtually”, his match should get tested or get on PrEP. In doing so, Raj explicitly rejected the unequal distribution of responsibility for both traditional and biomedical forms of risk management.

Paul Flowers (2001) and Kane Race (2001) have historicized this asymmetry, which they argue is the product of certain knowledge regimes enabled by the antibody and viral load tests. Whereas the identification of a “gay lifestyle” as the main risk factor in the early days of the U.S. epidemic meant “the responsibility and blame for HIV risk management were distributed evenly across all gay men and were, to a great extent, met by solidarity” (Flowers 2001: 53), the development of the antibody test in 1985 shattered this homogeneity by producing the HIV-positive person as “a new site for the

inscription of [HIV/AIDS] stigma” (Race 2001: 174). Race argued that this process of “responsibilization” intensified with the advent of HAART in 1996. “While the designation of ‘undetectable’ status exempts the subject from the status of abject,” explained Race more than a decade before the $U = U$ consensus, “it also implants an imperative around individual self-surveillance upon which the subject’s capacity to retain that (non-contaminate) status depends” (2001: 177–178). Raj’s disclosure policy reflected this doubleness.

Not only did Raj challenge the unequal distribution of responsibility for risk management, he recognized and rejected the stigmatizing trope of the criminally-contagious HIV-positive person that underpins it. “I know what I went through,” he said, his voice edged with indignation,

and I know I’m not going to make someone else go through the same. So this whole playing with the guilt feeling doesn’t really work. I’m *undetectable*, and I’m using a condom, or just fucking blowing someone. So I don’t really need to come out, and I don’t think I should feel guilty.

Raj invoked his suppressed viral load alongside traditional forms of safer sex to counter the normative notion that HIV-positive people must always disclose their status. Undetectability allowed him to reason that he is already doing his bit for risk management by maintaining a suppressed viral load.

Although this conflation of taking responsibility for *individual* and *public* health by taking ART is not new (Race 2001: 179), it has recently been amplified in North-America by campaigns with titles like “HIV STOPS WITH ME” (Guta et al. 2016). Raj’s invocation of guilt hints at the way this logic overlaps with that of HIV criminalization. In 2012, Canada’s Supreme Court upheld laws criminalizing HIV status non-disclosure including when condoms are used, but exempted those with undetectable viral loads. As Sarah Schulman (2016) explained, Canadian activists are wary of celebrating the exemption, because making the legal requirement to disclose contingent on viral load does not challenge the logic of criminalization itself. Rather, it exemplifies the way “viral load surveillance becomes increasingly implicated in HIV criminalization” (Guta et al. 2016: 98) by facilitating the framing of those who refuse treatment or fail to maintain an unsuppressed viral load as resistant, risky and in need of surveillance and intervention (Schulman 2016: 128).

Where does that leave someone like Vinay, who was conflicted about starting treatment? Knowing himself to be forgetful and messy with medications, Vinay worried that starting treatment early might undermine his health in the long run. His doctor, at the local government ART center, supported his decision to postpone treatment (which Vinay, like Raj, would get privately). Perhaps the doctor recognized that “minimizing adherence challenges in order to emphasize the benefits of treatment as prevention for public health purposes has been equated with violating core principles of medical ethics vis-a-vis the individual patient: to *do no harm* and to *respect autonomy*” (Guta et al. 2016: 88). When I interviewed him, the former ART consultant to the WHO stressed the need for proper counseling before starting treatment, but endorsed the principle of TasP. “If he was HIV-positive,” the doctor said indignantly, referring to a syphilis patient he had just scolded for failing to show up for his penicillin shot, “how many people would he have infected in the five months he was not treated?”

Vinay is, in his own words, “really horny”, and would like to be able to have sex with people other than his boyfriend without having to disclose his status. “I was speaking to this doctor on Grindr who was *desperate* to sleep with me,” he told me, cracking up Raj. “And I figured that since he’s a medical professional, it should be okay with him, he should have a better understanding.” Vinay was quickly disabused of the notion that medical professionals are less likely to stigmatize people with HIV. “Why are you on Grindr?”, the doctor replied. “Don’t you feel ashamed? Why are you even speaking to people like this, what if you pass it to someone?” In a U-turn, Vinay told the doctor that he was just kidding, not because he wanted to sleep with him, but because he wasn’t sure “what he would do next.”

The contrast between Raj’s confident righteousness and his boyfriend’s experience of being shamed back into the proverbial closet demonstrates the profound ambivalence of Undetectability. On the one hand, it enables Raj to challenge the unequal distribution of responsibility for risk management and disclosure. But although he opposes all forms of HIV criminalization, Raj’s invocation of viral suppression to absolve himself of feelings of guilt is structurally homologous with contemporary

forms of HIV criminalization that exempt people with Undetectable viral loads from the requirement to disclose, raising concerns that “those categorized as virally unsuppressed by this new form of classification will be marked as increasingly dangerous” (Guta et al. 2016: 98). According to these entangled medical and judicial logics, even the mere presence of someone like Vinay on a dating app can be construed as a criminal wrong, as the doctor he chatted with implied.

In this way, Undetectability has both de-marginalizing and marginalizing potential (Persson et al. 2016). It enables new ways of navigating the question of responsibility for risk management and disclosure, most notably ethical non-disclosure. Yet the casting of viral suppression as a form of taking responsibility risks marginalizing those refusing or failing to achieve this by further positioning the HIV-positive person as the “natural delegate of risk management” (Race 2001: 179). Thus intensifying the moral imperative of viral containment, TasP deepens the unequal distribution of HIV risk management even as it promises to normalize HIV. Instead of resolving the problem of stigma, Undetectability gives rise to new ways of managing it.

Social danger

“Actually, I’m undetectable,” said Bilal when Gautam asked him about PrEP in a WhatsApp conversation a few days after they had sex. “What do you mean you are *undetectable*?” asked Gautam. He panicked when Bilal elaborated. The links he sent to webpages explaining $U = U$ did little to temper Gautam’s anger. “I wish you had told me so I could have at least had a say. And why didn’t you use a condom?!?”, he wrote.

“I didn’t tell you because of *this*,” replied Bilal just before Gautam blocked him. “This is exactly the kind of stigma I’m talking about. Why don’t you put yourself in my shoes for a second?” Gautam used to get tested for HIV so frequently that the staff at his local lab started to recognize him and, Gautam worried, speculated about the reasons for his obsession. When, a few weeks after his encounter with Bilal, one of these tests came back positive, Gautam “just wanted to go stand in the middle of the road and die,” as he put it to me. Unsure who to turn to, Gautam unblocked Bilal on WhatsApp, to send him a slew of questions, but stopped short of telling him about the diagnosis. “In 2019, you don’t ask someone who is HIV-positive to explain everything to you,” came the reply. Gautam shot back: “In 2019, you should have the ethics to inform someone before you have bareback sex with him.”

The message exchange illustrates what researchers in the UK describe as a serological divide in terms of who accesses TasP discourses and how TasP discourses are received (Young et al. 2016). Gautam’s response to Bilal’s status disclosure was a demonstration of the stigma that stopped Bilal from disclosing without being prompted in the first place. Crucially, his undetectable status gave rise to contestations over responsibility for risk management, disclosure and education rather than resolve the problem of stigma. These contestations eventually prompted Gautam to block Bilal’s number, thereby foreclosing further engagement with Undetectability. Gautam only internalized its meaning after testing positive himself, when he, as he explained to me a few months later, “understood where he [Bilal] was coming from.”

Although I never met Bilal, many of the people I interviewed shared his position on disclosure:

Nobody wants to hide, put on a mask. But if you disclose, guys not only stop talking to you, they will spread rumors about you. They might do anything, actually. (Karan, 35, Mumbai)

It’s my responsibility to be vocal about it. But even though you’re undetectable, they might go through any length to tell everyone [that] this person is bad. I don’t want a bunch of people standing in front of my house one morning saying, oh he’s poz, etc. I don’t want to take that chance. (Matthew, Bengaluru, 37)

I have to keep it private because it is stigmatized. I don’t have a problem telling people if they react normally. It’s like [being] LGBT: I can tell you I am homosexual, but people should be able to take it, right? I shouldn’t be traumatized by your response, right? And then you’ll go and tell a hundred other people who respond in a hundred other ways . . . that’s very hard to take, no? If you judge me, discriminate me, I can’t take it, right? I also need to have safety. (Karthik, 25, Chennai)

Why should I cause them a panic attack if I know I am not posing any risk? (Sri, 39, Bengaluru)

I will keep it to myself. It will not be met with compassion. (Arvind, 34, Mumbai)

These comments turn the idea of “safety” in the context of HIV on its head by hinting at the considerable *social danger* involved in status disclosure, ranging from reputational damage to physical violence. The common comparison to queer “coming out” drives home the way in which HIV continues to be experienced as a secret that requires closeting and disclosure, rather than a manageable chronic condition like any other. Some interlocutors explicitly contrasted the universalism of Undetectability to their situated lived experience: “U = U is okay,” said Amit, a 26-year old think tank employee in New Delhi, “but the way the message is put forward is very important. In a country like India, you can’t expect people to disclose and be safe.”

Sometimes this social danger takes the form of Grindr profiles that are made to name and shame an allegedly HIV-positive person. “What I see happen is that when people come out clean saying they are positive, pictures are spread on groups with messages saying ‘stay away from this person, he’s positive’”, explained Santosh, elaborating on the apprehension about disclosure with which I opened this article. “Without even realizing that that person can’t really transmit anything if he is undetectable, or without giving any attention to the fact that person wanted to be upfront and honest with you.” Rather than offering insurance against being maligned in this manner, “coming out clean” makes one vulnerable to vilification. Crucially, Santosh anticipated that Undetectability would not make disclosure any less of a damned-if-you-do-and-damned-if-you-don’t scenario.

I came across several such profiles during my fieldwork and feared becoming the target of one myself. “Fraud HIV guy,” claimed the handle of one, its display picture featuring someone I had interviewed just weeks ago about being on PrEP. “Guys be safe,” warned the profile bio, “this profile is fake he is using my friends pics dnt share ur details with this dog he is a son of *randi* [prostitute] and a HIV guy make him viral to all if u know him let me know or contact any police station.” In other instances I witnessed or recorded, HIV stigma was similarly weaponized to exact revenge or sabotage the sexual/romantic prospects of a more popular peer. The profile’s suggestion that people who know my interlocutor should contact the police to stop him from making everyone “viral” explicitly aligns the sentiment behind such campaigns with the logic of criminalizing non-disclosure.

In India, the HIV AIDS (Prevention and Control) Act 2017 safeguards against what some caution may be a global trend toward punitive HIV surveillance (Guta et al. 2016), in theory if not in practice (Bhatini 2020). Drafted by the activist New Delhi-based Lawyers Collective over a decade prior to its approval by the Rajya Sabha (the upper house of India’s Parliament), the Act not only protects confidentiality, but also prohibits the propagation of hatred against people with HIV. Yet while the Indian government has long replaced its initial punitive approach to the epidemic with a human rights-based one, Sarah Schulman’s use of the word “endangered” (2016: 127) to describe the impact of criminalization on people living with HIV in North-America resonates with the sense of social precarity described by many of my interlocutors. In lieu of a legal framework for prosecution,² the creators of Grindr profiles like the one detailed above weaponize stigma. “It sabotages your whole life,” Gautam explained, hinting at how HIV undercuts class and caste-based privilege. “My family is well-known in Chennai, so I can’t risk that.” It is because of this social danger that he has resolved to hide his status from everyone but his therapist, a close female friend, and a visiting anthropologist, thus foreclosing peer-to-peer solidarity with Bilal and others.

This apprehension about disclosure presented a significant methodological challenge. I once interviewed someone about what he referred to as his “long and troubled history” with High Fun, as sexualized drug use among gay men is known in India. Throughout his long narrative, Faisal maintained he was lucky that at least he had not picked up HIV. “People say stuff like – ‘oh, he must be HIV-positive from all that High Fun’”, he said bitterly, demonstrating the interlocking nature of HIV and High Fun stigma. “Even though I’ve been on PrEP for I don’t know how many years.” After two hours or so, the interview gave way to a more reciprocal exchange. “I’ll be honest with you,” Faisal interjected when I began telling him about the HIV diagnosis I received a few months before starting fieldwork. “I’ve been positive for six years. But I don’t want it to be talked about.” PrEP helped Faisal

side-step what he called the “major stigma” associated with HIV, while Undetectability provided the justification: “I was put on medication straight away, so I knew I wasn’t infecting anyone”. TasP thus contributes to the closeting of HIV in more ways than one.

There are important exceptions. Sunny, a returned expat in Mumbai who used to run workshops with a sexual health clinic abroad, told me he discloses his status on Grindr because he feels he has a responsibility to educate “the community”. “But there are times when I remove it from my profile,” he explained, “when I just can’t be bothered to go through that whole thing. Since I’m not putting anyone at risk, they don’t *need* to know.” Because of the absence of transmission risk, disclosure (for Sunny) becomes a social service rather than a moral obligation, further illustrating the way Undetectability itself may militate against the exposure of HIV-negative or untested people to the gospel of $U = U$. (Sunny also suggested that the internalization of stigma complicates Undetectability, making it hard for people “to accept that you are ‘clean’ in the sense that you’re not going to be infecting anyone else, that your *spunk* is not *toxic*.”)

When HIV-negative or untested people do encounter Undetectability, their engagement with it is mediated by stigma. “It doesn’t matter whether you are undetectable or not,” said Arvind in Mumbai. “[People think:] ‘I just don’t want anything to do with it.’” His words were almost identical to Santosh’s: “Whether it’s PrEP or Undetectability, people just don’t want to talk about anything related to HIV, because they know there is a risk they’re taking if they’re hooking up every day.” This resonates with the observation that focus group participants in Scotland “were concerned that existing forms of HIV-stigma would preclude those not affected from HIV from engaging in this critical ‘new’ information about HIV-risk” (Young et al. 2016: 418). Several interlocutors internalized the resulting serological divide through a before/after comparison. “I don’t blame people who freak out,” said Karthik in Chennai, “because before testing positive, I didn’t know HIV is not AIDS, I didn’t know about undetectable.”

Gautam told me he is still angry at Bilal, reflecting the tenaciousness of dominant norms around status disclosure that he himself – because of social danger – cannot not live up to. And his decision to block Bilal on WhatsApp illustrates the mechanism of avoidance that precludes or meets disclosure particularly well. On Grindr too, chats have a way of disappearing – a sign one is blocked – once a seropositive status is mentioned, leaving the HIV-positive person with little opportunity to explain the evidence-base of $U = U$, even as dating app formats for prompting HIV-status may have de-stigmatizing potential elsewhere (Race 2015). There are plenty of exceptions: someone once apologized to me for not knowing about Undetectability, adding that it should not be my “responsibility” to educate him. I knew several people in sero-discordant relationships, in which one partner is HIV-negative and the other HIV-positive, and was in one myself. Nonetheless, Gautam’s failure to place himself in Bilal’s shoes until he tested positive attests to the existence of a serological divide that mediates both access to Undetectability and its interpretation. His reluctance to disclose in the face of social danger related to the preservation of his family’s social status demonstrates the way in which Undetectability may in certain contexts contribute to the *closeting* of HIV, rather than its de-stigmatization, thereby foreclosing widespread engagement with it.

This contrasts with developments in North-America, Australia and Europe, where scholars remark with some optimism that “people are becoming more open about their viral loads” (Guta et al. 2016: 97) even as they worry that the increasingly salient suppressed/unsuppressed binary and the “new elite status of undetectable” (Grace et al. 2015: 346) may lead to forms of in-group stigmatization (Persson 2013; Persson et al. 2016; Schulman 2016). Although a marker of privileged access to health care and viral load monitoring, it would be a stretch to describe being undetectable as in any way “elite” in the context of same-sex male dating in India. Interlocutors often emphasized the context-specific nature of the forms of social danger they faced in their conversations with this European researcher, thus challenging the universalizing biomedical triumphalism that characterizes contemporary HIV/AIDS discourses (Kenworthy et al. 2018). Their insights reveal a second paradox inherent in TasP, namely the way in which it precludes the forms of solidarity on which it relies for widespread engagement by

further privatizing and individuating the experience of living with HIV, a process that has been underway since the advent of ART (Flowers 2001). Yet it would be naïve to assume that overcoming the resultant serological divide is all it takes to dismantle stigma.

“#ScienceNotStigma”

The aim of the $U = U$ Campaign is to disseminate the scientific consensus regarding the effectiveness of treatment as a form of prevention, both by lobbying prestigious institutions and persons to publicly endorse the validity of $U = U$ and through social marketing campaigns. Its premise is that knowledge of Undetectability will translate into reduced fear of transmission, thereby “dismantl[ing] the HIV stigma that has been destroying lives and impeding progress in the field since the beginning of the epidemic” (Prevention Access Campaign 2020). Underlying this assumption is a common conceptualization of HIV stigma as an individual’s negative attitude resulting from ignorance, rather than a *social process* that “feeds upon, strengthens and reproduces existing inequalities of class, race, gender and sexuality” (Parker and Aggleton 2003: 13). It follows that if only people had access to correct, up-to-date information about HIV/AIDS and its routes of transmission, the problem stigma would be solved. #ScienceNotStigma, one of the hashtags accompanying the $U = U$ campaign, condenses this position.

Gaurav, a public health professional in Delhi, is invested in this message in more ways than one. As a trained medical professional and consultant to NACO, Gaurav understands the agency’s apprehensions about endorsing $U = U$. “Most people with HIV in India are from a lower socio-economic background with limited literacy,” he explained, “and we fear that if we tell them that they’re undetectable, they might stop taking their medication.” At a more personal level, Gaurav is enthusiastic about Undetectability. He told me he cannot hide his status from sexual partners “in good conscience”, despite understanding himself to not be posing any risk. When I asked whether he believes one must always give the other person the option of evaluating the evidence-base of the $U = U$ consensus for themselves, Gaurav turned the question on its head. “If they accept the science,” he said, “they accept me.”

But what does it mean to accept the science? In Pune, I visited another gay medical professional, this time an HIV-negative one. We had arranged an interview to discuss the uptake of PrEP and PEP in India, which Pranab prescribes in the capacity of a private physician. PEP (which is taken post-exposure) is only available at government hospitals in cases of heterosexual rape and occupational hazard and PrEP is not available at all, exemplifying the partial nature of biomedicalization (Clarke et al. 2003). “It’s wealthy, privileged, upper middle to upper class guys who are educated,” said Pranab when I asked him about the demographic on PrEP in India, echoing the findings of a 2017 survey (Patel et al. 2018). “Most gay men don’t even know PrEP exists.” Though NACO’s PrEP trials with “key populations” and PrEP awareness campaigns are mainly accessed by the working-class sexual minorities associated with NGOs/CBOs, insofar as non-trial access to PrEP is restricted to private prescriptions or (illegal) over-the-counter purchases it remains a prophylaxis for the privileged.

Like Raj, I am cautiously optimistic about PrEP’s ability to democratize risk management. But despite being on PrEP himself, Pranab explained he would not sleep with an HIV-positive person because “there is still that 1% chance.” He told me that he always asks people about their HIV status and requests what he, perhaps in a Freudian slip, called a “clean” lab report to prove it. Pranab looked a little surprised when I asked how he responds when people say they are positive and undetectable.

P: I’ve never had anyone tell me that they were positive. I kind of weed profiles off. You don’t put too much time into conversations when you know there is something about it that just doesn’t click with you. So I haven’t had that. I have had someone tell me that they were undetectable a couple of times, but I didn’t engage in any of those interactions. I kind of let them whither away as politely as possible.

C: Can you describe how that filtering works? Like, what are the markers?

P: [laughs] Well, you can sort of tell from a person’s profile, their level of . . . understanding of just general things. You know, the way they structure their sentences, the things they write about, you can

tell whether you will be able to have a same wavelength as them to [be able to] converse with them, or whether you're coming from completely different worlds. And if that's the case it's gonna be *awkward*, you won't know what to talk about, how to communicate . . .

C: And you think that's linked to the likelihood of them being HIV-positive?

P: I think there's definitely a knowledge gap. And that's where the problems are, where you're just completely *ignorant* and unaware – not bothered to learn about the problems as well.

Pranab's risk management is a blend of biomedical methods and more intuitive forms of risk reduction, according to which certain kinds of people are more likely to have HIV than, for instance, a white researcher. (I did not disclose my status during our conversation, opting to privately savor the irony instead.)

Anthropologists and cultural theorists have long known that “new knowledge and information about perceived sexual risk will always be interpreted within the context of pre-existing systems of meaning” (Parker 2001: 167), with biomedical discourses but one strand of what Paula Treichler (1999) termed an “epidemic of signification”. In Pranab's case, these systems of meanings involved a set of value judgments and assumptions that combined to relegate HIV to a “completely different world”. Clicking with someone, wavelengths, awkwardness, syntax, communication, the ability to converse in English, being educated – these are all euphemistic ways to communicate a preference for partners from privileged backgrounds, as Rohit Dasgupta (2017) also suggested in his analysis of online gay male dating in India. Pranab's investment in scientific rationality notwithstanding, his re-formulation of a common prejudice about the poor as ignorant and lazy through the medicalized HIV-jargon of “knowledge gap” and his conflation of a clear and a “clean” lab report blur the lines between the social and the biomedical.

In her critique of *My Brother . . . Nikhil* (2005), a film which fictionalizes the AIDS-related discrimination faced by Dominic D'Souza, Shamira Meghani (2020) argues that the concept of “untouchability” is foundational to how HIV stigma is conceptualized in the Indian context. This is particularly apparent in a scene in which men promptly evacuate a pool after the protagonist, a competitive swimmer, jumps into it. Though hers is a purely textual analysis based on critical readings of the film and two additional texts, my research provides abundant ethnographic evidence for Meghani's thesis. I conducted interviews with people who belong to a (predominantly *savarna*, or caste Hindu) privileged, urbane demographic that constructs itself as post-caste (Sabramanian 2019; Teltumbde 2018). But, as Rahul Rao suggests in his reading of Meghani, untouchability provides a kind of template for other forms of marginalization: “Just as racism forges the discursive structures in which subsequent queerphobic moral panics take shape, caste oppression does something similar in the South Asian context” (2020: 177). My fieldnotes are punctuated by tales of doctors refusing to touch their patients, liberal colleagues at law firms no longer sharing their lunch tiffin despite comprehending Undetectability, and housemates moving out overnight upon the discovery of a seropositive status.

In suggesting that Pranab's “weeding” method is related to the way HIV stigma is inflected by the grammar of caste, I do not mean to reify paired dichotomies of scientific/Western/modern and cultural/Eastern/traditional. Indeed, HIV stigma and its echoes of untouchability trouble the tradition/modernity binary through which caste is rendered a rural issue (Meghani 2020). Instead, my conversation with Pranab demonstrates the way social meanings of HIV shape the way people make sense of its medical facts, including Undetectability. This chimes with anthropological critiques of individualist or culturalist accounts of HIV stigma that frame it in terms of a knowledge deficit. “To properly understand issues of stigmatization and discrimination, whether in relation to HIV and AIDS or any other issue,” argued Parker and Aggleton (2003: 16), “requires us to think more broadly about how some individuals and groups come to be socially excluded, and about the forces that create and reinforce exclusion in different settings”. The issue, in other words, is not (only) whether Pranab believes there is risk of HIV transmission or not, but rather that he would not want to have anything to do with *the kinds of people* that (he thinks) contract HIV in the first place.

This partially explains the avoidance that was a recurrent theme in my interviews and my own experiences, and which I suggest forecloses widespread engagement with Undetectability. Conversely, interlocutors like Gautam experience a positive serostatus as undercutting their social status, derived from class and caste privilege, which in turn discourages disclosure. It is in this sense that stigma is “often just the tip of the iceberg”, and is grounded in “powerful social inequalities that are much harder to identify and conceptualize” (Castro and Farmer 2005: 53). And while the examination of the intersections of HIV stigma and caste- and gender-based marginalization that Meghani (2020) calls for is beyond the scope of this article, the mutually-reinforcing nature of these oppressions was glaringly evident. For example, during a focus group discussion with sex workers from rural Karnataka at the NGO that hosted me, the women explained that doctors still refuse to touch them despite decades of sensitization efforts, instead treating them as vectors of infection who merit treatment only insofar as that helps protect general public health. (The women confirmed they had access to viral load testing, but had not heard of Undetectability.)

The $U = U$ campaign is undeniably empowering for someone like Gaurav, who, much like me and like his peers elsewhere (Tan et al. 2020), has invested it with hopes of finding romance. Yet in relying on the assumption that knowledge of Undetectability translates into acceptance of people living with HIV, TasP discourses remove from view the context-specific forms of social inequality that structure and texture HIV stigma everywhere. The reliance on biomedical, individuating solutions is a marked shift away from an earlier understanding that combatting stigma entails empowering the already-stigmatized communities affected by HIV/AIDS, a truism that influenced Sujatha Rao’s interpretation of NACO’s mandate when she was the agency’s Director General (Lakkimsetti 2020; Rao 2017). We might then wish to replace the convenient assumption that scientific fact will solve the problem of stigma with the undoubtedly more complicated and more politically sensitive effort to promote an ethos of #SolidarityNotShame.

Conclusion

The experiences detailed in this article suggest that rather than resolve the problem of stigma, Undetectability gives rise to new ways of managing HIV’s continued social exceptionality (Moyer & Hardon 2014). But while it enables those on effective treatment, like Raj, to challenge the unequal distribution of responsibility for risk management and disclosure, Undetectability risks rendering those who are not virally suppressed, like his boyfriend Vinay, as irresponsible and dangerous. Insofar as it further places the onus of prevention on the HIV-positive person, TasP shores up the logic of criminalization even as it purports to normalize HIV. Moreover, as the exchange between Gautam and Bilal illustrated, by enabling ethical non-disclosure in the face of *social danger*, Undetectability may contribute to the closeting of HIV rather than its de-stigmatization – thereby precluding the forms of solidarity on which TasP relies for widespread engagement. Yet even if this serological divide were to be overcome, Undetectability is unlikely to eliminate HIV stigma, revealed in my conversation with Pranab to be about much more than ignorance alone. Indeed, the celebration of Undetectability as a solution to stigma obfuscates the ways in which the biomedicalization of HIV/AIDS policy comes at the cost of the community-based efforts that could actually begin to address stigmatization in all its context-specific complexity (Rijneveld 2020).

For these reasons, we must continue attending ethnographically to the gaps between universalizing medical discourses and lived experiences of illness and illness-related stigma at a time when social approaches to HIV/AIDS are increasingly losing ground to biomedical constructions of the epidemic (Flowers 2010). After all, as medical anthropologist Robert Ariss reminded us in a book that was published after he died of AIDS-related illness in 1994, “we can learn from [HIV/AIDS] as much as we can contribute to the effort to live with it” (Ariss and Dowsett 1997: 14).

Notes

1. The threshold for Undetectability is now typically between 20 to 50 HIV RNA copies/ml, though viral suppression is defined as less than 200 HIV RNA copies/ml (Prevention Access Campaign 2020).
2. Although the Indian Penal Code pertains two Sections, 269 and 270, regarding the spread of infectious diseases that have been used to criminalize heterosexual HIV transmission on at least fifteen occasions (HIV Justice Network 2020), it is unlikely that gay men would take legal action in a case of non-disclosure.

Acknowledgments

I am immensely grateful to the HIV-positive men who entrusted me with their stories. My understanding of HIV/AIDS policy in India derives from countless conversations with HIV/AIDS workers and activists across India, but particularly those at Sangama NGO in Bengaluru. Feedback from Dr Orkideh Behrouzan helped me articulate the arguments I present in this article. I am also grateful to National Institute of Advanced Studies (NIAS) in Bengaluru for enabling my fieldwork.

Funding

The research on which this article is based was enabled by a studentship from European Socioal Research Council (ESRC).

Notes on contributor

Cornelis J. Rijneveld is an ESRC-funded PhD Candidate in Anthropology at SOAS, University of London. Address correspondence to: Cornelis Rijneveld, SOAS, Anthropology and Sociology Department, 10 Thornhaugh Street, Russell Square, London WC10XG. Email: cornerijneveld@gmail.com. ORCID:0000-0002-3262-6564

References

- Ariss, R. M., and G. W. Dowsett 1997 *Against Death: The Practice of Living with AIDS*. Amsterdam: Gordon and Breach Publishers.
- AVERT 2019 WHO test and treat policy and change in ART uptake. <https://www.avert.org/infographics/who-test-treat-policy-and-change-art-uptake>
- AVERT 2020 HIV and AIDS in India. <https://www.avert.org/professionals/hiv-around-world/asia-pacific/india>
- Bhaskaran, S. 2004 *Made in India: Decolonizations, Queer Sexualities, Trans/national Projects*. New York: Palgrave MacMillan.
- Bhatini, T. 2020 Two years since HIV & AIDS act was notified, govts have done little to implement it. *The Wire*. <https://thewire.in/government/hiv-AIDS-act-two-years-implementation>
- Boyce, P. 2007 'Conceiving *Kothis*': Men who have sex with men in India and the cultural subject of HIV prevention. *Medical Anthropology* 26(2):175–203. doi:10.1080/01459740701285582
- Castro, A., and P. Farmer 2005 Understanding and addressing AIDS-related stigma: From anthropological theory to clinical practice in Haiti. *American Journal of Public Health* 95(1):53–59. doi:10.2105/AJPH.2003.028563
- Centers for Disease Control and Prevention. 2020. Evidence of HIV Treatment and Viral Suppression in Preventing the Sexual Transmission of HIV. CDC. <https://www.cdc.gov/hiv/>.
- Clarke, A., L. Mamo, J. K. Shim, J. R. Fosket, and J. R. Fishman 2003 Biomedicalization: Technoscientific transformations of health, illness and U.S. biomedicine. *American Sociological Review* 68(2):161–94. doi:10.2307/1519765
- Cohen, L. 2005 *The Kothi Wars: AIDS cosmopolitanism and the morality of classification*. In *Sex in Development: Science, Sexuality and Morality in Global Perspective V*. Adams and S. L. Pigg, eds., Pp. 1–38. Durham, NC: Duke University Press.
- Dasgupta, R. K. 2017 *Digital Queer Cultures in India: Politics, Intimacies and Belonging*. Milton Park, UK: Routledge.
- Díaz, R. M. 2006 *In Our Own Backyard: HIV/AIDS Stigmatization in the Latino Gay Community*. San Francisco: University of California Press.
- Dube, S. 2015 *An Indefinite Sentence: A Personal History of Outlawed Love and Sex*. New York: Atria Books.
- Flowers, P. 2001 Gay Men and HIV/AIDS risk management. *Health* 5(1):50–75. doi:10.1177/136345930100500103
- Flowers, P. 2010 HIV Transitions: Consequences for self in an era of medicalisation. In *HIV Treatment and Prevention Technologies in International Perspective* M. Davis and C. Squire, eds., Pp. 109–25. London: Palgrave Macmillan.
- Girard, G., S. Patten, M. LeBlanc, B. D. Adam, and E. Jackson 2018 Is HIV prevention creating new biosocialities among gay men? Treatment as prevention and Pre-Exposure Prophylaxis in Canada. *Sociology of Health & Illness* 41(3):484–501.

- Grace, D., S. A. Chown, M. Kwag, M. Steinberg, E. Lim, and M. Gilbert 2015 Becoming 'Undetectable': Longitudinal narratives of gay men's sex lives after a recent HIV diagnosis. *AIDS Education & Prevention* 27(4):333–49. doi:10.1521/aeap.2015.27.4.333
- Guta, A., S. J. Murray, and M. Gagnon 2016 HIV, viral suppression and new technologies of surveillance and control. *Body & Society* 22(2):82–107.
- Hardon, A., and E. Moyer 2014 Anthropology of AIDS: Modes of engagement. *Medical Anthropology* 33(4):263–69. doi:10.1080/01459740.2014.889132.
- HIV Justice Network 2020 India. Available at: <https://www.hivjustice.net/country/in/>
- Kenworthy, N., M. Thomann, and R. Parker 2018 From a global crisis to the 'end of AIDS': New epidemics of signification. *Global Public Health* 13(8):960–71. doi:10.1080/17441692.2017.1365373
- Khanna, A 2016 *Sexualness*. New Delhi: New Press.
- Lakkimsetti, C. 2020 *Legalizing Sex: Sexual Minorities, AIDS, and Citizenship in India*. New York: New York University Press.
- Lorway, R., and S. Khan. 2014 Reassembling epidemiology: Mapping, monitoring and making-up people in the context of HIV prevention in India. *Social Science & Medicine* 112:51–62. doi:10.1016/j.socscimed.2014.04.034
- Manian, S. 2019 *HIV/AIDS in India: Voices from the Margins*. Milton Park, UK: Routledge.
- Meghani, S. A. 2020 HIV Stigma, Gay identity, and caste 'untouchability': metaphors of abjection in *my brother . . . Nikhil, The boyfriend*, and "Gandu Bagicha". *Journal of Medical Humanities* 41:137–51. doi:10.1007/s10912-017-9437-5
- NACO 2017 National Strategic Plan for HIV/AIDS and STI 2017 – 2024: "Paving the way for an AIDS free India". <http://naco.gov.in>
- Nataraj, S. 2020 *Consent is compulsory: Informed consent in HIV testing of pregnant women in India*. PhD thesis, School of Public Health and Preventative Medicine, Monash University.
- Nguyen, V-K., N. Bajos, F. Dubois-Arber, J. O'Malley, and C. M. Pirkle. 2011 Remedicalizing an epidemic: From HIV treatment as prevention to HIV treatment is prevention. *AIDS* 25:291–93. doi:10.1097/QAD.0b013e3283402c3e
- Parker, R. 2001 Sexuality, culture, and power in HIV/AIDS research. *Review of Anthropology* 30:163–79. doi:10.1146/annurev.anthro.30.1.163
- Parker, R., and P. Aggleton 2003 HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science & Medicine* 57(1):13–24. doi:10.1016/S0277-9536(02)00304-0
- Patel, V., A. Dange, S. A. Golub, S. Neytra, Y. Parekh, C. Pina, J. H. Arnsten, et al 2018 Barriers and facilitators of PrEP. Paper Presented at Conference on Retroviruses and Opportunistic Infections Boston, MA.
- Persson, A. 2013 Non/infectious corporealities: tensions in the biomedical era of 'HIV normalisation'. *Sociology of Health & Illness* 35(7):1065–79. doi:10.1111/1467-9566.12023
- Persson, A., C. E. Newman, L. Mao, and J. De Wit 2016 On the margins of pharmaceutical citizenship: Not taking HIV medication in the "treatment revolution" era. *Medical Anthropology Quarterly* 30(6):359–77. doi:10.1111/maq.12274
- Prevention Access Campaign 2020 *Undetectable = Untransmittable*. <https://www.preventionaccess.org/undetectable>
- Rabinow, P. 1996 Artificiality and enlightenment: From sociobiology to biosociality. In *Essays on the Anthropology of Reason* P. Rabinow, ed. Pp. 91–112. Princeton, NJ: Princeton University Press.
- Race, K. 2001 The undetectable crisis: Changing technologies of risk. *Sexualities* 4(2):167–89. doi:10.1177/136346001004002004
- Race, K. 2015 *The Gay Science: Intimate Experiments with the Problem of HIV*. Milton Park, UK: Routledge.
- Rao, R. 2020 *Out of Time: The Queer Politics of Postcoloniality*. Oxford, UK: Oxford University Press.
- Rao, S. K. 2017 *Do We Care? India's Health System*. Oxford, UK: Oxford University Press.
- Rijneveld, C 2020 Chemsex and the failure of new HIV prevention strategies in India. *The Caravan*. <https://caravanmagazine.in/>
- Sangaramoorthy, T. 2018 Chronicity, crisis, and the 'end of AIDS'. *Global Public Health* 13(8):982–94. doi:10.1080/17441692.2018.1423701
- Schulman, S. 2016 *Conflict Is Not Abuse: Overstating Harm, Community Responsibility, and the Duty of Repair*. Vancouver, CA: Arsenal Pulp Press.
- Subramanian, A. 2019 *The Caste of Merit: Engineering Education in India*. Cambridge, MA: Harvard University Press.
- Tan, R., K J, J. M Lim, and K. K. W. Chan 2020 "Not a walking piece of meat with disease": Meanings of becoming undetectable among HIV-positive Gay, bisexual and other men who have sex with men in the U =U Era. *AIDS Care* 32(3):325–329F. doi:10.1080/09540121.2019.1668534
- Teltumbde, A. 2018 *Republic of Caste: Thinking Equality in the Time of Neoliberal Hindutva*. New Delhi: Navayana.
- Treichler, P. 1999 *How to Have Theory in an Epidemic*. Durham, NA: Duke University Press.
- U Equals U 2019 Dr. Fauci at IAS 2019: "The concept of U=U is the foundation of being able to end the epidemic." Youtube. <https://youtube.com>
- UNAIDS 2014. 90-90-90An ambitious treatment target to help end the AIDS epidemic. <https://www.unaids.org/>
- Van Hollen, C. 2013 *Birth in the Age of AIDS*. Stanford, CA: Stanford University Press.

- World Health Organization (WHO) 2016 Progress report 2016. Prevent HIV, test and treat all: WHO support for country impact. <https://who.int>
- Young, I., M. Davis, P. Flowers, and L. M. McDaid 2019 Navigating HIV citizenship: Identities, risks and biological citizenship in the treatment as prevention era. *Health, Risk & Society* 21(1–2):1–16.
- Young, I., P. Flowers, and L. M. McDaid 2016 Can a pill prevent HIV? Negotiation the biomedicalisation of HIV prevention. *Sociology of Health & Illness* 38(3):411–25. doi:[10.1111/1467-9566.12372](https://doi.org/10.1111/1467-9566.12372)