Epistemology and HIV Transmission:
Privilege and Marginalization in the Dissemination of Knowledge

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Theory, Cases, and HIV-Risk Intuitions

The philosophical work of feminists and critical race theorists has resulted in the formation and development of important epistemological concepts and theories. Many of these, such as theories of epistemic injustice, have been remarkably effective in confronting issues resulting from current, wide-sweeping power imbalances between and among the intersections of race, gender, socioeconomic status, and sexual orientation, among others. In this chapter, we apply some of the lessons from feminist and critical race epistemology to an area where philosophers have traditionally had less to say—namely, epistemic issues related to HIV and HIV transmission risk. More specifically, we bring together a broad swath of empirical work conducted in a range of disciplines alongside recent work in feminist and critical race epistemology to highlight and address these issues.

We identify ways in which popular social perceptions about HIV do not properly align with empirical findings, and we develop a framework for explaining this incongruency. Central to our discussion are the identification of epistemic harms related to HIV and some of the normative implications of the presence of these harms. By epistemic harm we mean damage done to an individual in their capacity as a knower (or harm done to a group in their capacities as knowers). We use the term epistemic harm as a general category that encompasses, among other
things, both epistemic injustice and epistemic oppression (cf. Fricker 2007; Dotson 2014). Epistemic injustice is “a wrong done to someone specifically in their capacity as a knower” (Fricker 2007, 1; emphasis added). Epistemic oppression “refers to persistent epistemic exclusion that hinders one’s contribution to knowledge production” (Dotson 2014, 115).

We identify these epistemic harms by examining case studies and research findings through the lens of feminist and critical race epistemology. Some of these harms, like Miranda Fricker’s hermeneutical injustice and Kristie Dotson’s contributory injustice, are previously identified harms that we are identifying in a new context. In looking at how these injustices arise and how they are (in some cases) being addressed, we identify patterns of marginalization and privilege among communities significantly affected by HIV and the combinations of knowledge and ignorance to which these patterns give rise. Because applying theories of epistemic harm in an extensive manner to issues pertaining to HIV is new terrain, our treatment is somewhat general. We hope this work will spur further discussion about how feminist and critical race epistemology can inform our understanding of the epistemic conditions of HIV-positive people and of those at risk of contracting HIV. To help frame our discussion, we open with four scenarios that will help us take stock of the epistemic landscape and provide reference points for our analysis:

**Scenario 1:** Adam is a gay, cisgender man living in the U.S. Adam has had five different male sexual partners in the past year. Adam asked each of his partners before having sex with them for the first time whether or not they were HIV positive. Each one told Adam that they were HIV negative and had been tested recently. Adam has good reason to think that each of the partners was being honest with him. Adam usually uses condoms when he has sex, but not always. Adam’s last HIV test was about a month ago. He tested negative, and he has not had sex since.

**Scenario 2:** Ben is also a gay, cisgender man living in the U.S. Ben has also had five different male sexual partners in the past year. Unlike Adam, Ben did not discuss matters related to HIV with his partners, but he thinks it is likely that if any of his partners were HIV positive, they would have said something. Unlike Adam, Ben does not usually use a condom when he has sex.
Ben’s last HIV test was about three months ago. He tested negative for HIV and has only had sex a few times since.

**Scenario 3:** Carrie is a straight, cisgender woman living in the U.S. Carrie has also had five different male sexual partners in the past year. Like Ben, Carrie did not discuss matters related to HIV with her partners, but she thinks it is likely that if any of her partners were HIV positive, they would have said something. Like Ben, Carrie does not usually use a condom when she has sex (although she uses birth control). Carrie’s last HIV test was about three months ago. She tested negative for HIV and has only had sex a few times since.

**Scenario 4:** Dan is a gay, cisgender man living in the U.S. Dan has been in a monogamous sexual relationship with an HIV-positive male partner for the past year. Dan’s partner was diagnosed with HIV five years ago and faithfully adheres to the treatment prescribed by his doctor, whom he meets with every three to six months. Dan and his partner have sex on a regular basis and do not use condoms. Dan gets tested for HIV twice a year. Dan’s last HIV test was six months ago, and he tested negative for HIV.

When juxtaposed, these scenarios raise interesting questions concerning perceptions of individual risk and understanding of risk. Many will confidently judge that Dan, the man having sex regularly with his HIV-positive male partner, has the greatest risk of contracting HIV and that either Adam, the gay man whose partners all identify as HIV negative and who uses condoms regularly, or Carrie, the straight woman, has the lowest risk of contraction. Many will also think that Carrie and Adam should have a fairly good understanding of their risk levels being low. Others might think that Dan has a less accurate understanding because it has been longer since his last HIV-negative test and because he has had sex regularly with an HIV-positive person since his last test.

Such judgments result from certain common assumptions about some of the major contributing factors in HIV transmission. Such assumptions include that the risk of sexual transmission from an HIV-positive to an HIV-negative partner is always relatively high (or at least never negligibly low), that heterosexual sex comes with a low risk of HIV-transmission, and that condom use is the most salient (or only) preventative measure to pay attention to in assessing risk levels for sexual transmission of HIV between serodiscordant couples (i.e. couples
with different HIV statuses). Assumptions like these are problematic in at least two ways. First, they fail to acknowledge how radically undetermined the above scenarios are—that is to say, such responses fail to identify the significance of a whole host of other factors relevant to knowledge of risk levels. People making such assumptions are working with a very simplified understanding of HIV transmission and risk. The empirical data we present will reveal the inadequacies of this simplified understanding. Second, once these additional factors are taken into account, it turns out that there are good reasons to think that Dan has the lowest level of risk of HIV infection and the most accurate understanding of his own low risk level. As we shall show, these outcomes are plausible upshots of recent epidemiological and sociological findings.

**HIV Research Findings and Initial Epistemic Implications**

**Basic Epidemiology of HIV**

HIV (human immunodeficiency virus) is a virus that attacks the body’s immune system and spreads through transmission of certain bodily fluids. The typical progression of the virus, when left untreated, is divided into three stages. The first stage, primary (or acute) infection, lasts for roughly three to six months. During this stage, the HIV-positive person’s viral load (the amount of virus present in the blood) is very high, making the person much more infectious compared to the second stage. During this stage, many but not all of those infected experience flu-like symptoms or other maladies.

The second stage, asymptomatic HIV infection, begins when primary infection ends. During the asymptomatic stage, the virus remains active and continues to replicate, but at a much slower rate. For those not on treatment, the length of this stage varies, although it is a matter of
years, sometimes a decade or longer, before the virus progresses to the third stage. In this second stage, HIV-positive persons may not experience any symptoms but remain capable of infecting others. How long this period lasts and how infectious a person is both depend on whether they are on proper medical treatment. (Current standard treatment consists of regular checkups with physicians and taking a pill or set of pills daily. This daily pill regimen to treat HIV is known as antiretroviral therapy—ART, for short.)

Those that reach the final stage of the infection develop AIDS (acquired immunodeficiency syndrome). By this stage, the virus has caused substantial damage to the HIV-positive person’s immune system (in the form of a very low CD4 T cell count), leaving them vulnerable to many opportunistic infections, which can prove fatal for someone in their immunocompromised condition. The viral load of a person with AIDS is high, leading to increased infectivity. Without treatment, people typically survive about three years with AIDS.¹

Thankfully, in the forty years since HIV/AIDS first came into cultural consciousness in the United States and around the globe, remarkable medical advances have been made in our understanding of and ability to treat HIV. Successful use of ART can help persons living with HIV or AIDS stay or become healthy, such that “with these treatment regimens, survival rates among HIV-infected adults who are retained in care can approach those of uninfected adults” (Günthard et al. 2016, 191). ART can also dramatically decrease or eliminate completely the possibility of infecting others (McCray and Mermin 2017). While not a cure, ART has been very successful in increasing quality of life and prolonging the life expectancy of persons living with

¹ For more information on HIV and the stages of infection, see the CDC’s (2015a) “About HIV/AIDS.” For another quick overview of HIV, see Malani (2016).
HIV or AIDS and has led to a reclassification of HIV from a fatal disease to a chronic, treatable condition.

Ignorance of HIV-Positive Status

One method to avoid contracting HIV—i.e., seroconverting—is to avoid contact with the virus completely. Common-sense thinking like this leads some people (many of them men who have sex with other men, or MSM) to engage in serosorting. Serosorting is the practice of intentionally selecting sexual partners who identify as having the same HIV status as you. But serosorting is based on the serostatus reported (or perceived to be reported) by potential partners. Such reports are effective only to the extent that the status reported matches the status those potential partners actually have, epidemiologically speaking.

Some HIV-positive individuals may be dishonest or give unclear responses that could be misinterpreted by others (Dodds, Bourne, and Weait 2009, 142). Alternatively, serosorters may make incorrect assumptions about what constitutes an indication that a prospective partner is HIV negative. For example, one might assume that silence on the topic is a tacit way of indicating that one is HIV negative. But research shows that, among HIV-positive MSM, clear reports of HIV-positive status are relatively infrequent, occurring perhaps less than half the time, and even in cases where disclosure does occur the disclosure frequently fails to be explicit (Dodds, Bourne, and Weait 2009, 142; Koblin et al. 2006, 735). Even when casting these issues aside, effective serosorting requires that those reporting their status know whether they are infected. Estimates suggest that roughly 13% to 20% of HIV-positive people in the United States...

2 Serosorting is also a practice engaged in by HIV-positive persons for various reasons. See Adams et al. (2014, 45).
do not know they are positive (Chou et al. 2012; Hall et al. 2015; McNulty, Cifu, and Pitrak 2016). In some communities in the US, those numbers are much higher. Research suggests that as many as nearly half of all HIV-positive people in certain communities may be unaware that they are HIV positive (Koblin et al. 2006, 735; Millett et al. 2006, 1010). An estimated 20,000 new HIV infections occur annually in the United States due to transmission from persons who are unaware that they are infected (Chou et al. 2012), and over 30% of new infections are transmitted from those with undiagnosed HIV, according to the Centers for Disease Control and Prevention (CDC).[^3] Thus, there are significant limits to one’s ability to knowingly avoid contact with HIV solely by relying on the reported HIV status of others.

**HIV Testing, the Window Period, and Epistemic Limits**

An obvious reason why many HIV-positive people do not know that they are positive is because they have not been tested. Increasing the percentage of at-risk individuals getting tested and the frequency with which they get tested is widely recognized as an important way to decrease the percentage of HIV-positive people unaware that they have the virus (McNulty, Cifu, and Pitrak 2016). There is also another factor at play here—namely, the window period between contraction of HIV and the ability of an HIV screening to accurately render an HIV-positive result. For a highly informed population, this window period might prove minimally problematic. But part of the problem here is epistemic; in other words, those tested may not understand the window period.

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[^3]: For more information, see CDC (2016c).
The time period between contracting HIV and testing positive for HIV is dependent on several factors, including the strain of HIV one has contracted and the type of HIV test being administered. The most common type of HIV test given is an antibody test, which identifies the presence of HIV by testing for the antibodies our bodies make in response to the virus. Because it takes time for these antibodies to be produced, currently, the quickest a person will test positive for HIV given a standard antibody test is two weeks, but evidence suggests it sometimes may take up to three months or longer to develop the necessary antibodies to test positive.4

If we think back to our four scenarios in the first part of this chapter, of Adam, Ben, Carrie, and Dan, given their regular sexual activity, any of them could have been infected with HIV when they last tested negative. Furthermore, for Adam and Carrie, even though their partners disclosed HIV-negative statuses, for all Adam and Carrie know, any of their partners could have been in a similar situation of having contracted the virus too recently at the time of their last HIV screening to have tested positive. This is not to deny the important epistemic advantage gained by HIV-negative screenings but rather to recognize the limits of that advantage. Our purpose here is to survey the epistemic landscape of HIV, while also being careful not to create an overinflated sense of risk.

These epistemic limits have very real practical effects. In 2006 the results published from a longitudinal study run with over 4,000 HIV-negative MSM conducted in six US cities found that over one-fifth (21.6%) of the seroconversions that occurred were “accounted for by unprotected receptive anal intercourse with partners believed to be HIV negative” (Koblin et al. 2006, 735). This number was in fact higher than the percentage of seroconversions accounted for

4 For more information on the HIV-testing window period, see Department of Health and Human Services (2015) and CDC (2016c).
by unprotected receptive anal intercourse with partners believed to be HIV positive (18.6%).

Crucially, in this study, partners were classified as HIV negative when “a partner told the participant they were negative and the partner had no reason to doubt it” (Koblin et al. 2006, 731), meaning that the seroconversion rate of 21.6% does not account for the cases of seroconversion due to contact with sexual partners whose status was classified as unknown. Seroconversions from partners with unknown status accounted for an additional 28.4%. Findings like these, along with a lack of awareness of the full window period for positive HIV results from HIV screenings, call into question the effectiveness of things like serosorting or assumptions about the low risk level of HIV contraction during sexual contact with self-identified HIV-negative individuals.

Viral Loads and Infectivity

Misperceptions cut both ways. Many who do not see relevant differences in risk levels for sexual contact among partners labeled as HIV negative also fail to see relevant differences in risk levels for sexual contact among HIV-positive individuals. One of these relevant differences among HIV-positive persons is the HIV-positive person’s viral load. Viral load is important when considering risk of infection because higher viral loads are strongly linked to greater infectivity (McNulty, Cifu, and Pitrak 2016).

A person’s viral load is particularly high during primary HIV infection. The high level of virus in the blood and semen leads to elevated infectivity during primary HIV infection (Pilcher et al. 2004, 2789–90). A 2008 study found that primary infection was twenty-six times more infectious than the second asymptomatic stage (Hollingsworth, Anderson, and Fraser 2008, 687). Thus, for biological reasons, primary infection is a time in which transmission is more likely.
This is compounded by the epistemic factor that many people in the primary-infection stage are unaware of their infection (Pao et al. 2005, 89; Koblin et al. 2006; 735, Chou et al. 2012). As a result, these individuals may be less apt to take precautions and may unintentionally disclose a status that does not accurately reflect the presence of infection. Such biological, behavioral, and social elements combined have led to primary infection serving as a particularly potent factor in the ongoing spread of HIV (Cates, Chesney, and Cohen 1997; Koopman et al. 1997, 249; Brenner et al. 2007). Studies estimate that between one-quarter and one-half of new infections occur during primary infection (Pao et al. 2005, 86). One study estimated that in 2010 infection from undiagnosed HIV-positive men, the majority of whom were in the primary-infection stage, accounted for 82% of new infections in the UK (Phillips et al. 2013).

**ART and Suppressed Viral Loads**

While research has shown the high infectivity of primary HIV infection, it has also shown that with proper treatment infectivity is very low or nonexistent for many HIV-positive people. A noteworthy case of such findings occurred in 2014 when a group of European researchers reported their initial findings on HIV-transmission risk through condomless sex between serodiscordant couples in which one partner was HIV positive, on ART, and had a low viral load (less than 200 copies/ml) and the other partner was HIV negative (Rodger et al. 2012, 2016). The study, known as the PARTNER study (referring to partners of people on ART), revealed that, over a two-year period, an estimated over 40,000 occasions of condomless vaginal or anal sex (comprised of roughly 16,400 instances of sex between men and 28,000 instances of sex

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5 In addition, the HIV-negative partner could not be on PrEP or PEP (prophylactic methods for HIV prevention) at any point in the study.
between men and women) within a sample of 767 couples resulted in zero cases of transmission of HIV from the positive partner to the negative partner (Rodger et al. 2014, 2016). This result is congruent with results from previous studies (notably, Cohen et al. 2011), although PARTNER represented a significant advancement over previous studies due to the larger sample size of MSM couples. The researchers in PARTNER concluded that risk of sexual transmission for those on ART with a highly suppressed viral load was very low and that their best estimate was there being zero risk (Cairns 2014; Rodger et al. 2014, 2016).

ART has proven highly effective for the vast majority of those who faithfully adhere to the treatment and can lead to viral loads significantly more suppressed than even the less than 200 copies/ml required for participation in PARTNER. In fact, ART allows many people’s viral loads to get so low that the presence of the virus cannot currently be detected, which, depending on the test, typically requires a viral load of less than 40 to less than 75 copies/ml. During periods in which they achieve such low viral loads, individuals are referred to as undetectable. This is a term that many HIV-positive people use to convey information about their viral load, adherence to treatment, and identity (Grace et al. 2015, 333).

Since the release of the PARTNER-study results, numerous medical providers and organizations have publicly endorsed the view that those with undetectable viral loads are incapable of transmitting HIV (Prevention Access Campaign 2017). This view is often encapsulated by proponents as “undetectable = untransmissible” (see, for example, King 2016). On September 27, 2017, the CDC joined this consensus in a public letter stating that “people who take ART daily as prescribed and achieve and maintain an undetectable viral load have

6 For an accessible discussion of the preliminary results from the PARTNER study, see Cairns (2014).
effectively no risk of sexually transmitting the virus to an HIV-negative partner” (McCray and Mermin 2017).

Developments in Prophylaxis

Recent developments have also provided new means for HIV-negative individuals to decrease their likelihood of infection independent of the precautions that may or may not be taken by their partners. In 2012, a new means became available in the United States with the Food and Drug Administration’s approval of Truvada (emtricitabine/tenofovir disoproxil fumarate) for the purpose of HIV pre-exposure prophylaxis (PrEP; Jefferson 2012). Such prophylaxis consists in HIV-negative persons at higher-than-average risk of HIV contraction taking Truvada on a daily basis. Clinical studies have shown that Truvada, when taken consistently, reduces the risk of HIV transmission via sex by more than 90% and of transmission via injection-drug use by more than 70% (CDC 2015c). And PrEP usage in combination with other forms of prophylaxis, like condoms, further reduces the risk of HIV transmission.7 Between 2008 and 2014, there was an 18% drop in the number of annual HIV infections in the United States, and the CDC has suggested that this may be due in part to usage of PrEP (NCHHSTP 2017).

Reviewing the Epistemic Implications

Reflecting on this research, we can revisit our four scenarios. Dan, who regularly has condomless sex with his HIV-positive male partner, may have initially appeared to have the

7 For more information on PrEP, see CDC (2015b, 2015c).
highest risk of contracting HIV. But recall that Dan’s partner faithfully adheres to ART and meets with his doctor regularly. These regular visits include measurements of Dan’s partner’s viral load. Given Dan’s partner’s adherence to ART, Dan’s partner has a high chance of having a very low viral load. If Dan’s partner’s viral load is undetectable, research like PARTNER shows that this makes Dan’s chance of contraction of HIV from his partner effectively nonexistent. In addition, even if a minuscule risk remains, Dan can further reduce any remaining risk by going on PrEP. Thus, if Dan is on PrEP and his partner has a low viral load, not only is the likelihood of Dan contracting HIV effectively nonexistent, Dan also has a high degree of knowledge about his risk level given the information Dan’s partner gets from his regular doctor visits and given the information Dan gets during his own visits to the doctor because he is on PrEP.

In contrast, Adam, Ben, and Carrie all have a variety of unaccounted-for variables that influence their risk levels (e.g., when their partners were last tested, whether any of their partners use injection drugs, whether any of their partners are in primary infection), which certainly influences how clearly they understand their own level of risk. Adam, Ben, and Carrie are also in a more precarious position when it comes to assessing the honesty of their potential partners’ reports on HIV status and risk. And, as will be discussed more in the following section, their partners may be incentivized to be dishonest. But the communication of wrong information is not limited to cases of dishonesty. Issues can arise when someone reports a status without having been tested at all or when tested at a time that doesn’t account for a window period—something of which the person being tested may not have known to be mindful.

As concern about the HIV/AIDS epidemic has receded from the forefront of the general population’s consciousness in much of the United States, Canada, and Western Europe, many advances in our understanding of and ability to treat HIV, along with their implications for how
to avoid contraction of HIV, have failed to become widely known or well understood across the public as a whole. In 2013 and 2014, only 21% of adults in the United States were aware that ART could reduce the risk of an HIV-positive person infecting a partner, and only 14% were aware of PrEP and its ability to lower risk of contracting HIV (Firth et al. 2016). The extent to which a person is apt to be well informed about advancements in HIV treatment and to have thought through the implications of those advances for personal health and/or risk management is correlated with their perception of their likelihood of being at risk of contracting HIV or of knowing others who are HIV positive or at higher-than-average risk of becoming so. In turn, the likelihood of being at higher risk is correlated with many aspects of one’s social situation. For example, MSM, Black people, and intravenous-drug users (among other populations) continue to account for a highly disproportionate amount of new infections in the United States (CDC 2016b). Given the ways in which these groups are already marginalized and stigmatized, the

8 The ramifications stemming from such a lack of awareness about the realities of HIV range from the legal to the political to the social for HIV-positive individuals. Over thirty states in the United States still have laws geared specifically toward the criminalizing of certain activities by HIV-positive people, including eleven states where activities like spitting and biting that have virtually no risk of transmission are criminalized (Lehman et al. 2014). In October 2017, Betty Price, a Georgia state legislator, anesthesiologist, and wife of former Health and Human Services Director Tom Price, asked during a public hearing if it was legal to quarantine HIV-positive people (Tinker 2017). And, earlier in 2017, the gay dating app DaddyBear, which self-identifies as the “No.1 gay sugar-daddy dating app,” created waves by not allowing HIV-positive members to join, citing as reasons that “most mature gay daddies grew up under the macro environment of AIDS epidemic and scare, so they know how to protect themselves and you, and enjoy safe sex with you” and that, in the words of DaddyBear’s CEO, “No one would like to date people living with HIV unless he is living with it. Most gay sugar daddies are not living with HIV, so they don’t want to bring home any unwanted souvenirs” (Koff 2017).

9 Firth et al. (2016) provides confirmatory evidence showing that Black adults in the US and gay and bisexual adult males in the US are better informed about the benefits of ART and PrEP—although these differences are quite small.

10 For demographic information broken down by race, ethnicity, and “risk groups,” see the CDC’s (2016b) “HIV in the United States: At a Glance.”
further marginalization and stigmatization of being HIV positive has led to complex patterns of risk management, methods of knowledge collection and dissemination, and forms of communication (or communication avoidance) concerning HIV.\footnote{Our chapter focuses on the United States. The reason we have limited our scope despite the notable impact of HIV/AIDS on many other parts of the world, particularly the African continent, is because the epistemic circumstances are not unified geographically, and to try and take cross-cultural issues into account in addition to intracultural issues in the United States would not be doable in a single chapter of this length. That said, we recognize the need for and encourage the additional development of work in this area that addresses the epistemic circumstances of other parts of the world.}

\textbf{Epistemic Harm, Epistemic Injustice, and HIV}

We are now in a position to identify some of the epistemic harms related to HIV and HIV transmission. Much more could be said on the topic than we have space for, but we hope to offer a sampling of the sorts of issues that arise in what follows. We first argue that two previously identified types of epistemic harm affect HIV-positive people: hermeneutical injustice (Fricker 2007) and contributory injustice (Dotson 2012). We then examine the state of social knowledge and linguistic practices concerning HIV and, to an extent, sexually transmitted infections (STIs) more broadly to identify a different type of epistemic harm that we call \textit{structural-linguistic epistemic harm}.

\textbf{Hermeneutical Injustice, Contributory Injustice, and the Epistemic Resources of HIV-Positive MSM}

Miranda Fricker (2007, 1) writes, “hermeneutical injustice occurs . . . when a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of
their social experiences.” Members of dominant communities, who frequently control the development of collective interpretive resources, due to their lack of interest in or awareness of certain salient experiences of those in nondominant groups, often prevent the development of the resources needed to explain or understand the experiences of the marginalized. On Fricker’s account, the unfair disadvantages that the marginalized face due to an inability to explain, or even understand, their own experiences constitute hermeneutical injustice.

At least implicitly, this characterization of collective interpretive resources seems to assume that there is a single shared set of resources. Following Rebecca Mason (2011), we argue that although the collective resources are often insufficient to provide understanding of certain experiences within broader knowledge communities, nondominant groups are often very successful in developing their own additional resources, which may not be part of the collective resources of the larger community, to understand their experienced world. Thus, Mason asserts, and we concur, that “marginalized groups can be silenced relative to dominant discourses without being prevented from understanding or expressing their own social experiences” (301).

In this latter sort of circumstance, rather than being mystified by an experience that does not yet have robust epistemic discourse, the marginalized are unfairly disadvantaged because those in power fail to understand or to make use of the hermeneutical resources developed by the marginalized. When this failure is willful, Gaile Pohlhaus (2012) calls this willful hermeneutical ignorance. This unwillingness of the powerful to learn about or make use of the hermeneutical resources developed by the marginalized leads to an avoidable and epistemically unjust gap in understanding between the powerful and the marginalized.

Mason’s distinction between different types of discourse communities and Pohlhaus’s identification of willful hermeneutical ignorance point to a second type of epistemic injustice
that arises when the dominant engage in willful hermeneutical ignorance in a way that disadvantages nondominant populations. Kristie Dotson (2011) calls this contributory injustice. In the case of contributory injustice, the injustice of being unfairly silenced and/or misunderstood by the dominant constitutes the epistemic wrong. This is contrasted with Fricker’s understanding of hermeneutical injustice in which there is the separate wrong of the marginalized being robbed of the ability to understand or explain their own experiences due to a lack of adequate hermeneutical resources. In what follows, we argue that both forms of injustice are present for HIV-positive MSM. We think these injustices apply to HIV-positive people generally, but, by way of example, we focus here on MSM.

To see how these injustices arise, it will be useful to take stock of several different, sometimes overlapping, communities with differing levels of marginalization. Sexually active adult males can be separated into a dominant community, those who engage in exclusively heteronormative sexual activity, and a nondominant community, those who engage in forms of non-hetero-normative sex, including sex between MSM. Another distinction can be made with HIV-negative MSM constituting a comparatively dominant community and HIV-positive MSM an additionally marginalized community. This puts HIV-positive MSM in a doubly marginalized position and HIV-negative MSM in an intersectional position in which they are both marginalized as part of a broader group and dominant within a specific community. In the remainder of this section, we first describe ways in which many HIV-positive MSM have developed resources to understand their world (as well as looking at those who do not have such resources). We then identify hermeneutical and contributory injustices in light of these knowledge- and discourse-community distinctions.
Two areas of discourse relevant to understanding the world as HIV-positive MSM are medical/health discourse and social/relationship interaction discourse. The former refers to understanding HIV as a virus, as well as to precautionary measures and treatment. The latter refers to social processes such as the stigmatization and isolation that may occur as a result of one’s status and the perceptions of HIV-positive people by HIV-negative people. As we will show, both these areas of discourse have important epistemic components.

Many HIV-positive MSM develop epistemic resources relevant to understanding the virus and its potential health impacts. As we learn more about HIV and new treatments are developed, these epistemic resources expand, but they are limited by the pace and focus of medical and scientific research. Fricker acknowledges the complexity of trying to understand one’s own experiences living with medical conditions that are not fully understood or diagnosable. In situations where little is understood about a disease but this lack of understanding is not due to any kind of willful ignorance or prejudice, the lack of collective cognitive resources is a case of “circumstantial epistemic bad luck” and not a case of hermeneutical injustice for those suffering from the disease (Fricker 2007, 152). When HIV/AIDS first began to spread and impact MSM living in the United States, their own and others’ inability to understand the virus or how it affected social practices was limited by the state of knowledge in the medical community at large. Thus, initially, HIV-positive MSM may have encountered a state of circumstantial epistemic bad luck. (Although to the extent that bias against MSM may have influenced initial diagnoses, treatment, and research, this period in

12 This is not to say there isn’t important overlap between the medical and social realms, but for our purposes it will be useful to talk about these areas as two things that, at the very least, are not identical to one another.
which the harm to HIV-positive people was merely circumstantial epistemic bad luck may have been very short or nonexistent.)

As we have learned more about HIV and as affected communities have developed modes of communication that allow for an increased understanding, contributory and hermeneutical injustices have replaced any circumstantial epistemic bad luck that may have obtained initially. This is because there are many epistemic resources currently available to help explain the experiences of HIV-positive MSM, which many HIV-negative people, including many HIV-negative MSM, fail to recognize or use. Focusing on the developing discourse around serostatus, communication, and safe-sex practices, we can see the ways in which dominant HIV-negative MSM commit epistemic injustices against nondominant HIV-positive MSM.

As the biomedical research on viral loads and transmission rates expanded, the new term *undetectable* emerged, referring to HIV-positive individuals with low viral loads associated with decreased transmission risk. In a longitudinal study, Grace et al. (2015) found that viral-load information impacts communication and sexual activity. First, they found that many HIV-positive MSM report abstaining from sex during the period shortly after diagnosis, in part in order to avoid transmitting the virus (338). This period of abstinence typically ended when viral loads decreased, especially for those labeled *undetectable* (340–41). As this label is increasingly used in medical discourse, it translates into social discourse. *HIV positive* alone does not fully reflect the relevant experiences of many undetectable MSM. And when our experience of the world cannot be expressed by our current epistemic resources, we develop new ways of understanding our lives so that we can understand our world and, in some circumstances, explain it to relevant others (Pohlhaus 2012, 719). As one participant in Grace et al.’s (2015, 341) study notes, “Most guys, they put ‘undetectable,’ actually, instead of that they’re positive” when
discussing online dating and sexual partnering. Several HIV-negative MSM participants noted that knowledge about HIV and undetectable status was an important factor in their decision to engage in sexual activity with an HIV-positive partner (Grace et al. 2015, 343). HIV-positive MSM have constructed a set of epistemic tools to understand their own experiences and transmission risks, and the willingness of HIV-negative MSM to use these tools impacts sexual decision-making and can decrease stigmatization of HIV-positive MSM (and HIV-positive persons generally).

When HIV-negative individuals refuse to acknowledge, educate themselves about, or use the terms and practices around undetectable, a contributory injustice occurs, often as the result of willful hermeneutical ignorance. For example, a disclosed positive serostatus frequently is sufficient for HIV-negative individuals to cease pursuing any relations with an HIV-positive individual, even if the HIV-positive individual’s viral load is undetectable and the developing discourse is used to communicate this information. This is part of a general tendency in which HIV-positive men report “that they sense fear among HIV negative men regarding HIV/AIDS and that many men avoid the topic of HIV and will avoid potential sex partners if the topic does arise” (Courtenay-Quirk et al. 2006, 62). Such responses from HIV-negative individuals fail to account for or attend to salient aspects relating to the health or infectivity of HIV-positive MSM and indicate a distrust of health-based self-knowledge reports by HIV-positive MSM. Recall our character Ben, who assumes that silence about status indicates safety. Any discussion of HIV status often leads to avoidance, despite open discussion of status typically being a sign of diligent

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It is important to note that not all members of the HIV-positive MSM community endorse the adoption of these epistemic resources and some suggest that these terms should not be used in relational negotiations on social media, though this view is not particularly pervasive (Ramallo et al. 2015, 305).
research and commitment to not transmitting HIV. We are not claiming that concern about contracting HIV constitutes an injustice, but an unwillingness to investigate and understand the current research on HIV-transmission risk unjustly results in the further marginalization of HIV-positive people, even among communities where risk is high overall and understanding these identities is relevant to the health of the broader MSM community.

Additionally, this willful hermeneutical ignorance results in an increase of risk for HIV-negative participants by limiting conversations about HIV prevention and decreasing the likelihood that an HIV-positive partner will disclose their status. Due to the high level of stigmatization of HIV, MSM may not be willing to discuss HIV prevention for fear that others will think they have HIV (Ramallo et al. 2015, 308). The hesitancy to mention HIV in any capacity radically undermines the development of epistemic resources around sexual health and HIV prevention. In addition, Ramallo et al. (2015, 300) note that HIV-positive MSM might not discuss their HIV status with potential partners online prior to engaging in high-risk sexual activities. They write, “The HIV-positive participants expressed conflict in whether to be forthright by disclosing their status on social networking hook up sites, and the potential consequences of men being uninterested in them” (305). In cases where HIV-positive MSM avoid disclosing—for any of a variety of reasons including fear of rejection, nervousness, shame, or discomfort being honest—they may further do something epistemically unjust to their potential partners—leading to a cycle of reciprocal epistemic injustice.

Ramallo et al. attribute serosorting by HIV-negative individuals to HIV stigma. Not only does the popularity of serosorting result in a decreased chance of HIV disclosure, but utilizing serosorting as the primary tool for sexual safety also emphasizes a dichotomy between those that know they are positive and those that believe (including those who falsely believe they know)
they are negative. However, due to window periods, infrequent testing, and other risky sexual behavior, decisions made utilizing this distinction are unreliable; reinforcing this dichotomy harms the MSM community as a whole.

Additionally, because of society’s slow uptake of the new hermeneutical resources developed to explain and understand the medical and social aspects of living with HIV, many HIV-positive people themselves lack any sort of exposure to hermeneutical resources that can be used to describe their own experiences and identities. As a result, hermeneutical injustice still obtains in the portions of society where HIV-positive people lack the hermeneutical resources needed to explain or understand their own experiences. This occurs in addition to the contributory injustice experienced in other segments of society where HIV-positive individuals are marginalized and silenced because others fail to recognize or make use of the hermeneutical resources those HIV-positive individuals possess and use in explaining their own experiences and identities.

In summary, willful hermeneutical ignorance on the part of HIV-negative MSM leads to both contributory and hermeneutical injustices for HIV-positive MSM, further marginalizing this group in the MSM community. In addition, the further stigmatization and unwillingness to learn about current HIV research decreases the likelihood of fruitful conversations between serodiscordant individuals that may engage in sexual relations. These epistemic injustices hurt the MSM community. Acceptance of epistemic resources aimed at helping explain the experiences of HIV-positive MSM by the MSM community at large (as well as other communities) is an important step toward epistemic justice, decreased marginalization, and lower seroconversion risk.
Elizabeth Anderson (2012) distinguishes between transactional and structural injustices. Transactional injustices are violations of justice in particular interactions, while structural injustices are derived from global properties of a system of rules governing transactions. Anderson points out that this distinction applies to epistemic injustices. A similar distinction between harms arising from specific interactions and harms derived from global properties of the rule systems governing transactions also applies in considering epistemic harms more generally. In viewing language practices as having a rule-governed type of structure, we see that certain language practices, which currently govern discourse about how HIV status operates, generate systemic epistemic harm by covering over some of the risk factors and knowledge gaps relevant to risk management for HIV exposure.

Ben has been seeing a guy, Joe, and the two are considering becoming sexually active. In discussing this possibility, Joe asks Ben, “Are you negative?” (meaning HIV negative). Carrie recently met a man on a business trip. Before inviting her up to his room, he asked, “Are you clean?” (referring to being “clean” of [without] STIs). Adam uses the MSM dating and hookup app, Grindr, to meet guys. A guy he’s considering meeting sends him a message reading “ddf?” (short for “[are you] drug and [sexually transmitted] disease free?”).

On the surface, once translated, these questions may seem relatively straightforward. But there are underlying epistemic problems with the structure of these questions. First, these questions conflate an epidemiological status with an epistemic status. Presumably, when one asks “Are you clean?” or “Are you negative?” they’re asking about what diseases you do or do not have. Interest in your test results is implied because such test results are the primary means by which you can secure information about your epidemiological status. But when the two
statuses (epidemiological and epistemic) are woven so tightly together in conversation, the distinction between them is minimized, if not lost. Due to this conflation, a respondent may mistakenly take his knowledge about his test results to constitute knowledge about viral status, or, even in cases where this conflation hasn’t been made internally, a respondent’s language may allow an interlocutor to draw mistaken conclusions about the level of information had by the respondent.

In addition to the epistemic problems with such language, there are also other important ways in which such language problematically contributes to the stigmatization of HIV, HIV-positive people, and those with other STIs. For example, the argument has been made that the phrase “ddf” is problematic because “it puts HIV status on the same level as drug use” [Humburg 2016]. And many of those fighting to end HIV stigmatization have pointed out the stigmatizing effect of framing HIV status in terms of being “clean” or “dirty” (e.g., King 2012).

Concerning the epistemic issues, one could try to address the epistemic problems with the language by giving a nuanced response that pulls the epistemic and epidemiological statuses apart, but the linguistic and social rules governing such interactions often provide disincentives for doing so. On the linguistic level, the syntax of these questions encourages yes or no answers and can render responses of other forms infelicitous. Thus, these responses imply (and perhaps even require) a level of trust that is unwarranted. Furthermore, if whenever one makes an assertion, one is claiming knowledge (as those who have defended the view that knowledge is “the norm of assertion” have argued, e.g., DeRose 2002), such yes or no responses constitute knowledge claims despite factors that frequently prevent one from knowing the answer to that question (factors like outdated test results, having never been tested, or not taking into account the window period). Socially, someone who gives a nuanced response is often viewed with
suspicion. Nuance can suggest that one is untrustworthy or has something to hide. For example, it probably will not go over well for Adam if he types back “probably” or “it depends on what you mean” or anything along those lines.\textsuperscript{14} Thus, the current structure of such linguistic practices harms on two levels: (1) it distracts from the gap between one’s epistemic state concerning HIV status and one’s epidemiological condition, and (2) it disincentivizes more honest or nuanced expressions that try to make clear the epistemic gaps.

We call this type of epistemic injustice a \textit{structural-linguistic epistemic injustice} because it is the structure of the language and the accompanying social practices that create the epistemic harm. This situation harms askers because they are less apt to receive the best information with which to make an informed risk assessment, and it harms those asked because it encourages either giving epistemically suspect answers or risking social consequences by providing a more informative response.

This cycle of harm is perpetuated by, and in turn contributes to, other forms of epistemic injustice. Where a systematic absence of understanding of the harm of current social and linguistic practices surrounding discussions of HIV and STIs prevails, hermeneutical injustice occurs. For HIV-positive people, the hermeneutical injustice occurs via sociolinguistic practices that harm them and contribute to their stigmatization and isolation and that stunt the development of other sociolinguistic practices that may make clearer their epistemic reality and stigmatized

\textsuperscript{14} The reasons why this may not go over well are varied, and we don’t have the space to lay out any kind of complex psychological account as to the different reasons why a questioner may not respond well to a nuanced response. But among the reasons why one may not want a nuanced response are a desire to avoid the discomfort of having to consider as a more likely option that a partner may have HIV or an STI, that the question asker may never have really wanted to know the answer (but rather only wanted to discharge the duty of asking a responsible question), and the desire to avoid the distrust that one may associate with nuanced responses.
condition. For HIV-negative people, the hermeneutical injustice occurs via sociolinguistic practices that hide the epistemically salient factors to their own risk. And contributory injustice occurs in cases where some parties recognize the epistemic and social issues of current sociolinguistic practices but are negatively affected when they attempt to break these practices with more honest and nuanced responses. Furthermore, those who avoid deviating from current social or linguistic practices because of fear of negative consequences encounter a type of epistemic harm, which Dotson calls epistemic smothering. Epistemic smothering is “the truncating of one’s own testimony in order to ensure that the testimony contains only content for which one’s audience demonstrates testimonial competence” (Dotson 2011, 249). Testimonial smothering often occurs when one chooses to suppress their own testimony because they perceive the testimony to be risky or unsafe (249–50). If one avoids giving nuanced and helpful responses about HIV status because of a perceived risk from doing so, one’s testimony is smothered, and a coerced silence occurs. Thus, the structural-linguistic epistemic injustice present in the discourse regarding HIV has the potential to lead to testimonial smothering and coerced silence.

These structural-linguistic epistemic harms, and the epistemic injustices both caused by and resulting from them, can be addressed via the promotion of alternative language that makes the epistemic reality clearer. These harms and injustices can also be addressed via the promotion of other means such as education, which may help people come to properly understand the epistemic reality even if the social language norms, for a time, remain unchanged. These remedies can be implemented both on a transactional level (e.g., a personal commitment to responding in an epistemically forthright way despite social consequences) and on a structural level (e.g., a public-health initiative to educate people about the social realities of HIV
transmission). In addition, given the way language communities work, amassed transactional remedies have the power to become a structural remedy.

To some extent, such remedies have occurred in the MSM community. For example, many users of MSM dating apps have changed the dialectic by posting things like “last tested HIV negative on [month/day/year]” or “on PrEP” on their profiles. And, in recent years, the developers of many of these apps have added areas to profiles dedicated to providing a place for users to share information about status, testing, and other preventative measures (Staley 2015). Such actions result in a movement toward the normalization and encouragement of disclosing this kind of information. By posting information explicitly about testing dates, one highlights the epistemic intermediary, and by posting about prophylactic practices, one highlights steps being taken to minimize risk. These new phrases come with their own problems, but they still seem to represent a marked improvement in bringing epistemic limits to the fore. Cases like these show ways in which our language and understanding can be used to obscure or illuminate our epistemic situations and create or rectify epistemic injustices for those at risk for contracting HIV.

Conclusion and Additional Steps

The prevalence of HIV and the drastic changes in understanding and treatment of HIV in the past forty years have given rise to complex patterns of knowledge and ignorance among different communities. In this chapter, we’ve brought together empirical, epidemiological, and sociocultural research about HIV with discussions of epistemic injustice to develop a framework for identifying and potentially addressing harms done to individuals and groups in their capacities as knowers in relation to their sexual activity, health, and identity. In our discussion,
we have addressed the hermeneutical and contributory injustices committed against HIV-positive MSM in the quest to both understand and communicate transmission-risk levels and the structural-linguistic epistemic injustices that arise out of sexual-health communication patterns. These discussions not only highlight the types of epistemic injustices committed against MSM but also point to strategies for decreasing the potential risks associated with sexual activity.

Though we believe this discussion moves the conversation in a useful direction, there are other important, related topics that must be explored further to give a more complete theory of epistemic harms in relation to HIV. Just as sexual orientation and HIV status interact to produce varying levels of marginalization and privilege, so do other factors such as gender, race, and socioeconomic status. For example, the evidence regarding the racialized development of HIV-criminalization laws highlights the importance of race in both the perception of HIV-positive individuals and their epistemic situations. Anthony Lemelle (2003, 275) argues that HIV-specific “laws are available to profile and arrest African Americans, in much the same way that powder and crack cocaine federal status were used to unevenly prosecute African Americans.”

Furthermore, Black women account for nearly two-thirds of women newly diagnosed with HIV (CDC 2016a), and 44% of Black trans women have HIV (Black Women’s Health Imperative 2019). This rise of HIV prevalence among Black people in the United States is often left invisible in mainstream discussions of HIV and prevention.

Finally, we’ve left out of our account the often-justified lack of trust in government and public-health authorities found among many members of communities where HIV acquisition is prevalent (for example, communities that have been harmed by “public health” initiatives in the past) (Davidson and Satta 2021). Though our discussion of epistemic harms can certainly explain some aspects of these cases, we acknowledge and emphasize that more work must be done to
provide a fully intersectional account. A fully developed account of epistemic harms is not reached without taking issues related to gender and race into account. We hope that our work here is a starting point for continued work in this area.


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