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On Some Topologies of PrEP

Introduction

In this chapter we once again attend to the complex eventuations of PrEP RCTs but broaden our analytic horizons to situate these within an account of the relationship between globalization and localization. In other words, we look at the ways in which the specific emergence and role of abstraction in PrEP RCTs are played out as convolutions or, better, ‘involutions’ of globalizing and localizing processes. By drawing on the idea of involutions, in which the global emerges out of the local and vice versa, we return to the idea that PrEP RCTs are part of an assemblage that entails multiple and heterogeneous relations. Moreover, we imagine this assemblage topologically: topology, used circumspectly, seems to us to throw an inventive light on what PrEP RCTs are and can become. Most notably, topology allows us to trace how seemingly distal relations play a part in the eventuation of PrEP and clinical trials.

In the preceding chapters we have argued, not least through the juxtaposition of quantification and qualification, that the application of various external criteria such as those that ground gold standard-ness of RCTs neglect the ways in which PrEP RCTs are events in which their constitutive elements (pills, bodies, subjects, HIV, etc.) are emergent. As we shall elaborate below, topology is particularly suited to the analysis of such emergence – where, rather than drawing on external criteria of assessment or measurement, these criteria are seen to emerge from the event or assemblage itself, even where such an assemblage might include elements that seemingly belong elsewhere. On this score, we draw on another eventuation of HIV, this time in the particular form of UNAIDS’s AIDS Clock, to examine additional aspects of the eventuation of PrEP RCTs.
It should be apparent that in some ways we have already been conducting a topological analysis, though mediated by such concepts as event and eventuation. What topology offers is an explicit focus on the spatiotemporal character of the relations between the abstraction of gold standard-ness and the various external criteria that are associated with this, and the emergence of bodies, HIV, people in specific PrEP RCTs.

For instance, let us turn again to the article by Padian et al. (2010) which both advocates ‘gold standard RCTs’ and engages with the issues that they throw up. In partial response to the difficulty of accurately assessing background community HIV incidence against which to measure HIV incidence within the trial, Padian et al. (2010) call for improved assays to detect when HIV infection has occurred in individuals. This would allow for a more accurate estimate of the incidence of HIV infection as it exists at the time of the trial’s implementation. Improved HIV testing technologies are said potentially to ‘reduce trial costs by providing a more accurate basis for sample size calculations and assisting in the more reliable selection of populations with sufficiently high HIV incidence to permit trials of shorter duration’ (2010:631). The same authors also note that in the protracted delay between designing and undertaking a trial – potentially as long as a decade – the local epidemic may be affected by new interventions or changes in what they refer to as ‘the epidemic phase’.

Evidently there is a keen awareness of the complex relations entailed in these measures of HIV infection and the authors advocate a continuing assessment of trialists’ own ‘original assumptions’ (Padian et al., 2010:632). The manner by which such assumptions are to be on-goingly assessed, however, rests on a singular space-time calibration. To explicate: insofar as trialists focus on HIV incidence per se in order to design a trial (and even though there is clear concern that a trial might be out of date at the time of implementation because of changes in HIV incidence), HIV incidence remains the abiding criterion. This is an external criterion whose shifting value affects whether a trial is useful or otherwise: it serves to calibrate the spaces and times of the design of the trial against the times and spaces of its implementation. By comparison, our argument is that such a comparison is better understood through emerging criteria that might incorporate, for instance, availability of other drugs, or changes in local healthcare provision. In this case, the topological operation of ‘homeomorphism’ might usefully apply: as such, by emphasizing or de-emphasizing certain characteristics, objects (or events) that initially appear very different are rendered similar. The point for the case of PrEP RCTs is that a topological analysis of events