How do ‘Public’ Values Influence Individual Health Behaviour? An Empirical-Normative Analysis of Young Men’s Discourse Regarding HIV Testing Practices

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Philosophical arguments stemming from the public health ethics arena suggest that public health interventions ought to be subject to normative inquiry that considers relational values, including concepts such as solidarity, reciprocity and health equity. As yet, however, the extent to which ‘public’ values influence the ‘autonomous’ decisions of the public remains largely unexplored. Drawing on interviews with 50 men in Vancouver, Canada, this study employs a critical discourse analysis to examine participants’ decisions and motivations to voluntarily access HIV testing and/or to accept a routine HIV test offer. Within a sub-set of interviews, a transactional discourse emerged in which the decision to test features an arrangement of ‘giving and receiving’. Discourses related to notions of solidarity emphasize considerations of justice and positions testing as a ‘public’ act. Lastly, ‘individualistic’ discourses focused on individual-level considerations, with less concern for the broader public ‘good’. These findings underscore how normative dimensions pertaining to men’s decisions to test are dialectically interrelated with the broader social and structural influences on individual and collective health-related behaviour, thereby suggesting a need to advance an explicit empirical-normative research agenda related to population and public health intervention research.

Introduction

Within and across many global settings, voluntary HIV testing participation rates among young men remain disproportionately low compared to other population subgroups (Shoveller *et al.*, 2010, Knight *et al.*, 2013). Given the public health imperative to enhance HIV testing rates among those unaware of their seropositive status, young men represent a population of particular importance as expanded HIV testing initiatives unfold (e.g., scaling up of routine HIV testing practices). Despite the clinical and epidemiological rationale for expanding testing among population subgroups, such as young men, some scholars have expressed concern that practices to enhance HIV testing uptake may not

sufficiently align with values and principles associated with applied medical ethics that emphasize individual freedoms (e.g., patient autonomy) and the limits of State action (e.g., coercive public health practices) (e.g., Csete and Elliot, 2006; Gostin, 2006; Smith, 2011; Vonn, 2012). Alternatively, emerging theoretical work has argued that public health interventions, including HIV testing initiatives, ought to be subject to normative inquiry that considers ‘public’ values. This emerging body of literature reflects on how relational concepts (e.g., solidarity, reciprocity, health equity) also represent important considerations within public health (e.g., Baylis *et al.*, 2008; Dawson, 2010; Prainsack and Buyx, 2011; Dawson and Jennings, 2012; Dawson and Verweij, 2012).

Nonetheless, while this growing body of literature has provided much theoretical guidance on how these concepts should inform the practice of public health, including policy and decision-making processes, the extent to which relational normative considerations may (or ought to) inform and shape the health-related practices of the ‘public’ remains less clear (Dawson and Jennings, 2012).

Young Men and HIV Testing

Traditionally, low HIV testing participation rates among young men (as compared with the practices of older men or of women) has been linked to various social and structural influences, including masculine expectations related to sexual health that differentially limit their engagement with health-promoting practices (Shoveller *et al.*, 2009, 2010, Knight *et al.*, 2012, 2013; Duck, 2009; Oliffe *et al.*, 2012). For example, getting tested for sexually transmitted infections (STI) or HIV can be perceived as potentially emasculating experiences for young men (Duck, 2009; Knight *et al.*, 2012, 2013), exposing them to clinical encounters in which their sexuality, sexual identity and sexual behaviour may be ‘interrogated’ and, in some situations, their bodies ‘inspected’ (e.g., genital exams) (Shoveller *et al.*, 2010, Knight *et al.*, 2012). While some research has also identified factors that may ‘motivate’ men to seek testing (e.g., a sexual experience they consider to be ‘high risk’, the beginning or end of a sexual relationship, experiencing symptoms) (Shoveller *et al.*, 2010; Katz *et al.*, 2013), there has been very little empirical research regarding the extent to which young men’s HIV testing practices may be influenced by normative considerations, including notions of responsibility/obligation to Self, as well as various relational considerations to Others.

The Ethics of HIV Testing: Individual and Relational Perspectives

Within the scholarship of bioethics, ethical discussions regarding HIV testing have concentrated on individual-level considerations, with a particular emphasis on the ethical treatment of the patient within clinical encounters (Dawson, 2011; Knight *et al.*, 2014). For example, within ethical discussions related to the recent expansion of routine testing practices, a dominant set of ethical concerns asserts that individuals may feel pressured to accept a test when it is offered (e.g., given the influence of clinician-patient power differentials), and that failure to opt out may be the result of disempowerment and a lack of individual autonomy (e.g., within potentially coercive clinical

interactions). This characterization is usually juxtaposed with an autonomous and informed decision to consent to testing (Rennie and Behets, 2006; Smith, 2011). With respect to voluntary testing, the act of *choosing* to voluntarily access HIV testing has been characterized as something that may require a degree of agency beyond the reach of some individuals (Armstrong, 2008).

To date, there appears to have been less philosophical interrogation of how individual ‘acts’ associated with HIV testing may also have normative implications, with the exception of some arguments that assert that individuals have a ‘sexual responsibility’ to know their serostatus so that they can exercise their responsibility to protect their sexual partners (Dixon-Mueller, 2007). These arguments, however, do not appear to fully afford consideration to how various ethical dimensions (e.g., reciprocal obligations, enactments of solidarity) are empirically instantiated and serve to shape the HIV testing practices of the ‘public’ in the everyday world (Knight *et al.*, 2014).

Some theorists have suggested that the majority of the work in the area of HIV prevention and treatment specifically and the field of bioethics more broadly disregards how individuals are influenced by relational normative motivations, such as a shared awareness of mutual interdependences—particularly within the context of infectious diseases (Baylis *et al.*, 2008). In part, this has led to a growing body of theoretical work arguing that relational (as opposed to predominantly *individualistic*) lines of normative inquiry are needed in order to better ‘situate’ individual interests (e.g., self-interest) among features of the broader contextual conditions (e.g., among various social, relational and structural ‘forces’) (Baylis *et al.*, 2008). For example, some theorists have argued that public health interventions should be considered in light of relational normative ‘dimensions’ that seek to promote health equity through enactments of solidarity or obligations to Others, including those within one’s ‘close’ interpersonal networks, in addition to so-called ‘distant’ Others (e.g., those that are socially or geographically distant). These more recent works present arguments that, in (re)conceptualizing HIV testing as an intervention that seeks to benefit both individuals and populations, various relational and public values ought to be more strongly invoked (Bayer, 2010; Dawson, 2011).

As yet, it remains somewhat unclear as to ‘where’ relational concepts or values *should* be situated (e.g., within: policy, the individual, the community or all of these) (*cf.*, Prainsack and Buyx, 2011, 2012; Dawson and Jennings, 2012; Dawson and Verweij, 2012; Krishnamurthy, 2013). Similarly, the extent to which

relational and public values *empirically* influence the ‘autonomous’ decisions or health practices of individuals and populations (e.g., young men) also remains largely unexplored—particularly within the realm of infectious diseases. We suggest that generating data in this area may yield opportunities to produce philosophical frameworks that are more sensitive to how individuals and communities ‘construct’ normative meanings related to their health behaviour (Knight, 2015; Ives, 2008). These analyses may also provide opportunities to begin to consider the extent to which it is empirically feasible to invoke relational values, such as solidarity, reciprocity or health equity, to understand testing practices among young men.

To begin to address these unresolved theoretical and empirical issues, this article examines how the values and principles pertaining to several tenets of public health (solidarity, health equity, reciprocity) manifest in everyday discursive practices of young men. The aim of this study is therefore to conduct an exploratory analysis (both normatively and empirically) of the discourses of young men regarding the values that influence their decisions and motivations to voluntarily access HIV testing and to accept/decline a routine HIV test offer. The empirical results of this discourse analysis will be discussed in light of the ongoing theoretical and applied public health work in this substantive area.

Methods

Methodological Orientation

The methods and techniques used in this study are informed by a critical discourse analysis (CDA) (Fairclough, 1995, 2003) of a qualitative data set (in-depth, semi-structured interviews) collected with young men, which posits that discourse (in this case, the discourses of young men pertaining to their HIV testing practices) reflects *population-level*, *social* phenomena and transcend individual-level relational interactions and decision-making processes (Fairclough, 2003). By employing a CDA approach, it becomes possible to examine how empirical data gathered through in-depth interviews with young men regarding their HIV testing experiences might be influenced by broader systems of knowledge and various structural features of power relations (e.g., those stemming from the expectations of heterosexual patriarchy), rather than solely ‘describing’ their attitudes, preferences and beliefs

(including moral preferences) regarding various testing practices.

By drawing on methods and techniques from CDA, this study actively integrates individual- (e.g. experiential) and population-level (e.g. data pertaining to broader social structures) empirical research and normative analysis of the generated data regarding various moral concepts. In doing so, we situate our study within the emerging field of empirical population and public health ethics (Knight, 2015) as we seek to advance new philosophical and empirical rigour in this area. As such, the aim of this study is to distil empirical and normative representations of solidarity, health equity and reciprocity in young men’s discourses (Fairclough, 1995), and how these meanings may influence young men’s health-related practices (e.g., HIV testing practices). Specifically, we employ a Faircloughian (1995) method of CDA that focuses on: various features of the text, such as grammar and word choice; the context in which the discourse is produced and practiced, such as the audience in which the discourses are produced and deployed; and the broader societal influences, such as various historical, socio-political, economic and institutional contexts from which various discourses emerge. By employing CDA, we seek to identify how various normative considerations are identified and operationalized (e.g., as young men’s health practices are discursively justified as ‘ethical’) (Chouliaraki and Fairclough, 1999), as well as how various normative discourses may influence the HIV testing practices of young men more broadly, as a social phenomenon.

Data Collection Techniques

Ethics approval was obtained from the University of British Columbia (BC) to recruit and interview young men ages 18–24 years according to the following recruitment and interview procedures. Participants were recruited through the use of posters in clinical (e.g., youth sexual health clinics) and non-clinical (e.g., bus stops; youth centres) settings frequented by young people, as well as through online advertising (e.g., Facebook Adverts; Craigslist volunteers’ webpage). A purposive sampling strategy was employed in order to maximize an array of perspectives among socially diverse population sub-groups of young men, including across various sexual identities, ethnicities, ages and testing experiences. Men from the At-Risk Youth Study (Wood *et al.*, 2006), a prospective cohort study of street-involved young people who have previously reported they used illicit drugs, were also invited to participate. Potential participants contacted the research

office via telephone, email or in-person to screen for eligibility and to schedule an interview. Eligibility criteria included being or having previously been sexually active with another person, being between the ages of 18 and 24 years, identifying as a man (including both cis-gender and transgender men), having previously tested or considered HIV testing and having the ability to speak and understand English.

Audio-recorded interviews took place in research offices between June and November 2013. Before starting the interview, interviewers explained the purpose of the study and reviewed with participants a written informed consent form. Interview guides were semi-structured and in-depth in order to elucidate a variety of young men's experiences with voluntary and routine testing. Specifically, interview questions addressed various topics related to HIV voluntary and routine testing (e.g., experiences with deciding to test), as well as their reasons for not testing under either voluntary or routine testing regimens. Participants were also asked to describe the social contexts in which their decisions to test (or not) took place (e.g., location, comfort levels, topics, tone of conversations and reactions of their health care providers), as well as the various responsibilities or obligations they feel they have to themselves, as well as other young men may have to others (e.g., to their sex partners). Participants also were asked to describe how they perceived various socio-cultural and structural conditions (e.g., gender norms, community expectations regarding young men's sexual health-related practices) might influence their ability to make an autonomous decision regarding HIV testing. In order to further elicit how participants construct normative meaning to testing practices, we also drew on techniques from empirical ethics that allowed us to better understand their perceptions regarding various 'hypothetical' situations (e.g., offering counterfactuals and thought experiments) (Ives, 2008). All participants received a CDN \$25 honorarium. Participants also completed a socio-demographic questionnaire.

Data Analysis Techniques

Interviews were transcribed, accuracy checked and uploaded to NVivo 10TM to manage the data analysis. The texts (i.e., interview transcripts) were analysed to explore various discourses (e.g., subverting and/or contesting discourses) (Fairclough, 2003) by asking two key analytical questions: (a) What dominant discourses do men employ to morally justify their HIV testing practices?; and (b) How do men's discourses elicit individual-level considerations (e.g., concerns about Self) or

relational considerations (e.g., considerations for Other(s)) with regards to their testing practices?

To begin, the interview transcripts were read and re-read using these two analytical questions as a rubric, employing constant comparative techniques (Strauss and Corbin, 1998) to develop an initial set of codes, and to identify broad themes across interviews, paying special attention to the discourses that illuminated men's various ethical 'motivations' for testing (e.g., voluntarily seeking a test and/or accepting a routine offer). Codes were then iteratively developed by using an open coding approach within the interview transcripts and avoiding, where possible, preconceived theoretical constructs (Glaser and Strauss, 1967). As data collection and analysis progressed, constant comparative techniques were used to test emergent ideas about the connections between existing theoretical concepts (e.g., relational considerations about testing) and to identify new themes. A coding schematic was then organized into 'trees' to group the open codes into abstract conceptual categories. In doing so, this analysis is based on both an inductive approach to develop an initial coding schema (e.g., 'tree' and 'child' nodes) (Thomas, 2006), as well as a deductive approach in which the findings were compared and contrasted to the existing theoretical and empirical literature base (e.g., masculinities theory, ethical discussions pertaining to voluntary and routine testing, theoretical work related to relational autonomy and solidarity).

The codes that we settled upon from this process consisted of the various relational and individually oriented 'reasons' that emerged within an analysis of men's discourses regarding their motivations and decisions to test. Specifically, this consisted of the following codes: (i) *Individual dimensions*: This code includes discourses by participants that incorporate considerations of both the benefits and risks of HIV testing as they relate directly to the *individual who is considering testing*; (ii) *Interpersonal dimensions*: This code includes discourses that incorporate considerations of the benefits and risks of HIV testing as they relate to *another person or persons* (e.g., sex partners); (iii) *Public dimensions*: This code includes discourses that incorporate the perceived benefits and risks as they relate to the *broader public's interests* (e.g., the interests of the community, public health). After several iterations of the analysis, two conceptual categories emerged: (i) *Considering the Other in deciding to test: Relational considerations*; and (ii) *Self-interest, relationality and individual motivations to test or not test*. Each of those conceptual categories is presented in the findings section of this chapter; quotations from the interview transcripts are used to illustrate specific

features of the discourses that featured within each of these two conceptual categories.

Study Setting

The study took place in Vancouver, BC, the largest city located on Canada's Pacific Coast. Vancouver is home to a large and long-standing queer community; the city also has a large population of street-entrenched youth. Within Vancouver, voluntary HIV testing services are available at most specialized and general health care facilities, including youth and/or sexual health clinics, general medical clinics, as well as through family doctors and emergency rooms. In 2010 the BC provincial government committed to supporting BC's Seek and Treat for Optimal Prevention of HIV/AIDS program which includes scaling up routinized HIV testing. In 2012, the Medical Health Officer of Vancouver Coastal Health recommended that all primary and acute health care settings routinely offer testing to all adult patients who have not had an HIV test in the last year. Finally, in May 2014, the BC Office of the Provincial Health Officer put forward HIV testing guidelines recommending the implementation of routine testing practices province-wide.

Findings

In total, 50 young men between the ages of 18 and 24 years were interviewed (mean age: 21.7). See Table 1 for the socio-demographic characteristics of the sample. The quotations from participants' discourses are identified by a pseudonym (selected by each participant), supplemented by a brief description of the participant's profile (age, ethnicity, sexual orientation, voluntary and/or routine testing experiences and number of times tested).

Considering the 'Other' in Deciding to Test: Relational Considerations

In order to understand how participants consider HIV testing practices as constituting and being influenced by various relational normative dimensions, participants were asked to describe the motivations that lead them to seek out testing or accept/decline a routine test offer. Within the 'Considering the Other' discourses, a *quid pro quo* 'transactional' discourse emerged across many interviews in which the act of testing was positioned as relational between patient and clinician. Within this discourse, participants described varying levels of

Table 1. Socio-demographic characteristics of study participants

Socio-demographic variable	(n)	(%)
Ethnicity		
Aboriginal	6	12
African-Canadian	1	2
Euro-Canadian	26	52
Latin	2	4
South East Asian	7	14
Middle Eastern	1	2
Other	7	14
Living arrangement		
With parents	9	18
With friends or partner	22	44
Alone	7	14
In a shelter or on the street	11	22
In a recovery house	1	2
Previously tested		
Never	5	10
One or more	45	90
Testing approach experienced		
Voluntary testing	32	66
Routine testing	5	10
Both voluntary and routine	8	14
None	5	10
Sexual orientation		
Bisexual	8	16
Gay	7	14
Heterosexual/straight	34	68
Two-spirit	1	2
Gender identity		
Transgender man	1	2
Cisgender man	49	98
Recruitment medium		
Online advertising	23	46
Posters	2	4
At-Risk Youth Study	24	48
Other	1	2

autonomy as well as moral or social obligations towards their clinicians, which might influence their decision to get tested for HIV. For example, one young man who was living on the streets at the time of the interview described how he had previously gone to the emergency room to seek treatment for a broken nose. While he had not been offered a routine HIV test at the emergency

room, he hypothesized that he would have felt that he 'owed' the health care practitioner a test, as a *quid pro quo* for having treated his broken nose:

Interviewer: And would it change the situation for you at all if the doctor or nurse said, you know, they dealt with your broken nose and they're moving on and they said, 'We now recommend everyone get an HIV test. Do you want to participate today?'

Cocolish: I'd feel very good because they just fixed my nose so I might as well get tested for them. It'd kinda be, like, a balance sorta thing. You fix my nose I'll give you an HIV test. After they did me a favour and fixed up my shattered nose.

Interviewer: Would you feel obliged to do the HIV test?

Cocolish: Yeah. I'd feel like I should do it just because they did something for me. So it sorta evens it out I guess. [...] Because I know they probably want me to get it and I know they fixed my nose so I might as well help them out. (22, white, straight, voluntary and routine, $n = 3$).

Within these transactional discourses, participants also recognized a 'mutuality' within the clinical interactions in which both parties could benefit. For example, Cocolish described how an interaction around HIV testing could provide an opportunity to 'help' his clinician. By agreeing to be tested for HIV, Cocolish situates his decision to be tested as helping his clinician fulfil the role of physician. He also situates his receipt of medical care ('I know they fixed my nose') within his broader understanding of what is expected of a clinician ('I know they probably want me to get [tested]'). Evident within these 'transactional' discourses is the extent to which the participants' decision to test turn at least in part on the reciprocal and symmetrical arrangements of 'giving and receiving' (e.g., 'You fix my nose; I'll let you test me for HIV'), rather than exclusively for their own self-interest or moral concern for their sex partners. Furthermore, the way this discourse is presented in the interviews reveals a degree of agentic capacity afforded to the 'patient' within this type of transactional discourse that may even exceed the agentic capacity said to be afforded to the clinician—the clinician is positioned as having to fix Cocolish's nose as well as having to ask the question about HIV testing, while Cocolish presents himself as deciding whether to accept the offer of an HIV test (albeit a choice that is viewed in light of his receipt of medical treatment).

Narratives that drew on descriptions of interpersonal social connections tended to position the act of testing as a reciprocal act that is based on a 'reasonable

expectation' that others will get tested 'if I do'. In this discourse, participants described how notions of reciprocity within sexual and romantic relations influenced their decisions to voluntarily seek a test or accept a routine offer. For example, Ion and Robert both described how they expect themselves *and* their sex partners to test based on considerations for their mutual well-being:

It [HIV testing] would—it's the responsible thing to do. There's an expectation that you will care enough about yourself that you will be able to pass that care onto others. So it's a reasonable expectation to have of someone. They would wanna know. [...] To keep us safe. (Ion, 22, Aboriginal, Two-Spirit, routine, $n = 1$)

After we'd [Robert and his girlfriend] been dating for a couple of months, my girlfriend told me that I should go get tested and I fully agreed. And I went to the clinic on [address]. [...] And [the nurse] just said, 'Oh, you're just here for a check-up?' And I said, 'Yeah, I'm just here for the safety of my partner *and*, you know, for myself'. (Robert, 22, Latin American and white, bisexual, voluntary, $n = 1$)

Thus, within narratives such as Ion's and Robert's, a discourse emerged in which the value of (and for) one's interpersonal social connections positions the act of testing as reciprocal. Testing is aligned with 'reasonable expectations' within social relations. Within these discourses, enactments of 'self-care' were discursively linked with notions of 'mutual care'. For example, Ion's use of the pronoun 'us' underscores how testing practices are implicated within notions of responsibility and care for both partners, where each partner is poised to (mutually) benefit from their own as well as their partners' testing practices. In this discourse, the act of testing was featured as an act that is 'responsible' and 'caring' and something they should do in order to keep *both* themselves and their partners 'safe'. As a result, this sub-set of discourses tended to elicit many of the various theoretical features of social capital (e.g., the value of one's social network), including both the reciprocal and beneficial dimensions that can be derived from caring for Self and Other(s) (i.e., both parties benefit from these social arrangements).

Underscoring the reciprocal features of these discourses, some participants described how interpersonal relations (e.g., shared interests and trust with peers or sex partners) shaped their perceptions about the normative dimensions of HIV testing behaviour. For example, participants who said that they regularly get tested also described how their practices were strongly affiliated with the norms espoused in their social networks that

explicitly supported or encouraged regular HIV testing. For example, Kaiser described how he had previously been involved in a relationship with a man who had stressed the importance of regularly accessing testing among gay men:

I was like seeing this guy for a couple years, and he probably like, he was 29 and I was 21, and I remember one of the first times we hung out he gave me like the talk, of like, listen, you're young, but you need to go do this because so and so's a nurse, and he sees all these young men get AIDS because they don't get tested and they aren't safe, and he was just reaffirming that it was something that he cared about and went and did, and now it's just like a habit for me after that. (Kaiser, 22, white, gay, voluntary, $n \geq 5$)

Here, Kaiser reveals the processes that lead him to 'take up' voluntary testing on a regular basis, stemming largely from another man's representations of the socio-historical and epidemiological features of the HIV epidemic and the positioning of a 'responsible' gay masculinity as one who pro-actively takes care of sexual health (e.g., by regularly taking a HIV test). Thus, within this subset of discourses, influences of social capital on participants' HIV testing practices were discursively emphasized by the role of social relations and mutual benefits (i.e., to both individuals and collectives). This discourse does not feature the various qualities of relational solidarity (seen in other discourses) in which reciprocal or symmetric power relations are potentially unimportant and not necessarily required (Dawson and Jennings, 2012; Prainsack and Buyx, 2011).

In other discourse, the act of testing was not portrayed as transactional or reciprocal; rather, some participants positioned HIV testing as a social practice that is embedded in notions of justice and the broader public 'good'. For example, Sam, a young man who felt he was at relatively low risk and thus had never actually been tested (although he had considered it), described how he would respond to and deliberate about a routine offer:

Sam: If it's recommended, I'd force myself to do it because this is—because I think highly about the recommendations that people give me. And I think about them like—'Is this for good or is it for bad?' And, and in this case it's for good, so I'll force myself into it. Like, I should do it right away—yeah.

Interviewer: And tell us a little bit more about why you would think that's for good. Is it good for yourself or is it good for...

Sam: It's good for society as well—not just for me. (Sam, 21, Arab, straight, never tested)

Sam's discourse begins to position his decision to test as an act that will also benefit society. For Sam, his decision to test in the context of a routine offer is driven by both his concern and respect for a clinician's recommendation as well his understanding of his own mutual interdependence with broader society. In doing so, Sam's discourse associates the individual 'act' of testing as also having 'public' meaning and purpose: if he 'forces' himself to test—an act that he ultimately constructs as '...good for society as well—not just me'—then Sam's acceptance of a routine offer is one that emphasizes a moral concern for the Other (including the 'distant' Other) without obvious reference to transaction or reciprocity, *per se*. This type of discourse was usually surfaced by participants in explicit ways (i.e., with little ambiguity regarding testing as a practice that *should* be done to benefit the broader community) and often was devoid of descriptions about individual-level benefits. For example, Prometheus described:

I think it's important like, for the population as a whole, all the community, everybody in general is interconnected with, you know, the whole. It's weird, it's like a sexual network. Everybody is connected with each other, right? And the only way for us to eliminate HIV, really, is to have... like, a *collective* effort where *everybody* is tested and *everybody's* in. (Prometheus, 20, Taiwanese, gay, voluntary, $n = 3$)

As Prometheus' quote illustrates, this discourse linguistically links testing with sympathy and understanding the needs of Others ('everybody') stemming from an awareness of mutual interdependence between Self and Others—both among romantic and sexual partners as well as more broadly with 'distant' Others. This discourse reveals how collective agentic practices (e.g., enactments of solidarity) can have the potential to position HIV testing practices as a social phenomenon with implicit public health benefits. In discourses where solidarity is featured as a normative consideration related to testing practices, individual-level acts are assigned 'public' value and are positioned as being integral to the broader collective's commitment to advancing justice (e.g., the individual-level act of testing is positioned as an important part of the collective's efforts to 'eliminate HIV').

Self-interest, Relationality and Individual Motivations to Test or Not Test

Within a subset of interviews, participants used discourse to relationally position themselves as dominant

males. For instance, a discourse distinct from the previously described relational considerations (e.g., in which obligations or responsibilities to Others were either explicitly or implicitly espoused) emerged across a subset of interviews where participants described how they engage in HIV testing to derive personal benefits, as the following excerpt illustrates:

I've had situations in the past where I've gone in and I've just been for something else and they said, 'Well do you want to do it [HIV test] since you're here?' And I'm like, 'Yeah sure, why not?' [...] But I would say if you're going in to the hospital anyways and you're getting something checked out anyways and they offer it to you, there's no reason not to accept it. ... short of, really. ... an *ego* thing. (Smith, 23, white, straight, voluntary & routine, $n = 4$)

Smith's description underlines how individualistic (rather than relational) motivations may be linked with stereotypical representations of male 'ego' (e.g., not engaging in testing in order to avoid being perceived of as weak or self-indulgent). Conceptions of hegemonic masculinity that denigrate self-care (operationalized as testing in this case) were often overtly ridiculed in participants' discourses, with (masculine) self-interest and individual choice being positioned as important drivers that motivate individuals to engage in HIV testing. Discourses that primarily featured descriptions of individuality and self-interest were unlikely to invoke descriptions of solidarity, but they did sometimes feature strong portrayals rooted in normative concerns. For example, Billy-Bob described how normative concerns—in his case, a highly masculinized portrayal of competition—'trump' other concerns (e.g., dominant masculine expectations portraying help-seeking behaviour as weak or feminine):

I just feel like, if you engage in risky business, then you pay the 'troll toll'. I mean, might as well 'buck up', you know, just like go and do it. Just have a clear mind. Whatever it is, it is and there's no going back. [...] If you find out you're clean that's like the best feeling in the world. You do that multiple times you feel like, 'Fuck yeah! Fuck all of you! I'm cleaner than you fuckers!' And you just love it. (Billy Bob, 20, white, straight, voluntary, $n \geq 5$)

As this example illustrates, these discourses can position the act of testing (and being declared 'clean') as a highly masculinized virtue. For example, by 'bucking up' and 'paying the troll toll', Billy Bob deploys a discourse in which HIV testing practices are positioned as a masculine-affirming practice. Taken in the context of

'engaging in risky business'—another (hyper-)masculine virtue—this example positions the act of testing as a 'manly' action (e.g., imbued with masculine power references) that he, as a powerful individual, has the autonomy to undertake. The (self) affirmation of his 'moral superiority' over others demonstrates a set of relational considerations that appear to be more oriented towards deploying (masculine) power over others than the previously described discourses that emphasized notions of shared interdependence (e.g., 'self-care' as 'mutual-care').

In light of the very low testing rates among young men more generally, it was not surprising to identify a discourse that featured individual motivations to *not* engage in testing. While everyone in our sample indicated that they had *considered* testing (often based on a set of relational considerations, such as beginning a new sexual relationship), a dominant discourse emerged to assert the claim of not needing to get tested because they perceive themselves as being at low risk for HIV (and/or STIs), as the following excerpt from Herbert's interview illustrates:

Part of me thinks that maybe I need, you know—maybe I should be more rigorous about doing the testing. But part of me also, I'm not sure. Maybe it's just laziness, I don't know. [...] If I get tested semi-regularly, that's not the worst thing in the world. Better than doing nothing. But at the same time, the part of me that, you know, wishes that I was just, you know, a 'model' sort of HIV-tester person. I haven't brought myself to do it for some reason or another. [...] I mean, I wanna say that I would go get tested every time I change partners. [...] And so that's what I would like to do but like so many things in life, like flossing, I don't do it every day. Part of me thinks it's risky but then part of me also thinks that, sort of, taken in context on the whole 'My sexual behaviour isn't risky', and so I don't know what the appropriate thing is but at least in my mind, that's kind of what I think of as being the 'right' thing to do. (Herbert, 23, white, straight, voluntary, $n = 2$)

Herbert's quote reveals a discourse that resounds with dissonance between being a responsible young man (e.g., 'a "model" HIV tester') against a contextual backdrop in which dominant masculine norms do not prioritize regular (sexual) health care-seeking behaviour among young men. Within this discourse, a 'model HIV tester' is positioned as one who takes up and enacts responsible behaviour *and* is the kind of man who can contest dominant masculine norms that de-emphasize sexual health-seeking practices. A thread of this discourse moves beyond dissonance, to more fully

reflect a disregard for Others, in favour of enhancing one's masculinity by preserving his self-interest. For example, John explained why he decided *not* to get testing, despite being asked by his girlfriend to seek testing before beginning a sexual relationship together:

When I started that relationship she [my girlfriend] was a virgin and she wanted me to do the test. So, I kind of felt like I had to do it. I was just going to do it because she wanted me to do it. But then, . . . I didn't do the test. [. . .] I am sure that I don't have HIV. . . . (John, 23, Latin American, straight, never tested)

As this example illustrates, in this discourse, it is possible to acknowledge a level of obligation to Others, but that this relational concern can be neutralized—so that a decision based on one's own self-interest can be realized. John's story underlines how conceptualizing HIV testing as 'non-relational' (i.e., of no normative consequence to Others) can erase from the discourse notions of obligations to Others—thereby potentially erasing concerns (and actions) regarding broader social injustices (e.g., unequal gender power relations within the heterosexual patriarchy).

Discussion

Relational Discourses Regarding Testing

These findings provide a rich opportunity to reveal how various relational concepts within bioethics generally—and public health ethics, specifically—relate not only to the theorization of the normative by reference to principles, but also by reference to the real-world applicability and explanatory potential of these normative theories and concepts. Within the relational discourses pertaining to men's HIV testing practices, several different types of discourses emerged. First, a transactional discourse emerged among a sub-set of interviews in which the decision to test featured an arrangement of 'giving and receiving'—between men and their clinicians or between men and their sex partner(s). The act of testing was positioned as 'self-care', while concurrently constituting qualities of 'mutual care' (e.g., concern for their sex partners' well-being and/or their clinician's recommendations). Within the reciprocal discourses, features of young men's social capital (e.g., their social networks) also emerged as an important influence on their normative motivations/reasons for testing. In this discourse, men recognized (even lauded) their membership within a broader collective, positioning their decision to get tested as a moral consideration.

These data also reveal how individual and collective agentic practices relate to recent conceptualization(s) of the normative concept of solidarity (Dawson and Jennings, 2012). As Dawson and Jennings (2012) describe, individuals acting on the basis of solidarity do so not for individual benefit (necessarily), but rather for moral concerns for Others. Thus, discourses related to solidarity were differentiated from the reciprocal discourses, which featured the influences of mutual (and reciprocal) benefits (i.e., to both individuals and groups). In the current study, discourses related to solidarity emphasize considerations of justice and position testing as a 'public' act (e.g., for the 'greater good' of society)—an act that does not feature direct obligations but remains deeply 'social'.

The findings featuring relational discourses offer support to public health actions that rely (empirically) on or are (normatively) founded upon relational values. Indeed, these data underscore the extent to which bioethical theory that disregards relational considerations may lack a sufficient understanding of how individuals make autonomous (yet inherently relational) decisions for the 'common good', rather than based solely out of notions of self-interest. These findings support moving normative theory within public health ethics away from framings that tend to disavow how thoroughly—from an empirical perspective—relational all individual choices and actions tend to be. For instance, this analysis moves beyond some of the conventional orientations of public health ethics in which the social dimensions and experiences of individuals are often 'presumed' rather than being empirically determined (and/or normatively assessed).

Individualistic Discourses Regarding Testing

A set of 'individualistic' discourses also emerged, focusing on individual-level considerations (e.g., 'costs' and 'benefits' for Self) and their influences on men's decisions to test. For example, some participants described how they would seek testing in spite of various social and structural constraints (e.g., HIV-related stigma, normative masculine expectations that de-emphasize health-promoting practices among men) for their own self-interest. This discourse emphasized the instrumental value of testing (e.g., the utility of knowing one's status), while downplaying relational considerations (e.g., mutual interdependencies with 'Others').

Unequal gender power relations and men's various (hyper)masculine identities also tended to feature more predominately within the individualistic discourses. For example, the men frequently deployed a masculinized discourse about self-interest (i.e., personal strength and

freedom to make ‘autonomous’ decisions) to alleviate the extent to which HIV stigma presented a barrier to testing. Instead, the act of testing was (re)positioned as a masculine-affirming practice in which potentially feminizing traits (e.g., help-seeking) were transformed into masculine traits (e.g., being ‘cleaner’ than everyone else). In doing so, participants were able to ‘attain’ some of the moral obligations they feel towards themselves, while maintaining (or attaining) the ‘virtuous’ qualities they associate with hyper-masculinity.

‘Ethics as Structure’

The findings from the current study underscore the extent to which we must ‘see and accept the essentially “social nature” of the ethical’ (Dawson and Jennings, 2012: 76), particularly with regard to our understanding of various relational and individual imperatives to test. For example, the findings of the current study reveal how young men’s HIV testing practices are deeply influenced by social, structural *and* ethical influences. For instance, the moral considerations described within the current study were co-constructed with other social-structural phenomena, such as dominant and normative masculine expectations regarding men’s sexual health-related practices. For example, these findings show how ‘constructions’ of normative meanings related to testing practices are implicated within various constructions of masculinity, including instances in which ethical considerations (re)aligned men’s conceptualizations of hegemonic or idealized masculinity to also include qualities more commonly associated with femininity (e.g., care and compassion to Others, including ‘distant’ Others). As a result, these findings emphasize the need for more robust theory that positions normative dimensions and ethical considerations as being dialectically inter-related with the social and structural influences that also shape individual and collective health-related behaviour (i.e., ‘ethics as structure’). Conceptualizing the influences of ‘ethics’ as being dialectically integrated within ‘structure’ may provide opportunities to more meaningfully advance both ethical public health policy as well as the field of public health ethics more broadly. For instance, in theorizing ‘ethics as structure’, we can more easily step away from the ‘dogma of autonomy’, which tends to dominate within conventional approaches to bioethics (as outlined by Dawson, 2010), while still featuring individual autonomy as important and inherently relational.

Implications for the Practice of Public Health and Public Health Ethics

These findings raise important questions to consider regarding both the practice of public health (e.g., health policy and delivery practices) and public health ethics (e.g., normative theorization regarding relational values). Specifically, given that these findings provide insights into situations in which the health-related practices of the ‘public’ (in this case, the HIV testing practices of young men) *are* in fact empirically influenced by relational values in some circumstances, several important questions arise. For example, do the various normative motivations related to testing (e.g., individualistic and/or relational) have different implications for health equity and/or social justice? And, if we accept, as Jennings (2015) suggests, that it is ‘*the task of public health (its discourse, its ethics, its educational and public service messaging) to shape... self-identity and foster a moral imagination that can see the good and freedom in relational terms*’ (p. 5), is there a public health impetus to ‘advance’ efforts to encourage young men to ‘take up’ relational values in their HIV testing practices? If so, *how* can public health ‘mobilize’ young men to test based on ‘public’ and relational values?

At this juncture, it also is important to highlight how several important implications related to notions of justice and health equity arise when considering how solidarity influences individual and collective health behaviour. For example, it is important to underline that enactments of solidarity are not inherently ‘just’ (Krishnamurthy, 2013); for instance, relational accounts of solidarity do not necessarily accord a ‘goal’ (e.g., one of social justice) of any particular orientation (Dawson and Jennings, 2012). As a result, enactments of solidarity ought not necessarily be viewed as constituting intrinsic value (e.g., within health policy development). As others have previously theorized (Krishnamurthy, 2013), efforts to advance notions of justice might be more meaningfully attained within social conditions that promote relations of solidarity. Data from the current study indicate that routine HIV testing policies and practices can and do provide the social (and institutionalized) conditions for young men to test for both individually and relationally motivated reasons/values, and in some circumstances, advancing justice (e.g., when unequal gender power relations are reconstituted to be more equitable). We suggest that our findings provide a helpful platform from which to continue much-needed normative and empirical work—particularly if, as others argue (*cf.*, Baylis *et al.*, 2008; Jennings, 2015), there is indeed value in encouraging individuals to make health

decisions based on reasons or values that are inherently 'relational' and in which there are (empirically derivable) implications for shared interests (e.g., in the context of infectious diseases).

In conclusion, our findings indicate that, in some situations, young men do test based on relational values; ongoing empirical-normative inquiry exploring how public health efforts can (or ought to) encourage individuals to 'take up' relational actions may be an important task for those within population and public health ethics—particularly if we are to meaningfully move beyond the individualistic orientations dominating the majority of normative inquiry in this substantive area. As others have previously argued (*cf.*, Hans Albert, 2000; Reiter-Theil, 2004), the 'is' and the 'ought' must be separate, but that in order to suggest a value should be practiced/adhered to (i.e., an 'ought'), it must be empirically feasible or possible to do so (i.e., an 'is'). As we have previously argued (Knight, 2015), it may be, after all, 'a very difficult task to "do the right thing" in our efforts to improve population health without engaging in a set of robust, transparent (and ethical) empirical and normative practices' (p. 21).

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