From Deadly Disease to Chronic Condition
A Study of the Gay Casualties in the ‘War on AIDS’ in Sweden

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Abstract

Every society in the world has its own AIDS story. A story of uncertainty, moral panic, and social persecution of sexual and ethnical minorities. Sweden is no exception. However, what makes Sweden an exceptional case worthy of anthropological attention, is the fact that even though Sweden in retrospect never experienced an ‘actual’ AIDS epidemic, Swedish AIDS politics were still characterized by severe political coercion and social governance other European nations failed to live up to. This thesis deals with the implementation of public policy and legislative regulations, put into force as to ‘combat’ the new threat of AIDS in Sweden. By engaging as a moderate participant, and conducting interviews with and amongst state agencies, as well as NGOs working with the issues of HIV and AIDS in Sweden, I sought to examine the bureaucratic processes of producing and negotiating knowledge surrounding HIV. Considering that certain groups, such as women, gay men, and migrants, always have been the targets of AIDS education, while leaving (white) heterosexual men exempted, I turned my focus to the depiction of gay men found in bureaucratic artefacts and past legislative debates. When it comes to HIV prevalence in the West, gay men have always been overrepresented. Yet, they have failed to become one of the most prioritized prevention groups. The depiction of the “gay man” during the AIDS crisis was hugely ambivalent, as ‘he’ was seen as both an unfortunate victim and a dangerous perpetrator. With this study, I hope to make the issues of HIV and AIDS visible again.

Keywords: HIV, AIDS, blood, knowledge production, policy, bureaucracy, documents, risk, gay men, prevention, treatment, stigmatization, heteronormativity
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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-Retroviral Therapy/Treatment</td>
</tr>
<tr>
<td>DN</td>
<td>Dagens Nyheter, a daily newspaper</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HIV+</td>
<td>HIV-positive</td>
</tr>
<tr>
<td>HIV−</td>
<td>HIV-negative</td>
</tr>
<tr>
<td>IVO</td>
<td>The Swedish Health and Social Care Inspectorate (Inspektionen för vård och omsorg)</td>
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<tr>
<td>LGBTQ</td>
<td>Lesbian, Gay, Bisexual, Transgender, and Queer</td>
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<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental Organization</td>
</tr>
<tr>
<td>Noak’s Ark</td>
<td>Noaks ark (in Swedish)</td>
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<tr>
<td>PG</td>
<td>The Positive Group (Positiva Gruppen)</td>
</tr>
<tr>
<td>PLWA</td>
<td>People Living With AIDS</td>
</tr>
<tr>
<td>PLWH</td>
<td>People Living With HIV</td>
</tr>
<tr>
<td>Prop.</td>
<td>Swedish Government Bill (Proposition)</td>
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<tr>
<td>PWID</td>
<td>People WhoInject Drugs</td>
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<tr>
<td>RFSL</td>
<td>The Swedish Federation for Lesbian, Gay, Bisexual, Transgender, and Queer Rights</td>
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<td>RFSU</td>
<td>The Swedish Association for Sexuality Education</td>
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<tr>
<td>SFS</td>
<td>Swedish Legislation (Svensk författningssamling)</td>
</tr>
<tr>
<td>SLL</td>
<td>The Stockholm County Council (Stockholms läns landsting)</td>
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<tr>
<td>SOSFS</td>
<td>The Swedish National Board of Health and Welfare Statute Book (Socialstyrelsens författningssamling)</td>
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<tr>
<td>SOU</td>
<td>Swedish Government Official Reports (Statens offentliga utredningar)</td>
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<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>VD</td>
<td>Venereal Disease</td>
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Chapter 1: Introduction

[My research deals with] the declaration of the AIDS epidemic and about the kind of war this declaration has unleashed. A glance at the rhetoric which circulates in the field of AIDS can leave no doubt that war has been declared. From the scientific characterization of the behaviour of HIV in the infected body to the writings of AIDS activists and theorists, the language of militarism prevails. Warfare analogies, concepts of attack and retreat, triumph and defeat, infiltration and discovery, are drawn upon to describe the machinations of the virus at every level of scale, from the microscopic to those of community and nation.

Catherine Waldby (1996: 2)

“Declarations of epidemic are declarations of war” is what Waldby exclaimed in the beginning of her book *AIDS and the Body Politic* (1996: 1). The book, as she clarified, is about this so-called ‘declaration’ and “the kind of war [it] has unleashed” (ibid.: 2). Waldby was referring to the warfare analogies and the “language of militarism” that prevail in the field of AIDS. The rhetoric that circulates within biomedical science, and that also has come to spread to all other kinds of media, utilize concepts (and binaries\(^1\)) such as attack and retreat; triumph and defeat; infiltration and discovery. As further illustrated, nowadays, we talk about the body’s *defence* against the virus, or how victims ‘lose the battle(s) to AIDS’. The research efforts mobilised in the name of the virus are referred to as “efforts to combat AIDS”; that is to say, efforts in the “war against AIDS” (cf. Waldby 1996: 2). Yet, as Edelman pointed out (1994: 81), if military metaphors are general to the AIDS discourses,\(^2\) there is little agreement on where the battle lines are actually drawn. These metaphors of warfare are seen to have been carried well beyond the fields of biomedicine, and its technical capabilities (Waldby 1996: 3). Treichler (1987) dubbed it the ‘epidemic of signification,’ as

\(^1\) Binary opposition, see: Lévi-Strauss (1955) and Derrida (1981).

\(^2\) The concept of *discourse* is very central to my study, and will be used continuously. I refer to the Foucauldian sense of discourse, that is, “a way of speaking, arranging and presenting representations of the world in a logical order” (O’Farrell 2005: 41); or “ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and relations between them” (Weedon 1987: 108).
the military metaphors have come to infect the entire AIDS-body politic, and thus imply a quite different position for biomedicine within the political field (cf. Waldby 1996: 3). Also, as Watney pointed out so insightfully, the casualties of this ‘AIDS war’ are not the viruses themselves but the people living with the infections. The war concerns nothing but to proclaim, define, and protect “the public good,” which is done in terms of preserving and regulating “the public health”…

… [f]or the “war against AIDS” has never principally targeted HIV, or its multiple, tragic consequences in the lives of individuals or communities. On the contrary, from the perspective of the state, it has been precisely and skilfully targeted against those of whom an AIDS diagnosis is held to reveal a far more deadly threat that reaches to the very heart of the epistemology of modernity, and the compliant identities it lovingly nurtures within the strict categories of gender, race, and sexuality.

Simon Watney (in: Michaels 1997 [1990]: xxii)³

This is a thesis about HIV and AIDS. Or to be more precise, it is about HIV and AIDS in Sweden. As many scholars previously have illustrated, people unremittingly tend to associate the AIDS epidemic with the area of Sub-Saharan Africa; countries like South Africa, Lesotho, Swaziland, and Botswana (e.g. Whelehan 2009; Nguyen 2010; Nattrass 2012; Crane 2013). Even though our ‘knowledge’ is far from being absolute, and pointing out that statistics can be overly misleading and misrepresentative, it would not be ‘wrong’ to say that these people are ‘right’. To quote Mark Twain, “[t]here are three kinds of lies: lies, damned lies, and statistics” (2006 [1906], emphasis added); however, in this case they do speak for themselves quite clearly, if I am to be ‘truthful’. Although it is highly problematic if we were to compare, it is estimated that around seven thousand people live with HIV in Sweden⁴ while UNAIDS have estimated that nearly six million people live with HIV in South Africa.⁵ It is also worth noting that UNAIDS estimated that only 28 per cent of these six million people are given antiretroviral treatment.⁶ In Sweden, it is estimated that over 90 per cent of the five thousand

³ See also Watney (1988) for his further reasoning.
⁴ A number given to me by my informants, but similar estimations can be found in Herlitz (2007), SMI (2013a, 2013b) and FHM (2014a, 2014b).
people living with HIV are under effective treatment. However, I would like to argue that there is no shame in stating the ‘facts’ of HIV prevalence for everyone to hear; on the contrary, to quote one of my informants, we would just make these people “injustice” in not telling them how it ‘really’ is. Not mentioning the ‘ugly truth’ will just continue to feed the stigma, something the continent of Africa as well as all the people living with HIV today, have been put through enough of during these last decades. Yet, I wish to proclaim (with the risk of pulling a cliché) that HIV is something that concerns everyone – no matter what anyone says, although it seems to be of the opposite in contemporary discourses. With this thesis I hope to put HIV and AIDS back on the agenda, and to dare people to speak of it once again, as being silent is the same as being ignorant.

AIDS is considered a pandemic. That is to say, it is an infectious disease that has spread through human populations across a large region; for instance multiple continents, or even worldwide. The reason why I decided to study the virus in Sweden is because of the nation’s interesting history and relation to HIV and AIDS. As one of my informants – “B.” – pointed out to me and as Thorsén (2013) also made us aware of, Sweden never experienced an ‘actual’ AIDS epidemic back in the 1980s. Yet, Swedish AIDS politics from this decade are still ill-spoken of (globally) for its strict regulations and harsh social coercion (cf. Svéd 2000; Rydström & Tjeder 2009). Besides that, Sweden is also notorious for its “contra-productive” criminalization of HIV transmission. Since 1982, over forty people (out of a mass of ca. seven thousand) have been brought to court on the charge(s) of transferring HIV to someone else – showing no consideration to whether the person in question knew about his or her condition or not. Intentional and non-intentional transmissions of HIV have been treated as the same criminal offence, and are still considered criminal acts in Swedish legislation. This makes Sweden the leading state in Europe when it comes to prosecuting People Living With HIV (PLWH) (RFSU et al. 2011: 4).

I was first introduced to the complexity of Swedish HIV prevention back in 2012 and 2013, while working on my bachelor’s thesis on the topic of Swedish blood-safety regulations (see: Nyman 2013). In August 2012, a debate re-emerged in Swedish media regarding whether the

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7 A number given to me by my informants, but similar estimations can be found in Herlitz (2007), SMI (2013a, 2013b) and FHM (2014a, 2014b).

8 During an interview, 2014-11-11.
blood-safety regulations in Sweden could be considered discriminating or not, as they still exerted certain coercion on the group of gay\(^9\) (and bisexual) men; or to be precise, “Men who have Sex with other Men”.\(^{10}\) That is to say, even though the life-time ban of gay men as blood donors were lifted in 2010\(^{11}\) they were still ‘in-officially’ banned, as gay men with active sex lives were (and still are) recommended not to (and in the end prevented from) donating blood. The reason behind this is because gay men have been considered a ‘high-risk group’ since the advent of HIV in Sweden 1982. The official regulations neither define, nor discern, between ‘safe’ and ‘unsafe’ sexual practices (that is to say, the use of a condom does not alter the evaluation).\(^{12}\) One of the foremost queries stated at the time was: How come gay men are banned, when all government (as non-government) medical follow-ups indicate that gay men do not have more sex, or sexual partners, than heterosexual men do? Waldby actually raised the exact same question in her book. As written: “Why have women and gay men become the targets of AIDS education, while heterosexual men are exempt?” (Waldby 1996).

My research objective at the time was to examine this debate, and the potential consequences of depicting the blood-safety regulations (and blood-donor system) as discriminating acts. In the end, I came to realise one thing – that it is virtually impossible to discuss blood, and blood products, without touching upon the subjects of HIV, AIDS, and the risks of ‘contamination’.

When I conducted an interview with the chairperson of RFSL,\(^{13}\) Ulrika Westerlund,\(^{14}\) back in 2013, we ended up talking a lot about the deeds of preventing the spread of HIV in Sweden. At the time, HIV prevention (on a political level) appeared to me as nothing but a complex and contradictory mess.\(^{15}\) High-ranked bureaucrats with no medical expertise, or knowledge of the ‘actual’ situation of HIV in Sweden, were authorized to decide on the final outcomes,

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9 When it comes to the concept of “gay,” I approach it as an *emic* term. That is, I refer to the people who identify themselves as gay.

10 See this article for a further example: [http://www.op.se/jamtland/ostersund/annaler-socialstyrelsen-for-diskriminering](http://www.op.se/jamtland/ostersund/annaler-socialstyrelsen-for-diskriminering) (accessed on 2015-05-12, copy in author’s possession).

11 Official statement from the National Board of Health and Welfare, 2010-07-12 (copy in author’s possession).


13 The Swedish Federation for Lesbian, Gay, Bisexual, Transgender and Queer Rights.

14 Westerlund has given me the permission of using her actual name.

15 It is worth noting, however, that Swedish HIV prevention has changed a lot since back then.
while the widely recognized experts\textsuperscript{16} on the subject were left out of the negotiations. This resulted in the limited funding assigned to HIV prevention being used rather ineffectively. That is to say, rather than prioritizing the groups that are said to be more ‘risky’ than others, the decision was to focus on the general public (i.e. ‘norm groups’); which meant that already marginalised groups were further marginalised.

This complexity caught my interest, as it did not make any sense to me. Thus, even though it did not belong to my original research objective at the time, I felt I had to learn more about it. I asked Westerlund further questions, but before giving me a short summary of how the system was structured (back then), she said to me:

“If you are planning on getting yourself into the process of mapping the HIV prevention, you are going to have a rough time ahead of you”.\textsuperscript{17}

Yet, here I am – two years later, trying to make this social complexity a lot more comprehensible – for myself, and hopefully, for others.

**RESEARCH OBJECTIVE**

As this thesis’ title suggests, HIV has been through a quite significant and transformative turn in how it has converted from being this widely obscure and deadly epidemic, to becoming a chronic condition similar to arthritis, asthma, or diabetes (cf. Deeks et al. 2013; Matic et al. 2006).\textsuperscript{18} Yet, caution is needed when making certain comparisons, as the AIDS pandemic is “both like and unlike past epidemics and disease states” (Lindenbaum 1992: 323).\textsuperscript{19} Therefore, I claim my research resolve to be an investigation of (some of the) social aspects of this transformative turn, and what this has led to for some social groups. I have been vastly inspired by Waldby (1996) and Epstein (1996) when it came to conducting this study. Namely, the violence of biomedical practice has been the concern of my research. As noted

\textsuperscript{16} Non-governmental organizations, such as RFSL; RFSU; Noak’s Ark; and HIV-SWEDEN, are more often than not considered the experts on these types of questions.

\textsuperscript{17} Interview conducted with Ulrika Westerlund, 2013-02-12.

\textsuperscript{18} However, it should be noted that this is mostly in the West. HIV is still a widespread issue in many other parts of the world, with Sub-Saharan Africa being targeted worst.

\textsuperscript{19} See also: Lindenbaum (1998); Brandt (1988); Whiteside and de Waal (2004).
by Waldby, “biomedicine has successfully established its right to represent the real of the disease [of HIV]” (1996: 5, emphasis in original) – it has the greatest of legitimacy, and can set the terms that other discourses must observe. Like Waldby (1996), I want to call this legitimacy into question by demonstrating the complexity between biomedical knowledge and non-scientific systems of thought. Biomedical knowledge cannot be “quarantined from general ideas operative in the culture, even when it understands its concepts to be carefully and directly deduced from the factual evidence of the body” (Waldby 1996: 5). It constantly absorbs, translates, and recirculates ‘non-scientific’ ideas – that is, ideas about sexuality, about social order, about culture – all in its technical discourses (ibid.: 5).

**Aim**

My aim is to examine bureaucratic processes of producing and negotiating knowledge. More specifically, I focus on how knowledge surrounding HIV is implemented in public policy-making; above all, public health legislation in Sweden. Analytically, I am interested in the relationship between public perception and understanding of HIV, and the epidemiological development of the said virus. In order to limit this confined study to the wide notion of HIV and AIDS discourse; that is to say, in order to turn it into a manageable set of fieldwork practices, my main research objective has been resolving around investigating how gay men have been renowned and depicted in official (legislative) documents, and other relating artefacts, with the advent of HIV in Sweden. Although gay men have been vastly overrepresented in the West when it comes to HIV prevalence, yet, they have failed to become one of the most prioritized prevention groups (RFSL 2011). I have been looking at how they have come to be associated with the HIV virus, and what this has entailed for them as a non-normative social group. Not only when it comes to their actual bodies but also their ability and agency to utilize social space, and access to civil liberties such as privacy and solidarity. To put it in terms by Watney (1988): I want to illustrate how people, rather than viruses, have been the true casualties of some aspects of HIV-preventive practice. More

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20 Bisexual men are generally included in this ‘group’ as well, and I am not out to exclude but rather to put focus on them too, but as my material mostly refer to ‘these’ men as gay I am inclined to do the same. Therefore, on some occasions, I will refer to them as both gay and bisexual, while on others they will be referred to as gay only.
specifically, I will focus on three explicit legislative implementations concerning HIV in Sweden. That is to say, by which circumstances they were introduced, and how they have gradually transformed over the years, to see if there is anything in the past that might help us understand why some things are as they are today. These three are: (1) the Act on Banning Sauna Clubs;\(^{21}\) (2) the Diseases Act;\(^{22}\) and (3) the Swedish blood-safety regulations.\(^{23}\) My foremost research question has been: If gay men are as statistically overrepresented when it comes to HIV in Sweden (and in the West), how come they have not been as prioritized as meant to, something that has been embolden by both national as international actors? Why were they turned into these immoral perpetrators, a dangerous threat to the community, instead of being foremost seen as unfortunate victims like everyone else affected by HIV and AIDS?

**Clarification**

However, it has to be noted that gay men are not the only ones affected (as a group) by HIV, and they are also not the only “high-priority” prevention group in the West. Therefore, only mentioning them might reproduce the stigmatic image of them as the only ‘associates’ of HIV. Yet, I have two main reasons for doing this in my study, nonetheless. First of all, even though statistics and epistemological monitoring might be vastly misleading, they do speak for themselves. Gay men are overrepresented when it comes to HIV infection in Sweden (see: Brorsson & Herlitz 1988; Herlitz 2007; SMI 2013a) – and in the West in general – but they have also been very prominent as victims, losing many of their beloved ones to the virus (cf. Svensson 2007). Not showing any consideration to this would be a way of covering up an important actuality of HIV – an actuality entitling them to certain rights as (gay) citizens, I argue. Secondly, gay men were used as an example amongst the majority of my informants. Even though I myself uttered “People Living With HIV,” most of my informants specified this even further by exemplifying with the group of “gay men”.\(^{24}\) In the end, it did not seem

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\(^{21}\) SFS 1987:375.  
\(^{24}\) This might indicate that some groups are easier to talk about than others.
reasonable to discard of this account, and therefore, I decided to focus on them and their experiences with HIV and its legislation in Sweden. Just to be clear – I am not out to question this so-called “overrepresentation” – but rather, I am out to question (and investigate) the rhetoric depicting them as an overrepresentation, and the kind of knowledge that legitimates such a rhetoric. Also, I want to be clear in saying that I do not mean “Men who have Sex with Men” (or MSM) when I say gay, or bisexual, men. ‘MSM’ is a pure political simplification\(^{25}\) referring to all kind of sexual practices between men, regardless of sexual identity. ‘Gay’ and ‘bisexual’ men extend well beyond this connotation – something I will get back to later on in this paper.

Discursive knowledge

Knowledge is an operation that produces objectivity through the practice of collective inquiry with instruments about the world. There is nothing really mysterious [about] that. Truth is a completely different question because truth is not [necessarily associated] with knowledge. Knowledge is about objectivity – that is, one kind of truth – but there are many others. There is truth about politics; truth about diplomacy; truth about religion; truth about law; truth about art. Every time there is a difference between [what is considered] true and false, so I do not think we have any advantage to associate knowledge with truth; knowledge is objectivity that is already large enough, and largely difficult enough.

Bruno Latour (2013)\(^{26}\)

I am interested in looking at Swedish HIV prevention as a consequence of diverse discourses, value conflicts and configurations occurring over time and space. In a Foucauldian sense, ‘knowledge’ is neither absolute nor universal (Foucault 1980, 1995 [1977]). Knowledge as we know it is just a consequence of prevailing context and social discourse, being negotiated and

\(^{25}\) That is to say: “[a] simplification [that], in turn, makes the phenomenon at the centre of the field of vision far more legible and, hence, far more susceptible to careful measurement, calculation and manipulation” (Scott 1995: 191; see also Scott 1998).

\(^{26}\) Latour said this in a video called “Bruno Latour: The Relativist,” released on YouTube by the University of Bergen (UiB) in 2013. The quote has been transcribed and slightly edited by me. https://www.youtube.com/watch?v=0jZrCVjwcIo (accessed on 2015-06-06)
therefore changing over time. Hence, as knowledge is negotiated, how has this come to affect the public perception of HIV? What has the notion of “HIV” come to signify today? I should point out that I am not out to examine and evaluate whether certain knowledge is ‘true’ or not; rather, I want to examine the processes of producing this said knowledge as ‘true’. Notice how I further on will be using knowledge, truth, and fact moderately synonymously. To be precise: “truth” and “fact” are certain discursive knowledge that I will put under contestation, as in this context, these concepts should be acknowledged as nothing more than mere political power-tools, utilized in order to legitimize certain practices.27 I do want to refer back to Latour regarding this, in how he said that ‘truth’ is not necessarily associated with what is considered to be ‘knowledge’. Knowledge is tied together with objectivity – that is, scientific objectivity, which means there is only one kind of established truth, which is legitimate in itself. Yet, as Foucault argued, truth is imagined and differs between social contexts (cf. 1980). However, by studying these different social transitions, I argue that it will be possible to comprehend (and generalize) how the bureaucratic structure has come to reflect the institutional practices of HIV prevention, and the knowledge of HIV itself.

THE FIELD

As a graduate student, there were two issues which puzzled me as I began my research. First was the recognition that the concept of ‘traditional’ fieldwork continued to enjoy prominent status in the discipline; second was the concept’s tenacity. In designing a field-based project, ‘fieldwork’, marked by travel to a geographically distant place inhabited by ‘exotic others’, was the definition that I thought had been overturned by critics who had argued for a more critical conceptualization of the concept in terms of encounters and relationships rather than ‘natural’, ‘taken-for-granted’ geographic locations. Yet, despite the trenchant criticism expressed over the last thirty years of the concept of culture as a discrete self-contained entity and bounded location, along with the increasing attention paid to

27 Statistics are examples of social mechanisms where certain knowledge is turned into “truth” or “fact,” and later on implemented as to legitimize future reasoning, practices, or reforms. They are effective instruments in utilization of power, even though they can say very little on how ‘reality’ actually is manifested (see: Huff 1954; Urla 1993; Asad 1994; Porter 1995; Hacking 2002 [1986]).
theorizing about the interconnectedness of the world, anthropology, I realized, continued to cling at a certain level, to a colonial view of the world.

Virginia Caputo (2000: 20-21)

Constructing the ‘field’ was the first major obstacle I ran into while conducting my research. Even though it was clear to me from the start that I would base my fieldwork in Stockholm (Sweden) it did not make it any easier for me to construct or to gain access to it. I shared the experiences of Caputo, in the sense that I strongly felt that I should conduct my anthropological study in a typical ‘Malinowski’ ideal,28 as that is how I imagined anthropology to be. Anthropologists spend a lot of time in the field, and that is what I wanted to do; in addition to feeling that is what I had to do. This is where my troubles started, as I was denied access to the most adequate places for the study I had in mind.

I formally asked three organizations whether I could conduct participant-observation at their headquarters, but all my requests were turned down. My first inquiry went to the Public Health Agency,29 the main state actor in issues concerning public health in Sweden since January 2014. They had to deny since the period assigned to my fieldwork (November and December, 2014) collided with some of their internal maintenance work, I was told. After that I sent a request to the Stockholm County Council,30 the self-governing local authority of Stockholm and in close collaboration with the Public Health Agency. Like the foregoing they had to decline because of (what they told me) ‘depleted economic resources’. Lastly, I asked the non-governmental organization of Noak’s Ark,31 established in 1984 and the first organization in Sweden to engage in HIV-preventive work. As Noak’s Ark works after an agenda rather than a governmental mission, engaging with them implied other ethical obligations. For instance, their headquarters is supposed to act as an ‘oasis’ for People Living With HIV, away from prosecution and discrimination. My presence would have jeopardized this, which would have gone against both my research objective and my ethical commitments as an anthropologist. In the end, I did not engage with them further. We could not reach a solution regarding me being there while still preserving the environment as is. However, in

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28 See: Malinowski (1922).
29 http://www.folkhalsomyndigheten.se/ (accessed on 2015-02-20)
30 http://www.sll.se/ (accessed on 2015-02-20)
31 http://www.noaksark.org/ (accessed on 2015-02-20)
retrospect, I cannot say this had a negative outcome. With my initial objective being to examine bureaucratic structures and policy-making, Noak’s Ark would have been an unfit place to stay at, as they are (as I was told) “not part of any bureaucracy”.

At that moment though, I felt vastly distressed by my situation. As a huge part of my conceptualization of how anthropologists go ahead about conducting research was imbedded in the concept of ‘fieldwork,’ and how that is to be executed, I was still stuck in the traditional methodological approaches introduced by Malinowski. That would mean that I would not be able to get hold of a sufficient amount of data without a proper executed fieldwork; which I had been denied. This is where I had to stop and take a step backwards. With the support of people around me, I was finally able to realize that contemporary anthropology involves a lot more than just following in the footsteps of Malinowski. Actually, that way of conducting anthropology and conceptualizing the field, has become quite ‘antiquated’ as anthropology has turned into this vastly flexible and open-minded academic discipline. That is, when it comes to what you are able to study and how this is to be executed. For example, some anthropologists have turned to conducting ethnographic fieldwork online, where they are out to show what ethnography can tell us about these ‘virtual worlds’. They advocate that we no longer can treat the virtual and the actual as distinct or separate; therefore, making them legitimate sites of study (e.g. Boellstorff 2008, 2012; Nardi 2010). With that established, the next move for me was to discard of the old-fashioned ways of reasoning that had been clouding my senses, and start to rethink the concepts of the ‘field’ and doing ‘fieldwork’.

As the ‘field’ in an anthropological sense is a lot wider than just the physical place where you as a researcher visit and conduct your research, constructing it means to think abstractly and creatively. The ‘field’ is a concept that you have to grasp, and to make use of; yet, it is also something that you have to understand. After finally coming to terms with my conceptualization of the relationship between ‘field’ and doing ‘fieldwork,’ it all became very clear to me what the field actually was, and how I should construct and gain access to it. My field is neither the Public Health Agency nor the County Council; they are mere actors and separated spaces within it. The field is the discourse of HIV itself; or, to be even more precise, the practices of HIV-preventive work. Therefore, my purpose as an anthropologist is to find (or to ‘construct’) the physicality of this practice, in addition to its materiality. I have decided to do this through the notion of ‘studying through’; that is, to follow the social and
bureaucratic processes of the policies dealing with the issues of HIV in Sweden. That includes the official documents as well as inquiries and investigations, also to be acknowledged as the materiality of bureaucracy. All the same, I argue that these are highly socially constructed, and that this has to be acknowledged, therefore making it as important to look to the contexts where they were constructed, and by whom.

Even though my fieldwork involved visiting several different places in Stockholm, I do not consider my fieldwork a multi-sited one. According to Hage (2005: 464), “multi-sited ethnography” is a typical buzzword, as the significance of the concept has not been explored by many of its users. He argued that it is not a question of being for or against it; he simply did not think that a thing such as multi-sited ethnography could exist (Hage 2005: 465). It deals with the question of health, as the body of the anthropologist simply cannot cope with fast and intense traveling. In the end the relation to the field itself got thicker, rather than the actual ethnography. As illustrated by the examples presented by Hage, fieldwork is about being involved with people. However, as he was studying a transnational family, it became difficult to look at it as separated sites. Rather, it was the same site; the same people, involved in places over transnational space (Hage 2005: 466). Multi-sited research involves a lot more than the aspect of physical space, which is the only thing that separates the sites in my case. It is also a question of locality, and I did not study different localities as every site was located in Stockholm.

As I see my object of study as the discourse of HIV itself, this implicates studying every instance involved in Swedish HIV-preventive work. Therefore, I would rather define my research in terms of yo-yo fieldwork (Wulff 2002). That is, “yo-yo movements between [and] around” sites in Stockholm, where “my repeated returns serve to strengthen my bonds to the field” (ibid.: 118, 122-123). With a less stationary position in the field, one has to prioritize the usage of time to another extent. As Wulff stated:

A spin-off effect of a multi-local yo-yo fieldwork, where one is not in the field continuously, and which also has to do with the usage of time, is that one gets information about what is happening when one is off field, so to speak. (2002: 122)

33 For definitions of this, see: Marcus (1995), Hage (2005), and Falzon (2009).
In my case this involved getting familiar with the different documents regulating the several instances of HIV prevention or negotiations of HIV value-configurations. However, the question of cultural critique and ethnographic authority\(^3\) has to be raised as well (cf. Gusterson 1998: 13). With postmodern theories as a base, I regard the HIV-preventive practices as social constructs, and as Gusterson put it: “It goes without saying, of course, that my own interpretation of their constructions is itself a construction” (1998: 13). It is not a fabrication, yet they are facts interpreted from a certain point of view, through my own preoccupations and presumptions. It is what Haraway would call “situated knowledge” (1991: 183-202); “shaped not only by the nature of the situation I studied but also by my own positional relationship with that situation” (ibid.: 1991; quoted in Gusterson 1998: 13).

**METHODS AND DATA**

In fact already in the “Archaeology of Knowledge,” Foucault [1972] refers to discourses as systems of thoughts composed of ideas, attitudes, courses of actions, beliefs and practices that systematically construct the subjects and the worlds of which they speak. He traces the role of discourses in wider social processes of legitimation and power, emphasizing the constitution of current truths, how they are maintained and what power relations they carry with them.

Iara Lessa (2006: 285, emphasis added)

In other words, social reality is produced and made real through the discourses, and social interactions cannot be fully understood without reference to the discourses that give them meaning. As discourse analysts, then, our task is to explore the relationship between discourse and reality. Discourses are embodied and enacted in a variety of texts, although they exist beyond the individual texts that compose them. Texts can thus be considered a discursive “unit” and a material manifestation of discourse.

Nelson Phillips and Cynthia Hardy (2002: 3-4)\(^3\)

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\(^3\) See e.g. Clifford (1983).

\(^3\) See also: Chalaby (1996).
Postmodernism made the social sciences open up as scientific disciplines (Börjesson 2003: 15). This especially applied to the types of analytical data and material made use of by scholars, as they have now widened to include kinds that previously were left untouched. Börjesson argued that “the point of departure is now that no hierarchy of knowledge or content can be put between different types of material” (cf. 2003: 15). This means that the ways of evaluating sources have changed. Certain material, such as legal texts or governmental inquires, should no longer be considered ‘closer to the truth’ than information gathered from e.g. newspaper articles, blogs, or comments written in an online forum. Rather, as Börjesson said, they are all parts of social reality; they all claim to say something about reality. The material is ‘constructed as constructed’; it ‘exists’ in reality as much as it ‘portrays’ reality (2003: 15-16).36

It all concerns with what I want to proclaim is of significance for my study. In referring to what Renkema said: “Discourse studies is the discipline devoted to the investigation of the relationship between form and function in verbal communication” (2004: 1), I proclaim a wish to investigate the relations between the different types of communication of HIV and AIDS in Sweden. Even though my main concern deals with bureaucratic communication, I do not acknowledge it as of “higher status” than other sources of information. Therefore, my data also consists of e.g. newspaper articles; educational material/brochures; commercials and advertisement; documentaries (and other films); as well as some biographies and autobiographies written by people living with HIV and/or AIDS. As previously stated, all this can be said to represent manifestations of reality, thereby making it eligible data in a poststructuralist sense. However, in order to understand bureaucracy and policy as social constructs, I do have to put particular emphasis on bureaucratic communication and material; therefore, giving it certain scope.

36 All translations in this text are mine, unless otherwise noted.
Anthropology and ethnography

The study of AIDS not only demonstrates ethnography’s particular ability to describe in elegant detail the ways by which people make sense of and cope with everyday life and its problems, but provides the occasion for refining ethnographic techniques and technologies.

Joseph A. Kotarba (1990: 260)

In order to make these ordinary occurrences of human thoughts and social actions intelligible, I have made use of qualitative methods and toolkits such as ethnographic fieldwork, observations, and interviews (of different sorts) in addition to document and archive studies. My aim has been to study what Boellstorff would have called episteme; that is to say, I have set out to study “knowledge systems and beliefs rather than capabilities and habits” (ibid.: 66; quoted in Forrest 2009: 8). However, I do think it is important to be careful with terminology. What do I mean when I say “ethnography”? What is its relation to anthropology? These two have been used quite synonymously over the past decades, and often without discussion or definition. According to Bate, ethnography has come to mean three things: a type of method or fieldwork activity (the ‘doing’ of ethnography); an intellectual effort or paradigm (the ‘thinking’); and a narrative or rhetorical style (the ‘writing’) (1997: 1151). Hence, it is important to look at ethnography as a process. Ethnography is a set of practices, yet, also a manifested product, while also being a dogmatic way of thinking about these certain practices and products. Ethnography is all of these things at the same time; you do not utilize ethnographic methods unless you are dedicated to presenting an ethnographic product, and ‘doing’ ethnography demands a certain way of reflecting about yourself and your actions in the field. It derives from the very activity of the ethnographer, a presence both involved and detached, allowing precise descriptions and multiple perspectives, thus providing a distinctive understanding of the world that deserves to be shared (Fassin 2013: 642).

During an early stage of this project, I was often asked why this could be considered to be anthropology. It is indeed a very relevant question, as we constantly have to keep this reflexive distance from our empirical data and ourselves as researchers. Responding by referring to our methodology, such as: “because it is an ethnographic study” or “because I

37 I should be clear on the fact that I have looked at archives of both physical and digital kind.
conducted participant-observation,” does not work as a justification. Even though one major characteristic of anthropology is the one of making use of ethnographic methods, we are far from being the only ones to do so. Anthropological knowledge is an essential matter beyond ethnography. Thus, ethnography is a ‘mere’ tool to implement and present our anthropological findings. Simultaneously, ‘participant-observation’ is a medium through which we use ourselves as embodied instruments, in order to accumulate empirical data for our research. Hence, my study is not anthropological because I made use of ethnographic means – it is anthropological because I utilized a certain way of thinking and reasoning through the use of ethnographic means (Sanday 1979; quoted in Bate 1997: 1152-1153). The ‘thinking’ of anthropology is, as Czarniawska-Joerges phrased it, a “frame of mind” (1992; also in Bate 1997: 1152). It is not about doing or about certain techniques, but of thinking and looking at the world and oneself in a particular way.

**Participation**

Ever since Malinowski (1922) ‘re-discovered’ its value, the method of participant-observation has become one of the most centered concepts within anthropology. He said that the goal of the anthropologist is “to grasp the native’s point of view, his relation to life, to realise his vision of his world” (Malinowski 1922: 25, emphasis in original). However, participation as practice is not uniform. It can take many shapes, all depending on the aspects of research topic; social environment; to the researcher herself, and the relationship with her informants. As Gold stated, the anthropologist (or ethnographer) might end up adopting one of four possible roles while in field: complete observer; observer-as-participant; participant-as-observer; or complete participant (1958; quoted in Davis 2008 [1998]: 82). He argued that the activities of participating and observing are difficult to handle simultaneously. That is to say, depending on where you end up and with whom, your role as participant might take a more or less explicit profile. In my case, I argue that I ended up doing what DeWalt and DeWalt called ‘moderate participation’ (2011: 23). As described:
[It] occurs when the ethnographer is present at the scene of the action, is identifiable as a researcher, but does not actively participate or only occasionally interacts with people in it. This level of observation could include structured observation as well as very limited participation. (DeWalt & DeWalt 2011: 23)

The researcher maintains a balance between ‘insider’ and ‘outsider’ roles. For example, in how educational researchers observe classrooms. They are in the classrooms, but principally as observers, not as participants (DeWalt & DeWalt 2011: 23). As Ambjörnsson stated, within these contexts participant-observation is very misleading as a concept (2007: 38). It can provide inaccurate associations, as the researcher is not participating in the actual practices of teachers, such as preparing classes or grading exams (Ambjörnsson 2007; quoted in Strömberg 2014). The researcher is denied this kind of access, comparable to how I had to refigure and improvise my position when I was denied certain access (see: The Field). As my situation was closely tied to different ethical obligations, belonging to me and my informants, it was not possible to enter the scene as a full-time participant-as-observer. Still, I was allowed to make short visits and conduct interviews with staff, enabling certain participatory aspects. However, I do claim it is of vital significance to emphasise that all kinds of social interaction and/or communication are part of conducting ethnographic fieldwork. Even though my ‘physical’ position in the fieldwork was limited to an extent, I have still been able to procure varied sets of data in form of e-mails, phone calls, and limitary observations.

Yet, I claim that ‘participation’ is something we as anthropologists take a bit for granted. We utilize this concept, referring to our position in the field and our relationship towards the many people within it, still, without giving it explicit definition or certain consideration. What does it mean to ‘participate’? What does it actually demand of the anthropologist as a social researcher, in addition to all the people we come to call informants (or friends)? Lee and Ingold argued that to participate (as a practice) is not about walking into [a field], but to be walking with [people] (2006: 67). It is about heading in the same direction, sharing certain vistas. Lee and Ingold were interested in exploring the relationship between the act of walking, experiences of embodiments, and forms of sociability; thus, suggesting that the sociability of walking could be seen as analogous to the one of the ethnographer and her subjects (2006: 67-69). This in, how they said: “...emotions are realised through walking.

38 I am mainly referring to my time at Noak’s Ark.
Emotions can be channelled through, and even become, the movement of the body” (ibid.: 71). However, this would manifest ‘participation’ as a physical practice, related to an as much physical place. With the field of digital anthropology growing even wider, and anthropologists increasingly turning to study digital phenomenon, this is no longer the case (e.g. Boellstorff 2008, 2012; Kelty 2008; Nardi 2010). As Boellstorff stated:

The methodological contribution of participant-observation is that it provides ethnographers insight into practices and meanings as they unfold. It also allows for obtaining non-elicited data – conversations as they occur, but also activities, embodiments, movements through space, and built environments. (2012: 55)

In studying the virtual reality of Second Life, Boellstorff (2008) set out to explore what he called the ‘virtually human,’ analysing that virtual worlds do have significant consequences for social life (ibid.: 5). As stated, “insightful research has claimed that online culture heralds the arrival of the post-human,” Boellstorff’s line of analysis was to illuminate how the Second Life culture was profoundly human (ibid.: 5) and a legitimate site of culture (ibid.: 61). He took the methods and theories of anthropology and applied them to a virtual world, assessable to him only through a computer screen (ibid.: 4), taking the emergence of these ‘worlds’ as given and instead setting out to analyse “the cultural practices and beliefs taking form within [them]” (ibid.: 5). Boellstorff did not begin his research with any specific topic in mind – instead, his founding question was methodological. That is to say, he asked what ethnography could tell us about virtual worlds (2008: 61).

Boellstorff saw participant-observation as the core method for digital anthropology, typically implying the ‘doing’ of ethnography. However, as he stated, ‘ethnography’ as a process involves a lot more than just methodology (2012: 53; see also Bate 1997). Therefore, in rethinking digital anthropology, he issued for addressing not just theoretical frameworks and the socialities we study, but also how we engage in the research itself (ibid.: 53). Digital anthropology is about the relationship between the virtual (the online) and the actual (the physical or offline) (Boellstorff 2012: 39), and Boellstorff advocated on treating the digital “not as an object of study, but as a methodological approach, founded in participant-observation” for investigating the relation between the virtual and the actual (2012: 40, emphasis in original). He argued that:
This is the idea that we can no longer treat the virtual and the physical as distinct or separate. [...] [T]hat they are scholarly conceits that falsely separate online and offline contexts rather than ontologically consequential gaps that constitute the online and offline. [...] While less evident in this particular quotation, the sense that one can no longer see the online and offline as separate – despite the obvious fact that they are, depending on how you define ‘separate’ – encodes a historical narrative that moves from separation to blurring or fusion. (2012: 40-41)

Meaning, it is not about separating the online from the offline, or ranking the online above the offline. Boellstorff himself did not acknowledge the online as more ‘real’ than the offline; rather, he saw the opposition as the ‘virtual’ versus the ‘actual’ (cf. 2008, 2012). As he said, “what are virtual worlds if not made up?” (2008: 60). Virtual realities are as socially constructed as anything else manmade, making the online actual rather than (more) real. It demands for another definition of ‘reality’ as the online and the offline are separate manifestations of what we experience as real. This is where the framework of participation is challenged, as anthropologists no longer are limited to participating in actual (physical) rooms but also in virtual ones, made possible through binary codes and digital screens. Participation is not as much about going but as it is being somewhere, examining how cultural practices and beliefs are taking form. This can be achieved through observing any type of social arena – virtual as actual.

Interviews

I conducted eight interviews for this study, with representatives and employees of different actors involved in questions concerning public health and HIV in Sweden. The said interviews were of both structural and semi-structural kind, all depending on how much time respective representative was able to offer me. As most of my informants were bureaucrats, or in other ways associated with bureaucratic practices, the amount of time given to me and the questions I had prepared varied from person to person. Some only had an hour to spare, and therefore I had to prepare certain questions rather than trying to keep the conversation as open as possible. It would have taken too much time of the interview to get them to talk ‘freely’ about the bureaucratic related topics. The shortest interview lasted for 35 minutes, and the
longest lasted for one hour and 20 minutes. I recorded all of them and later on transcribed them, in order to make further analyses of them easier. Still, for security reasons, some of my informants had to walk me up and down the stairs from the reception, which resulted in us talking ‘off record’ before and after the actual interviews. It was interesting to see the contrast between ‘on-stage’ and ‘off-stage’ character (cf. Nyqvist 2013) as the ways of talking about their positions and assignments differed from whether they were being recorded or not. Not necessarily in what they said, but how they said it, illustrating the clear boundaries of formal and informal situations. Being on-stage and in-character made them talk in a certain way and about certain things, which is something I had to reflect on regarding interviews as set situations, and the ‘knowledge’ I which I would gain from them.

Seeing my field as the discourse of HIV itself, a recurring question is what can actually be seen as a construct and what can be said to exist beyond or independent of these ‘discourses’. According to Börjesson social structures have both discursive and non-discursive elements (2003: 31). Nonetheless, analysing discourse(s) is about putting different phenomena into perspective while also giving it a meaningful coherence; or in other words, putting it into context. Not only what is actually being said, but also how it is said and how it could have been said. Therefore, I argue it is of significance to acknowledge how my conducted interviews are potential results of discourses as well. They are based on nothing but expectations, aspirations, and limitations; belonging to both me and my informants. During our conversations, my informants said nothing but what was expected of them as official representatives, as well as what they expected me to ask them. The actual interview situation could be said to be a crossing point between different processes of legitimization, in addition to the already established relations of social expectations and aspirations. None of us were anticipated to go ‘out’ of character (cf. Nyqvist 2013), making the interview nothing but an adjusted process of negotiation, between the interviewer and the interviewee. It relates to what Haraway said about “situational knowledge” (1991: 183-202) as the actual ‘situation’ was not only shaped by the nature of the situation, but also of my own relationship towards that certain situation.
THEORETICAL FRAMEWORK AND PREVIOUS RESEARCH

The base for my theoretical framework is twofold. As I am dealing with issues of HIV, anthropological theories and contributions on the topics of medicine, medical practices (e.g. Good et al. 2010; Agic 2012; Livingston 2012) as well as HIV and AIDS (e.g. Butt & Eves 2008; Whelehan 2009; Dilger & Luig 2010) become vastly significant. Yet, my purpose is to examine certain (discursive) knowledge production and bureaucratic materiality; that is to say, consequences of diverse bureaucratic notions and practices. This means my thesis also intersects with the anthropological studies of policy, bureaucracy, and organizations (e.g. Shore & Wright 1997; Hull 2003, 2012a; Shore et al. 2011; Garsten & Nyqvist 2013; Nyqvist 2008, 2015). However, this should not be considered an issue. It is not a conflict of interest, and the frameworks will not terminate each other. This is yet another example of the many possibilities of the anthropological discipline, as we study all the different sectors of society.

It is possible to apply several perspectives on the topic of medicine and its practices; in this case, I have chosen to study it through the notion of official policy and bureaucratic regulations. Therefore, I have to grasp the meanings of not only medical practices and instances, but also of bureaucratic mechanisms and policies as social instruments. ‘Discourse’ is relevant in that I see these collective practices and manifestations as parts and consequences of the institutionalised representations we have come to call social discourse (Foucault 1972, 1980; Rabinow 1986). In the coming paragraphs I will be presenting theories important to my study, in relation to discussing and contextualizing previous research on topics close to mine.

The anthropology of AIDS

As Herdt and Lindenbaum suggested (1992), AIDS has come to signify our era. That is, we are living in the time of AIDS (Haver 1996; Kopp 2002; Hunter 2010). In 1989, the journal of Medical Anthropology was first of its kind to publish a complete issue especially dedicated to the global emergency of HIV and AIDS. Twenty-five years later, in 2014, the same said journal published its fifth special issue on the same topic (Hardon & Moyer 2014: 255). The latest issue (2014) was on the topic of normalization of HIV and AIDS, implying it might be the last one, as stated by the editors Hardon and Moyer (ibid.: 255). Yet, as they conclude in their editorial, due to “continuous uncertainty resulting from social and economic inequality
and persistent stigma,” they argued that AIDS has yet to normalize as a chronic disease, even though effective treatment is in use (cf. 2014: 260). Meaning there could be more editorial issues to come. Hardon and Moyer argued that now is as good a time as ever to, so to say, ‘take stock of the way’ anthropologists have engaged in the field of AIDS the past quarter of a century. As already established, the situation of HIV and AIDS have taken quite a serious and transformative turn, going from being this non-treatable39 deadly disease to become a chronic condition, requiring life-long treatment and medicalisation (Hardon & Moyer 2014; see also Matic et al. 2006). However, HIV and AIDS are still highly stigmatized, both in the global North and global South – and regarding what Hardon and Moyer said about “continuous… social and economic inequality” – HIV and AIDS are still without a doubt as problematizing as ever. Even though the majority of People Living With HIV in states like Sweden are offered antiretroviral therapies free of cost, this is still not a reality for people living in, for instance, regions of Sub-Saharan Africa (e.g. Nguyen 2010; Livingston 2012). Therefore, HIV and AIDS remain as widespread as ever.

As Hardon and Moyer illustrated in their editorial note, since 1989, anthropologists have engaged in the global pandemic of HIV and AIDS in two distinct phases: the prevention era (pre-2000) and the treatment era (post-2000) (2014: 255). The modes of engagement have been as widely varying as the anthropological discipline itself; all from examining how patient health practices and perceptions are used to strengthen the effects of hegemonic public health interventions, to critical reflections on such types of intervention. This in purpose of challenging epidemiologists, and global-health program administrators, in order to handle issues concerning social inequalities and stigma in interpretations of HIV-related diseases (ibid.: 255-256). The most common mode of engagement is presumably the one of subaltern alignment: “a research strategy in which medical anthropologists reveals what really matters for people who have little power to influence global health efforts” (ibid.: 256). Subaltern alignment is a form of ‘deep hanging out’ or as Pigg (2013) said, ‘sitting with our interlocutors to find out what is at stake in their everyday lives’ (quoted in Hardon & Moyer 2014: 256). One could argue, as Hardon and Moyer did, that this type of alignment is the ‘hallmark’ of anthropology in how we take pride in ‘being spokespersons’ for the cultures and

39 That is to say, effective antiretroviral drugs are in use but a vaccine has yet to be discovered.
communities that lack the power to speak for themselves (ibid.: 256). For instance, in how Clifford further wrote that:

Ethnographers are more and more like the Crée hunter who (the story goes) came to Montreal to testify in court concerning the fate of his hunting lands in the new James Bay hydroelectric scheme. He would describe his way of life. But when administered the oath he hesitated: “I’m not sure I can tell the truth. . . . I can only tell what I know”. (1986: 8)

Dilger stated that more recent anthropological research has started to focus on HIV and AIDS as a social reality, “embedded in specific social and cultural contexts” and how these in turn are “modified, transformed, and challenged by the presence of the disease” (2010a: 1). The work published during the first years of the epidemic (back in the 1980s) tended to, as Dilger phrased it, “assume an applied and rather narrow approach to the disease” (ibid.: 1), focusing specifically on concepts such as risk behaviour, risk groups, and prevention. Thus, according to e.g. Farmer (1999) and Schoepf (2001), a ‘thick description’⁴⁰ of HIV and AIDS imply not merely examining the “political, economic, and social forces” that prepared the (so to say) “ground” for the spread of the epidemic in a said regional or historical setting (quoted in Dilger [2010a]: 1). It also involves, as Dilger said:

…the cultural, moral, and political responses that various actors in a society have developed in relation to the disease and that give the epidemic its particular shape and meaning in a specific location and context. (Dilger 2010a: 1)⁴¹

Several anthropologists⁴² have made it clear that there is something specific about HIV and AIDS, therefore extenuating the several studies that have evolved out of this topic over the last decades (cf. Dilger 2010a: 2). This is due not only to that international and national responses to the virus have been given an “exceptionalism status”;⁴³ that is to say, not only exceptional in relation to the high rates of morbidity and mortality caused by the epidemic, but also due to the inconsistent funding allocated to ‘fight’ HIV and AIDS, which is “always” too much or not enough in comparison to other viruses and/or diseases (ibid.: 2). It also deals

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⁴⁰ See: Geertz (1973).
⁴¹ See also: Setel (1999) and Heald (2003).
⁴² For instance: Comaroff (2010), Talle (2010), Dilger (2010b) and Klaits (2010).
⁴³ See also: Benton (2015).
with the “social, economic, and political impact” HIV and AIDS have had on societies and communities in predominantly Sub-Saharan Africa, leading to the virus being given the label of a ‘development issue’ (World Bank/Africa Region 2000; Fredland 1998) or a ‘security crisis’ (Ostergaard 2002; Schönteich 1999). The so called ‘exceptionalism’ is reflected by the social realities and experiences associated with HIV and AIDS in these numerous African countries, with regard to not only the multiple prevention, care, and treatment programs established there, but also to the resilient societal stigma attached to it since HIV started to emerge as the social and cultural reality it is known as today (Dilger 2010a: 2).

With this in mind, I refer back to Treichler (1987) and her account of AIDS as an “epidemic of signification,” in hopes of finding a wider understanding of how to approach these issues. That is, how she argued that AIDS can be said to exist at a point “where many entrenched narratives intersect, each with its own problematic and context […] acquires meaning” (Treichler 1987: 283-284). In relation to this, Barnett and Whiteside inquired that the pandemic of AIDS has come to disrupt the ways that people live and organize their lives, “changing not only the individual lives but also the trajectories of whole societies” (2002: 13). Various concepts have been applied by scholars in order to describe, as well as to analyse, the complexity of HIV and AIDS. They range all from notions of disputes (Fassin 2007: 30 ff.), competing discourses (Seidel 1993), and even to social spectacles (Watney 1987), which further illustrates the massive scope of this topic.

One anthropologist, Setel, utilized the concept of ‘paradox’ when he approached the issue of AIDS. In attempt to show that AIDS in Kilimanjaro has been an “outgrowth of culture, history, demography, and political economy” (1999: 236), he argued that AIDS was “a plague of concentric catastrophes, of disordered relations of power from the interpersonal to the international, the productive to the reproductive, the societal to the sexual” (ibid.: 236). In the end, he said, our ability to comprehend and respond to the epidemic of AIDS will depend on how we “understand the dynamics of transmission” in a social and cultural context (2006: 2). For the residents of Kilimanjaro, “AIDS has been a plague of paradoxes” in that paradoxes, as well as irony, have been the cores of the social experience of AIDS and at the centre of modern life in general. As an example, Setel argued that the colonial and postcolonial institutions, such as the church, were seen as escape routes from the “increasingly crowded mountain slopes” where fewer and fewer households could be sustained by agriculture. Yet,
these said “escape routes” were also associated with vulnerability to AIDS (2006: 2-3). Other ironies emerged within the context of the AIDS epidemic itself, in for instance how “vulnerability to HIV has been attributed to the excesses of ‘bad moral character’ and ‘desire’ among the young” (2006: 3-4). These local concepts are profoundly contradictory aspects of the social experience of AIDS, as Setel claimed that vulnerability and risk are as much born out of demographic and economic necessity, as individual behaviour (ibid.: 3-4). His objective was to “unravel [these] contradictions” in contemporary sexual and reproductive life, and to “demonstrate how AIDS has been experienced in this context”. This in purpose of showing how the paradox of AIDS, in its fullest sense, “[was] that this new disease [was] enmeshed in historically shaped social environments” (ibid.: 4, emphasis in original). Thus, the epidemic of AIDS was not a discrete event. Setel argued that the transformation of sex and reproduction in formal as informal settings shaped both the epidemiology of AIDS, and the terms in which it was comprehended by (2006: 4).

Sothern theorized about AIDS as-post-crisis, pointing to how issues also can emerge out of successful treatment and certain risk reduction. As noted, he wanted to refer to the two recent interrelated changes in “the epidemiological and political scripting” of AIDS (2006: 145). The first was the rise of antiretroviral treatments that have come to re-script the temporality of living with AIDS, and stretch the compressed temporal horizon of HIV. That is, how diagnosis once promised a swift death but now promise and estimate People Living With AIDS (PLWA) to live for many years. This has resulted in a discussion of a “safer sex fatigue” amongst gay men, simultaneously with the ever-growing numbers of PLWA, which according to Sothern contribute to the rise of HIV infections in the developed world (ibid.: 145; see also Tun et al. 2003). Secondly, Sothern wanted to flag how the political efforts surrounding HIV and AIDS, apart from the many AIDS service organizations, have shifted well beyond trying to prevent the spread of the virus (i.e. HIV) and promote AIDS research funding, to now also include “substantial advocacy programs and service provision for PLWA” (2006: 145). Sothern argued and reaffirmed that with the advances of antiretroviral

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44 Comparable to what Hacking said about “making up people”; that is to say, how some social masses are ‘suddenly’ established when they are quantified, and ‘lined up’ for others to observe (2002 [1986]).

45 AIDS service organizations are community based organizations that provide support for people with HIV and AIDS. While their primary function is to provide needed services to individuals with HIV, they also provide support services for their families and friends as well as conduct prevention efforts.
treatments and therapies, people were able to live longer with HIV, resulting in the spectacular and politicized deaths characteristics of earlier moments of the AIDS crisis being less prominently (2006). Yet, authorities started to worry about gay men not being afraid of HIV anymore. Therefore, as stated, the ‘new’ cultural understandings of AIDS-as-a-post-crisis see HIV and AIDS as a “manageable illness,” which resulted in a contradiction emerging between HIV prevention that was based on an explicit othering of the HIV+ body, and the advocacy programs\textsuperscript{46} on the behalf of PLWA (ibid.: 2006). The space of the HIV+ therefore (as Sothern argued) “simultaneously is and is not ‘just like everyone else’”; it is a paradoxical site, not reconcilable with the gay identity politics that emerged next to the politicization of AIDS-related deaths (Sothern 2006; see also Haver 1996).

\textbf{Safety, security, risks}

Security is mostly a superstition. It does not exist in nature, nor do the children of men as a whole experience it. Avoiding danger is no safer in the long run than outright exposure. Life is either a daring adventure, or nothing.

Helen Keller (1957)

This certain quote by Keller has always fascinated me. It contains a huge amount of significance, and is touching upon dimensions Keller herself probably did not even realise. In all, Keller wanted to advocate on how security cannot protect you from the unexpected. Security is an illusion that we force upon ourselves to strive after; yet, all the security in the world cannot protect you, or the ones next to you, from that which you do not expect to occur. Parents live with the belief that they can protect their children from everything. According to Keller (and ‘common sense’ I imagine) they cannot, and trying to uphold that thought will just do our children a disservice. Keller wanted to encourage people to live their lives, and stop trying to protect themselves from things that might never happen. That is, things that only exist in our heads.

\textsuperscript{46} Advocacy (program) is a political process by an individual or group which aims to influence decisions within political, economic, and social systems and institutions. Advocacy can include many activities that a person or organization undertakes including media campaigns, public speaking, commissioning and publishing research or conducting exit poll.
Keller’s view on security relates to the postmodern theory of knowledge of social constructionism (Berger & Luckmann 1966). I refer to how she said “it does not exist in nature”; that is, it is not a natural (essential) phenomenon. It does not exist on its own accounts, but is manifested through the social practices of what we call ‘security’ and ‘insecurity’. Yet, it is something people strive to maintain, without questioning the least. It is what Bourdieu would call *doxa* (1977: 164), meaning how the “natural and social world appears as self-evident” and how “every established order tends to produce… the naturalization of its own arbitrariness” (Bourdieu 1977: 164). It is “taken for granted… [and] seen as self-evident and undisputed” (ibid.: 164) and what I would like to call, a way of ‘practicing’ orthodoxy (cf. Nyman 2013: 20-23). As a social construct ‘security’ can only be imagined, and *not* experienced. This illustrates how unnatural the notions of safety and security actually are, and how apparent ‘unsafety’ and ‘insecurity’ are as constructions. However, it is not just a question of whether security exists as something essential, but also of what is needed for us to be able to talk about security. It is a social dichotomy, or a pair of binary oppositions (Lévi-Strauss 1955; Derrida 1981); linguistic concepts in contrast significant for each other’s existence, where the opposition of ‘insecurity’ is used as to legitimize the practice of maintaining orthodoxy known as ‘security’ (Nyman 2013: 20-23; cf. Bourdieu 1977).

The social constructivist perspective is further illuminated by Gusterson (1996). As he said: “Perceptions of risk, however much they present themselves as objective or unquestionable, are inherently social” (1996: 2). In studying a nuclear weapons laboratory, Gusterson argued that what is true of risk ‘in general’ is particularly true of risk in regards to these nuclear weapons. As we do not have a definitive, scientific way of comparing the risks enacted and alleviated by nuclear weapons, “the very logic of nuclear weapons is inherently, profoundly paradoxical and self-contradictory since it is the essence of deterrence to prevent disaster by threatening it” (1996: 2-3). This in, as stated, we still do not know whether to see nuclear weapons as objects that will protect us from the risk of conventional war, or rather, to see themselves as the risk from which we need to be protected from. Gusterson claimed it is possible to represent anything in the world (from a nuclear missile to the very notion of peace) in a severe number of different ways. He stated that: “Our often unthinking representations of the world are partial constructions of it” (ibid.: 2) and that these (partial)
constructions are not only produced by us, but also as the “social entities that precede us” they take part in producing us as people (cf. Gusterson 1996).

Further on, Gusterson used risk as an example. In quoting Douglas and Wildavsky (1982), he argued that although we know from experience that “some things are dangerous,” it is in the contingent nature of life “that we cannot predict all the risks we [may] face” (1996: 2). Even if brave attempts have been made by mathematicians, in the end, it is severely difficult to rank and compare different kinds of risks. As Douglas and Wildavsky queried:

Can we know the risk we face, now or in the future? No, we cannot; but yes, we must act as if we do. Some dangers are unknown; other are known, but not by us because no one person can know everything. (1982: 1)

That is, on what basis are certain dangers guarded against, while others are relegated to secondary status? Douglas and Wildavsky listed three peculiarities in their argumentation: (1) that “disagreement about the problem is deep and widespread in the Western world”; (2) how “different people worry about different risks”; (3) and “knowledge and action are out of sync; whatever programs are enacted to reduce risks, they conspicuously fail to follow the principle of doing the most to prevent the worst damage” (1982: 1). That is to say, the major issue – as argued by Douglas and Wildavsky – is that substantial disagreement remains over what is to be considered ‘risky’, how risky it is, and what to do about it.

In his article from 1992, Rabinow argued that “[w]e can see the beginnings of the dissolution of modernist society happening” through the recent transformations of the concept of risk (1992: 242). He cited Robert Castel (1981) describing his work as an “interrogation of post-disciplinary society,” in order to illuminate the increasing institutional gap between diagnostics and therapeutics. This gap is not new, yet it “poses a new range of social, ethical and cultural problems” with the prominent progress of biosociality (Rabinow 1992: 242). ‘Biosociality’ in Rabinow’s terms is when new genetics cease to be a “biological metaphor for modern society” and instead becoming a “circulation network of identity terms and restriction loci,” where a new type of auto-production will emerge (1992: 241). He puts it in relation to ‘sociobiology’, a concept explicated by Marshall Sahlins (1976) as a type of social project. As Sahlins claimed, the production of society has been put at stake from the “liberal, philanthropic interventions designated to moralize and discipline the poor and degenerate,” to racial hygiene and social extirpations, to “entrepreneurial sociobiology and its supply-side
social sadism” (Rabinow 1992: 241; cf. Sahlins 1976). According to Rabinow, if sociobiology is culture constructed on the basis of a metaphor of nature then biosociality is nature modelled on culture understood as a practice (1992: 241).

Rabinow explained modern prevention as a process of “tracking down risks” (cf. 1992: 242). However, he did not refer to, as said, “the result of specific dangers posed by the immediate presence of a person or a group, but rather, the composition of impersonal ‘factors’ that make a risk probable” (ibid.: 242). Here he points to the projection from using identity-based concepts such as “risk group” to behaviour-based ones such as “risk behaviour” (cf. Young & Meyer 2005; Owczarzak 2009; Hesslow 2010; Berner 2011; Boellstorff 2011; Nyman 2013).

The concept of risk group has become quite obsolete. It is no longer used in the context of Swedish HIV bureaucracy, neither by bureaucrats nor social activists. Instead, it has been replaced by concepts such as “prevention group,” “target group” or “focus group”. This is an apparent strategy of addressing the affected people in a less contaminated and stigmatic way; addressing them as victims rather than perpetrators (cf. Nyman 2013). Unless directly quoted, I will not use the concept of risk group, which I will be bringing forth later on. This projection is far from being without difficulties and consequences, which is something I will discuss in more detail later on. It all refers to that the ‘risk’ in question is not estimated on who it involves; rather, it has to do with the impersonal social factors leading to the opportunity of the said ‘risk’, and what it might result in (cf. Farmer 1996, 2004). Prevention, as explained by Rabinow, is not surveillance of the individual but of the “likely occurrences of diseases, anomalies, deviant behaviour to be minimized and healthy behaviour to be maximized” (1992: 242; emphasis added). The risk concept is being projected away from monitoring the individuals and groups “known to be dangerous or ill” towards the risk factors that deconstruct and reconstruct the actual social subject(s) (cf. Rabinow 1992: 242-243). As illuminated by Rabinow, the target(s) at risk is no longer a person, but a population. Risks are now associated with social agency and action, rather than identity and personality; “[i]t is

47 The so said ‘knowledge’ is based on statistics and apparent prevalence. However, I argue it is as important to acknowledge how these individuals and groups are being manifested as ‘dangerous’ as it is to look to medical follow-ups. The image of them as “dangerous or ill” is being reproduced by how people choose to talk about them, as much as by the statistics said to ‘reflect how reality is actually manifested’ (cf. Urha 1993; Asad 1994).

not who one is but what one does that puts one at risk… one’s practices are not totalizing, although they may be mortal” (Rabinow 1992: 243).

**Documents, the materiality of bureaucracy**

Documents might also look unusual as anthropological, but if one studies processes of governance, or what we also call governmentality, the role of documents is really crucial to examine.

Saida Hodžić, on *AnthroPod* (October 21, 2013; ca. 13:40 min. in) Latour was the one to describe documents as “the most despised of all ethnographic subjects” (1990: 54). Yet, as Riles pointed out, documents provide a quite useful point of entry into contemporary problems of ethnographic method, for a number of reasons (2006b: 2). As she listed first, “there is a long and rich tradition of studies of documents in the humanities and social sciences”. Secondly, and more importantly, she argued that documents are to be treated as “paradigmatic artefacts of modern knowledge practices” (2006b: 2) as ethnographers must contend with them in one way or the other, in any corner of the world. Riles, and her fellow colleagues, were as noted not interested in the new subjects of ethnographic work, per se, but rather the *nature* of ethnographic knowledge itself. They drew attention to particular aspects or dimensions of ethnographic work – that is to say, the act of ethnographic conceptualization and response (Riles 2006a). Thus, they set out to explore and examine how ethnographers become caught in “others’ conceptualizations… how they appreciate and empathize” – but most of all – the objective was to draw attention to, and experiment with, “anthropologists’ *response* to their subjects, and to one another, as a form of ethical and epistemological engagement” (Riles 2006a: 1). Hence, Riles concluded that documents provide a ‘ready-made ground’ for experimentation with how to “apprehend modernity ethnographically” (2006b: 2).

49 “The concept of governmentality points to the perception that political technologies such as statistics are internalized in individuals’ minds, bringing with them certain norms and ideas that then becomes shared and indisputable” (Thedvall 2006: 21; see also Foucault 1991).

50 Hodžić was interviewed in one episode of AnthroPod, the podcast of the anthropological journal of *Cultural Anthropology*. She commented on a recent publication of hers (see: Hodžić 2013). The podcast can be found here: https://soundcloud.com/cultural-anthropology/anthropod-episode-4-1-saida (accessed on 2015-07-20).

51 See: Riles (2006a).
Hull esteemed that “[m]ost social science accounts of bureaucracy have emphasized administrative organization, discourse, norms, rules, and informal behaviour” (2012a: 252). Documents, thus, as ethnographic artefacts, have not received much attention from anthropologists. His explanation of this was that traditional “social science division of labour” left more formal organizations to researchers of other disciplines, such as sociology, political science, and economics (Hull 2012a: 252; see also Pletsch 1981). Anthropologists, on the other hand, had concentrated more on ‘non-modern’ and ‘small-scale’ societies, that “were seen to operate without or independent of [such] formal organizations” (Hull 2012a: 252; see also Lévi-Strauss 1973 [1955]). In quoting Latour (1990), Hull illuminated how bureaucratic records often have been overlooked as a problem, in their own right. This because, as Riles expressed (2006c: 79), anthropologists tend to produce and use documents in an equal way their subjects do as well. The problem at hand is not the natives’ writing, per se; it is not out of place or farcical, but rather, often too much like ‘our’ own. Also, documents have been overlooked because, as Hull put it (2012a: 253), “it is easy to see them as simply giving immediate access to what they document”. The invisibility of documents is, however, a significant phenomenological quality. Latour argued that to restore ‘the visibility of documents’ – analytically – to look at them rather than through them, is to treat and turn them into mediators; “things that transform, translate, distort, and modify the meaning or the elements they are supposed to carry” (2005: 39).

As recent scholarship has shown, bureaucratic documents are produced, used, and experienced through certain social procedures, techniques, aesthetics, ideologies, cooperation, negotiation, and contestation (Hull 2012a: 253). However, this ‘scepticism’ collides not merely with classic account of documentation, but also “with the understanding of many bureaucrats”. Several producers of documents claim to represent, or engage, with “autonomous entities” – that is, “realities ‘in the world’ independent from processes through which they are produced” (Hull 2012a: 253). Thus, it comes to no surprise that the main theme running through the anthropological research on bureaucratic documents, is to what extent or in what way is the efficacy of bureaucratic texts due to their capacity to represent; “to stand for something else”. According to Harper (1998), scholarly work emphasise on two corresponding problems in the ethnographic study of documents: administrative control and the construction of subjects, objects, and socialities. Still, documents are not simply...
instruments of bureaucratic organizations; rather, they are “constitutive of bureaucratic rules, ideologies, knowledge, practices, subjectivities, objects, outcomes, and even the organizations themselves” (Hull 2012a: 253). Also, they are artefacts (cf. Riles 2006a) that anthropologists (and others) take to be documents in processes they take to be bureaucratic, as argued by Hull (ibid.: 253).

To give a further example: in his study of how the Pakistani government shaped the social life through its planning and regulatory control of the built environment, in Islamabad, Hull demonstrated how even though “documents appear to have escaped their paper confinement,” we are still severely surrounded and governed by flows of papers, whose materiality have vast consequences (2012b: 1). Hull illustrated how governing papers are central to governing the city, and also how papers are the means by which residents “acquiesce to, contest, or use this governance” (ibid.: 1). He named this material form of documentation and communication “graphic artefacts”. As his research took shape, he gradually came to realise how the modernist program for shaping social order had expanded “a material regime of another, equally significant sort”; that is to say, a regime of paper documents. In the end, the objective became to challenge the epistemological and ontological problems of documents, and the programs raised by recognizing the relative autonomy of objects. As he said:

Bureaucratic writing is commonly seen as a mechanism of state control over people, places, processes, and things. But the political function of documents is much more ambiguous. In Islamabad, a high-modernist planning project typical of the postcolonial world, paradoxically, has been partly undermined by the very semiotic technologies that made it so quintessentially modern: its documentation and communication practices. (Hull 2012b: 5)

I wish to enlighten the social aspect of documentation, and its resulting “artefacts”. Policies may seem to be, as Bourdieu put it, “self-evident” (1977). However, this is far from being the case. They are socially manifested and implemented; not naturally given. Thus, they are also maintained by being socially practiced. They do not exist by their own accounts, but only through our actions and continuous reification of their existence. Yet, they are also objectified; in the process of being documented, they are turned into physical documents – or “artefacts” as both Riles (2006b) and Hull (2012b) put it – something that is intermittently referred to, and given certain mandate. Documents are social constructs, yet also, mechanisms
by which definite governance and social coercion is operated. They are authorized to apply, even legislate, certain privileges and obligations for different persons and bodies. I am interested in this connotation, and my resolve involves demonstrating it further through clear ethnographic examples.

‘Studying through’

…when it was understood that the construction of fields could involve tracing webs of relations between actors, institutions and discourses, a notion of ‘studying through’ was close at hand.

Ulf Hannerz (2006: 24)

Reinhold was the first one to utilize the notion of ‘studying through’, and this in her doctoral dissertation on Section 28\(^{52}\), ‘discourses of homosexuality’, and historical as well as ideological struggles in Haringey, United Kingdom (see: Reinhold 1994). She developed it from Nader’s notion of “studying up,” that is: “doing ethnographies not only of disempowered groups, but of groups who wield power in society, perhaps even more than the ethnographers themselves” (cf. Nader 1972). As Reinhold disclosed, she did not see her argumentation as an ‘eyewitness account’ that purported to tell what ‘actually’ happened in the Council chamber or the Parliament, but rather a “balanced account of action, contestation, negotiation, perception, and belief that took place on a wide-ranging and volatile political terrain” (1994: 29). Her attempt was to connect policy on a broader national level down to local level, and as the narrative progressed, “the two levels increasingly [appeared] to exist in relation to and in negotiation with each other” – as they did in actuality, she argued (ibid.: 29). The purpose of developing this certain notion was to illustrate “simultaneity of action, in multiple locales” while examining “the evocation and transformation of a dominant ideology of homosexuality”; this in studying “action and context [while applying] them to a discussion of the negotiation and construction of dominant meaning” (ibid.: 30).

\(^{52}\) Section 28 of the Local Government Act 1988 caused the addition of Section 2A to the Local Government Act 1986 (affecting England and Wales and Scotland and Northern Ireland), enacted on 24 May 1988. The amendment stated that a local authority “shall not intentionally promote homosexuality or publish material with the intention of promoting homosexuality” or “promote the teaching in any maintained school of the acceptability of homosexuality as a pretended family relationship” (see: Local Government Act 1988 Ch. 9).
As noted, Reinhold had the objective of studying a specific political moment (see: Section 28) across multiple sites, all drawing together a range of concerns regarding ideology and discourse (1994: 477). In order to illustrate this, she adopted a complex and ‘anthropologically eclectic’ methodology, and this is what she referred to as ‘studying through’ (ibid.: 477). Methodology, she argued, can be defined as a “collection of methods or sources”; different central implements within the anthropological toolkit. It is a system of method, which is “strategically conceived by the ethnographer who must use methods in order to gain information with which to construct knowledge”. This would mean that methodology is not just a system of method, but also a ‘strategy for knowledge’ (ibid.: 477). Therefore, in the end, her object of investigation was vastly influenced by her strategy. As she claimed:

[I]f I was to apprehend action at multiple sites in the manner that I did, I needed a different [methodological] approach from much of anthropology in my choice of research site. After all, to investigate multiple sites without a focus would be conceivably to study everything all at once – very difficult conditions in which to do research. (Reinhold 1994: 477)

She chose Haringey and its links to the wider national legislation for the reason that although these events were not geographically bounded, they were bounded by what her investigation “indicated as containing this type of core account of action, interests, and outcome” (ibid.: 477). As she posed an issue that addressed the production of meaning at multiple sites, her…

…strategy for knowledge had, de facto, to include methods that would capture data that [laid] outside the usual anthropological toolkit. [The] strategy for knowledge had to grasp multiple levels of action and communication in order to assess what happened outside the research site as a result of the actions taken in it. (Reinhold 1994: 478)

By applying this methodology (of ‘studying through’), Reinhold was able to apprehend ‘action and agency’ at a level that resided outside of interactions amongst people in one or several places. It allowed for her to ‘show a range of links’ between two otherwise artificially separated levels, sometimes perceived as the ‘local’ or the ‘global’ (ibid.: 478). That is to say, ‘studying through’ as methodological approach offered insight to what occurred within and outside a single locale. Myself, I saw the notion of ‘studying through’ as a fitting tool, in that I embraced the objective of investigating what Shore and Wright called: “[the] ways in which
power creates webs and relations between actors, institutions and discourses across time and space” (1997: 14). I wanted to trace a certain political reasoning (or ‘paradigm’) regarding knowledge concerning HIV, and the bodies that were assigned or seen to ‘retain’ certain risk patterns. To ask questions already stated by Waldby (1996): How come groups such as women or gay men have become targets of AIDS education, while (white) heterosexual men are left exempted? Why are some risks always traced back to some specific social masses? These said risks are no longer just outlined and managed – they are objectified and dispersed, and treated as indisputable ‘facts’. In order to grasp this process of producing ‘knowledge’, I had to study ‘through’ a collection of policies “and the idea of attempting to grasp the ‘interactions (and disjunctions) between different sites or levels in the policy processes’” (Shore & Wright 1997: 14; quoted in Nyqvist 2008: 29). That is to say, I had to apply a strategy that made it possible to ‘grasp multiple levels of action and communication’, in order to apprehend ‘action and agency’ found at levels outside of certain social interactions.

ETHICS

As the American Anthropological Association’s Code of Ethics say:

Anthropological researchers have primary ethical obligations to the people, species, and materials they study and to the people with whom they work. These obligations can supersede the goal of seeking new knowledge, and can lead to decisions not to undertake or to discontinue a research project when the primary obligation conflicts with other responsibilities, such as those owed to sponsors or clients.


Our primary ethical obligations are towards the people we study, and to the people whom we work with. This refers to our informants, and/or the other people connected and affected by our research. It is our duty to make sure to do no harm and to think through the possible ways that the research might cause harm. It is important to uphold what Davis called (2008 [1998]: 54) a relation of ‘informed consent’. That is, to clearly explain to our informants what

our research is about, and what this might demand and result in for them. Be transparent about the research goal, all in all.

As my fieldwork only involved participant-observation to a lesser degree, I was not faced with the difficulties of how my presence might have disturbed the ‘everyday’ environment and wellness of my informants. However, this is just one aspect of fieldwork, and therefore my major consent was projected towards the interviews instead. I made sure to give the people I interviewed a detailed description of my project long before the actual interviews took place, and then an oral synopsis of it when we were sitting down, as to make sure they knew what they gave consent to. Also, I made sure to inform them about their right to remain anonymous. Only one of all my informants explicitly asked to remain anonymous, with regards to the nature of our conversation. However, in order to be consistent, I am going to give all of them pseudonyms in this thesis. That is, all except one; Ulrika Westerlund, the chairperson of RFSL, who asked me to use her real name when I interviewed her back in 2013.

It is not uncommon for anthropologists to give other names to places where they conducted their fieldwork, in order to protect the integrity of their informants. However, as some of my major informants are employees of state agencies, this was not possible to do in my case. That is, even if I would give them other names, it would still be fairly easy for the reader to find out who and what I am talking about. This could also be said about the several NGOs; they are all actors with either an official mandate or an agenda. Therefore, my main concern is to protect the individuals within the social collectives, rather than the collectives themselves. Yet, as some of my informants’ position would still be given away through the use of an ‘actual’ pseudonym, I am just going to name them as a single letter, next to the name of the association they belong to. This might result in them being objectified to a larger extent. However, I deemed it the only appropriate solution, as their integrity is of my highest concern.

All my interviews were conducted in Swedish, and have therefore been translated into English for this thesis. This is of certain concern, as the Swedish language differs quite a lot from English in some cases. So, in order to make an accurate and understandable translation, what was said had to be rephrased to different degrees. The purpose was not for the actual meaning to get ‘lost in translation’ and where the English word differed too much, the original Swedish
one will be added next to it in brackets. Thinking back to what Asad (1986) said about cultural translation, I do argue it is important to reflect on translation as a practice. As Asad said, “perfect translation is usually impossible [to achieve]” (1986: 142). Is it even possible to make accurate translations, or are we just reinterpreting social contexts? Is translation as a practice just about finding ‘positive’ equivalents in respective languages? (cf. Asad 1986: 147; also in Gellner 1970). In the end, the quality of the ‘translation’ is entirely dependent on the translator’s ability in the said languages. With that said, my hopes are that my translations will not misrepresent my informants’ positions and opinions, and present them in a bad way.

TERMINOLOGY

As Treichler (1987, 1999) cleverly put it, AIDS is an “epidemic of signification”. 55 It contains a lot of meanings, different to each time, place, person, and context. Even though it is over 30 years since HIV was ‘discovered’ in Sweden and a lot of things have changed since back then, some remain the same. HIV can now be treated in a very effective way (SMI 2013b; FHM 2014a, 2014b) – yet, the stigma still subsists (e.g. Kroeger 2003; Brada 2013; Liamputtong 2013). People Living With HIV (PLWH) are continuously recommended not to disclose to everyone they know; keeping the amount of people knowing to a limit. 56 In order to maintain what Ruth Benedict 57 said: “the purpose of anthropology is to make the world safe for human differences,” 58 while also refraining from continuing to stigmatize HIV and AIDS by using antiquated, stigmatized, and contaminated terminology, I will hereby proclaim which terms and concepts I will be using – and which ones I will not. As my study is primarily concerned

55 That is to say: “AIDS exists at a point where many entrenched narratives intersect, each with its own problematic and context in which AIDS acquires meaning” (Treichler 1987: 283-284).

56 In this context I refer to how doctors and other medical staff recommend recently diagnosed people not to tell overly many people about their status. For instance, to tell family members and close friends, but not everyone at work. This is meant for the patients’ own well-being, as HIV is far from being accepted in all of society. However, this does not refer to potential sex partners, as PLWH and PLWA are obligated to inform their partners about their HIV status. This is called the ‘duty to inform’ regulated in the Communicable Diseases Act (SFS 2004:168) and it refers to other STDs and STIs besides HIV as well.

57 See: Benedict (2005a [1934]) and (2005b [1946]).

58 “Discover Anthropology”
with the effects and implications of how certain concepts and terms are being cited and implemented into practice, disclosing this is of huge significance.

First of all, if I am to be precise, ‘AIDS’ is not a disease but a syndrome. HIV is a treatable virus, while AIDS is a collective term for all the diseases the body cannot protect against if HIV is left untreated. Bredström explained it as: “a range of opportunistic infections that appear as a consequence of the destruction of the immune system” (2008: 40). However, as Treichler (1987, 1999) and many others have showed us, AIDS carries the symbolic meaning of a disease, and therefore I will be using the term in reference to this symbolic meaning (as it is difficult to avoid, as well) (cf. Bredström 2008). If I refer to the ‘actual’ infection, I will use ‘HIV’. A matter of fact, as around 90 per cent of the people living with HIV in Sweden are under effective treatment, AIDS is not an actuality as it was before (in Sweden, at least). Likewise, all policy documents and bureaucratic (as preventive) practices talk about ‘HIV’ rather than ‘AIDS’. Therefore, I will mostly refer to ‘HIV’ when discussing the social discourse of the AIDS epidemic, all in all. However, sometimes I will refer to it as ‘HIV and AIDS’ as they are connected nonetheless; I prefer HIV and AIDS before ‘HIV/AIDS’ as the latter makes it sound like they are interchangeable, which is far from being the case.

When it comes to the people affected by HIV, I will be referring to them as People Living With HIV (henceforth referred to as PLWH) and People Living With AIDS (henceforth referred to as PLWA). These concepts have international status and are used by scholars, such as Waldby (1996). They are often used synonymously, but I will be using them separately, as I argue the difference between HIV and AIDS has to be acknowledged. That is, HIV is a virus and AIDS is a syndrome caused by that said virus. ‘PLWH’ and ‘PLWA’ as concepts also reflect the general way of addressing the people affected, as used by those

59 “Vi lever alla med hiv”
http://www.vileverallamedhiv.se/om-hiv (accessed on 2015-02-17)


61 These estimations can be found in Herlitz (2007), SMI (2013a, 2013b) and FHM (2014a, 2014b).

62 Earlier in this introduction I made use of the concepts of ‘HIV positive’ and ‘HIV negative’ (see: Aims) but I will try to avoid this in the coming parts, unless directly used by my informants or certain documents.

63 They are used by e.g. the World AIDS Campaign.
employed within the practices of contemporary preventive work in Sweden. To be precise, they are human beings *living* with HIV (and AIDS) rather than mere embodiments of the virus itself. Therefore, I will try not to use terms such as: “infected,” “contaminated,” “diseased,” or “pestilential” (et cetera) whenever possible. However, so far I have (and will continue to) talk about ‘HIV infection’ and ‘HIV virus’. These are medical terms, generally accepted by most communities and instances involved in HIV-preventive work. When it comes to the virus, I will be talking about it as *spreading*, while people are *transmitting* and *contracting* it. (That is to say, unless I present some sort of direct quote.)

Previously, I mentioned the notion of “Men who have Sex with Men” (henceforth referred to as *MSM*) (see: Aims). This is a constructed term, an objectified risk group referring to sexual practices between men. It does *not* refer to gay men in general, and neither will I when using it. In fact, what it does is erasing the sexual-minority person(s) in public health discourse (see: Young & Meyer 2005). When using ‘MSM’ I will be referring to this specific construction, manifested to address these objectified risk opportunities. I will not be using the term ‘homosexual’, as Bredström said: “[it] comes with a history of negative connotations; homosexuality has, for instance, been defined as an abnormality within both medical science and society at large” (2008: 41). Instead, I will be using ‘gay’ and ‘lesbian’ as Bredström did (2008: 41). However, I will be referring to ‘homosex’ as a same-sex practice and it will be in relation to ‘heterosex’, following both Bredström (2008) and Wilton (1997). Referring to ‘safe’ and ‘unsafe’ sex, I am emphasising on how they are commonly conceptualized in public debate (cf. Bredström 2008: 40-41). That is, practices with different substantial risks of transmitting HIV or other STDs/STIs. However, I do agree with Richardson (2000: 125) in what she said about this definition being too narrow, and that it should include absence of physical and psychological violence in sexual relations as well. As I mentioned before, ‘risk group’ has come to be an antiquated term (see: note 5). It is not used in most recent published documents, and none of my informants made use of it. It has been replaced by concepts such as: “prevention group,” “target group,” and/or “focus group”. I will be using these newer

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64 I will be discussing this concept in more detail later on, but for more research on the history of the MSM category, see: Young & Meyer (2005), Hesslow (2010), Berner (2011), Boellstorff (2011), and Nyman (2013).

65 As pointed out by Bolton, it is a widespread preference among ‘women who have sex with women’ to not be included in a general category of *gay*, but instead to be called “lesbian” (1995: 162, note 1). Honouring this, I will be using the term *gay* to refer to ‘Men who have Sex with Men’ – thus, referring to them as ‘gay men’.
established terms, unless ‘risk group’ is explicitly applied by an informant, researcher, theory, or in an older document. However, ‘risk behaviour’ is still generally applied and will therefore be included in this thesis.

DISPOSITION

This thesis consists of six chapters. After this introduction chapter follows one background and more ‘in-depth’ chapter on how HIV was discovered, and what happened when it ‘arrived’ in Sweden. Thereon follows three refined empirical chapters, and at last, one concluding chapter. In this foregoing chapter, Introduction, I have introduced the analytical concepts, toolkits, and frameworks, together with several methodological aspects, needed for grasping the forthcoming major discussions of this thesis. In chapter two, Background, I epitomize (in short) the history of the HIV virus – what it is, what it does, how it was discovered, and where it is believed to have originated. Further on, I go more into detail regarding what occurred when it was discovered in Sweden. That is, how the authorities decided to act with the advent of HIV in Sweden. In chapter three, the (Gay) Sauna Clubs, I set out to discuss the Swedish Act on Banning Sauna Clubs that was implemented in 1987 as a preventive measure, and how it can be said to have been a result of moral panic. In chapter four, the Diseases Act(s), I continue by turning my focus to the different constellations of Diseases Acts that has been in force since HIV was discovered in 1982, and how they have changed over the years. I also discuss the so-called ‘duty to inform’ and what it supposedly does to HIV prevention. In chapter five, Blood Safety, I discuss the so-called genealogy of gay men and blood donation, pointing to the emergence of the category of ‘MSM’ and the rhetoric of risk group contra risk behaviour. Thus, in chapter six, Conclusions without Closure, I set out to conclude and disclose the heteronormative structures that permeated the legislative regulations of the 1980s, and largely persist nowadays as well, leading to gay men still being put through acts of prosecution, stigmatization, and de-familiarization.
Chapter 2: Background

WHAT ARE ‘HIV’ AND ‘AIDS’?

The term AIDS refers to a critical stage of the HIV infection when a large number of CD4 helper lymphocytes have been destroyed and the body is not able to mount an effective immune defence against secondary pathogens or the toxic effects of the HIV virus itself.

L. S. Zegans (2001, emphasis in original)

In anthropology, HIV and AIDS can refer to many different things. It is all about social perception – different to each individual – while in medicine, the definition is not as broad. Even though HIV-preventive work focuses more on educating the public on how HIV spreads, rather than what it actually is, I argue it is important to remark this as well, as it offers an explanation to why HIV spreads the way it does.

I would like to quote Bredström (2008: 40) in stressing out that HIV is a virus, while AIDS is a syndrome caused by that said virus. HIV (Human Immunodeficiency Virus) enters the body solely through ‘contaminated’ body fluids (e.g. Bredström 2008: 19) and “it needs to pass through an entry point in the skin and/or mucous membranes into the bloodstream” (Barnett & Whiteside 2002: 38). Therefore, the most common modes of transmission are unsafe sex, use of ‘contaminated’ blood products, use of ‘contaminated’ needles, and/or transmission from mother to child (Zegans 2001: 344; Bredström 2008: 19). HIV makes up a so-called ‘retrovirus’; that is to say, it can alter the flow of genetic information within a cell (Zegans 2001: 345). In other words, “it is an RNA virus that needs to make a DNA copy of itself in

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66 CD4 (cluster of differentiation 4) is a glycoprotein found on the surface of immune cells such as T helper cells, monocytes, macrophages, and dendritic cells (e.g. all are types of white blood cells running the immune system).

67 In the oldest and broadest sense anything that can produce and causes disease in its host, such as a virus, bacterium, prion, fungus, or parasite.

68 The concepts of ‘safe’ and ‘unsafe’ sex are of significant interest, and something I will be getting back to later on. However, in this context, it is meant to refer to the times when contraceptives have not been used during sex. Nonetheless, in the end, it has come to refer to a specific kind of sex, and a certain type of bodies.

69 Ribonucleic acid (RNA) is a polymeric molecule. It is implicated in various biological roles in coding, decoding, regulation, and expression of genes.
order to replicate” (Bredström 2008: 19, note 6). An HIV infection never heals, and once transmitted, the affected persons have to live with it for the rest of their lives. As already stated, the virus attacks “crucial cells in the immune system, mainly the so-called CD4+ T cells... [t]his leads to a slow breakdown of the immune system, and the body becomes vulnerable to opportunistic infections” (Bredström 2008: 19-20). When there is a risk of such infections, or when they have already appeared, the affected person is said to have developed the syndrome of AIDS (Acquired Immune-deficiency Syndrome) (ibid.: 20). However, this is a process that can take many years. HIV more often than not shows either very ordinary symptoms (e.g. common cold) or no symptoms at all, until it has gotten to a high-developed and mutated stage (cf. Zegans 2001). As it can take years before the infection is discovered, “it is highly likely that a person does not know that he or she is [affected] and so runs the risk of exposing others to the infection” (cf. Bredström 2008: 20).

There are different strains and subgroups of the HIV virus. Zegans wrote that:

There are two types of HIV viruses which have been shown to cause AIDS in humans: HIV-I and HIV-II. These viruses share similar molecular structures and [also] cause similar pathological disruptions. Currently, HIV-I causes the majority of cases of AIDS throughout the world, while HIV-II is found mostly in Africa. There are many different subtypes among the HIV-I strain. These viruses can rapidly change their molecular structure within the body, making them difficult for the immune system to destroy. The mutability of these viruses also makes them difficult targets for preventive immunization strategies. (2001: 344-345)

This illustrates how HIV is not a monolith entity, but a complex collective of different strains that are more or less virulent. These strains do not cancel each other out, as it is quite possible to establish a condition with the infection acquiring a second strain of the virus, co-existing with the first one. This is called a HIV superinfection (also known as HIV reinfection) which may cause more rapid disease progression or develop a resistance toward certain HIV medication (Smith et al. 2005). Since 1996, very efficient antiretroviral therapies are in use, thus transforming the situation of HIV quite radically. Nowadays, HIV infection is widely

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70 That is to say, a definite cure has still to be discovered. Highly active antiretroviral therapies (ARTs) have resulted in dramatic changes in the course of the disease, nonetheless (cf. Bredström 2008: 20).

71 This is a type of white blood cell.
considered a chronic condition, rather than a deadly disease. Yet, due to great ignorance apropos the virus and how it actually can be transmitted, People Living With HIV are still being largely exposed and subjected as individuals.

WHEN ‘HIV’ WAS DISCOVERED

AIDS as an epidemic is ‘officially’ said to have erupted in Los Angeles, in June 1981, when the U.S. Centres for Disease Control and Prevention reported “unusual clusters of Pneumocystis pneumonia”72 (caused by a form of Pneumocystis jirovecii73) in five gay men.74 A year later, in June 1982, the said syndrome was named “GRID” (Gay Related Immune Deficiency), as it had been continuously reported amongst gay men. However, health authorities soon realized that far from all of those diagnosed with GRID identified themselves as “gay”. These opportunistic infections were also to be found amongst haemophiliacs,75 Haitian immigrants, and (heterosexual) intravenous drug users, making the name “GRID” both invalid and misleading as a concept.76 A couple of months later, in August 1982, the syndrome were being referred to by its newly coined term: Acquired Immune-deficiency Syndrome (AIDS) (e.g. Marx 1982; Connor & Kingman 1989; Crawford 2013). However, even though 1981 is nowadays seen as the year when the epidemic had its ‘official’ outburst, several earlier cases (of what is believed to be AIDS) have now been concealed. For instance, two cases from 1959 have grown to become quite famous among academics. One was a man who died in Congo, and the other one was a 49-year-old Jamaican born Haitian-American man, who died in New York City (e.g. Zhu et al. 1998; Hooper 1999; Pence 2008).

72 Pneumocystis pneumonia (PCP) is a form of pneumonia, caused by the yeast-like fungus Pneumocystis jirovecii. It is especially seen in people with cancer undergoing chemotherapy, HIV and AIDS, and the use of medications that suppress the immune system.

73 As stated in the note above, Pneumocystis jirovecii is a yeast-like fungus of the genus Pneumocystis.


75 Haemophilia is a group of hereditary genetic disorders that impair the body’s ability to control blood clotting, which is used to stop bleeding when a blood vessel is broken.

HIV (Human Immune-deficiency Virus) was officially isolated and discovered in 1983, by Luc Montagnier and Françoise Barré-Sinoussi (e.g. Connor & Kingman 1989). They were able to show that the core proteins of this certain virus were immunologically different from those of HTLV-I, a retrovirus discovered by Robert Gallo in 1980 (e.g. Connor & Kingman 1989). Even though Gallo is also said to have ‘discovered’ HIV around the same time, Montagnier and Barré-Sinoussi are today considered (and acknowledged) to have been the first ones to do so, as they argued that their discovery was unrelated to HTLV-I while Gallo claimed his was a string of it. Thus, Montagnier and Barré-Sinoussi named their discovery “LAV” (Lymphadenopathy-associated Virus), while Gallo named his “HTLV-III”. In January 1985, these two were actually revealed to be the same virus, and of the same source; hence, they were given the new name of “HIV” (e.g. Marx 1985).

Even though several theories and rumours on how HIV (and AIDS) actually manifested circulate, the one seemed to be most accepted at this time of writing, is the one on how HIV is said to have crossed from primates into humans as a “post-mutation” (Whiteside 2008: 1). The retroviruses found in at least 45 species of West and Central African non-human primates are called SIVs (Simian Immunodeficiency Viruses) and as stated by Worobey et al. (2010), the SIVs seem to have been present among these primates for at least 32,000 years, or more. The virus strains of SIVsmm and SIVcpz (found in the primate species of sooty mangabey and chimpanzee, respectively) are believed to be those which crossed the species barriers, resulting in the strains of HIV-I and HIV-II (Kestler et al. 1990; Whiteside 2008: 22-23). That is to say, the most common subgroups of HIV found today. In many cases of the SIV infection affecting these primates, however, the turnout is of non-pathogenic nature; i.e. the infection is non-fatal, as SIV rarely develops into SAIDS (simian AIDS) (Kestler et al. 1990). Therefore, these natural hosts are believed to be immune, as despite high levels of circulating virus, they never reach the later stages of the infection (ibid.: 1990).

Nonetheless, I am not out to pin-point or to discuss whether this certain theory, or if any of the other theories or rumours, can be claimed to be ‘true’ or not. My interest rather lies in examining the point of intersection, as the AIDS discourse has come to mean so many different things over the years (cf. Henriksson, 1987, 1995). I refer to Treichler, in how she said: “the AIDS epidemic... is simultaneously an epidemic of a transmissible lethal disease

77 A retrovirus often associated with adult T-cell leukaemia/lymphoma.
and an epidemic of meanings or signification” (1987: 263). She argued that science is not the true material base generating our merely symbolic superstructure. Thus, our social constructions of the virus are not based upon “objective, scientifically determined reality” – but upon what we are told about this so-called ‘reality’ and the prior constructions routinely produced within the discourses of science (1987: 265). Rumours are, as argued by Kroeger, “more than just wrong or incomplete information; they are socially constructed, performed, and interpreted narratives, a reflection of beliefs and views about how the world works in a particular place and time” (2003: 243). Yet, narratives are like memories; that is, anything but accurate accounts of the past, or social reality in all.78 Rather, they are dynamic entities recounting actuality in a rigorously contextual way. Hence, I am not interested in examining whether an essential ‘truth’ about HIV and AIDS can be isolated, but to explore the enactment of certain ‘truths’ through ethnographic methods and reasoning.

**WHEN HIV ‘CAME’ TO SWEDEN**

The AIDS epidemic did not reflect well on the 1980s in Sweden, and had a negative outcome on the views on sexuality, ethnicity, and gender. That which at the time was known as the “gay plague” on the other side of the Atlantic Ocean was soon of huge concern to the Swedish people. The first AIDS-related death in Sweden occurred in 1983, and it did not take long before all the newspapers were filled with different horror stories covering this ‘new threat’. Some of the papers even claimed that the virus could spread through the bite of a mosquito,79 which gave rise to near public panic. As a result, several motions of the most extreme nature were put forward, such as that all carriers should either be tattooed in the axilla or confined to special ‘camps’. Although none of the most inhuman suggestion went through, Swedish AIDS politics were still characterised by strict supervision and social coercion other

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79 I would really like to stress out that this is *not* the case. As Media AIDS says on their website: “Firstly the mosquitoes’ mouth parts do not operate like a hypodermic needle. The tube which injects the host with saliva is separate from the canal which the mosquito uses to suck blood from the same host. Therefore blood only flows into the mosquito and only saliva is injected; blood is not flushed out of the same canal”. See: [http://www.mediaaids.org/content/page/mosquitoes_can_transmit_hiv_aids](http://www.mediaaids.org/content/page/mosquitoes_can_transmit_hiv_aids) (accessed on 2015-05-07).
countries failed to live up to. The Swedish Diseases Act\(^{80}\) was revised in 1987,\(^{81}\) giving medics the authority to internalize HIV-positive people suspected of violating the health regulations. Later the same year the so called Ban of Sauna Clubs Act\(^{82}\) was implemented, a law that forbade the operation of clubs enabling for people to meet for sexual rendezvous. Other countries did not fear to criticize Sweden for its harsh AIDS politics, but to no avail; the Ban of Sauna Clubs Act was not abolished until 2004. However, HIV-positive people could still be put under compulsory care and get deprived of their social liberties.

Jens Rydström and David Tjeder (2009: 208)

The first case of HIV infection in Sweden was discovered in August 1982, as recalled by Pehr Olov Pehrson, a well-known and now retired Swedish infectious-disease specialist. Back in the 1980s, Pehrson was one of two young physicians who alongside their regular duties welcomed the men who were remitted elsewhere, due to several unusual and undeclared symptoms (in: Arnedotter & Holm 2009). As elicited, Pehrson did this despite of all the resistance and disapproval he had to face from his fellow colleagues and superiors. He was later on appointed the directorial positions of the HIV receptions at Roslagstull Hospital\(^{83}\) and Karolinska University Hospital\(^{84}\) in Huddinge (ibid.: 2009). The first person to fall ill of AIDS in Sweden was a man named Roar Klingenberg.\(^{85}\) He was born 1941 in Norway, and came to seek medical care for diverse symptoms including enlarged lymph nodes; exhaustion; nasty coughs; and extreme weight-loss. Klingenberg’s immediate response was to deny, making excuses such as that he was smoking a lot, alongside many other bad habits of life. However, it was to no avail – he was showing all the symptoms of what had come to be known as AIDS in the United States, which at the time was unknown to physicians in Sweden, as recalled by Pehrson (in: Arnedotter & Holm 2009). Thereafter, Klingenberg was hospitalized, in purpose of conducting further investigations regarding what might have

\(^{80}\) This refers to the Communicable Diseases Act (SFS 1988:1472).

\(^{81}\) However, the changes were not implemented until year 1988.

\(^{82}\) SFS 1987:375.

\(^{83}\) Swedish: Roslagstulls sjukhus.

\(^{84}\) Swedish: Karolinska universitetssjukhuset.

\(^{85}\) The first one to be documented, that is to say.
happened to him. He died two years later in September 1984. Thus, Klingenberg became the second AIDS-related death in Sweden, as another man had died of it one year earlier in 1983 (Rydstöm & Tjeder 2009: 208).  

Klingenberg has been depicted as the “archetype” of the first five years’ AIDS patients. The “archetype” stamp refers to how the AIDS epidemic (in retrospect) is said to have had its ‘official’ outburst in Los Angeles, USA, in 1981, where gay men were the primary sufferers. Klingenberg was gay, and it is suspected that he contracted HIV when he was abroad (in: Arnedotter & Holm 2009). He lived in denial of his disease for a very long time, and thus did not seek the medical care needed until it was too late, giving the virus enough time to develop into a crucial state. As claimed by Pehrson, the situation also took a turn for the worse with the past health-care system being in denial as well, thus resulting in a detain of diagnostics, which did not only affect Klingenberg but a lot of other people falling ill of AIDS too (in: Arnedotter & Holm 2009). It did not take long before AIDS had been given abusive nicknames such as ‘gay plague’ or ‘gay cancer’ (Svéd 2000: 230), with gay and bisexual men being turned into scapegoats rather than acknowledged as people in need of help (Berner 2011: 389).

1983-1985

As stated by Ljung (2001), the public reception of the AIDS epidemic can be divided into three separate lapses. Even though she herself focused on the reception in Sweden, and as will I, she also made sure to enlighten that this pattern should not be considered ‘characteristically’ Swedish, but rather, something archetypical of the West (Ljung 2001: 21; see also Watney 1997; Shilts 1988).

Ljung placed the first lapse between the years of 1983 and 1985 (2001: 21). It can be said to be characterized by few societal alerts, as at the time, AIDS was seen as a vastly delimited problem solely affecting the delimited group of gay men. According to Weeks, this would explain the political decision of not ‘combating’ the potential epidemic with nothing but limited resources and inputs (1995: 15 ff.). However, although the several cases of HIV

86 See also: http://www.svt.se/smittad/de-forsta-aren (accessed on 2015-07-12).
infection found in Los Angeles, New York, and San Francisco illustrated that AIDS is a syndrome that could affect groups other than gay men, for some reason, gay men were the ones to be pointed out as the major ‘risk group’ in Sweden (Ljung 2001: 21). At the time, the connection between AIDS and gay men was so resilient, that AIDS became designated toward this type of sexual background. As already mentioned, AIDS was previously known as GRID (Gay Related Immune Deficiency), and thus, clearly defined by male same-sex sexual interaction, which played its part in how the virus came to be perceived (Ljung 2001: 21). AIDS (i.e. Acquired Immune-deficiency Syndrome) as a term was not implemented until year 1982. Although the newfound concept focused on what the virus actually does within the human body, instead of pointing out certain groups as its carriers, it still played on certain apprehension of sexual behaviour as the actual cause. This by utilizing the word Acquired, as argued by Ljung (2001: 21).87

As the link between HIV and AIDS was not discovered until 1984, back then, there did not yet exist a way to determine how many people were actually affected. Thus, the patients who were diagnosed later on had already fallen ill of a late-staged AIDS. Rendered projections of the actual quantity of HIV infections in Sweden executed at the time were thus characterized by significant uncertainty (Ljung 2001: 22). However, even if experts were still vastly unsure of what was actually causing this syndrome, or how it was transmitted, clear signs of optimism could still be traced in some segments of Sweden (Ljung 2001: 22). Various newsprints urged people not to give in to despair, stating that the medical expertise was doing everything they could to come up with a potential solution (see: Aftonbladet 1983-08-12, 1983-08-25). Nevertheless, in some sectors, AIDS was still seen (and treated) as the ‘most mysterious’ and ‘enigmatic’ disease in contemporary time. Thus, public media could be seen as divided between those who expressed faith in medical science, and those who showed distinct distrust towards it (Ljung 2001: 22).

By the year-end of 1983 and 1984, the National Board of Health and Welfare, in Sweden, went out with the announcement that the risk of an AIDS epidemic breaking out in Sweden had now ‘officially’ passed. This announcement was vastly criticized, and even had to be retracted. It does show however, as Ljung argued, that the Swedish authorities did not expect

87 The reason for this, though, from a medical perspective, was also to separate acquired syndromes from genetic ones (Ljung 2001: 21).
AIDS to develop into the societal issue it in retrospect did (2001: 22). Thus, in summary, the first epoch was distinguished by HIV and AIDS being seen as a relatively “defined and limited problem” (Ljung 2001: 22) that would solve itself without any interference.

1985-1994

Ljung marked the second lapse between the years of 1985 and 1994 (2001: 22-23). This epoch would be best illustrated as an awakening, as this is when AIDS returned to the centre of political attention due to a certain ‘scandal’. In February 1985, a young boy suffering from haemophilia contracted HIV from a unit of blood plasma given to him at a Swedish hospital. Soon after this, it was revealed that the National Board had demanded that gay men and People Who Inject Drugs (PWID) should be banned from donating blood (Ljung 2001: 22). Ljung argued that this deed could be seen as a way of associating the risks of blood transfusion with the groups believed to be the cause of the epidemic. That is, how AIDS was deliberated a syndrome originating from gay men and PWID; a syndrome which could easily be transmitted to the rest of society, if contact with these said groups was made. It did not take long before AIDS was deemed worthy of national attention, due to the revelation that masses outside of the previous stated ‘risk groups’ was in danger of being affected as well (e.g. Henriksson 1995; Ljung 2001). AIDS was no longer the ‘enigmatic disease’ only befalling ‘the others’ – but something concerning society in all, and demands of immediate action was soon raised.

Due to newfound ways of diagnosing whether someone was affected by HIV or not, the number of documented HIV infections in Sweden almost tripled (from 324 to 968). This fact was enlightened harshly in public media, although newsprints mostly focused on the tripled number, rather than the fact that developed diagnostics contributed to people discovering their predicaments in earlier stages (Ljung 2001: 23). AIDS increased as a newsprint topic around the same time, with papers headlining it all as the “new threat” while also personating the groups vastly associated with the syndrome – i.e. gay and bisexual men; sex workers; PWID; Africans; and people who had contracted AIDS through blood products (Ljung 2001: 23). However, it should also be noted that a substantial heterosexualization of AIDS started to

occur as well, as argued by Ljung (ibid.). With AIDS now being of public concern, no one was deemed safe from contamination. AIDS was something that could be contracted by anyone, regardless of sexual or other social affiliation. To prevent such a thing from taking place, drastic measures of all sorts were suggested; all from implementing “sexual passports”\(^\text{89}\) to tattooing people in the axilla, aiming for simple ways to identify people suspected of living with AIDS. Thus, People Living With HIV and AIDS came to be associated with a rather ambivalent image. On one hand, they were seen and acknowledged as unfortunate victims of a painful and deadly disease – on the other, they were constructed as dangerous perpetrators, threatening those still unaffected by the virus (Ljung 2001: 23; see also: Hesslow 2011; Nyman 2013).

During this period it was formally confirmed that HIV transfers through sexual intercourse, as well as through blood transfusions (Ljung 2001: 25). However, due to ‘cautious wording’ stated by medical experts, such as “AIDS spreads essentially through…” or “current research indicates that…” public media was able to make wide and unsubstantiated discussions on whether HIV could transfer through other means as well. As Shilts argued, one could observe how two separate modes of expression collided (1988: 301, 322). On one side was the medical sector, where experts uttered nothing but what they with absolute certainty could confirm. On the other side, thus, one would find a more common mode, where the cautious wordings made by experts were interpreted as signs of uncertainty and lack of knowledge. Also, as Rosenberg clarified, the role of bacteria had developed in another direction within the consciousness of the common public (1993: 276). That is to say, it was easy for (so to speak) ‘laymen’ to think that contagious substances (such as HIV) could transfer as easy, and on the same conditions, as bacteria. Thus, when medical expertise made statements such as that HIV, in fact, was not as contagious as originally thought, people did not believe them. The situation did not improve by how separate experts said different things. Further debates were characterized by extremely contradictory statements, resulting in how something deemed as ‘safe’ all of a sudden would be seen as ‘dangerous,’ and vice versa (Ljung 2001: 23-24; also Aftonbladet 1987-07-17).

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\(^89\) Basically a ‘passport’ that stated the health condition, as well as HIV status, of its carrier. The idea was that each individual had to renew this regularly (Ljung 2001).
This epoch would therefore be best described as characterized by processes of social categorization, as groups and individuals were immensely allocated into sides of being either ‘safe’ or ‘unsafe’. However, true indecision regarding whether this ‘categorization’ could actually be made transpired as well.

1995-2000

The third and last lapse unfolded between years of 1995 and 2000 (Ljung 2001: 26-27). Ljung argued that this epoch would be best described as less confrontational, and largely imprinted by silence when it came to talking about AIDS. The attention in public media had declined quite drastically, and been displaced towards the World AIDS Day on 1st of December. Newsprint articles now focused on other aspects of AIDS. For instance, how it remained a widespread issue in many developing countries, such as regions south of Sahara, while it had developed into more of a chronic condition in the Western world (Deeks et al. 2013). People Living With HIV (PLWH) were also given more public space, and possibilities of talking about their experiences of living with a highly stigmatized disease. However, paradoxically enough, new types of depictions of PLWH and PLWA began to emerge, despite the less confrontational attitude towards HIV and AIDS during the time. Ljung exemplified this through an extraordinary case that took place in 1997 (see: DN 1997-01-26; Aftonbladet 1997-01-17) where an African-American man residing in Helsinki, Finland, was suspected of having infected several Finnish women with HIV. Revenge soon became a recurring theme, where PLWH/PLWA were depicted as vastly vindictive individuals who knowingly transmitted the HIV virus to other people (often referred to as ‘HIV men’ and ‘women’ in Swedish media, see: Aftonbladet 1998-10-26; DN 2003-10-23). Ljung wrote that it is difficult to explain why these representations were given such prominent positions. However, she argued that one way to interpret it would be to relate them to general feelings of insecurity regarding the moral status of people, and the assessments of these (2001: 26-27).

Even though she did divide the Swedish AIDS reception into three separate lapses, Ljung argued that these said periods were not as linear as one might think (2001: 27). Rather, they were built on one another, in relation to the past depictions of sexually transmitted diseases and the connection to how societal issues in the end are defined. That is to say, ‘echoes’ of the
first two periods can be found in the third one, when it comes to the view on PLWH/PLWA and their relation to the rest of society (ibid.). How AIDS has developed over the years is apparent, nonetheless. It started out as a vastly delimited problem affecting delimited groups, later on turning into an actual threat to public health. Then at last, it was once again seen as a delimited issue, with potential of becoming more of a public one. In the end, what can be said about the situation of AIDS in Sweden? As several people already have pointed out (e.g. Svéd 2000; Berner 2011, 2012; Thorsén 2013; Rydström & Tjeder 2009), in Sweden, AIDS never turned into a widespread societal issue. The horrors of the 1980s never came true, and the overall (heterosexual) public was not infested in the same scale as other groups were. This might have contributed to why the interest of AIDS started to decline during the 1990s, as it was no longer seen as a potential threat to public health – and public health is, and remains, vastly heteronormative (Epstein 1996; Waldby 1996). 

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90 Heteronormativity is the belief that people fall into distinct and complementary genders (man and woman) with natural roles in life. It asserts that heterosexuality is the only sexual orientation or only norm, and states that sexual and marital relations are most (or only) fitting between people of opposite sexes. Consequently, a “heteronormative” view is one that involves alignment of biological sex, sexuality, gender-identity and gender roles. Heteronormativity is often linked to heterosexism and homophobia (Lovaas & Jenkins 2007).
Chapter 3: The (Gay) Sauna Clubs

§1. In purpose of protecting people from contracting some of the diseases mentioned in the annex of the Communicable Diseases Act (SFS 1988:1472), this law sets out to decide on banning the apparatus of certain events and social gatherings.

§2. Social gatherings to which the public has access to cannot be arranged or provided, if they with concern to the design or the condition of the premises, or the operation that occurs or is supposed to occur within it, are intended to facilitate the enablement of sexual relationships and liaisons.

An event or gathering with limited access through personal invitations, formal memberships, or any other conditions is free to operate without affection of §1; unless the event and/or gathering is to be seen as a public one, with regards to the extent of the social circle, the conditions of entering or other circumstances that makes it similar to those mentioned in §1. This also applies if the said event or gathering is without a doubt part of a larger movement, which solely operates to organize events or gatherings of this calibre.

§3. Those who organize these events or gatherings mentioned in §2 shall be sentenced to prison for two years at most, or if there are mild circumstances, to pay certain fines.

If it lies a risk in that an event or gathering mentioned in §2 will take place, the Police Authority\footnote{Polismyndigheten in Sweden. \url{https://polisen.se/Om-polisen/Nya-Polismyndigheten-1} (accessed on 2015-05-07).} will be in charge of suspending, vacating, and/or prohibiting access to the said premises.

The Act on Banning so-called Sauna Clubs and Other Similar Operations (SFS 1987:375)
The tale of the Swedish sauna clubs

Once upon a time, Sweden had a viable gay sauna-club culture. Then came the evil witch Gertrud Sigurdsen and with her magical wand, she created the “Act on Banning Sauna Clubs and Other Similar Operations”. After this, [gay men] had to be content with visiting dark porn-video clubs.

QX (2002-12-03)

Even though it might have appeared so, this was not the case. The ‘gay’ sauna clubs, as they were known as, had only been around in Sweden for about ten years when they got banned in 1987. The ‘phenomenon’ never reached the status of ‘culture’ – though, I argue it should not even be depicted as that and they were never operated as ‘clubs’ in that sense, either (QX 2002-12-03). The concept of ‘sauna club’ (in a Swedish context) was coined in the factual process of implementing the law (see: SFS 1987:375) in order to ban these ‘types’ of operations (QX 2002-12-03). Before that, gay (and bisexual) men went to ‘ordinary’ saunas and/or bathhouses – that is to say, ‘ordinary’ in that sense that they lacked labels, yet, aimed towards norm groups of the general public. At first, this was tolerated; that is until the 1970s, when gay men and gay culture started to end up in the spotlights, due to the gay liberation movement (e.g. Hoffman 2007). Even though claims were made (and won) on some areas, all battles did not end in success. It did not take long before gay men were thrown out of saunas and public baths, which made them turn to the (later on) established ‘gay saunas’ – and as already noted, they were to be blamed for the spread of HIV in Sweden (QX 2002-12-03).

A (gay) sauna club, bathhouse, or steam-bath, is a commercial space for “Men who have Sex with other Men” (MSM) and should not be confused with public bathing in general. These spaces are primarily for sexual liaisons, rather than bathing. However, the label of “gay” can be vastly misleading, as pointed out by Woods and Binson (2003a, 2003b), far from every man visiting these baths consider themselves gay – regardless of their sexual behaviour. The

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92 Sigurdsen was Health minister of Sweden between the years 1985 and 1989. During that time she was also the chairperson of the National Commission of AIDS. She is often seen as the one responsible for implementing the Act on Banning Sauna Clubs and Other Similar Operations.

93 SFS 1987:375


baths have come to be allotted with gay and bisexual men, though, as throughout history, they established themselves as safety zones for non-heterosexual people (Bérubé 2003). For legal reasons, many bathhouses and sauna clubs require certain membership to enter; although membership is generally open for any adult person to proclaim. However, these bath establishments should not be equated with brothels of any sort, as customers pay only for the use of the facilities. Any sexual interaction occurring is neither provided by the staff nor the establishment in whole, but between customers only with no money exchanged. Thus, for legal reasons yet again, several bathhouses explicitly prohibit commercial sex, and ban known sex workers from entering the premises (e.g. Brett 2006).

The Swedish ‘Act on Banning so-called Sauna Clubs’ is an interesting artefact on several accounts. First of all, even though gay men were the primary ones (in fact, the only ones) to be affected by its input – in how they lost their most prominent gathering spot as a result of it – the artefact itself, in its final version, did not mention gay men, or sex between men the least. This, I argue, illustrates the antagonism between government authorities and social individuals at the time. Also, as Engström (2003) pointed out, this Act is yet another example of a legislative regulation aimed at gay men (and lesbian women, too) but with no objective of consolidating their social position in Swedish society. Rather on the contrary, as the Act in retrospect has been described as nothing but moralistic and forcefully heteronormative, urging towards a change of unfitting sexual behaviour said to be ‘common’ amongst gay men. Likewise, from a criminological perspective, the Act seemed to be unfruitful as there were no signs of it actually verifying to be as effective as originally intended. Hellman (2001) argued that even though it is difficult to judge whether the Act has had any negative outcome on Swedish HIV prevention, it is very unlikely that it would have worked in its favours. HIV prevalence amongst gay men had already started to decrease long before its implement (ibid.: 41) and while in use it proved vastly difficult to apply, and thus, few people were prosecuted because of it (ibid.: 42).

Another significant aspect that is of analytical interest to me is one concerning the time it takes for an implementation to commence. Hage wrote that there is politics around “what waiting entails” (2009: 2). Who has the power to make their time appear more valuable than somebody else’s? Waiting defines class and status relations in, as Hage phrased it, “the very obvious sense of ‘who waits for whom’” (ibid.: 2). As Engström (2003) said, back in 1987, it
only took four months for the proposition (1986/87:149) to go from being just that, into becoming a vigorous Act in Swedish legislation. However, when it came to a discussion of a potential withdrawal of it, the process nearly spanned over two decades. The Swedish Government decided on 5th of September 1996 that it was about time to re-value the exiting legislation on prevention of communicable diseases (Dir. 1996:68; SOU 1999:51, pp. 1), which included both the Diseases Act (SFS 1988:1472) but also the Act on Banning Sauna Clubs (SFS 1987:375). The investigation was originally intended to span over two years, but was extended to three, and the conclusion was thus presented to the Government in year 1999 (see: SOU 1999:51). However, it then took another four years before an official proposition of some sort was presented to the Swedish Parliament, in 2003 (see: Prop. 2003/04:30; SFS 2003:421), and then one more year for the changes to actually be implemented (see: SFS 2004:168).

“Where it was safe to be gay”

As Bérubé (2003) pointed out, gay baths (and bars) are integral parts of gay political history. They contradicted the stigmas of gay people as “sinners, criminals, and diseased” – giving them a sense of pride in themselves and their sexuality (ibid.: 33-34). In the United States, gay baths and bars became “the first stages of a movement of civil rights” for gay people. Before there were any openly gay political leaders or organizations, “pioneers” (as called) spontaneously established gay bathhouses/saunas and gay/lesbian bars; risking arrest and jail sentences, even losing their families or their jobs, as well as putting themselves in potential danger, in order to transform public bars and baths into safety zones “where it was safe to be gay” (Bérubé 2003: 34). The gay bathhouses therefore represent a major success in a political struggle to overcome social isolation, and to be able to develop a sense of community and pride. A struggle that has been going on for centuries, and still has to be won on many areas (ibid.: 34). It was during the late 19th and 20th centuries that public baths and health resorts started to transform into the gay institutions they have come to represent today. Back in these days, all sexual acts between men were seen as ‘crimes against nature’; that is, they were considered and treated as public and illegal offences (Murphy 1990). Thus, men having sex with other men had no legal right to privacy, and were therefore forced to become sexual
‘outlaws’ (Bérubé 2003: 34). In response to this, gay men became experts “at stealing moments of privacy” and finding so-called ‘cracks’ in society, where they could meet without risk of getting caught, or judged.96

When it came to the attacks on along with the potential closures of the (gay) bathhouses and saunas, Bérubé was critical. He argued that the closures only would “relocate the sexual activities that [took] place in the baths” (2003: 50). In the end, it would only create more issues than it would solve, both in high and unexpected social, financial, and health costs to the gay community, the cities, and the general public as well. Instead, to avoid unforeseen social problems while also taking strong measures against the AIDS epidemic, Bérubé suggested a number of things.

Firstly, as the bathhouses are such integral parts of the gay community, they should be used as community resources to promote safe-sex activities and safe-sex education (Bérubé 2003: 52-53). As they have undergone several dramatic changes the last 100 years, which gay men have risked and even lost their lives to in bringing about, they should be allowed to “continue these rapid changes in order to serve the community’s needs during [a potential] health crisis” (ibid.). Secondly, bathhouses should remain and be preserved as the zones of safety, privacy, and peer support they have grown to become, as long as gay men are attacked on the basis of their sexuality (2003: 52). As Bérubé stated, gay men and lesbian women are still assaulted, or otherwise victimized because they are gay (for Swedish data, see: SLL 2011; SFHI 2008; UngS 2010). Thirdly, in order to ‘fight’ HIV and AIDS in effective ways, it is crucial for the city councils and the gay community to have a good relationship of cooperation. Thus, these closures as well as all the sex arrests and political backlashes that are bound to follow, will just act in the opposite way, and make “city agencies and the gay community adversaries once again” (ibid.: 52-53). Closing the bathhouses will just further foster, and increase, the mistrust of health authorities. Instead, Bérubé advocated that the gay community should be allowed to “devote all of its resources” – including the bathhouses – in purpose of promoting the health programs and safe-sex educational measures needed to save lives (2003: 53).97

96 This is comparable to what Wright (1997) called “refuse spaces”; that is, “unwittingly ignored sites of varying shapes and sizes: they can be peripheral areas on the margins of cities or vacant lots inside them or just a few square meters behind a corner” (quoted in Höjdestrand 2009: 78).

97 Even though Bérubé mostly referred to the North America, I argue that his thoughts are as applicable to the Swedish society, considering how alike the West has been when it comes to the issues of HIV and AIDS.
Bearing the social significance of the gay saunas in mind, it is worth considering the proposition(s) of forcefully terminating them as not just acts of preventing and tracking down risks (cf. Rabinow 1992), but also as initial attacks on the core of the gay community and their agency of utilizing social space. By eliminating what was at the time seen as ‘contagious sites,’ health agencies also eliminated one of the principal zones where it was safe for gay and bisexual men, together with other people of the LGBTQ\(^{98}\) community, to gather and meet others sharing their social predicaments. Thus, the proposition of banning bathhouses and sauna clubs was not just seen as an attack on the actual premises, but also on the gay community in all, which I will continue to discuss in more detail.

**Proposition 1986/87:149**

**The Main Objective of the Proposition**

The proposition proposes the implementation of a law that forbids the arrangement of events or social gatherings that risk spreading infectious diseases. The law would entail that it is no longer allowed for the general public to arrange an event, or social gathering, especially devoted to facilitating possibilities for sexual liaisons. This law hereby forbids the operation of so-called video and sauna clubs for gay men. Those who violate this prohibition shall be sentenced to prison.

We propose that the said law come into force on July 1 1987.

*Prop. 1986/87:149 (pp. 1)*

As observed, the initial target of the proposition was put on the front page, giving no further indicates of these ‘operations’ other than the infamous video and sauna clubs for gay men. The proposal was further introduced by epitomizing how the situation of AIDS in Sweden had turned out so far, putting particular emphasis on the ‘major inputs’ that had been made:

In the last few years our country has made great endeavours, and invested considerable resources, on preventing the dispersion of the virus known to cause AIDS. (Prop. 1986/87:149 pp. 3)

\(^{98}\) Lesbian, Gay, Bisexual, Transgender, and Queer.
Svéd (2000: 227) would have argued that this should be understood as an act of illuminating significant march of “political determination,” while making it clear to the public masses that the authorities treated the issues of AIDS with great insight and priority.

However, as it seems, this is not where it all started. According to one of my informants — “O.” — who is a representative of the Positihive Group (PG), a patient group and social venue point for Men who have Sex with Men (MSM) in Sweden, this certain Act was a result of a de-moralizing of the gay video and sauna clubs, initiated by the Swedish press. As I was told, it all began in October 1986, when a man named Peter Bratt, who was working at Dagens Nyheter (DN), started to publish a series of articles.

“O.”: I remember it quite well. It was because of some articles published by Peter Bratt, who worked at DN. Those said articles basically resulted in the implementation of the Ban of Sauna Clubs Act. He visited Manhattan, if you know what that is, and was really shocked over what people were up to. It was disgusting what he wrote. Well, DN acted quite disgustingly in overall during the 1980s, but Bratt especially. I actually remember the exact date; it was the 10th of October 1986, the day it was published.

Fredrik: And it was a big coverage?

“O.”: Oh yeah, it was really huge. And it basically… it was after it got published that the Ban of Sauna Clubs Act got set into motion. It was implemented only one year later.

Fredrik: So, he was not involved, so to say, “officially,” yet it was something that was based on and emerged out of something he wrote, and published?

“O.”: Yes, that is exactly how it was. No, Bratt was just a reporter working at DN. He was quite young back then. And AIDS was really huge at the time, when it just arrived in Sweden. He is quite interesting, though. Basically, the whole legislation is based on his… not interviews, but he was there, kind of like “wallraffing” [walltraff] at the gay place, you know. Really intimidating, actually.

(Interview with “O” from the Positihive Group [PG], 2014-11-24)

The said article was ‘supposed’ to have depicted what was ‘actually’ going on in the sauna clubs. Instead, it all turned into what nearly could be described as a horror story, where gay

99 Dagens Nyheter is a Swedish daily newspaper.

100 Manhattan was an old cinema located at Hantverkargatan 49 in Stockholm. It was later renamed Video Pan.

101 It is a Swedish word and journalistic term which means “to work undercover”. It got its name from the German journalist and author Günter Wallraff, famous for his undercover work.
men and other visitors were portrayed in the most inhuman way. They were reduced to nothing but mere animals; ‘copulating’ like beasts, where concerns for sexual health became like a distant memory.

In the coming sections, I will be presenting Bratt’s first article from October 1986.

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HERE YOU ARE ALLOWED TO SPREAD 'AIDS'

*He walks into the club called Video Pan in Stockholm to have sexual intercourse with men he does not know and faces he cannot see. He does not use a condom. He is in risk of contracting AIDS - or spreading it to someone else.*

The walls were all painted pitch black, and the dimmed light in the entrance hall got even paler in its contrast. There, a man sold tickets for no more than 40 SEK, with no fuzz, like any regular movie theatre. They used to show matinee films here, during the 1930s, when it was known under the name of Manhattan. It had been renamed twice, though; first to Ri-Manhattan, and then a second time to Ri-Mondo. However, now it is known as Video Pan and offers a completely different type of entertainment. It is located at Hantverkargatan 49, quite close to the fire station. Our first impression was that the entire premises seemed to be made out of black chipboards, like it was nothing but a big theatre backdrop. We had to fumble our way through the darkness, all the while listening to door creaks and crunches from creeping steps. Dark figures appeared around us. We could glimpse their eyes. Human silhouettes turned up beside us, but then quickly vanished back into the dark. We did not hear any human voices, only howls and shouts from running video-units. In the old saloon, which sloped down the wall where the old stage had been, now stood three transversal rows of cubicles, with five cubicles placed in each row. Several corridors ran down each of them. Each cubicle had its own attire consisting of a video, a chair, a garbage can, and stashes of paper towels. At the highest peak of the premises stood, what we would like to describe as, two tall ‘bar counters’ with walls of pitch black chipboards placed in front of them. Visitors often stood here and leaned towards them, all while watching videos shown in the front.
Their faces were slightly visible, but their bodies were completely blocked by the chipboards in front of them.

Copulating

When we first walked into the premises we decided to stay next to the doors as to get used to the dimmed light, which was nearly non-existent at some places. Almost like if it was meant for guidance only, and not for lightening up the actual premises. First, we saw a man standing behind the high counter. He watched the video in front of him with a rigid gaze, all while masturbating. As he stood close enough to the edge, this was easily understood by how he moved his arms. Suddenly, a shadow appeared next to him, and after a while we noticed how this shadow started to copulate with the masturbating man from behind. It did not take long before they were finished, and the shadow left while pulling its pants back up. It sat down in one of the chairs placed right next to a video-unit, and thus became slightly visible in the dimmed screen-light. As it turned out, the shadow was a man in his 30s with blonde hair and glasses. He looked totally ordinary.

Open cubicles

You would not have been able to tell him apart from any other stranger met on the street; neither from his way of acting nor from his way of moving. Over by the said “bar counters” people would watch all different sorts of pornos; anal porn, violent porn, and even regular porn, i.e. normal intercourse between men and women. Then, we found men sitting and masturbating by themselves in the cubicles. A couple of them even left the doors slightly open or ajar, like if they wanted to invite others to come inside. In some of the rooms, we found ejaculation running down the floorboards. Further down the premises, they showed homosexual porn. The videos displayed young men giving each other blowjobs, or copulating with one another in showers or hot tubs. You saw nothing but ejaculating male genitals, or male anuses being rubbed in with butter. All the men sneaked around each other with nothing but blank expressions to show. We heard nothing but creeks and creeps from their running steps. On our way towards the exit, we spotted the glimpse of a cigarette in the dark by one of the “counters,” where someone sat and smoked. When we walked
closer, we could not help but to observe a small scope beneath the counter. Its purpose was soon explained to us, when we saw how a man went to stand by the spot we had observed earlier on. He stood there for a while in the dimmed lights, seemingly very indifferent to his surroundings. We also heard a weak slurping sound. The man made a small movement but then walked away rather indolently while pulling his pants back up. Soon thereafter we saw how another man crawled out of the previous said scope, and walked away in the opposite direction. We estimated that there were about 20 to 30 men inside the premises, all in the age range of 30 to 40 years old. A video-unit was suddenly switched off; one which was about to show a porno of sadistic nature. Apparently, the owner had ultimately realised that we did not belong to his regular crowd of visitors, and thus took alarm to our presence.

Sauna clubs

‘Men Only’ is located over at Hagagatan 56. It is a homo sex club, also known as a sauna club. Here, you pay nothing but a small entrance fee of 50 SEK, which includes a towel and a key to a personal locker. During our visit, we found a room with about 20 armchairs. There, we observed a group of men watching a video. They were basically naked, wearing nothing but towels wrapped around their waists. They did not speak to each other. Another group of men hanged around by the door. Some of them were fully dressed, while some were only wrapped in towels. The light was not as dimmed down as over at Video Pan, and the atmosphere was not as arid or dreary either. The visitors were younger, some even in their teens. In total, we estimated that there were about 30 visitors, all in all. Further down, they had three smaller rooms, all with its own video-unit. A lone man, probably in his late 40s, was sitting in one of them while masturbating. Behind the private lockers, we found a sauna that was dimmed down to pitch black, with a shower right next to it in the dark. Men walked in and out of it with a continuous flow. Next to it laid six cubicles and small rooms along a corridor, each with mattresses covering the whole floor. From one of the rooms we could hear the moaning from a copulating couple. The visitors did not seem to talk to one another. Furtive gazes seemed to be the only language utilized between them. Visitors could also pick up brochures containing information from Venhäl san at Södersjukhuset over
The reason why I present this piece so comprehensively is because I deem it necessary to understand the situation that was at hand. Considering how significant Bratt’s input on this ‘issue’ was, in how he literally triggered his fellow colleagues to follow his lead and thus launched a massive (media) insurrection on the existence of these gathering points, it bears massive denotation from a genealogical perspective. It all took place during a rather short time-span, with the debates of a potential Act aiming to prevent such operations emerging about 12 months after the first articles had been published. Then, it only took four months for the proposition to be put into force, which was under extraordinary circumstances, considering how the traditional referral procedure had been disused. It had been replaced by a mere ‘hearing,’ where only the foremost actors involved had been invited to participate. This was due to, as former Minister of Health Gertrud Sigurdsen phrased it herself: “A customary referral proceeding would delay this errand [of addressing a potential public hazard] in a most unacceptable way” (Prop. 1986/87:149, pp. 7).

“Images of the enemy”

In his report to the National Board of Health and Welfare, sociologist Henriksson vastly criticized the Swedish media, and Peter Bratt exclusively, in how they had depicted the sauna clubs and their visitors, after the advent of HIV in Sweden (see: Henriksson 1990). He named the report Images of the Enemy, and it set out to examine how ‘homosexuality’ had been

102 Venhälsect (the Gay Men’s Health Clinic) is an exceptional medical reception at the hospital of Södersjukhuset (SÖS) in Stockholm, made to especially target and help the groups of ‘Men who have Sex with other Men’ and People Living With HIV.
produced and communicated in Swedish media, during three eras: (1) starting in the 1950s and going over to the 1960s; (2) from the middle 1960s all the way to the 1980s; and (3) finishing off at the end of the 1980s, with the discovery of HIV in Sweden (Henriksson 1990: 4). Even though he originally set out to look at the depiction of ‘homosexuality’ in overall, in the end, the depiction of gay men became the main object of investigation – rather than gay men and lesbian women. As Henriksson observed, it was obvious that male ‘homosexuality’ had been given a significantly greater presence in media, unlike its female part (1990: 4). Yet, the question remained – how had they been depicted? In which contexts were ‘the homosexuals’ (as they were entitled) allowed speaking for themselves, and who were allowed to speak of them – ‘the homosexuals’? (ibid.: 4).  

Henriksson analysed this wide-ranged material through the use of theories and concepts from mass media research on war; thus, the name Images of the Enemy was obvious. However, these images are well beyond just “ethical prejudices” (Henriksson 1990: 5) as stated, but contain stronger socio-psychological reactions than ‘mere’ feelings of dislike towards something, or the feeling of antipathy towards certain people. As Wahlström (1989) said, they act as opportunities for people (groups, nations, et cetera) to ventilate their fears and feelings of threat and insecurity, aimed at their own community. Nevertheless, it is their own fears that are channelled through these images of the ‘enemy’; thus, the said images say a lot more of those who utter and formulate them, rather than the imagined enemies themselves. Henriksson argued that:

The images of the enemy accelerate when the group uttering them feel threatened by someone they see as an outsider. The enemy is then described as a “stranger”. However, not all “strangers” or unknown groups are portrayed as enemies. It is not until the so-called “others” are threatening central values of the own community; religious, political, or ideological values important to the own identity, that these images of the enemy are utilized. (1990: 5)

When it comes to public media, Bourdieu and Passeron (1977) stated that journalists are able to exercise their power on the basis of symbolic capital. As they said, professional journalists are relatively liberated in picking which headlines to pursue, and in which style these are to be

103 Compare to Dahl (2009).
presented; provided, that is, that they heed the ideology set by their news agency (Bourdieu & Passeron 1977). Henriksson argued that this is what was going on back in the 1980s, when HIV ascended as an issue and the sauna clubs were turned into scapegoats (1990: 63). He explicitly described it as a “campaign” that was led and put into force by Peter Bratt to make the authorities intervene, and shut down the so-called sauna clubs. The issues of AIDS came well in hand when people like Bratt wanted to attack the gay community. That is to say, normally they would have been accused of being intolerant, or prejudiced, but due to HIV and AIDS it was once again legit to make assaults upon gay men and their way of lining (ibid.: 63). The gay lifestyle, or the ‘homosexual culture,’ was not just portrayed as immoral, but contagious, and thus easily turned into ‘enemies of the society’.
Chapter 4: The Diseases Act(s)

Satisfying the public need...

As it says in its first paragraph, the Law of Communicable Diseases Act (henceforth referred to as the Diseases Act) has the purpose of “satisfying the public need for protection against the proliferation of infectious diseases” (SFS 2004:168, Ch. 1 §1). At the time of writing, the Act covers over sixty different kinds of diseases, where the majority of them are classified as ‘notifiable’ disease. This means that every suspected, or confirmed, case has to be reported to the County Medical Officer and the Public Health Agency. Around fifty of these said notifiable ones are also ‘subjected to mandatory contact tracing,’ which obliges the patients in question to the best of their ability give information on how he or she believes he or she might have been infected, and who else might have been exposed to infection. Moreover, thirty of these previous stated diseases are also classified as ‘dangerous to public health,’ and three are classified as ‘dangerous to society’.

When it comes to HIV prevention, and with my research objective in mind, there are two sections of the Diseases Act (SFS 2004:168) that are of particular interest to me. These are: the so-called ‘duty to inform’ (Ch. 2 §1-2) and the directive of coercive isolation (Ch. 5 §1-16). Both of these were implemented with the previous Diseases Act (SFS 1988:1472) during the 1980s, as to ‘combat’ the escalating issues of AIDS. However, due to this thesis’ limited scope and also considering that only one of these two circulates in Swedish media on a regular basis, I will only be addressing the ‘duty to inform’ and the issues it is said to produce. It is worth mentioning, though, that these two sections are closely entwined. People Living With HIV (PLWH) who do not submit to the ‘duty to inform’ may be put under coercive isolation, as in accordance with the Diseases Act. The Act on Banning Sauna Clubs was officially decommissioned on April 7, 2004 following the implementation of the currently actualized Diseases Act (see: SFS 2004:168). This was eagerly anticipated, much appreciated and welcomed by the diverse NGOs engaged in HIV-preventive work in Sweden (see:

104 In Swedish: Allmänfarlig sjukdom resp. Samhällsfarlig sjukdom; translation in accordance with SoS (2007).
FROM DEADLY DISEASE TO CHRONIC CONDITION

considering it had been suggested as early as back in 1999, after the Commission on Prevention of Communicable Diseases had concluded in their three-year long investigation that the past legislation had grown obsolete (Dir. 1996:68; SOU 1999:51). The Commission’s original intent was to propose a regulation of the sauna clubs in the Act on Public Order (SFS 1993:1617) even though they had concluded that the aforesaid Act had shown no indicates of having any significant effect whatsoever on HIV-preventive practices in Sweden (QX 2003-11-13). However, this claim was not supported by the Government, and thus, they decided not make such an intervention (ibid.).

Andersson wrote in 2003 (pp. 229) that several politicians and authorities alike all agreed on that the Diseases Act implemented in 1988 was a result of public (moral) panic, and thus, excessively harsh. At the time, all people involved were very anxious to gain control over what was expected to turn into the ‘worst epidemic’ in contemporary time. The notorious result was an Act which allowed for People Living With HIV to be put under indefinite isolation; forced a statutory duty upon them, urging them to inform their partners about their HIV status; and, obliged their physicians to without delay contact the health authorities every time a new case of HIV was discovered (Andersson 2003: 229).

The Act was soon widely known for its harsh nature and regulations, which other nations failed to live up to. Not only did it violate the recommendations laid forward by the World Health Organization (WHO) but also those of the Council of Europe (CoE), which were all built on the free will and solidarity of individuals (Andersson 2003: 229). Due to this, back then, Sweden was the only member state of CoE not to sign the recommendations concerning PLWH:s rights and entitlements. As the attitude towards HIV and AIDS changed during the 1990s, so did the need and wish for a more considerate Act showing significant concern

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105 RFSL: http://www.rfsl.se/?aid=7092&p=3815 and http://www.rfsl.se/?p=3815&aid=6803. (Both accessed on 2015-08-06)

106 The theory of ‘moral panic’ was coined by Stanley Cohen in 1972 [2002]. He argued that societies “appear to be subject, every now and then, to periods of moral panic. A condition, episode, person or group of person emerges to become defined as a threat to societal values and interests; its nature is presented in a stylized and stereotypical fashion by the mass media…the condition then disappears, submerges or deteriorates and becomes more visible. Sometimes the object of the panic is quite novel and at other times it is something which has been in existence long enough, but suddenly appears in the limelight. Sometimes the panic passes over and is forgotten, except in folklore and collective memory” (Cohen 2002 [1972]: 1).

107 Andersson wrote her piece in 2003, before the motion of a new Diseases Act was presented, which has to be taken into account when reading it.
for PLWH and their situation. Thus, the Government issued, after severe pressure from RFSU, RFSL, and HIV-SWEDEN, a re-valuation of the legislation (something I touched upon earlier on; see also: Dir. 1996:68) (Andersson 2003: 230). In the end, it took the proclaimed committee three years to come to a final pleading (SOU 1999:51), which foremost consisted of these proposals, among other things:

- That the coercive isolation shall only be utilized under extraordinary circumstances.
- That the ‘duty to inform’ remains, but at the same time, the general public shall be urged to be responsible and show awareness of infectious diseases.
- That physicians should no longer be obliged to report directly to the health authorities after a case of HIV is discovered. Instead, they should focus on developing a trustfully relationship with their patients.

(Andersson 2003: 230)

As Andersson stated, something all Parliament representatives and consultative bodies agreed on back then, was that the new Act should concentrate on eliminating all unequal treatment and privileged access applied to those living with HIV (2003: 230). The said Act and its regulations should instead reflect the emerging situation of HIV; that is, how it is turning into a chronic disease, not much different from diabetes, arthritis, or asthma. However, some state actors, among them the National Board of Health and Welfare, demanded that both the ‘duty to inform’ and the coercive isolation remained unchanged from the previous Act (SFS 1988:1472). In the end, their wishes were heeded, as the current Diseases Act (SFS 2004:168) omitted much to be desired (Andersson 2003: 230).

**How the categorization of HIV changed**

Setel argued that our ability to comprehend and respond to AIDS as a societal issue will depend on how we understand the dynamics of transmission in a social and cultural context (2006: 2). After I compared the three different Diseases Acts that have been in force since the discovery of HIV in Sweden, it became vastly evident how the separation and definition of different infectious diseases had changed on every account. Thus, the definition and

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108 They are all major NGOs in Sweden working with issues concerning HIV prevention.
categorization of HIV changed with it as well and how it was designed to be approached as a potential threat to public health. If I may turn to the first one, which was enacted in 1968 (SFS 1968:231) and thus already implemented and in force when HIV was discovered in 1982, Swedish legislation divided infectious diseases in three separate categories: (1) diseases dangerous to public health; (2) venereal diseases; (3) and other contagious diseases.

§4. Communicable diseases are divided in ‘diseases dangerous to public health,’ ‘venereal diseases,’ and ‘other contagious diseases’. The Government shall decide which diseases are to be considered dangerous to public health or venereal ones.

(SFS 1968:231)

The second one, enacted in 1988 (SFS 1988:1472) as a direct input to ‘fight’ and to prevent the potential threats of HIV and AIDS, had only two main categories alongside a third subcategory. The venereal diseases had now been merged together with the diseases dangerous to public health, thus establishing a new main category of ‘diseases dangerous to society’. Other contagious diseases remained unchanged as a category. However, a new subcategory of ‘notifiable diseases’ was now in force. This meant that the County Medical Officer now was obliged to alert the health authorities regarding every newfound case of a disease belonging to the category of ‘dangerous to society,’ and most of the ‘other contagious’ ones as well.

§3. The communicable diseases are divided into ones ‘dangerous to society’ and ‘other contagious diseases’.

The ones dangerous to society and some of the other contagious ones have to be reported in accordance with the regulations in this Act. These ones are to be named ‘notifiable diseases’.

The ones dangerous to society are mentioned in the annex attached to this Act. The Government will announce which of the other contagious ones are to be reported.

(SFS 1988:1472)

The infectious diseases themselves were divided into three subgroups. As stated in the attached annex, HIV was placed in the third category (1.3) together with gonorrhoea, chlamydia, syphilis, and chancroid (*ulcus molle*) – all of them sexually transmitted diseases
(STDs). This was an obvious response to the previous Act (SFS 1968:231) where HIV was soon after its discovery categorized as a venereal disease (Svéd 2000) prior to the new Act being implemented in 1988. (Thus, as noted, ‘venereal disease’ is an older term for ‘sexually transmitted disease’.)

Finally, the third and last one (and also the currently instituted one) enacted in 2004, consists of two main categories and two subcategories. The two main ones are ‘diseases dangerous to public health’ and ‘diseases dangerous to society’; thus, an assemblage of previous Acts’ constitutions, where HIV is now placed among those considered dangerous to public health. With this constitution, the diseases seen as ‘dangerous to society’ are those considered ‘extraordinary,’ thus requiring certain measures as to protect the public and societal functions deemed as especially sensitive to potential threats. Only three infectious diseases are at the time of writing included here: (1) smallpox; (2) SARS; and as of 2015, (3) Ebola. Smallpox and SARS are also classified as diseases ‘dangerous to public health’ while Ebola is not, due to it historically not being associated with the West (cf. Hewlett & Hewlett 2006). All of the infectious diseases classified as ‘dangerous to public health,’ as well as some the other ones, also belong to the two subcategories of ‘notifiable diseases’ and ‘diseases subjected to mandatory contact tracing’.110 Thus, with the new decade, it is not only seen as important to notify the health authorities of potential threats to public health, but also to trace these threats back to their proposed sources.

§3. This Act defines ‘communicable diseases’ as those diseases that may spread to or between humans and that may pose a potential threat to human health.

The ‘diseases dangerous to public health’ refer to the infectious diseases which may be life-threatening, implicate prolonged illness or severe suffering or result in serious consequences, and where it is possible to prevent further contamination by enacting measures aimed at the diseased.

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109 (SFS 2015:146) Lag om ändring i Smittskyddslagen. This was implemented as to respond to potential threats to public health in Sweden with the recent outbreak of Ebola in West Africa in 2014.

The ‘diseases dangerous to society’ refer to the ones dangerous to public health, but if spread further in society may result in serious disruption or risk of serious disruption to important public and societal functions, and thus require extraordinary measures.

The ‘diseases dangerous to public health’ and some of the other infectious diseases have to be reported or be traced back in accordance with the regulations in this Act. These are to be named ‘notifiable diseases’ and ‘diseases subjected to mandatory contact tracing’.

(SFS 2004: 168)

With the constant transformation of the definition and application of HIV, how are we as scholars meant to approach the system of thoughts we have come to know as ‘medical knowledge’? Turning back to Waldby and her investigation of how biomedicine has successfully established its right to represent the ‘real’ of disease (1996: 5), she scrutinized it by approaching it through the notion of social discourse. As observed, over the past decades, HIV has been re-defined at three different stages in Swedish legislation, at the same time re-defining it as a disease. This could be interpreted as a way of handling a potential threat to public health in a situation of uncertainty where conflicting agendas and knowledge claims were at hand (Berner 2011). Thus, in terms of Foucault, what we have come to apprehend as the ‘truth’ (of medicine) should be treated as the result of prevailing struggles taking place between different competing scientific, institutional, and political forces (i.e. discourses). Each time era is characterised by its own (so-called) regimes of truth, all making separate claims on what is to be considered true and false (Foucault 1993: 24-25, 2008; Hall 1997: 48-49; Hesslow 2011). I argue that this would indicate that the apprehension and assessment of risk is neither static, nor absolute, but a set of processual practices all dependent on prevailing context and social understanding of epidemiology; and thus, as Setel said, vastly dependent on our sociocultural understanding of the mechanisms of (medical) transmission.

\[\text{Regime of truth} \text{ as a concept can be compared to Brigitte Jordan’s concept of ‘authoritative knowledge’ (Jordan 1993 [1978], 1997). That is to say: that which a community of practice defines and accepts as adequate, relevant, appropriate, and suitable for explanations or justification.}\]

\[\text{~ 71 ~}\]
A ‘duty’ to inform

Obligation to seek medical care and give information

§13. He or she who has reason to believe that he or she has been infected with a ‘disease dangerous to society’ is obliged to seek medical care without delay, and to let the physician in charge perform the examinations needed to establish if he or she has indeed been infected with such a disease. He or she is also obliged to obey the health regulations given to him or her.

The set regulations in the first paragraph also applies to if a person infected with a ‘disease dangerous to society’ indicates that he or she has been in contact with someone in a way that might transmit disease.

§14. He or she who has been infected with a ‘disease dangerous to society’ is obliged to give information to the physician in charge regarding who the infection might have come from or been transmitted to, as well as to give general information on where the infection might have come from and where it might have gone.

(SFS 1988:1472)

Individual obligation of preventing infectivity

§2. He or she who knows or has reason to believe that he or she is infected with a communicable disease is obliged to take necessary measures in how to protect others from potential contamination.

He or she who knows that he or she is infected with a ‘disease dangerous to public health’ is obliged to give information about this to other people that he or she comes into contact with that might lead to transmission of that said disease.

(SFS 2004:168)

The so-called ‘duty to inform’ regulated in the Diseases Act since 1988, has been immensely criticized ever since it was first implemented and this by several different actors with similar or dissimilar agendas. RFSL, the Swedish Federation for Lesbian, Gay, Bisexual, Transgender and Queer Rights, is one of them. In my interview with their chairperson, Ulrika Westerlund, she told me how this so-called ‘duty’ can be said to indirectly confer the responsibility of talking and informing about HIV and AIDS to PLWH/PLWA and other high-risk prevention groups, leaving them alone to be turned into some sort of unofficial HIV-preventive mechanisms.
Nevertheless, we do think that this aspect of having to tell [others about your predicament] is improper and misguided, as it removes attention from the actual preventive message which should be about everyone’s responsibility on how to act [when it comes to safer sex].

(Interview with Ulrika Westerlund, 2013-02-12)

Further on, Westerlund argued how important it so to put focus on knowledge, about yourself and others, and how vital it is for each of us to know for sure when it comes to other people’s sexual health, which something I have previously touched upon (see: Nyman 2013: 17-19). This as it is virtually impossible to know whether a specific someone lives with HIV or not, unless you would ask the person straight out about it. “This illustrates the real issue at hand,” she said. The problem is not how to reach out to those who already know about their diagnosis, and thus already talk about it, but how to reach out to those who do not know about their HIV status. As said, how will they find out, if there is no one but them and other high-risk groups who are (urged) to talk about the situation of HIV and AIDS today? RFSL, with Westerlund in front, claim that this is what the so-called duty to inform does – it removes accountability from public view, giving the wider masses the right to neglect while the already marginalised are left to handle it all by themselves (cf. Christianson et al. 2008).

Those who really are at risk of transmitting the viruses to others are those people who live unaware of their HIV status, and thus neither medicate nor practice safe sex. The focus is misplaced at the wrong groups.

(Interview with Ulrika Westerlund, 2013-02-12)

The act of conferring responsibility to certain (and limited) groups can be traced back to the 1980s in Sweden, and the ambivalent portrayal of PLWH as simultaneously being victims and perpetrators. A statement that comes to mind is one made by the Swedish National Commission on AIDS in 1986, where ‘risk groups’ were directly held responsible for their own infection. They were set apart from those seen as ‘innocently infected,’ that is to say those who contracted the disease through blood products, blood transfusions or from birth (Bredström 2008: 46-47).
There is a reason why HIV infection has spread among certain groups, above all homosexual men and injection drug abusers. It is due to a certain kind of behaviour – multiple partners and, for example, anal sex or drug injection with contaminated needles – that the infection has spread among these groups. And one must of course distinguish between those who have been infected by blood or blood products and those infected by risk behaviour. Although it is behaviour, not group identity in itself, that aggravates the risk of infection, we have elected to speak in terms of groups at risk. This concept has the advantage of leading to a classification of target groups.\footnote{Swedish National Commission on AIDS, 1986: 16, emphasis added}

The link between (male) ‘homosexuality’ and AIDS was strengthened with the development of the first official AIDS policy documents, such as the one quoted above. These ‘risk groups,’ where gay men are included and actually put forward as the main group at risk, were often targeted as scapegoats instead of being treated as a particularly “hard-hit group” (Bredström 2008: 46). Additional ‘risk groups’ at the time were sex workers and People Who Inject Drugs (PWID). Hence, they were not only obliged to bear the shame of their own, but they were also assigned blame for what had happened (or might happen) to everyone else, which illustrates how uneven the situation of social responsibility of HIV and AIDS were at the time. However, my point is that this conferring of responsibility from the past is as current as ever due to the ‘duty to inform,’ and how social responsibility is thus still maintained uneven. As Hesslow wrote:

> When it comes to the discussion of HIV+ people as either victims or perpetrators, it is still as present today [as back then], due to the debates on the [duty to inform] and how [it] obliges HIV+ people to inform their sexual partners of their HIV status. If they would violate this [regulation] they could be put under compulsive isolation; an Act which is unique to Sweden, and cannot be found elsewhere. (2011: 15)

An example of opinion from this debate can be found in Dagens Nyheter (DN) from 2011, where Christer Winbäck, trained nurse and currently a Minister of Parliament for the Swedish Liberal Party, commented on the present-day situation of PLWH in relation to Swedish legislation, duties and responsibilities, as well as potential penalties:

\footnote{English in original.}
Winbäck points to several things with his statement. First of all, he refuses to abolish HIV transmission as a criminal offence, and this with no regard to whether the person in question knows about his or her condition. That is, he thinks of HIV as such a severe predicament that it should be assigned great penalties, if set health regulations are not met or upheld. Also, in how he discarded of a potential introduction of impunity, he seems to believe that PLWH would stop assuming responsibility of their conditions in case it would not be a criminal act of doing so. That Swedish law requires a directive which states that PLWH can be severely punished if they would not take their illness in full earnest. By supporting a ‘duty to inform’ he is not only displacing the institutional responsibility befitting a state, but he also strives to maintain uneven and heteronormative structures which fractionate the aspects of equality when it comes to living with HIV or AIDS. Structures which hold some people liable for the misfortune of the ‘innocently’ ones, while also refusing to acknowledge the same groups as the sufferers they truly are (Christianson et al. 2008).

Debates on whether it is time to re-valuate the Diseases Act, yet again, occur several times a year and especially in adjacent to Stockholm Pride and the World AIDS Day. RFSU, RFSL, and HIV-SWEDEN have for a long time urged Swedish politicians to address the issues of the ‘duty to inform,’ in hopes of breakiing the stigma bound to HIV and thus improve the preventive work (Sydsvenskan 2014-10-25). What they all hope to achieve is a society where more people dare to test themselves for HIV, and thus, take further responsibility in practicing safer sex. Looking to the situation today, those who contract HIV have, in most cases, gotten it from someone who does not know he or she is a carrier. However, as Veronica Palm said,¹¹³ the current legislation risks ending up contra productive, considering how it preserves a

¹¹³ Veronica Palm is a member of Swedish Parliament for the Social Democrats.
stigmatic image of PLWH rather than working on facilitating their position in Swedish society (Sydsvenskan 2014-10-25; see also HIV-SWEDEN in: ETC 2014-11-11). Also, as Case et al. demonstrated (1998), studies show that prosecution of HIV transmission does, in fact, not reduce the spread of HIV, which has also been pointed out by (e.g.) RFSU and HIV-SWEDEN (DN 2010-11-26). It acts as yet another proof of a contra productive legislation, they claim, in how it continues to focus on the wrong masses.

The counter-productivity of the ‘duty to inform’ has also been enlightened by RFSU, in how they said that it risks ‘lulling’ people in a false sense of security.114 That is, if PLWH are obliged by law to tell their sexual partners about their HIV status, how are people supposed to react when their partner(s) does not say anything? They might assume that the person in question is HIV-negative, even though he or she can as easily be unaware of his or her status. I was given further examples of this in my interview with “B.” – a representative of RFSU:

“B.”: With the new state of knowledge regarding infectivity, each individual PLWH may request to get the [duty to inform] removed by their general practitioner. The Diseases Act includes several directions, where this so-called ‘duty’ is just one of them. But, as said, now you can get that one removed, individually, if you are under effective treatment and live with undetectable virus levels. However, we at RFSU have always been critical of this so-called ‘duty to inform,’ as we argue that it risks to ‘lull’ people into a false sense of security. By now we know quite well that it is not the people who are aware of their HIV status that risk spreading it. Rather, it is the people who are still oblivious to it. Thus, when it comes to that, we argue that the so-called ‘duty to inform’ is quite pointless. […] I do think that it would be a good idea [to remove the duty to inform] as a wise person once said, a long time ago: “the responsibility is not 50/50 but 100/100”. […] Thereby, I am not saying that PLWH do not have huge responsibility. I know they do, and I know a lot of PLWH who take it all very seriously. However, I do refuse to believe that a certain direction in the Diseases Act would help to prevent the spread of HIV.

Fredrik: The fact that you actually can get this so-called ‘duty’ removed, that is completely new to me, I must admit.

“B.”: It was implemented very recently.

Fredrik: It was? That is very interesting, I must say. Does that not mean that HIV+ people are pledged not only to HIV– people, but to other positives as well?

“B.”: Yes, absolutely. That is how it is. In fact, people have an obligation of ‘informing’ vis-à-vis whoever they choose to sleep with, and using a condom is one

of these directions that PLWH are obliged to obey. So, yes, definitely, that is how it is. Also, there are several strains of HIV, so having unprotected sex with another HIV+ is not really an option. Obviously we at RSFU know that some people do not inform, and some might inform but do not use a condom, or use a condom but do not inform, and vice versa. Some of these can be found in Swedish criminal cases, sorry to say, and previously some were also forcefully isolated, in accordance with the Diseases Act. Above all, People Who Inject Drugs (PWID). However, that rarely occurs nowadays, but it was quite common back then. This was very unusual, globally that is, to counter the AIDS epidemic in such a harsh way. Sweden never experienced an ‘actual’ AIDS epidemic, but still, to counter it through these measures was very unusual.

(Interview with “B” from RFSU, 2014-11-11)

The ‘actual’ risk of infection…?

With ‘knowledge regarding infectivity,’ “B.” was referring to the knowledge of how HIV can be said to transmit from one person to another and how ‘contagious’ PLWH actually are as individuals. As recent years’ studies have shown, medical science has made immense progress when it comes to preventing HIV from developing into AIDS, turning this deadly disease to a chronic condition (e.g. Deeks et al. 2013; Sothern 2006). Back in 2008, the Swiss National Commission on AIDS caused quite a stir when they published some recent research findings. The results indicated that PLWH who were under effective anti-retroviral treatment (ART) showed less risk of infection, and should by that fact be considered sexually non-infectious (Vernazza et al. 2008). This was later on presented and implemented by the SMI in 2013(b), and the National Board of Health and Welfare was quick to follow in how they announced that PLWH could now get their ‘duty to inform’ removed, if they were under effective treatment and did not live with any other STDs (ETC 2014-11-11; see also: SMI 2013b; FHM 2014a, 2014b).

Studies have shown that the probability of transmitting HIV by vaginal intercourse is 0.05 per cent (five of 10 thousand) for men and 0.1 per cent (10 of 10 thousand) for women. By oral contact performed on a HIV+ man the risk of transmission is estimated at 0.01 per cent (1 of

115 I should also point out that they referred to PLWH who were under effective treatment, while also not living with any other STDs.

116 The Swedish Institute for Infectious Disease Control (Smittskyddsinstitutet), which was merged into the Public Health Agency of Sweden in 2014 (Folkhälsomyndigheten).
10 thousand) while it is immeasurable on a HIV+ woman (cf. SMI 2013b). However, the probability might vary massively, as a person oblivious to his or her HIV status (and thus not under medication) is a lot more contagious than one under effective treatment. As SMI confirmed in their investigation, the risk of transmission is minimal if the person in question is under effective ART. This estimation concerns anal, oral, as vaginal intercourse, and it applies regardless of gender, sexual identity, or type of sexual contact (ibid.: 2013b: 13-14).

If ART is to be considered effective and stabilized, it has to follow certain criteria. First of all, the virus level inside the blood plasma has to continuously be lower than 50 copies per ml, which has to have been verified at two consecutive occasions within a three to six months interval (SMI 2013b: 12). Also, the patient in question has to be deemed to have a continuously high treatment-compliance; that is to say, he or she has to show a clear tendency of following the provision of his or her treatment by pursuing to take his or her medication (ibid.). By seeking to understand these procedures, I refer to what Nguyen wrote on confessions and AIDS testimonials (2010: 14 ff.) and to what Biehl wrote on patient-citizenship in Brazil (2007: 283 ff.). Nguyen (2010: 8) sought to further explore the attempts to stimulate the production of HIV testimonials and the practice of “HIV disclosure” through the use of what Hunt (1997) termed “confessional technologies”. He argued that these technologies did much more than just training people to produce narratives of illness, but also to equip individuals with means to talk about themselves while also urging others to talk about themselves (2010: 8-9). Biehl’s argumentation is related to the title of his book – the Will to Live. That is to say, people had to show willingness to ‘live’ and to make efforts in changing their lives, if they wanted to access the Brazilian AIDS treatment policies (2007). In order to do this, they had to testify on their status of being HIV+ and to admit to their roles of being patients, which far from everyone did (Biehl 2007: 196).

With this in mind, I argue that the ‘duty to inform’ can be understood as a confessional technology. This in how it forces PLWH to constantly ‘confess’ and reaffirm their statuses as HIV+ while simultaneously showing a willingness to change in order to ‘survive’ by medicating regularly. In a way, they are being trained in how to testify – to their physicians,

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117 The virus level is considered immeasurable if it is under 50 copies.

118 Which is also relatable to what Petryna called “biological citizenship” (2003) and to what Nguyen called “therapeutic citizenship” (2005).
but also to potential sex partners, as they are law-bounded to do in the Diseases Act. Hence, if they display readiness to change and to develop as ‘law-abiding’ (patient) citizens, by medicating, they might be ‘rewarded’ by getting the ‘duty to inform’ (a duty of testifying) removed. However, this only applies to potential partners and other public masses, as they always have to ‘testify’ to their assigned physicians and other medical staff, in how their status (as non-infectious) has to be confirmed on a regular basis.
Chapter 5: Blood Safety

Gay men and blood donation: a genealogy

In her article *The making of a risk object*, Berner (2011) discussed the negotiations that took place between the National Board of Health and Welfare and the RFSL, the Swedish Federation of Gay, Lesbian, Bisexual, Transgender, and Queer Rights, in the beginning of the 1980s in Sweden around the time AIDS arose as a societal issue. She wanted to contribute to the research on how potential risks to public health are handled in situations of uncertainty, “when there are different and even conflicting agendas and knowledge claims among experts and between lay people and medical authorities” (Berner 2011: 384). Her article focused on one crucial episode in the traumatic chain of events, in several nations across the world, which led to the contamination of the blood supply with HIV and AIDS. More specifically, “what has been claimed to be a successful handling of the threat” (ibid.: 384-385) in a case that concerned the issue of the exclusion of gay men from blood donation, which put definitions of citizenship, risk, and the gift of blood at stake. Berner’s foremost argument surrounded that different constituencies acted in accordance with what they saw “as different risk objects,” all depending on their “different situated rationalities, forms of knowledge and political concerns” (2011: 385).

From a global perspective, it was quite a unique situation for the RFSL to urge gay and bisexual men not to donate blood. Sweden seemed to be the only place where such a scenario took place. As Berner wrote, the gay federations in the rest of Europe immediately rejected such ideas, as they saw it as nothing but yet another act of discrimination where biological phenomena were used for moralizing purposes (2011; also in Lacour 2008; Steffen 1999). The Swedish National Board of Health and Welfare hesitated for a long time before they decided on how to act, as they deemed that they lacked the necessary knowledge needed to make such a call. According to Berner (2011), RFSL and their likes had already been briefed by their offshore colleagues, and thus, saw the whole situation in another light. In fact, the

119 URL: http://www.rfsl.se/ (accessed on 2015-08-04)
National Board did not publish their first set of directives\(^\text{120}\) on how to handle all blood-related issues until autumn of 1984, and they made no direct reference to neither gay nor bisexual men, or sexual activities between men at all, for that matter (Hesslow 2011: 13). Rather, they emphasized “certain high-risk groups”:

> People belonging to certain high-risk groups […] will not be accepted as blood donors. (SOSFS 1984:27)

These ‘groups’ were not defined any further. However, Berner (2011) wrote that a certain sheet containing more specific instructions on which groups to approach had been passed around most of the Swedish blood centres the year before. This said sheet explicitly defined “sexually active gay men with multiple partners” and “sexual partners, male or female, of people from the other groups” as the main groups at risk.\(^\text{121}\) Hesslow claimed that these were the first set of directives to regulate gay men’s possibility of donating blood, explicitly targeting the sexually active men with multiple partners (2011: 15). Nevertheless, just a few months later in March 1985, the National Board wrote an exposition regarding the topic of blood donation and AIDS. The new directives had now been altered quite immensely in comparison to the previous ones. Groups-at-risk now included all gay and bisexual men who had engaged in sexual activities after the first documented case of AIDS in 1979, and not just the sexually active ones with multiple partners:

> Blood and plasma intended for transfusion […] shall not be taken from people belonging to these groups:
> - homosexual and bisexual men, who have had sexual intercourse with other men after 1979. (SOSFS 1985:4)

Hesslow set out to outline the Swedish authorities’ reception of AIDS, and concluded that they could be said to have unfolded in three dispersed steps (2011: 13-14). At first, the National Board was afraid of turning blood donors away, and thus acted rather passively and chose not to define any particular groups being at risk. The next step involved the said culling of previous ‘high-risk groups,’ stating that they were no longer welcome as blood donors. However, as Hesslow argued, this did not refer to gay and bisexual men explicitly but rather

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\(^\text{120}\) SOSFS, that is. They are legally binding.

\(^\text{121}\) These ‘other groups’ referred to: People Who Inject Drugs, Haitians and Africans (Berner 2001: 2, 15).
sexual behaviours with multiple sexual partners, which were a relatively small amount of people (2011: 13). The last step involved directives formulated as to restrict even further, with the definition of risk now including all gay and bisexual men who have had sex after 1979.

The situation did not change in the following years. It was during this time that the so-called sauna clubs had started to receive unwanted attention by people such as journalist Peter Bratt, which I covered in the previous chapter. However, this civic moral outrage was not reflected in the new set of directives that the National Board implemented just before the end of the decade. Although, they did initiate what Hesslow called a “discourse of displacement,” where the depiction of gay men as either victims or perpetrators were put at stake. They also reformed the public view on sexual identity vis-à-vis sexual acts (2011: 14). Furthermore, this is also when the explicit category of ‘MSM’ (Men who have Sex with Men) first was established and employed in a Swedish context:

The risk of transmitting the HIV virus exists above all among these categories:
[...]
- Men who have Sex with other Men
[...]
Those who sign up as blood donors shall be provided with this information and be urged to avoid from donating blood, if they believe they might have been exposed to infection. (SOSFS 1989:38)

Hesslow put certain emphasize on some of these changes (2011: 14). He argued that authorities now had started to, so to speak, problematize their own definitions and regulations, apparent in how they had gone from declaring some groups as “not accepted” to “might have been exposed to infection”. As stated, this could be interpreted as how authorities (i.e. the National Board) had taken notice to how previous statements had tended to produce gay men as vastly irresponsible people, and thus, to be blamed for their own disease (ibid.: 14). This scenario is further exemplified by the statement made by the Swedish National Commission on AIDS in 1986, which I quoted in the previous chapter:

And one must of course distinguish between those who have been infected by blood or blood products and those infected by risk behaviour. (1986: 16)
Back then, one issued a clear and significant distinction between those who had been given AIDS from ‘bad blood,’ and those who had contracted it as a result of their own ‘unfit behaviour’. Hence, the two scenarios could be said to have been judged as different infection routes. However, as Hesslow said, such a formulation was not to be found in SOSFS 1989:38. Thus, it would seem as the concept of ‘risk group’ (or ‘groups at risk’) had gone through a ‘discursive displacement,’ where “people in risk of infecting other” now read “people who are at greater risk of being infected” (2011: 14). That is to say, those previously seen a perpetrators were now seen as victims.

With the end of the 1980s and the start of a new decade, blood donation began to change as an instance in Sweden. The National Board experienced some internal disputes, all regarding the topic of a potential removal of the permanent ban of gay men (‘MSM’) as blood donors. The first response to this demand was published in 1994, where the new directive now read:

Individuals who previously belonged to [MSM, PWID, sex workers, or sexual partners of these] are no longer considered being part of these groups, and should thus be accepted as organ donors, if it with great certainty can be assessed that one year has passed between the last sexual rendezvous or exchange of needles, and that all other requirements are met. (SOSFS 1994:4; see also Hesslow 2011: 16)

However, as Hesslow pointed out, this is rather a step in the opposite direction. The reader is fooled to believe that MSM will be accepted as blood donors, when in fact, they will not (Hesslow 2011: 16). In then end, it turned out that the above-mentioned directive only applied to “organs and other biological matter, apart from blood and plasma” (SOSFS 1994:4). The National Board had decided to not include the definition of blood, which remained to be regulated by the previously mentioned SOSFS 1989:38 (Hesslow 2011: 16).

The permanent ban of gay men as blood donors were not lifted until year 2010 (ibid.: 19-20); however, this did not come without certain restrictions. That is to say, ‘MSM’ now had to wait twelve months after every ‘risk opportunity’ before they could be accepted as blood donors – which in the case of gay men, meant every time they had had sex. However, the directives did not (and still do not) distinguish between ‘safe’ and ‘unsafe’ sexual practices when it comes to homoex, which means that (general) sex between men is still perceived as a severe high-risk behaviour. Hence, as Hesslow argued (2011: 31-32), the legislation can be
said to remain unchanged – as gay men are only allowed to donate blood if they abstain from having sex (with men).

**Risk ‘grouping’ and the consequences of categorization**

By the mid-1980s, the menace of AIDS had made indiscriminate sexual behaviour a serious risk to health. Under certain conditions sexual behaviour can threaten health and psychosocial well-being. Unwanted pregnancies and sexually transmitted diseases (STDs) such as gonorrhoea and syphilis have long been potential negative consequences of sexual contact. Yet today HIV infection receives most attention.

J. Bengel (2001: 14012)

Schiller et al. argued that in the construction of AIDS risk groups, “*culture* has been used as a distinguishing criterion” in defining membership in ‘high-risk groups’ and as an “explanation of why members of these groups continue to practice *risky behaviour*” (1994: 1337). The identification of ‘risk groups’ is said to possess distinctive cultural traits, portraying AIDS as a disease residing in distant and separate populations. Yet, as Foucault said, being labelled as ‘at risk’ is a sign of weakness, as those in charge never have to defend or explain themselves (1978).

Berner used a constructionist perspective to approach the definition of risk. That is to say: “what is identified as a danger or a hazard in a specific situation may differ between actors in specific sociocultural contexts who bring competing forms of logic to bear upon risk” (2011: 386; see also Lupton 1999). By a risk object she referred to a “thing, activity or situation to which harmful consequences are conceptually ascribed”. In order to be defined as such an object it must first be constructed as *an object*, and then as risky; i.e. “identified as the cause of some identifiable harm or danger” (ibid.). Kendra (2007) argued that the definitions of risk objects are manifestations of power, used not only to...

...denote people or things that are perceived to be dangerous, but also to indicate that they are perceived...[as] that which is to be blamed if disaster occurs, the latent proximate causes of disaster...and...therefore the elements of a system that should be targeted for remedial action (Kendra 2007: 30–31; quoted in Berner 2011: 386).

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122 See also Becker (1963) for his similar “labelling theory”.

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That is to say, to be defined as a risk object potentially means to “lose power over one’s circumstances, and to face censure, regulatory constraint, official supervision, and other mechanisms of control” (Kendra 2007: 31; quoted in Berner 2011: 387). Berner acknowledged the efforts made by the Swedish gay community to put forward its own definition of a potential and relevant risk object, “as a form of rear-guard action to avoid the dangers of being singled out as a risk object by society” (ibid.). She also treated the initial reluctance of the medical authorities to define blood from gay men as a risk object “as recognition of the dangers involved in their power to publicly define someone or something as risky”. To put it in words by Kendra: “a power to objectify, to diminish, and to demote” (2007: 31; cf. Berner 2011). The exclusion of gay men from blood donation was not just simply a matter of the “technical governance of a risk,” but something that also “involved vast emotional issues of belongingness and citizenship” (Berner 2011). Albaek noted that “the symbolic meaning historically given to blood in a country may have a decisive impact on who is included and who cannot be excluded from the donor pool” (2001: 467). When addressing this symbolic meaning in the context of Sweden, Berner (2011) referred to an institutional approach made by Healy (2000). He argued that internationally different ways of organising blood donation provide donors with different kinds of “incentives and possibilities”; what he called a “collection regime” attracted not only more or fewer blood donors, but it shaped the “very act of blood donation” itself (Healy 2000; quoted in Berner 2011).

Although anthropologists have long recognized “risk” as a social construct (e.g. Douglas & Wildavsky 1982), the label “at risk” has also turned into a social resource. When it was applied on others, “it reinforced moral social orders that excluded groups deemed to be deviant,” but it could also be used as a self-label, as a means of procuring different health resources (Owczarzak 2009). These definitions of who ‘is at risk’ raised questions, then, of how different interpretations of risk could be “mobilized and incorporated into public health programs”. ‘Risk’ is not something static, but rather, something immensely complex dependent on several facets. Looking back over the years, the processes of dividing the diverse assessed risk objects into either ‘groups at risk’ or ‘risky behaviours’ have both introduced their own share of issues. In her article, Owczarzak approached the ‘question of HIV risk and the concept of risk’ more generally from the perspective of who is determined to be “at risk” for HIV in an era “when there are no risk groups, only risky behaviours” (2009: ~85~
418). As she argued, understanding HIV risk is a central concern in developing effective prevention strategies. ‘Who is and is not seen to be at risk’ has implications for what types of prevention messages are offered and to whom they are targeted (ibid.). In order to determine the direction of epidemics and allocate the resources for vulnerable populations, public health institutions labelled groups as being “at risk”. However, as Owczarzak argued, this way of defining risk only separated people on further levels:

…Prevention and surveillance based on “risk groups” reify boundaries between populations and reinforce the idea that those positioned outside these risk groups are not vulnerable to infection…In addition to becoming a recipient of public health resources, being labelled “at risk” for HIV, particularly by others, also invites accusations of blame and threat to the well-being of others, as well as stigmatization…“Risk groups” exclude the general public from HIV risk, and the stigma attached to the label “at risk” can be deployed for political or moral purposes… (2009: 419)

This certain model of determining HIV risk, which according to Owczarzak came to dominate the HIV preventive and educational efforts throughout the first decade of the epidemic, “utilized ‘AIDS-blame’ in exclusionary and moralizing rhetoric” (ibid.; see also Brown 2000: 1280). The focus on universal risk and objective risk calculation reflected “a shift away” from AIDS blame, “to a model of risk reduction based on behaviour, personal responsibility, and individual risk management” (ibid.). As Owczarzak wrote:

Together, the label “at risk” and focus on individual decision-making lend themselves to a narrow, biomedical interpretation of what creates risk. (2009: 419)

She argued that when risk is constructed as being eliminated or reduced through individual risk-management, “prevention programs often turn to focus on behaviour change and knowledge procurement, to the exclusion of addressing structural factors that shape risk” (2009: 419-420).

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“MSM”: THE MEN WHO HAVE SEX WITH OTHER MEN

The concept (and social category) of Men who have Sex with Men has been in use in HIV-related literature since at least the end of the 1980s, and the beginning of the 1990s, while the acronym of ‘MSM’ was coined and implemented around 1994 (Young & Meyer 2005; see also Dowsett 1980). Since then, MSM (and WSW123) have started to move beyond the HIV literature to establish itself in both research and health programming for sexual-minority people. As said, the terms “held the promise of reducing AIDS stigma,” which over the years have become increasingly attached to mostly gay men, but also to lesbian women, and users of the terms “helped to promulgate these now-familiar acronyms” (2005: 1144). Yet, scholars are troubled by how the acronyms are applied, since it seems they have come to “displace rather than coincide” with information about sexual identity. Young and Meyer wrote that the use of MSM/WSW seemed to be driven by the convergence of two perspectives. The first one was an epidemiological perspective; that is, “by using identity-free terms,” epidemiologists sought to “avoid complex social and cultural connotations that… have little to do with epidemiological investigation of diseases” (ibid.). ‘MSM’ was introduced as to reflect the idea that behaviours, rather than identities, placed individuals at risk for HIV infection. This was an important distinction, given how gay identity had initially been identified as a risk for HIV and AIDS. This resulted in gay, lesbian, and bisexual populations being stigmatized, and “confounded efforts to prevent HIV infection” (Young & Meyer 2005: 1144).

The second perspective that drove the adoption of MSM/WSW was the one of social construction, which suggested that sexualities (like other social categories) are products of social processes (ibid.: 1144; see also Foucault 1978; Butler 1990, 2004). Social constructionists challenged the idea of sexualities as categorical long before the implementation of MSM/WSW, and thus, rejected the use of sexual identity terms “across different cultural and historical contexts”. These perspectives seek more “textured understandings” of sexuality that do not assume alignments “among identity, behaviour, and desire” (ibid.). Young and Meyer argued that the labels have accomplished few if any of the aims that prompted them; either because the previous mentioned perspectives conflicted with one another or because labels, once unleashed, tend to develop a dynamic of their own. It is

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123 Women who have Sex with Women.
ironical how MSM/WSW have succeeded in forcing a “conceptual shift in public health from identity-based to behaviourally based notions of sexuality,” but have failed to generate more complex approaches to sexuality (2005: 1144). Although the “behavioural focus” is quite useful in some specific contexts, Young and Meyer argued that the “indiscriminative labelling of MSM and WSW” is problematic on theoretical, political, ethical, and epidemiological grounds (ibid.).

In place of a search for terminological perfection and historical closure, Boellstorff used a genealogical approach to track three unforeseen transformations in ‘MSM’ (2011: 288). That is to say, how it has gone from being a category “primarily excluding other notions of sexuality and gender to a category primarily including them”; “from a category primarily referencing behaviour to a category primarily referencing identity”; and “from a U.S.-based category to a category transnational in scope” (ibid.). Boellstorff argued that these transformations have ‘cultural consequences,’ from new possibilities for community and selfhood to new forms of transnational organizations, which in turn shape the scope and referents of ‘MSM’. Most authors that have made use of ‘MSM’ noted that the concept is problematic. As Boellstorff pointed out, it has been questioned from the outset (ibid.; see also King 1994; Scott 1993; Watney 2000) in addition to increasingly being put under sustained critique (e.g. Khan & Khan 2006; Muñoz-Laboy 2004; Patton 2002; Reddy 2005; Young & Meyer 2005). Boellstorff wanted to add to this body of research, by theorizing the “consequences of fundamental shifts in ‘MSM’ for the category as well as for what [he called] the anthropology of historicity” (ibid.: 289).

As stated, Boellstorff found his inspiration for this analysis in the realization that the most documents which employed ‘MSM’ included a footnote “bemoaning its awkwardness while [also] affirming [that] no better alternative exists” (2011: 290). There has been a sense, he argued, that “we already know ‘MSM’ will not work [as a concept]”. The term anticipates its own failure, “yet consensus and even unexpected confirmation emerge” (ibid.). From available documentation, Boellstorff stated that it seems clear that the category of ‘MSM,’ like the ‘homosexual’ (Foucault 1978), did not originate from any household or bar, park or disco (et cetera), but instead through scientific and bureaucratic coinage (2011: 291). It was created to signify behaviour without identity, such as in the phrase: “Men who have Sex with Men but do not identify as gay”. The category did not emerge out of pride marches or mass
media, but rather, in response to a need to analytically describe “for purposes of HIV/AIDS surveillance and behaviour change” men who engaged in intercourse with other men, but who did not identify as gay (ibid.). According to Boellstorff, ‘MSM’ was meant to invoke behaviour in complete distinction from identity, as in an epidemiological imaginary, behaviour could stand alone. That is to say, a gay-identified man who lives in celibate is not at risk for sexual transmission of HIV, while a straight-identified man who has had sex with other men is at risk. He is offered no protection from infection whatsoever by the mere fact of his self-identification; “it is not who you are, it is what you do” that matters (2011: 291). HIV obviously cannot determine the identity of those it infects, which is why ‘MSM’ came to hold the “promise of sidestepping identify” and lead to a more scientific understanding of the virus and its transmission. Thus, ‘MSM’ originated as a kind of “bureaucratized reverse discourse” opposed to a more everyday category (e.g. ‘gay’) in the context of HIV prevention. In the end, Boellstorff concluded that had the HIV and AIDS pandemic never arisen, the ‘MSM’ category “would never have taken form at the time or in the manner that it did” (2011: 293).

Statistics “goes without saying”: ethnographic statements

“OBJECTIVITY” arouses the passions as few other words can. Its presence is evidently required for basic justice, honest government, and true knowledge. But an excess of it crushes individual subjects, demeans minority cultures, devalues artistic creativity, and discredits genuine democratic political participation. Notwithstanding such criticism, its resonance is overwhelmingly positive. Attacks are rarely directed at true objectivity, but rather at pretenders who use it to mask their own dishonesty, or perhaps the falseness and injustice of a whole culture. Most often it is not closely defined, but simply invoked to praise or blame. In the United States, scientists, engineers, and judges are generally presumed to be objective. Politicians, lawyers, and salesmen are not.

Theodore M. Porter (1995: 3)

Throughout the text I have been dealing with different processes of claiming and stating knowledge. However, as Waldby (1996) said, some knowledge has come to be valued higher, and even succeeds in manifesting itself as the (objective) ‘real’. Thus, certain knowledge on
risk and its assessment becomes undisputable, and even authoritative. In the end, what does this mean? Who does it affect and in what ways? In the following sections I aim to put these notions to the test while also contesting the actual appliance of them, by analysing some clear (contradictive) statements made by my informants that I found extraordinary compelling.

Statement (1): the National Board of Health and Welfare

[I asked a question on risk assessment. Later on, we came into the subject of scientific eligibility and moral judgements.]

“H.”: That is not what our regulations are supposed to be based on. It is not morals, but scientific measures and reasons, and if there is a documented risk. And that has nothing to do with morality, as a rule. It could, of course, but in the end it does not.

“M.”: Our blood-safety regulations do not exclude certain groups, but they exclude risk behaviours.

“H.”: It is the risk behaviour that is the cause of exclusion, not the actual group.

“M.”: It is not the sexual identity, or the like, but rather have you had a risky behaviour, then you will be excluded.

Fredrik: But at the same time you said that some groups… [interrupted]

“M.”: Yes, but that is not an assessment from our side. Again, that is pure fact. The prevalence looks like this among some groups, and some of them have a higher frequency than others.

“H.”: It is all about having to classify if it results in a higher risk of contamination, and thus, the risk is higher and more prominent, and then we have to take a stand to that. But it is not about the actual group, as we are referring to the presence of high risk.

(Interview with “M.” and “H.” from the National Board, 2012-12-19)

All in all, the conversation above revolved around risk assessment, and how some groups are directly as indirectly suspended from donating blood. The first thing that caught my attention was the use of “fact”. That is, how it is considered fact that some groups have risker sexual behaviour than others. By referring to it as fact, they advocate on a certain kind of knowledge, thereby also making the statement objective and incontestable in itself. In this case, “facts” become like logic and thus unattached from subjective values and judgements. It cannot be questioned because it is not meant to be questioned; it becomes self-evident, undisputed and a
naturalization of its own arbitrariness’ (Bourdieu 1977). They also point to scientific authority (Clifford 1983, 1986) in how they state that the regulations are based on “scientific measures and reasons” – and not valued opinions – denoting some sort of automatic and self-evident objectivity that ‘comes with all science’. That is, they are allocating their regulations self-assigned (and indisputable) objectivity, in how they are based on science rather than opinions. However, the scientific methods they are referring to as objective science are nothing but statistics and epidemiological overviews, and thus, reduce risk assessment to mere numbers and enumerative practices of categorization (Bowker & Star 1999; Porter 1995).

When it comes to statistics, Asad said that:

…the statistical universe, as well as the categories of which that universe is made up, are the products not of experience but of enumerative practices…[and] can be expanded or contracted, segmented or merged, depending entirely on pragmatic rather than veridical considerations. (1994: 55-56)

Statistics, from a social constructivist perspective, are misleading and do not necessarily say anything on how ‘reality’ actually is manifested. Rather, they might produce a static image based on these ‘pragmatic considerations,’ and thus ignore social diversity. They ‘create,’ categorize or even ‘make up’ the masses they are supposed to enumerate, rather than to reflect the actual social constellation (Hacking 2002 [1986]). By referring to their assessment as scientific and its results as facts, the National Board are not only assigning themselves the plausibility and eligibility needed to maintain the doxa of their own practices (Bourdieu 1977), but they also ignore the consequences that are the result of these said practices. As Hesslow said, by not paying regard to safe and unsafe sexual practices when assessing ‘risky behaviour,’ it does not matter whether the regulations define a said groups as “MSM” or “gay men”; the same individuals are always targeted and suspended (2011: 32). The practice of sex between men is always defined as a severe high-risk behaviour, whether it takes place in a monogamous or polygamous relationship. Hence, gay (and bisexual) men will always be excluded as blood donors, unless they refrain from having sex (with another man).
Statement (2): the National Board of Health and Welfare

Fredrik: What view does the National Board have on the “high-risk groups” that are mentioned in the official HIV and AIDS strategy,\(^{124}\) and that are also advocated by the Public Health Agency?

“A.”: The Public Health Agency bases their decisions on prevalence. That is, the number of cases within a certain group that lives with HIV and ‘MSM’ is one of those groups. It is about the internal prevalence in Sweden, and it is higher among them in comparison to the rest of the population. However, what we agree on is that the most important – the most important – is the aspect of risk behaviour. Not about the actual group. Sure, that is an indication that you should pay more attention to potential risks. But it is the risk behaviour that determines, which means that a MSM-person with very organized and proper sexual relationships should not be considered risky. You should not be marked just because of that fact. It is the risk behaviour that will determine. That means when it comes to donating blood, we really urge the staff to focus and pay attention to a person’s risk behaviour. Not if you belong to the group of MSM or not, as being MSM is nothing per se, but the important thing is what people do.

(Interview with “A.” from the National Board, 2014-11-13)

Considering that this statement also comes from the authority of the National Board of Health and Welfare, it is of no surprise that a lot of the argumentation is the same. That is to say, epidemiology, prevalence, and enumerative knowledge are yet again established as the ‘regime of truth’ – the authoritative knowledge (Jordan 1993 [1978], 1997), which is stated as fact rather than opinion or as an alternative perspective. However, what became apparent through this conversation was the dynamics of risk behaviour contra risk ‘grouping’ and its relation to risk assessment and actual legislation. In this statement, ‘MSM’ as a category is laid forwards as a “[sexual] behaviour without identity” (Boellstorff 2011: 291, 297) – a behaviour separated from physical bodies. The statement is also highly contradictive and does

\(^{124}\) (Prop. 2005/06:60). This is a collective strategy concerning the societal inputs on preventing the proliferation and consequences of HIV infection, and other sexually transmitted diseases and blood-borne diseases. It was implemented in 2005 as a result of a certain session on HIV and AIDS that took place in the United Nations General Assembly in 2001. The document lists which groups are in need of extraordinary attention and support when it comes to HIV, and Men who have Sex with Men are listed here.
not follow what the actual legislation (i.e. directives) says. “A.” states that it is not about the actual group, but about the behaviour – it is what people do that matters (cf. Boellstorff 291). Nonetheless, as Hesslow argued:

As we can see in this transition, regarding MSM […] it is not explicitly the sexuality that makes these men illegible as blood donors, but the risk behaviour – that is to say, the fact that they have sex with other men. However, as all sex between men is seen as risky [taking no consideration to whether it is ‘safe’ or ‘unsafe’ sex] there is no difference to be found from previous legislation. (2001: 32)

With the current legislation, a monogamous gay man is seen and defined as in higher risk of contracting HIV than a ‘straight’ man with multiple sexual partners. Even though this gay man is HIV-negative (HIV-) and in a relationship with another HIV- negative man, both of them would be considered risky as gay men are so vastly overrepresented when it comes to HIV. Also, homosex is not distinguished from another but always classified as ‘unsafe’; that is to say, with the current legislation, there is nothing called ‘safe homosex’ (cf. SOSFS 2009:28; SOSFS 2009:29). This reasoning is further legitimized in how the National Board has stated that:

…you are only allowed to vouch for your own sexual behaviour, and never your partners, even though you have promised each other to live in a monogamous relationship” (Socialstyrelsen.se, 2010-09-30)125

However, this only applies to gay men and not to ‘heterosexuals,’ and thus portrays gay men as more likely to commit adultery than heteronormative men (see also: Hesslow 2011: 27-28). Hence, the category of ‘MSM’ is only helpful to heterosexual men, as they are not having sex with other men on a regular basis, and can thus be approved as blood donors. “A.” omits this by saying that MSMs should not be considered risky if they have ‘proper’ sexual relationships, and that being MSM is ‘nothing per se’. However, in the end, it is (as stated by law). I argue that the above statement, all in all, is a clear sign of what Boellstorff (2011) said about the ‘MSM’ concept. That is, it displaces terms like ‘homosexual’ and gay without establishing something new, while it also “anticipates its own failure” as it obviously cannot be applied the way (Swedish) bureaucrats want it to be (Boellstorff 2011: 290).

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125 This specific page is at the time of writing offline, but a copy is in the author’s possession.
Statement (3): RFSU, the Swedish Association for Sexuality Education

Fredrik: What view does RFSU have on the “high-risk groups” that are mentioned in the official HIV and AIDS strategy, and that are also advocated by the Public Health Agency and the National Board?

“B.”: Let me put it this way. One issue with categorizing people is the risk of some groups falling outside of the scope… Yet, at the same with, we have to look at the epidemiological pattern, both nationally and internationally. By doing that we can observe that… [sighs] “some groups” – personally, I hate to lump people all together like that – but still it is very clear that Men who have Sex with Men (MSM) and People Who Inject Drugs (PWID) are two of the main groups, together with people who have migrated to Sweden from non-European countries. That is how it is. Statistics… Damned lies and statistics, but they do speak very clearly for themselves. That is how it is. It is not the, if I may say so, ‘middle-aged white [heterosexual] man’ who is the main person at risk, or the one who has the highest prevalence of HIV.

(Interview with “B.” from RFSU, 2014-11-11)

I would like to start by pointing out that the statement above comes from a non-governmental organization (NGO), rather than a state agency. An NGO follows their own agenda, unlike state agencies that are bound by governmental commissions, which illuminates another significant social sphere, I argue. However, still, the foremost argument above turns yet again to how (self)evident and undisputable epidemiological and enumerative patterns are. That is, they are not questioned because they ‘cannot’ be questioned. Nonetheless, what discerns “B.” from the previous mentioned statements is how “B.” approaches these (knowledge) regimes critically. There are obvious tensions between “B:s” personal standpoint, professional ethics, and the authoritative knowledge that decides what is to be accepted as true and rejected as false. “B.” does not want to talk about certain groups as evidently riskier than others – yet, at the same time, this cannot be done, as “B.” has to relate and adjust to the prevailing (and authoritative) knowledge regimes (cf. Foucault 1993) that still persist in this field.

126 Prop. 2005/06:60.

127 This expression comes from Mark Twain (2006 [1906]).
Concluding thoughts

In the end, what all of these statements can be said to share is how HIV prevalence and epidemiological overview are seen as undisputable facts. They are produced as these scientific (and thus) objective reflections of how ‘social reality’ is supposed to be manifested. It is a clear example of Waldby’s account of how biomedical practices (and paradigms) have come to reflect and represent the ‘real’ of disease, thus becoming an undisputable social authority (1996: 5-6). Epstein argued that scientific fact-making is a collective process amenable to scholarly investigation (1996: 14). As stated, no scientific claim shines with its own light or carries its credibility with it. Credibility is the stake in an agnostic struggle (Epstein 1996: 14). Science is, as Epstein argued, “politics by other means,” and thus, the credibility of a knowledge claim depends on “the play of power”. Here, the scientist who can “appear to make nature ‘behave’ in the laboratory, whose rhetoric is more persuasive, [and] who is able to summon up the more compelling citations” becomes the most recognised (1996: 14-15).

Hence, biomedicine has, in a way, become the current regime of truth (Foucault 1993: 24-25) and thus is able to state what is to be accepted as true or rejected as false. It also relates to Bourdieu’s concept of “doxa” (1977); that is, the combination of orthodox and heterodox norms and beliefs. The unstated, taken-for-granted assumptions or ‘common sense’ behind the distinctions we make, and come to hold as ‘true’. It becomes evident because it is taken, seen, and treated as (self)evident (Bourdieu 1977).

However, I wonder, are these individuals (‘the groups’) really as self-evident as the (epidemiological) numbers claim them to be? I refer to Hacking, in how he wrote about the processes of, what he called, “making up people”. As he said:

We think of many kinds of people as objects of scientific inquiry. Sometimes to control them, as [sex workers], sometimes to help them, as potential suicides. Sometimes to organise and help, but at the same time keep ourselves safe, as the poor or the homeless. Sometimes to change them for their own good and the good of the public, as the obese. Sometimes just to admire, to understand, to encourage and perhaps even to emulate, as (sometimes) geniuses. We think of these kinds of people as definite classes defined by definite properties. As we get to know more about these properties, we will be able to control, help, change, or emulate them better. But it’s not quite like that. They are moving targets because our investigations
interact with them, and change them. And since they are changed, they are not quite the same kind of people as before. The target has moved. I call this the ‘looping effect’. Sometimes, our sciences create kinds of people that in a certain sense did not exist before. I call this ‘making up people’. (Hacking 2006)

He sought a better understanding of how this idea of ‘making up’ affected our very idea of what it is to be an individual, in looking at what people might be other than at what ‘we are’ (2002 [1986]: 99-100). In the end, he disclosed how “[n]ew slots were created in which to fit and enumerate people,” and argued that social change creates new categories of people, “but the counting is no mere report of developments”. It elaborately, often philanthropically, created new ways for people to be (ibid.: 100). He looked at the official statistics of the nineteenth century, and especially those obsessed with ‘analyse morale’. That is, ‘the statistics of deviance,’ the numerical analyses of suicide, commercial sex, drunkenness, vagrancy, madness, crime, et cetera. He concluded that the process of counting generated its own “subdivisions and rearrangements,” where classifications of over 4,000 different “crisscrossing for murder” were found, together with requests that the police classify each individual suicide in twenty-one different ways (ibid.: 100). His foremost argument was, which is also what I want to emphasize here, that he did not believe that these ‘motives’ existed until the practice of counting them came into being.

Hence, I argue it is possible to look at the ‘groups at risk of HIV’ as actual social consequences of enumerative practices, such as epidemiological overviews of prevalence. The social ‘groupings’ themselves might have existed prior to the AIDS epidemic – however, they were not in ‘greater risk’ until they were portrayed (and measured) as such. Thus, they are not risky in themselves, but only due to new sets of knowledge claims (cf. Epstein 1996). Nonetheless, I have not made it an aim of mine to contest this so-called ‘self-evident’ overrepresentation, even though it turned out very interesting. Rather, I wanted to emphasize on the rhetoric that manifests a certain overrepresentation, which the statements above partake in. Essentially, if these ‘self-evident’ numbers are as true as some claim them to be, they are all part of a dynamic contradiction, as the Swedish authorities have not followed them in their own directives when dividing state funds for HIV preventive inputs (see: RFSL 2011).
Chapter 6: Conclusions without Closure

The HIV-preventive prioritizations have previously always been clearly stated. It has been established in the National Strategy on HIV Prevention, adopted by the Swedish Parliament in 2005, that the Men who have Sex with Men constitutes a prioritized group. However, during the last two years something has happened when it comes to HIV-preventive priorities from the Government’s side, as well as the Counties and the Municipalities. Even if Men who have Sex with Men still are frequently presented as a prioritized group, the state grants for their internal inputs have been reduced. This cannot be interpreted as anything but a de-prioritization.

(RFSI 2011: 3, emphasis added)

Throughout the text I have been trying to find an answer to the social contradiction (or even ‘paradox’) which concerns the fact that gay men, a group characterised by high HIV prevalence, have not been one of the most prioritized ones when it comes to HIV-preventive inputs. Even though central agreements and regulations have been put forward as to make that a reality, in the end, as the quote above suggests, the amount of state funds allocated to HIV prevention with gay men as specific targets, has only been reduced over the years. As stated on several occasions, statistics and enumerative knowledge do speak very clearly for themselves – whether we see them as social constructs or not. How are we as anthropologists supposed to approach this? How can we talk about ‘certain victims’ of HIV, without actually stigmatizing and further marginalize those already marginalized? As I stated earlier in this work, my aim has not been to criticize the fact that gay men seem to ‘possess’ a higher prevalence of HIV. Rather, I have set out to put this rhetoric in a wider context, and in relation to different knowledge claims that have been made throughout history.

I have been looking at the historical process of three specific sections in Swedish public health legislation. These sections have all been related to the procedures of preventing HIV

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128 I am borrowing Setel’s formulation (1999: 236) as I want to illustrate how a conclusion is never concluding in that sense. Putting “conclusion” as a title might give the impression of this thesis trying to be a holistic entity of some sort – which is not something I have been trying to accomplish. Merely, I wanted to illustrate and relate some aspects of the wide notion of AIDS discourse, and how it has been shaped and re-shaped throughout Swedish history. A lot of things have been left out and will remain unsaid – but this does not imply that they are less prominent. Rather, it means that this topic is far too complex and versatile to be managed (in its entirety) in mere eighty to one hundred pages.

129 Prop. 2005/06:60.
and AIDS in Sweden, and thus, vastly involved in how gay men have come to be associated with this virus – which is why I turned to them to begin with. I sought to find the answer to my research question in the past to see if there is anything that can tell us why some things are as they are today. In the end, I came to disclose two ways of depicting gay men as overrepresented when it comes to HIV. The first one sets out to blame them – to depict them as this threatening and unfamiliar perpetrator, who is to be held responsible for the pain and misery of others. This was very common during the late 1980s, and especially around the time Peter Bratt initiated his scrutinizing attacks on the gay sauna clubs. The second depiction also emphasizes on gay men’s overrepresentation, but instead of blaming them, it rather illuminates their position as social victims through the enumerative knowledge. That is to say, telling these people that they are not in higher risk of contracting HIV would just deteriorate their condition. It would not help them the slightest. Thus, instead, the numbers are used to claim their rights as (gay) citizens, and to urge state-fund administrators to take their position into consideration, and make them a priority.

Modern prevention is about the tracking down of risks. “[N]ot in the sense of the result of specific dangers posed by the immediate presence of a person or a group, but rather, the composition of impersonal ‘factors’ that make a risk probable” (Rabinow 1992: 242). Prevention is not surveillance of the individual but of likely occurrences of diseases, anomalies, deviant behaviour to be minimized and healthy behaviour to be maximized. As Rabinow argued, we are partially moving away from the older face-to-face surveillance of individuals and groups known to be dangerous or ill toward projecting risk factors that deconstruct and reconstruct the individual or group subject (1992: 242-243). Catherine Waldby stated that declarations of epidemic are declarations of war, and glancing at the rhetoric which circulates in the field of AIDS, there is “no doubt that war has been declared” (1996: 2). In attempts to understand these structures of hegemonic heteronormativity and discursive displacement of sexual identity, I have applied Simon Watney as a major source in how he argued that people, rather than viruses, have been the primary casualties in the ‘war’ on AIDS (in: Michaels 1997 [1990]: 16). That is to say, prevention as an act has, in the end, not been about ‘fighting’ viruses but rather the people who live with them. I argue that this can be said about gay men in Sweden (and in the West in general), and especially in relation to HIV and AIDS. When HIV was first discovered in Sweden in 1982, gay men were the
primarily targets (as in the rest of the Western world). Yet, it was not branded as a societal issue until it spread beyond these delimited groups into the ‘wider masses,’ where they were turned into enemies that had to be kept away from ‘the innocent’ ones.

In the end, it all comes down to bio-politics. As Foucault described it, bio-politics is a new technology of power that exists at a different level, on a different scale, and that has a different bearing area, and makes use of very different instruments (1997). More than a disciplinary mechanism, bio-politics acts as a control apparatus exerted over a population as a whole or, as Foucault stated, “a global mass” (1997). Hesslow argued that we have to put the HIV and blood politics into a wider context of bio-political rationality, in order to fully grasp their significance (2011: 29 ff.). This rationality is built on, and thus strengthens, the heterosexual hegemony of contemporary society; a hegemony that is the result of collective sets of heterogenic discourses, which establish ‘heterosexuality’ as the norm. Hence, the risk-group logic can be said to be based on a demarcation of the ‘normal’ and the ‘pathological’. It is significant to point to how this logic presupposes the moral and political delineations which has, for example, allowed for the classification of ‘homosexuality’ as a disease for most of the twentieth century (Hesslow 2011). Defending what is seen as ‘normal’ is central to this type of rationality, Waldby argued (1996). Hence, the classification of ‘MSM’ should be understood as a way of protecting “the cleanliness of the category ‘heterosexual’ by excluding those who might introduce contamination into its ranks” (Waldby 1996: 144). It is not only a moralizing of the ideal blood giver, but also about the ideal sexual behaviour. By still putting certain coercion on (male) same-sex activities, in classifying it as a severe high-risk behaviour, it leads to the manifestation of a desired male ‘homosexuality’ resembling nuclear heteronormativity more and more, thus treating homosexuality as something undesirable in itself.

However, if the logic of risk rests solely on group affiliation, then the actual risk of ‘contamination’ that applies to all people is lost and made invisible – for white heterosexual men, as well. Thus, this logic (or rationality) contributes to the protection and enforcement of a white, heterosexual, and monogamous man as the norm, rather than to explain how diseases actually spread. In the end, if the risk-group logic was based on social actions and practices, instead of ‘risk behaviours’ masked as group affiliations, prevention as we know it would like a lot differently. However, this is not the case, and with HIV turning into a post-crisis (chronic) condition, other issues are expected to develop.
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