

慢性病的檢疫隔離與與道德重整：醫療治理、治療公民權與台灣愛滋列管產業

HIV Care as Moral Quarantine: Medical Governance, Therapeutic Citizenship
and the Making of the AIDS Surveillance Industry in Taiwan

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摘要

自 1990 年來，台灣的公衛體制就以種種強化愛滋污名的高壓手段，諸如具名通報、定期追蹤、強制篩檢、愛滋罪刑化，把感染者當嫌疑犯列管。2005 年，為強化對非法用藥感染人口的管控，台灣當局在醫療院所施行「愛滋個案管理」制度，晚近愛滋列管的重心於是逐漸轉移至照護領域。另一方面，倡議愛滋人權的民間愛滋團體不但避談列管體制的暴力，更與這個新興的醫療監控體制密切結合，形成新興的愛滋個管服務產業。跨國愛滋照護與防治技藝因而在這樣脈絡下而有了特殊的在地組裝。本文將以愛滋個管服務產業中身居要角的台灣露德協會為例，探究它與全球愛滋人權論述接軌的陽性培力計畫，如何造就了與個管體制之正規導向對齊的新好感染者主體，並藉由對晚近一個涉及性愛派對用藥的重大愛滋事件來彰顯此刻的愛滋人權如何奠基於後冷戰時期的性戒嚴「例外狀態」運作。我將論證，做為將感染者責任化的生命政治計畫，台灣愛滋個管服務產業是

個有門禁管制的溫馨社群，它將道德不馴的感染者(感染者間的用藥與無套性交) 排除於外。我的分析將關注環繞於性和用藥的污名，揭示愛滋列管體制的新道德威權如何以自我淨化的溫馨關懷進行治療支配，同時也詰問現下先行排除愉悅的愛滋人權格局。

Abstract

One defining character of HIV care in Taiwan is that it's built as an integral part of the punitive regime of HIV control, a regime buttressed by stigmatizing public health measures such as name-based reporting, quarterly tracking, mandatory testing, and above all, criminalization of HIV transmission. Within this context, transnational technologies of care and prevention have come to be assembled in specific ways. Notably, a new apparatus of the hospital-based HIV case management program was installed in 2005 as the state's attempt to tighten its control over the drug-using HIV population. With its increasing link to the burgeoning local AIDS service industry, the apparatus has emerged as the pivot of HIV governance of late. In this paper, I take this AIDS case management industry to task. Focusing on Taiwan Lourdes Association, a key player in the industry, and its empowerment program for people with HIV, I show how the new positive identity it fosters comes to align with the state's biopolitical project of responsabilisation. I then use a high-profile case of HIV criminalization involving gay sex parties and 'poz-poz sex' to demonstrate how the industry operates as a gated community that sequesters bad, viral sex. By attending to the violence of the therapeutic apparatus and in particular the neoliberal yet self-purifying culture of compassion it enacts, I hope to elucidate the liminal politics of shame that forms a halo around progression of HIV rights in Taiwan today.

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The AIDS Budget Crisis

In April 2014, Taiwan's Center for Disease Control (CDC) announced a draft bill to amend the HIV Control and Patients' Rights Protection Act (hereafter 'HIV Control Act'), the regulative basis of the country's HIV policy. While the ban on HIV-related border restrictions will finally be lifted, there is also a fundamental change to HIV care and treatment, a provision which has been free since 1989. Under the new plan, free HIV care will only be available for a period a two-year from diagnosis date of HIV infection, during which 'the patient's medical condition is expected to be stabilized'. After that, the patient will move onto a new treatment regime of 'maintenance', under which copayment through the National Health Insurance Program will be implemented under the category of chronic illness. (CDC, 2014)

This move of making HIV patients pay, branded by the government as 'normalizing HIV', is the initial outcome of the so-called 'AIDS budget crisis' in 2011, a crisis which triggered Taiwan's first treatment-based activism in the post-HAART (Highly Active Antiretroviral Treatment) era.¹ Over the years, the source of treatment expenditure for persons infected with HIV has moved back and forth between a special CDC budget (intended mainly for disease

¹ See Huang (2012a) for an account of pre-HAART Activism in 1990s Taiwan.

prevention and subject to parliament approval) and the National Health Insurance (between 1998 and 2005, under the category of ‘catastrophic illness’, which is exempted from copayment).² Due to the worsening of the state budget deficit in recent years, the CDC broke the news in 2011 that it was planning to introduce a copayment scheme, a special fiscal measure *analogous to* (rather than through) the NHS system. Angry at the abrupt policy turn and the government’s lack of engagement with the AIDS service sector and HIV patients, several key NGOs, including a newly setup group of HIV positive gay men called ‘Positive Alliance’, got together to form a coalition called ‘Taiwan AIDS Action’. The coalition was quick to attack the beguiling principle of ‘fairness’ that the CDC upheld, underscoring the fact that HIV patients, unlike other patients with chronic illness, are subject to life-time state surveillance. Even if HIV patients had to pay for their medical expenses, the coalition questioned, why should they be excluded from the NHS and pay extra? Framing the AIDS budget deficiency as a crisis of national security, the coalition called on the government to increase funding for prevention and treatment by adopting, like China, a comprehensive, top-down state response from the highest level of the administration, that is, the Presidential Office. Meanwhile, the coalition urged HIV patients – hitherto absent from interventions in HIV policy – to get involved in the campaign and speak for themselves. To this end, three sessions of public forums were held in different regions of the island, with the mood dominated by frontline workers’ worries about the negative impacts the new policy might have on patient care,

² Taiwan’s National Health Insurance program was implemented in 1997. With the introduction of the global cap system in 2000, private hospitals appointed by the CDC to run HIV clinics began to feel the strain of the costly HIV medicine. After the successful lobby by Taiwan Medical Association, which contended that HIV treatment is key to public health control and therefore paid for by the administration, the parliament amended the HIV Control Act to allocate the expenditure to the CDC’s budget in 2005.

especially for the underprivileged.³ In response to this NGO agitation, the CDC subsequently held a public hearing that was attended by the country's leading HIV experts in the medical establishment. Professor Chen Yimin, a US trained epidemiologist who had been key to CDC's policy-making, contended that a sustainable HIV care ought to be grounded in the domain of the NHS, suggesting the government to treat HIV care like liver care in NHS, which makes a distinction between acute infection (expenses fully covered by the NHS) and chronic condition (where copayment applies). The draft bill's two-phrase plan appears to follow his recommendation. (CNA News, 2012)

The AIDS budget crisis provokes some key questions around the biopolitics of HIV/AIDS in Taiwan today. At stake here is a particular regulatory context of active state surveillance that any meaningful claim to HIV rights has to contend with. For one thing, under the provisions of the HIV Control Act, treatment is also imposed an obligation. Other strident public health measures stipulated by the Act include named-based case reporting within 24 hours to health authorities (an administrative measure for highly contagious communicable diseases), tracking and contact tracing by local public health bureaus on quarterly basis, border restrictions, mandatory HIV testing of high risk groups, forced quarantine (removed in 2007), and, above all, the criminalisation of HIV non-disclosure, exposure and transmission. These harsh measures of public health control together constitute a punitive regime of name-based state surveillance under which people with HIV are permitted to organize their life. Ironically, just as the mandate of the human rights protection was added to the revamped Act in 2007, a gesture said to align with UNAIDS's international guidelines, the regime of state surveillance underwent a profound

³ For the coalition's statement and news coverage of the NGO response to the budget crisis, see <http://aidsactions.blogspot.tw/> ◦

transformation.⁴ In response to a perceived public health crisis around illicit drug use in the mid-2000, the CDC introduced a hospital-based HIV case management (HCM) program. Integrating positive prevention into HIV care, the program offers support, counselling and health advice services to cultivate self-care, with particular emphases on risk reduction and medical compliance.⁵ Crucially, while enrolment to the program requires patient consent (the ‘respect’ for the subject hence greatly enhances the legitimacy of the program), the case manager is, unbeknownst to many, obliged under the 2007 revamped Act to submit updated patient information and treatment progress to the CDC. To date, around 40% of the HIV population is managed under the program as its scale continues to expand.⁶ Curiously, while AIDS NGOs have been involved in the building of the program over the past few years, there currently exists no patient information about this new form of medical surveillance.

This context of HIV control and surveillance poses serious questions about Taiwan AIDS Action’s campaign. To begin with, what does treatment right mean in a therapeutic milieu where medical surveillance looms large? Further, what does it mean to demand maximal state intervention, when the Taiwanese version of ‘treatment as prevention’, under the overriding imperative of ‘positive-as-crime prevention’, has been well established and, indeed, intensified in recent years?⁷ How does one make sense of the NGOs’ acquiescence to the violence of state surveillance as they continue to speak in the name of people living with HIV? Finally, what sort of biomedical

⁴ Lo (2010) has used a civil society-based approach to write a legal history of the HIV control Act. I challenge this kind of liberal approach in this essay.

⁵ Instead of ‘adherence’, I use ‘compliance’ to underscore the abiding paternalistic authority of medicine in the Taiwanese context. On medical compliance, see (Race 2009); (Mykhalovskiy *et al.* 2004).

⁶ See ‘2014 Hospital Based HIV Case Management Program’.

⁷ A 2004 study of Taiwan (Fang *at al.* 2004) has been frequently cited by recent research on ‘treatment as prevention’ to show its efficacy. I thank Cindy Patton for this reference.

individualism does this name-based HIV surveillance engender and how is the culture of gay sex enacted through Taiwan's AIDS exceptionalism?

Tackling these questions, this essay seeks to advance a genealogical critique of the biopolitical present as HIV control in Taiwan comes to be increasingly biomedicalised. Situating the surveillant regime and its ontological transformation within a context pertaining to the problematisation of drug use since the mid-2000s, I demonstrate, with a particular focus on HIV positive gay men, how the apparatus of hospital-based HCM operates as a diffuse form of medical policing in the state production of moral citizenship. Further, by marking out the NGO sector's alignment with the medical apparatus, I point to the emergence of what I term the 'AIDS Surveillance industry' and explicate its role in the intensification of HIV control of late.

My aim is two folds. Firstly, I intend to examine the relationship between HIV control and moral sovereignty. In his ground-breaking book *Pleasure Consuming Medicine: The Queer Politics of Drugs*, Kane Race (2009) demonstrates cogently that drug-taking activities in late capitalist western societies represent an excessive conformity with the logic of consumer pleasure in the amoral market, over which the state stakes its claim as a moral arbiter. Through the exercise of what Race calls 'exemplary power', a spectacular display of disciplinary power mediated by mass media such as police raid, the state makes a bad example of drug takers via the politics of 'sending a message' to assert its moral sovereignty in the field of consumption, thereby enacting a paternalistic authoritarianism buttressed by medicine and the norm. Race's formulation of exemplary power resonate with the policing of HIV in Taiwan, as the Taiwanese state has made an example of HIV positive gay men over the last decade. Despite the country's democratisation since the lifting of martial law in 1987, militarised social control continues to operate, especially in the area of deviant sex. Indeed, moral sovereignty commands even a stronger presence in the field of drug consumption as online hook-ups

and the emergent practice of 'party and play' gradually become, however stigmatized, the mainstay of gay male consumerism in present-day Taiwan. As the country transforms itself to a 'regulatory society' of governance in the neoliberal era (Ning 2012), the policing of gay sex *through* the surveillant regime of HIV control, as I will elucidate, has come to serve as a key site of social exclusion under neo-moralism.⁸

Secondly, I purport to take Taiwan's AIDS industry to task, calling into question their unavowed support of the new form of medical governance that is integral to state surveillance. Although small AIDS groups and organisation began to emerge from 1992 onwards (more than 7 years after the first case of AIDS was discovered)⁹, it wasn't until the early 2000s that the local AIDS industry gradually came into formation, a process pertaining to the governmentalization of a developmental state formed under the Cold War structure. The mid-2000s was a particular historical juncture when transnational prevention and treatment technologies, mediated by some US-trained HIV experts and the NGOs they ran, suddenly arrived and began to take hold in Taiwan. The introduction of the system of hospital-based HCM, itself an assemblage of care and prevention, is a case in point. Significantly, as the apparatus of hospital-based HCM gradually turns into a new hub of HIV governance, Taiwan Lourdes Association, the community-based organization spearheading Taiwan AIDS Action, began to develop a new positive empowerment program that gave rise to 'Positive Alliance', the only HIV-identity based group in the coliation. I track the governmentality that Lourdes expounds to show its production of a compliant HIV subject-hood, a therapeutic citizenship that exemplifies the virtue of neo-moralism.

In what follows, I begin by showing how the apparatus of hospital-based HIV case management came to be installed as a rapid response to the

⁸ On neo-moralism, see Ning (2013).

⁹ On the history of early AIDS organizing in Taiwan, see Huang (2012a).

emergent subculture of gay sex party and the sharp rise of HIV prevalence among the hitherto neglected injection drugs user (IDU) population. Questioning the operations of the apparatus on ethical grounds and its deployment of 'harm reduction', I then proceed to juxtapose the exemplarity of Positive Alliance with a recent high-profile criminal case involving unprotected sex between drug-using gay men on the HIV registry to show how the biomedical management of HIV converges with criminal justice to discipline and punish those retained in care, that is, the suspects deemed in need of moral rehabilitation.

The Drug-Induced Public Health Crisis in the Mid 2000s

On the early morning of January 17, 2004, undercover police raided a residential apartment in Taipei, where a 'Home Party', the local term for gay sex party, had taken place.¹⁰ 92 gay men were arrested on the premises and the press and the broadcast media, upon answering the police's call, arrived immediately and were allowed into the 'crime scene' under investigation. What ensued was the unprecedented mass hysteria in Taiwan's history of AIDS. Occurring just a few days from the lunar Chinese New Year, a festive season of family gathering, the raid was broadcast through cable news channels for more than three weeks, with scenes of the promiscuous ruins depicting shamed-faced, half-naked young men being subjugated by masked policemen. Three days after the raid, with the release of mandatory HIV testing result came another wave of moral panic: 28 were found positive, including 14 already on the HIV registry. After a closed-door meeting with AIDS NGO representatives and HIV experts, the CDC decided to hand over the 28 gay men with HIV to the

¹⁰ The underground gay rave club culture took off in Taiwan around the late 1990s when ecstasy was introduced. Due to frequent police raids of club venues, gay clubbing went further underground and the new subculture of 'home party' was formed (Hung 2007). See (Chang 2010) for a very fine analysis of contemporary Taiwanese literary representation of 'home party'.

prosecution. Although months later the charges of HIV transmission for these men were dropped due to insufficient evidence, the intensification of sexual stigma had regrettably led one gay man to commit suicide. Still, the prosecution service took the trouble to state (obviously not wanting to send out the wrong message) that dropping the charges did not mean that Home Party was tolerated, adding that ‘gay people should not have a twisted understanding of the Law’ (FTV 2004).

In actual fact, it was the state who twisted the law. The CDC took the initiative to check their test result list against the police’s record, thereby infringing the mandate of privacy protection that was stipulated in the HIV Control Act at the time. Further, the 14 persons discovered to be positive should have never been handed over to the prosecution, because not knowing one’s serostatus fell and continues to fall outside the remit of the Act. Crucially, the event, which came to be known as the ‘Nong-an Home Party Incidence’, set a key precedent: the CDC’s unlawful intervention later came to be justified in the name of ‘prevention needs’, an exceptional measure normalised and regularised through the 2007 revamp of the Act.¹¹ In other words, people on the HIV registry in Taiwan live permanently in a state of (sexual) emergency in the post martial law era. Significantly, a new category called ‘illicit drug users involved in group sex’ came to replace the old category of ‘homosexuals’ in the revised mandatory testing list in 2007. This means that if you are a good homosexual these days, you can be exempted from the violence of the state checking up on you, but a new category of deviance – the sex/party subject – is formed. Additionally, ‘home party’ also becomes a generic term in the CDC’s name-based reporting system: anyone arrested in sex parties and tested to be HIV negative are now

¹¹ See Article 14 of the Act. This is a classic example of what Agamben (1998) calls ‘the normalisation of the state of exception’.

subject to three-month of tracking by local public health bureaus. (Taiwan CDC 2004)

Several months after the ‘Nong-an Home Party Incidence’, the CDC received alarming reports of the sharp rise of HIV prevalence among the injection drugs user in prisons. The increase rate of 77% prompted the CDC to swiftly introduce harm reduction policy. With Australian harm reduction experts like Alex Wodak flown in to help, pilot schemes of clean needles exchange, methadone treatment, HIV screening/AIDS awareness begun to run in different areas of Taiwan from the second half of 2005, and by 2006 the harm reduction policy was officially implemented throughout the country. In his study of the harm reduction policy in Taiwan, the sociologist Chen Jiashin has shown the policy-making as an assemblage of CDC officials, HIV experts and NGO workers, arguing that the policy itself is purely a utilitarian move. (Chen 2011a; 2011b) By medicalising the IDUs as patients and by framing the deployment of harm reduction within the teleological scope of social rehabilitation, the Taiwanese government was able to strategically make a ‘low-key’ intervention without appearing to contradict its overall prohibitionist drug policy.¹² Crucially, one of the profound effects of harm reduction policy is the reinforcement and intensification of anti-drug preventive measures directed at the young. For example, this period saw the onset of ‘HIV positive public speaking’ model of abstinence-based AIDS awareness education on the campus. Enacted by NGOs like Taiwan AIDS Foundation and Harmony Home Association, this mode of education typically entails a ritualistic act of confession

¹² What’s interesting about Chen’s study (2012a) is that the CDC maneuvered public opinion with its timing of the press release and then made use of the responses it elicited from civil society (demanding the government to take action) to increase their influence in cross-departmental negotiations with the police and the Department of Justice.

performed by an ex-addict, whose tale of redemption serves as a normative orientation for the young.¹³

It was this 'drug-induced' sense of public health crisis that led the CDC to review its means of HIV control. Longitudinal data of HIV populations was desperately needed, as the CDC came to realise. (Chen 2004a) In particular, the efficiency of HIV case management by local public health bureaus was called into question: public health nurses, lacking in professional training themselves, were seen as insensitive, intrusive and generally hated (Chen 2004b). Setting out to modernise its HIV control, Taiwan CDC keenly followed the US CDC's 2003 guidelines on the integration of positive prevention into hospital-based HIV case management. Accordingly, in conjunction with the pilot schemes of harm reduction, the CDC introduced another pilot scheme called, tellingly enough, 'Behaviour Therapy for Individuals with HIV' in the north, central and south of Taiwan from the second half of 2005, enrolling more than 500 hundred patients. By 2007, the hospital-based HIV case management program was officially launched.

HCM as Moral Quarantine

Run by nursing experts and doctors who were to become the dominant figures in the HIV sector, the three trials lay out the key parameters for the present HCM program. The southern trial, administered by Dr. Ko Naiying, a US trained nursing expert, established the model for the current program. In this US-based model, the case manager designs a tailor-made counselling plan based on initial clinical assessments (risk and STDs screenings), tracking every three months to monitor the patient's behaviour modification. Where necessary, the manager makes referrals to related NGOs for drug rehab or methadone clinics. (Ko 2006) The northern

¹³ On the critique of this mode of operation, see (Huang 2012b).

trial, run by another nursing expert Zhuang Ping, placed emphasis on softly-softly approach to counselling. Seeing building good relations with the client as conducive to enhancing overall medical compliance, Zhuang accentuated the importance of building a continuum of care starting from anonymous Voluntary Testing counselling. Crucially, as Zhuang makes clear, the heart-to-heart approach to HIV counselling requires further specifications of social differences between individual patients and subcultural practices, which posed a new challenge for HIV control in Taiwan at the time.¹⁴ (Zhuang 2006) In contrast to these 'positive' interventions based on benevolent care, the central trial had a harder edge to it. The administrator Dr Wang Renxian employed STDs testing as a device to verify the patient's reliability, also involving a team of psychiatrists to rectify those he considered 'deviant'. Wang recommended that for the purpose of long-term tracking, mandatory registration was necessary for those enrolled in the state-funded program. He also suggested that punishment be introduced as a coordinated plan for disciplinary purposes. These recommendations were all adopted by the CDC.

Significantly, half way through the pilot scheme, the CDC, already seeing the benefits of this new style of management, came up with a draft bill to amend the HIV Control Act in order to speed up the process of data gathering. Up till that point in time, all the CDC could obtain, under the Communicable Disease Act, was the patient data from the previous quarter, containing basic information like CD4 counts and viral load. The new management program, by contrast, was able to yield the information of a biographical individual (altitude, values, habits and lifestyles, and a timeline of behaviour modifications, etc..). Crucially, having dealt with the state of emergency set off by SARS (*Severe acute respiratory syndrome*) during 2002-2003, the CDC also became aware

¹⁴ In this regard, NGOs experiences and knowledge prove to be invaluable for medical surveillance. Indeed the training program of hospital-based HIV case managers routinely includes talks or lectures given by NGOs workers.

of the limitations of the Communicable Disease Act. So when the amendment of the Communicable Disease Act was passed by parliament in Jan 2004, it ushered in a post-SARS era of public health control: medical institutions are now mandated to submit to health authorities up-to-minute reports of patient treatment progress. It was this augmented power of state surveillance that the CDC intended to be incorporated into the HIV Control Act, such that the drug-using population could be managed more efficiently. In other words, while HIV becomes a chronic and manageable condition in the era of HAART, it is administered by the CDC at the same level of SARS: as such, HIV is ontologically enacted as a highly contagious disease.¹⁵ No wonder Dr. Wang of the pilot scheme refers to the HCM program as a 'quarantine policy for chronic illness'.¹⁶

What I find most objectionable about the program is its total lack of transparency. The consent form contains less than two lines that read, 'having been explained what this program is about, I hereby give my consent to join the program to receive counselling and health advice services'.¹⁷ One can imagine that patients would be easily persuaded to join what is essentially a surveillant program by the promises of 'enhancing the quality of life' or 'receiving whole-person care'.¹⁸ However, while the program claims to be voluntary, it is not always the case. For example, enrolment to the program is the precondition to get onto the second line treatment.¹⁹ Once again, this exceptional category shows the arbitrary power wielded by the CDC.

At issue here is how those enrolled in the program are enacted upon. For Foucault (1982) is 'the conduct of conduct', then the

¹⁵ See Mol (1999; 2002) for the politics of medical ontology.

¹⁶ See Wang, 'Case Management for Chronic and Communicable Disease'.

¹⁷ See Taiwan CDC (2013).

¹⁸ See Grob (2013) for a critique of 'patient-center' care.

¹⁹ See Taiwan CDC (2013).

question of ethics becomes paramount for guidance. **For the majority of those diagnosed with the infection of HIV in Taiwan, despite the presence of AIDS NGOs, the hospital based HIV case manager is likely to be their first and probably the only source of support. If the counseling in HIV case management was an end in itself instead of being integrated to state surveillance, then lending support to those isolated by stigmas around HIV might be valuable.**²⁰ **But as it stands,** the program exploits the vulnerability of the newly diagnosed so as to ‘win their hearts’.²¹ Crucially, the patient is pretty much kept in the dark as to what the nature of the case manager’s work is. Indeed, the latter is instructed not to say to the patient-client that he or she stands for state power. But the opposite is true: the case manager hides his or her own identity as a secret agent for the state, ‘communicating, when appropriate, with the public health sector or the governing body’, as a recently published nursing textbook subtly puts it (Shi 2013: 200). Indeed, the HIV case manager in the clinical setting, with her expertise in counselling, social work, public health, and nursing, easily outperforms the public health nurse. Indeed the former has taken on the key tasks previously assigned to the latter.²²

HIV state surveillance is now operationalised on a two-pronged system. The hospital based HCM program is in charge of 70% of the poz population seeking medical care while the public health sector takes care of the rest. Importantly, this one window policy that locates the poz subject in HIV medical

²⁰ In a cultural context where the authority of medicine remains largely unquestioned, the case manager is unlikely to encourage the patient to think about the workings of institutional power in the production of the social stigma around HIV/AIDS.

²¹ **It’s crucial to note that since the scaling up of anonymous testing has been well coordinated with the HCM program. (Ji *et al.* 2010)**

²² Of interest to note is that in the CDC’s performance appraisal, in the section of contact tracing, the case manager gets more points when he or she is able to track down the real identity of the patient’s sexual contact.

care creates an apparatus of management that is both intimate (the poz subject thinks he is under confidential care) and economically efficient (as it makes sense to have the point of contact in care). As an added bonus, the situation is perfect for the good cop bad cop routine when the hospital-based case manager plays mutton to the public health nurse wolf, and thus lures the poz subject into a make believe world of love and security where he may be more likely to disclose information that has nothing to do with medical care and everything to do with social control. Training manuals of the hospital-based HCM program provide ample of techniques and examples of gambit questions to disarm the 'client', that is, the patient/suspect under name-based state surveillance, especially when it comes to sussing out their history of sex and drug use. (Nurse AIDS Prevention Foundation 2009)²³

A key aspect to the building of 'client' relationship in the HIV case manager's training is to hide their aversion to alterity. But no matter how empathic and non-judgemental the case manager like to think they are, their liberal guidance is necessarily couched in the systems of normative knowledge, especially when harm reduction is the order of the day. Crucially, the technology of harm reduction is implemented in the HCM apparatus as a technique of self-care to reduce the harm that the individual with HIV might do to society as a whole, be it the reduction of the number of sex partners, the frequency of drug taking, or avoiding frequenting the spaces associated with both (such as 'home parties' or gay saunas).²⁴ Enacted upon those retained in medical care, this liberal form of governance proves to be more effective than the prohibitionist approach, because by allowing the patient a degree of autonomy and by keeping him or her under observation enable the case

²³ I am reminded by what Foucault (1990: 62) said about the confessional society: 'We belong to a society which has ordered sex's difficult knowledge [...] around the slow surfacing of confidential statements.'

²⁴ On harm reduction as embodied practices of the care of the self (in contrast to self-care), see Race (2008).

manager to intervene in the course of the patient's desire: to change and reform the HIV subject, in a benevolent way.

Crucially 'safe sex' comes to be exhorted as 'condom-only' in the program. This strident notion of safe sex corresponds to the new definition of risky sexual behaviour in the 2007 revamped of the HIV Control Act, which designates any membrane contact unsegregated by latex as dangerous. Thus, unprotected oral sex performed by a person with HIV (giving or receiving) does not count as safe, nor is bareback sex between positive men with undetectable viral load deemed acceptable. (Liu *et al.* 2007; Chen 2012) Interestingly, condomised 'safe sex' is proscribed by the CDC not only as a responsibility (not to infect others) but also a right. Amid the aforementioned AIDS budget crisis, the CDC, in an attempt to responsiblise people with HIV, came up with a notification for people who are about to start HAART, specifying their rights and duties. As the notification has it, people have 'the right to be informed' that unprotected sex could lead to super-infection, which would eventually exhaust the treatment options! (Taiwan CDC 2011)

STDs screenings thus come to serve in this therapeutic context as a standard device to monitor the patient's compliance to condom use. In her study of syphilis prevalence of those enrolled in the program, Dr. Ko Naiying urges the case manager to aggressively target those sexually active gay men, with CD4 over 400, using recreational drugs as they are more likely to 'relapse' after regaining health. (Ko *et al.* 2010) In a biopolitical context where the enhancement of CD4 counts has been fetishized by the CDC as a moral index of health, the singling out of a certain type of health positive gay men and putting them under intense scrutiny has profound implications for the particular type of biomedical individualism formed under medical surveillance. I will return to this point in the discussion of the outlawing of positive-positive sex later.

Crucially, if those sexually active gay men have good compliance to HAART and can stay clean of STD infections and/or drug use for two years, they can be classified as 'stable cases'. The socially rehabilitated patient can either choose to stay on in the program (but don't expect receiving much help and care from the case manager as their caseload is capped at 150, excluding the 'stable cases'), or exit the program and be followed by public health case management. In this regard, the two-year period of 'transitional phase', proposed under the policy change on HIV care that I described in the beginning of the essay, can now be understood as a period of state-funded behavioural therapy and moral quarantine. Under the current global trend of 'Treatment as Prevention' and with it, the scaling up of aggressive testing, the modus operandi of HIV control in Taiwan can perhaps be characterised as 'seek, test, treat, and retain in medical custody!'

Lourdes' Positive Empowerment

The HCM program has now become the nucleus of HIV control, establishing a managerial culture of medical surveillance at the level of governance. Scheduled meetings of HIV case management involving the public health, medical care and the NGO sectors are routinely held in different regions of the country to tackle 'special cases', thus enhancing the overall knowledge/power operations in managing the infected population. While a new breed of public health-based case managers emulating their counterpart have recently emerged, NGOs workers or volunteers have also been steadily absorbed into the program. Although the government sees AIDS NGOs as playing a role that supplements the two-pronged system, NGOs are actually indispensable to the operations of the new surveillant system in HIV care. Taiwan Lourdes Association's (hereafter 'Lourdes') rise as the leading community care provider makes an interesting case here, for it is central to the escalation of health managerialism in HIV governance.

Initially a small Catholic charity serving women and children, Lourdes' Home changed its direction in 1998 and its foray into the field of AIDS was marked mainly by social work approach, a specialty that had just begun to be established in Taiwan at the time. Under the supervision of United Way of Taiwan, Lourdes had by the mid 2000s transformed itself into a leading NGO, filling up the vacancy of HIV-related social services (such as housing and transitional services) that the Taiwanese state was unable to provide. Over the years it has been the key actor in mediating transnational technologies of HIV care and prevention such as harm reduction and positive empowerment program.²⁵ Interestingly although Lourdes positions itself as a community-based rather than faith-based organization, the community it claims to serve is 'fabricated', in that it's one that was brought into existence by Lourdes' particular enactments of transnational technologies,²⁶ which, as I argue, not only dovetails with its own secular agenda of 'soul governing' but also aligns with the HCM program.²⁷ Here I focus on their effort to empower gay men with HIV.

There are two phases in Lourdes' empowerment of people with HIV, each producing a group consisting entirely of gay men. In 2000 Lourdes set up a support group led by Paul Hsu, presently the general secretary of Lourdes. In his MA thesis entitled 'From Support to Self-Help: My Action and Reflection with AIDS Support Group' (2004), Paul Hsu employs the method of action research to reflect his role as a social worker in supervising the group. In his account, intense social stigma around HIV not only hampers the recruitment of patients

²⁵ In the mid 2000s, apart from translating booklets on treatment information published by I-Base, a UK-based treatment advocacy and information organization, Lourdes was instrumental in introducing harm reduction approach to HIV prevention.

²⁶ Medical anthropologist *Vinh-Kim Nguyen* (2005; 2010) has shown in his study of antiretroviral globalism that so-called 'community-based organizations' (CBOs) in the Third World context are both instruments and effects of transnational HIV technologies.

²⁷ I take the phrase 'soul governing' from Rose (1999).

from HIV clinics but also highly constrains the cohesion and the development of the group itself. Amongst the range of techniques drawn from the 'psy' disciplines that Hsu employs to strength the group, psychodrama proves to be pivotal as it enables Hsu to orientate the group towards the goal of spiritual growth. This can be seen in a scene of psychodrama in action as illustrated by Hsu and colleagues. In this instance, a gay man trying to come to terms with his own infection is guided by the director (Hsu) to converse with God. God promises him an antidote to HIV should he be prepared to offer something of equivalent value in exchange. This object comes to be interpreted as self-restraint (Hsu *et al.* 2003: 18-19), which is much needed for those already fallen from grace and seeking redemption.

This ethic of self-discipline renders the HIV subject governable, facilitating the integration of the subject into the given moral-sexual order as well. Out of those who availed themselves to such an ethical project emerged a subgroup called 'New Life', which later became the prototype of the self-help seeding group at Lourdes. (Hsu 2004) Of significance to note is that even though it was, according to Hsu, the perceived need to overcome stigma that catalyzed the forming of New Life, this driving force however was not materialized as a collective consciousness that questions the nature of social oppression around HIV/AIDS. What New Life discovered instead, partly through the technology of psychodrama, was the voice of 'inner child' within the self, which is, of course, *ahistorical*. This constitutes the severe limit of Hsu's purportedly self-critique of his professionalism.

What emerged from New Life is a new paradigm of empowerment that deploys the form of role modelling. To this end, talks given by senior members of New Life as well as HIV positive professionals from abroad become the routine feature in Lourdes' capacity building packages. In an empowerment workshop that I attended in 2012, three HIV positive role models were even

given the crown of 'international positive elites'!²⁸ Crucially, as Lourdes becomes increasingly involved in training the new HIV health professionals for the hospital-based HCP program, it also launched in 2010 a new empowerment initiative called 'the P Project', from which 'Positive Alliance' emerged. With its emphasis on positive outlook and positive prevention, the project forged a new appellation, Pasiti (帕斯堤), which is a transliteration of 'Positive', to displace the much spoiled identity term, 'the one infected with HIV'.²⁹ Significantly this gesture of de-stigmatization is articulated through homonormativity.³⁰ Guangge, a member of New Life and employee of Lourdes, was chosen to be the face of 'Pasiti'. Addressing the 2011 Taiwan LGBT pride rally, he came out as HIV+ and ex-drug user, urging gay men to renounce the sex partying lifestyle.³¹ Similarly, Shihao, another key member of Positive Alliance, celebrates his spiritual rebirth by way of confession in his HIV blog.³² Meanwhile, Mathew, whose heartwarming story of family acceptance is the subject of a documentary film, was elected to be the winner of Happy Life Award at Lourdes' 2013 Happy Life biannual conference. The panel of judges was representative of the AIDS Industry: Dr. Lo Yijun (an HIV doctor of the CDC), Zhuang Ping, the honcho of hospital-based HCM program in Taipei, and Lourdes itself. Significantly, the poz exemplarity consists of the following civic virtues: 1) Self-care and medical compliance; 2) Self-empowerment; 3) Co-operation and social participation; 4) Capacity and Innovation; 5) Community Work and Rights Advocacy.³³ Lourdes' biopolitical

²⁸ These poz elites are: Ken 仔('Rainbow China', Hong Kong), Joey (Hong Kong AIDS Foundation) and Laurindo Garcia ('B-Change', the Philippines). (Taiwan Lourdes Association 2012)

²⁹ See Taiwan Lourdes Association, 'On "Positi"'.

³⁰ See Finn and Sarangi (2009) for a critical discussion of 'normalising HIV'.

³¹ On Guangge's speech, see (Citizen Journalism 2011).

³² For Shihao's blog (named as 'spiritual food for gay men'), see <http://gsoup1069.blogspot.tw/>.

³³ See '2013 Happy Life International Conference', <http://23711406.blogspot.tw/2013/09/2013.html>.

production of 'happy life' thus performs a key disciplinary function in the making of therapeutic citizenship.

Outlawing Poz-Poz Sex

Against this backdrop of the happy poz, the Taiwanese state made an example of a HIV+ school teacher named Feng, who was arrested in late 2011 and charged with intentional transmission of HIV and drug offences. He was found guilty in Sept 2013 and sentenced to 12-year of imprisonment, the heaviest sentencing ever since the proclamation of HIV Control Act in 1990. What's significant about this case is that embodies the therapeutic violence of the regime of HIV surveillance in an ostensibly LGBT-friendly society. In Sept 2011, an anonymous email was sent to Feng's school, accusing him of spreading HIV. The school administration acted upon the email immediately, politely asking Feng to go for an HIV testing to clear his name, which Feng refused. The school then secretly asked the police to follow Feng. Weeks later, the police obtained a search warrant and arrested Feng at his flat on suspicion of illicit drug use as he was reportedly having fun with a hookup. At this point, he was forced to undergo HIV testing. When it emerged that Feng was already on the HIV registry, the media went into frenzy over his arrest as he fell under the cultural narrative of the evil poz, recklessly infecting other innocent gay men, estimated to be no less than a hundred. (Chang 2013) Without any valid evidence, the prosecution held Feng in custody as it vowed to put Feng into jail. (Huang 2012c) As Feng's tracks of sex networking on his computer became the incriminating evidence, the prosecution managed to get 13 gay men Feng's had sex with to testify against Feng. Crucially, Feng himself had been on HAART with undetectable viral load, and 10 of the witnesses were already on the HIV registry as well, all agreeing to have bareback chem sex with him. Apart from failing to disclose, Feng's crime largely lies in exposing others to the risk of reinfection. Crucially, since 2005, the category of repeated offender in Taiwan's criminal justice has been replaced by a new regime of punishment

where each criminal act counts as one punishment. So for example, Feng's sentencing includes two penalties based on two occasions of unprotected sex he had with the same positive guy. This is the first time, probably the first in the world too, that the small likelihood HIV reinfection came to be criminalized. The judge even went so far as to suggest in the verdict that the prosecution should pursue the ten positive witnesses! (Huang 2014)

Crucially, Zhuang Ping testified as prosecution's expert witness in Feng's trial, stating that the danger of reinfection was routinely emphasized in the health advice given to people retained in HIV care. However, it's crucial to date what science knows about reinfection is far from conclusive. Interestingly, Zhuang, hailed by the AIDS service industry as POZ's guardian angel, actually managed to track Feng down to give him counselling before his arrest. Despite the bad press he got, Zhuang said that she chose to stand by him. She couldn't bring herself to blame him for not having self-respect, Zhuang (2013) wrote on her Facebook Note (open to the public), because his will was 'kidnapped' by his addiction to methamphetamine. What he needed was more love and aid, she says. Surely love and aid could have been materialized in the form of expert intervention that contests Taiwan CDC's moralistic stance with regards to poz-poz sex. Surely Zhuang must have known that the stake of her expert witness was high, not just for Feng himself, but also for others detained in medical care.³⁴ Yet by avowing the official position, the PoZ Guardian Angel decidedly turns her back on Feng in her expert witness, therefore forsaking him outside the gated community of the good poz guys. In wake of the verdict, Positive Alliance broke the AIDS industry's silence around Feng's case by issuing a statement. The statement, reserved in its tone and appearing to be non-judgmental, urges those illicit drug users to adopt harm reduction while calling on people with HIV to enact universal protection of condom use.

³⁴ Zhuang (2013) makes this clear in an article discussing, with specific reference to Feng's case, the negative impacts of HIV criminalization on public health.

Positive Alliance could not even bring itself to acknowledge the fact that it was poz-poz sex, a form of risk reduction recognized to be effective, that was outlawed in this case.

Conclusion: Beyond the AIDS Surveillance Industry

I have argued in this essay that the regime of HIV control, as an assemblage of HIV care and state surveillance, enacts a benevolent form of therapeutic domination that is premised on the logic of moral contagion. And because of the AIDS service sector's reticence around this new form of medical policing, I chose to name them as AIDS Surveillance Industry.

By way of conclusion, I want to turn to Taiwan AIDS Society's 2013 World AIDS Day Campaign in order to return to the questions I raised concerning HIV rights. Launched by Dr Lin Xixun, the chairperson of the Society and Mathew from Positive Alliance, the 2013 campaign uses the slogan 'I-C.A.R.E' to promote testing, early treatment, compassion, and AIDS human rights, with C.A.R.E standing for 'compliance, acceptance, respect and employment'. Of course, the stark reality of state surveillance does not fit the compassionate baseline of the human right-based campaign. (Huang 2013) Appropriated by the trend of 'treatment as prevention' as it propels through the global scene, the language of human rights is too universal to have any local relevance, because it persistently refuses to address the particularity of HIV stigma.³⁵ As Feng's case makes clear, Feng lost his job because of the media exposé that plays on the stigmas of sex and especially drug use. Likewise, the whole civil society turned a blind eye to the state's sequestration of Feng. Feng is compliant with his HAART regimen, but his moral incompliance – promiscuity,

³⁵ As Cindy Patton (2011) points out in her critique of 'treatment as prevention', this de-politicised language, based on population rather than on individuals, not only massively glosses over the long-term side-effects of HAART on different individual bodies but also buttresses the authoritarian desire to seek out those deviant bodies and to control them for the greater good of society.

group sex, drug use, and barebacking – incurred severe punishment by the state.

I must note that a Committee for the Protection of Rights for People with HIV/AIDS has been set up since the 2007 revision of the Act. Yet ironically, the committee are peopled with those experts, scholars, NGO workers who have been deeply involved in the building of the hospital-based HCM program. Moving back and forth between public health policy-making and NGO-advocacy, these HIV experts harness the progressive language of HIV human rights to mask their roles in institutionalising the measure of moral quarantine *through* HIV care. A product of chrono-biopolitics, this administrative segregation enhances the quality of life desired and certified by the state to the regulatory exclusion of others.

In the meantime, in response to the CDC's call to 'diversify' the culture of case management (Qiu 2010), Lourdes has started to train a new breed of 'buddy' volunteers that assumes the role of para-HIV case manager so as to 'smooth over' patients' resistance to seeking medical care. (Hsu 2012) As the CDC plans to have all MSM taken into Hospital-based HCM program, this new force of volunteer-qua-HIV case manager will also play an active role in the burgeoning culture of gay health centres. Supervised by the CDC, these NGO-run centres have proliferated throughout the island since 2010, and Lourdes itself has given birth to two gay health centres (one of them has recently transformed itself to a registered NGO). Well-versed in the neoliberal language of (global) gay equality and LGBT diversity, they share the same brand image of the homonormative, offering HIV/STDs testing services that are linked to HIV hospitals. Recently, Lourdes has also started a new rehab project called 'Pleasure in Learning (harm-reduction)' group therapy (「學樂[減

害]團體」), targeting poz gay men using recreational drugs.³⁶ What emerges, then, is a cobweb of HIV governance that turns any risk subject into a ‘case’ and subjects it to intense state surveillance.

Significantly, just as HIV testing and treatment has been scaled up, militarized social control comes to be reactivated under the regime of HIV surveillance. In addition to entrapping gay men online, the state now hunts them down through their sexual networks, as Feng’s case makes clear. This means if you are caught and drug tested positive, a 6-week compulsory rehabilitation in the detention center under the Drug Control Act is in order.³⁷ If you are also found to be already on the HIV registry, you could be facing the same fate as Feng. In this regard, the compliant subject presumed in the ‘I. C.A.R.E’ campaign remains a sitting duck,³⁸ because the Taiwanese state wants to see whether the positive individual has been successfully rehabilitated by HIV care, whether he’s learned how to make use of his sex by keeping his consumer behavior within the bounds of moral sovereignty. Any moral relapse on his part *can* turn him into a bad example straight away.

At a time when the AIDS industry has been mobilised to support the cause of gay marriage (the campaign reached a new height last year), it could be argued that current advocacy of HIV rights and LGBT rights is founded upon the inclusive exclusion of the deviant HIV subject. Ironically, as the Christian right in Taiwan mobilizes the force of HIV stigma in their opposition to gay marriage, Positive Alliance, despite positioning itself as social movement, can only respond to the backlash by seeking recourse to a non-confrontational language while distancing itself at the same time from the stigmas of sex and

³⁶ See ‘Learning the pleasure in/of “harm-reduction” group therapy’, http://www.lourdes.org.tw/list_1.asp?id=2322&menu1=3&menu2=120

³⁷ I am conducting a new research project on how a new regime of drug control regime came into formation shortly after the lifting of Martial Law.

³⁸ I thank Ding Naifei for this point.

drugs. Crucially this sort of positionality fosters a neoliberal structure of sentiments that prevails in mainstream Taiwan. Members of the general public are now encouraged by the AIDS Surveillance Industry to cheer for positive people by saying 'Go go, my positive friend, you can do it!'. In a climate of neo-moralism where the positive individuals are further responsiblised through HIV care,³⁹ this kind of cheering amounts to nothing less than 'compulsory happiness' for those who haven't made 'it' (i.e. the happy poz). Instead of scratching the surface of liberal tolerance, Positive Alliance end up making the general public feel good about themselves. Model Positive people might be feeling happy about having a share in the happiness of the general public,⁴⁰ but I see this act of sharing as one of self-purification. Given that the privation of HIV experiences in Taiwan has been overdetermined by the biomedicalization of HIV surveillance over the past decade, how to move beyond the AIDS surveillance industrial complex and its gated community of benevolence have become the most pressing challenge for queer survivals in the biopolitical present.

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³⁹ On how to think beyond the framing of legal and technological devices that produce positive responsibility, see Race (2012).

⁴⁰ I draw on here Sara Ahmed's (2010) notion of 'social happiness'. On the neoliberal affect of 'compulsory happiness' and its violence of erasing queer historicity, see Love (2007).

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