Infected Deviants

Reading Epidemiology as Bio-power in Men Who Have Sex wth Men (MSM) Research

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Abstract

This paper examines the implications of the study of disease as a form of controlling and regulating people. Using a genderqueer analysis, unacceptable kinds of sex practices, sexual relationships, and sexual risks are explored. I also expose how discourses of harm elimination, quarantine, and celibacy are deployed within the *Canadian Guidelines on Sexually Transmitted Infections*' (2008) epidemiology section on MSM. Finally, I explore the implications of AIDSphobia, heterosexism, racism, colonialism, and classism on MSM in sexual health clinical practice and epidemiology.

Key Words: Risk assessment, sexual health, Canadian Guidelines on Sexually Transmitted Infections, STIs, HIV, men who have sex with men, bio-power, discourse analysis, unsafe sex practices, sexual minorities, epidemiology.

Résumé

Cet article examine les implications de l'étude des maladies comme une forme de contrôle et de réglementation des gens. Selon une analyse androgyne (genderqueer), j'explore les sortes de pratiques sexuelles, de relations sexuelles et de risques sexuels inacceptables. J'expose aussi comment les discours d'élimination des dangers, de mise en quarantaine et du célibat sont déployés à la section épidémiologique des HARSAH des Lignes directrices sur les infections transmissibles sexuellement (2008). J'explore enfin les implications de la phobie contre le SIDA, le sexisme hétérosexuel, le colonialisme et la stigmatisation des HARSAH dans les pratiques des cliniques de santé sexuelle et d'épidémiologie.

Infected Deviants: Reading Epidemiology as Bio-power in Men Who Have Sex with Men (MSM) Research

Since MSM are disproportionately affected by HIV/AIDS, this paper seeks to challenge heterosexist assumptions that have infiltrated the study of the disease and a few of their important implications for MSM. Based on a genderqueer discourse analysis research, I examine the study of disease using Foucault's concept of bio-power to uncover how power has come to work on the human body. Drawing on my own experiences in health care, both as a patient and a provider, I reflect on sexual health assessment practices in British Columbia. The *Canadian Guidelines on Sexually Transmitted Infections* produced by the Public Health Agency of Canada is the text examined in this study because of its national significance in clinical sexual health assessment. I focus exclusively on the MSM appendix of the *Guidelines* to highlight how epidemiology can be used to regulate and control populations. Throughout this article, I expose how various discourses work upon the body of MSM in order to name them as infected deviants which isolates and condemns them as outsiders of the acceptable boundaries of heterosexuality, gender borderlines, and sex categories.

I use discourse, in a Foucauldian sense, as a conceptual framework for this investigation of Canadian HIV policy. First, I situate how I use discourse and discourse analysis in this paper to delineate what my approach is and what it exposes. Second, I contextualize how HIV became a reportable disease and the significance of this decision for public health. By conceiving of epidemiology as bio-power, I expose in the third section of the paper how power has come to work on the body of MSM. Fourth, with a focus on class, race, and colonialism, I further examine harm reduction approaches in HIV policy to mark how abstinence and quarantine discourses work in combination with the construction of a deviant-making discourse. Finally, I establish how women who have sex with women (WSW) are also made deviant in the *Guidelines*. By viewing epidemiology as bio-power, I expose these discourses sabotaging their effectiveness.

Genderqueer Discourse Analysis

With a genderqueer discourse analysis, I am interested in power relations with my attention specifically focusing on how normalizing techniques and technologies are used with regard to sex, gender, sexuality, and sexual practices. I am particularly influenced by Foucault's concept of discourse; Hook (2001) sees Foucault's articulations of discourse as what is possible to be written, spoken, and thought and how discourse functions as a process of formation and constraint, production and exclusion that is keenly tied to knowledge and power (p. 523). My version of discourse analysis is however more aligned with feminist poststructural discourse

analysis (for example, Gavey, 1989; Strega, 2005) than with critical discourse analysis. My reason for this is that I am interested unequivocally in power relations and how they function as well as their material implications rather than the textual, literary details of discourse. My feminist commitments to examining gender and power significantly influence my work and use of discourse analysis, while my intrigue with poststructural understandings of gender and sex allows me to question important fundamentals in some (essentialist) feminist thought. I feel that feminist poststructuralism informs my lens of analysis while queer and trans theories propel me further to expose hegemonic, binary, and normative thinking in regards to sex, gender, and sexuality.

Reportable Diseases & Surveillance

As a regulating and governing body, the Public Health Agency of Canada (PHAC) not only produces clinical guidelines, but also has significant influence over how these sexual health services are delivered on a national level. In addition, PHAC's role is to provide a coordinated effort in fighting the spread of infectious diseases. One way of doing this is by studying the epidemiology of these infections. In order to accomplish this task, the government requires provinces to report the number of people who have certain diseases.

> As of January 2003, HIV infection was legally notifiable in all provinces and territories except British Columbia; however, it is expected to [and did] become notifiable in British Columbia on May 1, 2003. Eight provinces and territories had HIV reporting legislation in place by the mid- to late-1980s. The remaining five will have instituted legislation between 1995 and 2003. (Centre for Infectious Disease Prevention and Control, 2003, p. 9; PHAC, 2004)

Often this information not only includes how many people in each province are infected with a mandatory reportable disease, but also information pertaining to the area in which the person is living, their age, gender, "ethnicity," and transmission mode (PHAC, 2009). When HIV first became a mandatory reportable disease, numerous people objected to the mandatory nature of reporting. Medical associations and community-based AIDS service organizations argued that it might affect the likelihood of someone voluntarily going for HIV testing (Jayaraman, Preiksaitis, & Larke, 2003, p. 679). While I understand and value the epidemiological information gleaned from this process, this concern is not my only one. My other concern is a Foucauldian mistrust of surveillance. I speak to this further once I have exposed the remaining nuances of reportable infectious diseases.

What information is provided to municipal, regional health authorities, and

provincial public health officials as well as laboratories is a matter under provincial jurisdiction. While nominal (and non-nominal) testing is used in BC, each province decides their own requirements be it nominal, non-nominal, or anonymous screening. The province of BC considered making HIV a nominal reportable infection, meaning that the government would know the names of people who were infected with HIV (Quandt, 2002, p. 35). Although non-nominal HIV testing (that is a personal code identifying you with your blood, but only traceable to the facility where you were tested) is available in BC, my own experience is that my name is put on the vial of blood without asking me my preference. In addition to significant concerns about the lack of informed consent and breach of confidentiality, albeit in these limited instances, my experience as a health care professional affirms the challenges and contradictions in confidential HIV screening.

Epidemiology as Bio-Power

How do testing protocol and procedures shape my critique of the epidemiological approach in the *Guidelines*? How the information is collected, how it is used, and who it serves, affect my analysis of the "data" presented in the appendix of the *Guidelines*. While I explore some of the nuances of reportable diseases, I question how surveillance is used. I conceive of the surveillance of infectious diseases as a tool of power and therefore, am skeptical of its use and effects. I do acknowledge the importance of collecting this "data" and want to note conflicted feelings I have in interrogating the significance of STIs surveillance, something to which I later speak. In addition, I replace epidemiology with Foucault's notion of bio-power to show how the relations of power become visible.

> Bio-power is a conceptual tool that makes it possible to analyze historically how power has come to work in relation to the human body .... Sexuality is located at a privileged intersection between the individual and the population. It is a target of self-knowledge and the essential means to regulate the reproduction of a population. (Chambon, Irving & Epstein, 1999, p. 270)

In fact, Foucault (1978, p. 140) argued that the deployment of sexuality would be one of the great, and most important, technologies of power. By viewing epidemiology as a form of bio-power, I am able to interrogate these truth claims and make visible their political underpinnings and material consequences. Here, I interrogate the claim made in the *Guidelines* that the "incidence of syphilis, gonorrhea, Chlamydia, genital herpes, hepatitis A virus (HAV), hepatitis B Virus (HBV), and HIV infections has risen among MSM in Canada and internationally since the mid-1990s" (PHAC, 2008, p. 1). I do this by examining the "recent outbreaks of syphilis among MSM" (PHAC, 2008, p. 1). While I acknowledge the reappearance

of the syphilis epidemic in Canada and the devastating effects it disproportionately has had on marginalized populations, I am still unsettled about how this epidemic came to be portrayed as an MSM disease.

On my first read through this part of the *Guidelines*, I accepted what was described. I did this not because I was reading with an uncritical eye, but because the discourse of diseased MSM (read: gay men) is so normalized that even someone intentionally looking for these discourses is sometimes not attuned to them. As Gough and Talbot (1996) suggest, I effectively drew upon "discoursal common sense" in order to construct coherence in the epidemiology section (p. 226). The discourse of diseased MSM is so effective that I deployed it myself in having "expectations about who people are what they are like and the kinds of social practices they engage in" (Gough & Talbot, 1996, p. 224).

It was only on my second read when I was examining the meaning of lymphogranuloma venereum or LGV that I stopped to consider the meaning of the list of diseases MSM contract. As Gough and Talbot (1996) suggest, I began to draw on my own social locations to expose the heteronormative discourse. I started by noticing the list of references regarding the MSM syphilis outbreak. Yet, there are also considerable syphilis outbreaks in heterosexual communities (Gratrix et al., 2007; WRHA, 2004; PHAC, 2005).

I looked up in the references to MSM syphilis noticing that they were all American sources (PHAC, 2008a, p.1-2). I then began to look for Canadian information from the *Epi Updates* regarding syphilis on the PHAC (2009) webpage. Notably, several outbreaks of syphilis were prevalent among older men and younger women in Edmonton, where 90% were contracted through "heterosexual" sex (Gratrix et al., 2007, p. 64); also predominantly among "heterosexuals" in the Yukon (PHAC, 2005); and 91% of cases in Winnipeg were "heterosexual" (WRHA, 2004, p. 6). Calgary, Montreal, Ottawa, and Toronto are named as MSM outbreak areas (Gratrix et al., 2007, p. 61).

Certainly MSM have been affected by syphilis, but to allude to syphilis as contained within the MSM population is misleading. In previous research, I uncovered that researchers' understandings of "modes of transmission" are drawn from dominant understandings of sexuality, sex, and gender (Manning, 2010). Heterosexual-identified MSM certainly complicated the dividing line between the gay and straight communities. My point in interrogating the bio-power of syphilis is to undermine the notion of sexually transmitted infections as synonymous with MSM or "sexual deviants." This conflation of gay men, disease, MSM, and deviance is a recurring crystallization in my analysis of MSM discourse. These conflating and divisive categorizations present contradictions and reveal the multiple ways deviance discourse is used. MSM are sometimes separated from gay (White) men and sometimes they are not; this is one example of a divergent use of MSM. While MSM is an epidemiological category, which attempts to sidestep

the politics of sexual orientation of men who have sex with men, there are times where a distinction between gay men and MSM is made. Notably, this distinction happens by naming non-gay-identified MSM as other MSM. However, no matter how MSM is used, one thing remains elusive and dominant: the concept of "normal" people. The flipside of the deviance discourse is that it situates heterosexuality in a seemingly "normal" place that is above and out of reach of the consequences of deviance.

While the *Guidelines* highlight what seems to be an extraordinary list of STIs that MSM contract, they also identify "unsafe sexual practices" in which it is claimed MSM engage: "unprotected anal intercourse (otherwise known as bare-backing); an increase in the number of sexual partners; partner-finding on the Internet; other anonymous partnering venues (e.g. bathhouses); recreational and non-recreational drug use; and unprotected oral sex" (PHAC, 2008, p. 1). By having a separate appendix for MSM, there is no need to explain how this may be different or similar to the unsafe sex practices of those of the "norm." By exposing these "unsafe practices," I argue that they act as another way to label those with non-normative sexes, genders, and sexualities deviant.

In order to expose further some of the underpinnings in other examples of "unsafe sexual practices," I examined how risk is constructed in the *Guidelines*. Halperin (2007, cited in Berrong, 2008, p. 44) argues that "public discourses about 'the return of unsafe sex' have contributed to the repathologizing of homosexuality." The dominant discourse of gay men's barebacking is viewed as a deviant act as implied in the *Guidelines*. It is a telling example of how the study of the disease becomes controlling and regulating. To reframe this highly scrutinized sex act, Halperin affirms that risk is an ordinary part of life and gay men's engagement of bare-backing may be a form of abjection. "[A]bjection achieves a spiritual release from domination by derealizing its humiliating effects — by depriving domination of its ability to demean the subject;" it "offers a way of understanding the motivation of marginalized individuals without representing their acts as either intentional or unintentional" (Halperin cited in Berrong, 2008, p. 45). Viewing gay men's engagement in 'unsafe sex' in this way can be considered a form of harm reduction.

Harm Reduction & Unsafe Sex Practices

Harm reduction

> is an approach to policies and programs for people who use drugs [and practice other activities which require risk taking] which is directed towards decreasing the adverse health, social and economic consequences of drug use and drug distribution [and other forms of risk taking] to the individual user and the community. (CAS & CHRN, 2008, p. 6)

Having worked in HIV/AIDS service provision, harm reduction was my practice approach. Not only did I employ a philosophy of harm reduction and practices in my work, but also taught harm reduction to other service providers and promoted this practice in various health and social services settings. Although harm reduction is interpreted and applied differently as there is no authority overseeing its application, my analysis of the *Guidelines* is that they take up the language of harm reduction, but ask readers to draw upon abstinence-based ways of thinking. The idea of harm reduction and what is considered safe and unsafe is part of old harm reduction rhetoric. While the concept of "safe sex" has developed to "safer sex" to reflect that no exchange of bodily fluids is completely safe, what is not discussed is whether there is an alternative to "unsafe." While "safer sex" discourse acknowledges the inherent risk in sex, the binary opposite to safer sex is still unsafe sex. The binary in safe sex discourse is resurrected by this lack of discursive development allowing the reader to draw on dichotomous ways of thinking about sex; that is, sex is either unsafe or safe. Effectively this undermines the principles of harm reduction by suggesting that the goal is no risk in sex.

Further, I want to dislocate the seemingly neutral language used to describe "unsafe sexual practices." While the Canadian AIDS Society claims that "two risk factors account for the increase of HIV transmission: unprotected sexual behaviours and unsafe injection drug using practices" (CAS, 1997, p. 1), the *Guidelines* suggest there are many others. But are there really? I question what the actual risk factor is in the increased number of sex partners. Is it the frequency of sex, the number of partners, or is it the fact that it is often conceived of as unprotected? Is partner-finding on the Internet a risk factor or is the kind of sex someone has the risk factor? Can computers transmit STIs and HIV? Decena (2008) argues the risk factor of "non-disclosure" of sex partners for MSM of colour is not really a risk factor; he states, "having sex with either women or men is not intrinsically risky. What matters for risk assessment is the frequency of reported *unprotected* penetrative anal or vaginal sex with a potentially infected male or female partner" (p. 400, italics in original). Decena's argument clearly articulates concerns I share with what is conceived of as a risk factor. I question what dominant ways of thinking and constructions of deviance are perpetuated through the reproductions of discourses of deviancy.

Similarly, why is anonymous partnering considered to be risky? What is inherent about knowing someone's name that makes having sex with them less risky? Does naming anonymous sex venues as sites of deviancy attempt to sever and regulate non-heterosexual space? As typically "gay" spaces, I argue that bathhouses exist on the margins of society because of homophobia and sex surveillance. With the *Guidelines* claiming that these spaces are part of unsafe sexual practices, these spaces are marked as yet another layer of deviant status.

Decena (2008) discusses the role of compulsory disclosure of risk factors in

reducing sex risks. Similar to my arguments, he argues that there are several flaws in what is viewed as a risk factor. His critique of public health pressures for MSM of colour to disclose their sexual activities to their female sexual partners suggests that the intended consequence of this act is to effectively "*quarantine* them from heterosexuality" (Decena, 2008, p. 403, italics in original). His argument suggests the heteronormative and homophobic nature of the material consequences of MSM discourse; if a non-gay-identified MSM, especially if he is a person of colour, transgresses the acceptable lines of heterosexuality, he will be exiled from heterosexuality when he attempts to return and marked as deviant to justify his ostracization from the norm. This goal of quarantine, to use Decena's phrase, even occurs within the *Guidelines* section on epidemiology. While MSM of colour may be quarantined from heterosexuality, similar consequences are intended for HIV-positive MSM. The *Guidelines* suggest that the "lack of knowledge of their own and their partners' STI status, including HIV, is a concern" (PHAC, 2008, p. 1). To extend Decena's quarantine argument, abstinence discourse emerges again to suggest that if HIV-positive MSM were to disclose their status to their sex partners that they would be effectively quarantined and forced into celibacy. This idea of quarantining HIV-positive people is one of the original tenets of AIDSphobia, which is tied to homophobia and heteronormativity.

The idea of eliminating certain bodies from "public spaces" is articulated throughout Kawash's (1998) discussion of the homeless body as the "material counterpart to the phantomal public" (p. 322). She argues that "the exclusive nature of the public is produced and secured by materially blocking the bodies of those deemed undesirable and illegitimate" (Kawash, 1998, p. 323). While homeless people and people who use bathhouses are not mutually exclusive or completely inclusive groups, I think her ideas have relevance to the discussion of space and regulation in MSM discourse. The *Guidelines* declare bathhouses deviant spaces or, at least, unsafe and risky places. In addition, taking up Decena's quarantine argument, MSM are to be removed completely from the public domain. Effectively, this sets these spaces apart from worthy public spaces fit for normative people. As in the early newspaper articles of the 1980s, homosexuals, or those who have sex with other members of the "same" sex, specifically those who contracted the "gay cancer," continue to be effectively excluded from the public not only figuratively, but also literally (see Altman, 1981; Kinsolving, 2005; Robertson, 2002).

The *Guidelines* list "recreational and non-recreational drug use" as another "unsafe sexual practice" in which MSM engage (PHAC, 2008, p. 1). While drug and alcohol use have been linked to people consenting to forms of sex including unprotected sex to which they would not normally consent (Norris, Kitali & Worby, 2009), using substances in and of themselves is not a risk. Further, what puts people at risk of HIV and Hepatitis C when using substances is the sharing of drug tools such as straws, spoons, needles, and such (CAS & CHRN, 2008, p. v).

How the *Guidelines* limit the discussion of what the specific risks are reinforces dominant ideas of homophobia and deviance. Enumerating how many "risk factors" MSM engage in consolidates their deviant status. Further, by linking drug use to bathhouses and other deviant spaces, the reification of deviance becomes more ingrained and harder to argue against. At this point in the *Guidelines*, the reader is complicit in classifying deviants by their sex partners, behaviours, spaces, and drug use.

Yet, health care providers reading this document are not the only ones susceptible to the discourses deployed here. In fact, deviant discourse is so well integrated into society that even the people who are subjugated to it are complicit in employing it. The *Guidelines* cite that one reason for the "increase in unsafe sex practices among HIV-infected MSM has been attributed in part to the increasing proportion of HIV-infected MSM who feel healthy, are living longer, and are therefore having sex more often and with more partners" (PHAC, 2008, p. 1). This information presented here comes first from interviews conducted with HIV-positive men in the *Ontario Men's Survey* (PHAC, 2008, p.1). It is HIV-positive MSM who cite their own reasons for engaging in these "unsafe sex practices." While we often conceive of AIDSphobia as blatant discrimination against people with HIV/AIDS, I argue that this may be an example of internalized AIDSphobia because the implication of this statement is that they should have been dead. While this statement about living longer may seem mundane, what I find interesting about it are the layers of class, race, colonialism, and AIDSphobia embedded within it.

HIV was seen as a "death sentence" in the 1980s and early 1990s. Access to anti-retroviral and Highly Active Anti-Retroviral Treatment (HAART) shifted HIV from being a death sentence to becoming a manageable chronic illness — but only for some. In North America, class and race are two significant markers as to whether or not one will be privileged enough to receive such treatment (In The Life, 2008). When I left the HIV clinic in 2006, a new HIV drug had just been released on the market that cost $30,000 per month, clearly a drug unattainable to many people. On average, HAART costs between $12,000–$20,000 USD annually (Gonzalo, Goñi, Muñoz-Fernández, 2009, p. 83). In my experience, even though the government pays for the medication for people on social assistance, government-sponsored refugees for their first year in Canada, and Indigenous people with status, those who access provincial drug programs still struggle with paying deductibles. These subsidized drug programs have various limitations (the annual allowable cost of prescriptions) and specific requirements (paying an annual deductible all at one time) that make it difficult for people who are working poor, on Employment Insurance, or on Canada Pension Plan, requiring this type of medication to obtain it. There are a limited number of programs that provide ARV treatment to people without health coverage or legal immigration status.

Access to HAART and other life saving medications is only one example of how class has affected the perception of AIDS being a manageable chronic illness. However, access to health care, safe and affordable housing, healthy food, and sustainable amounts of income are important issues that significantly shape the quality and length of life of someone living with HIV/AIDS. Sadly and unjustly, issues of poverty disproportionately affect Indigenous people and people of colour in Canada due to on-going colonialism and systemic racism. So while gay White men may be living longer with HIV/AIDS, Indigenous people in Canada are not necessarily experiencing the same effect. The 2006 census reports that 3.8% of Canadians self-identify as Aboriginal, yet Aboriginal people represented 9% of new HIV infections in 2005 (PHAC, 2009a). What is more astounding and perhaps speaks more profoundly to the disparity between those who are living with HIV and those with AIDS is that Aboriginal people comprised 24.4% of AIDS cases reported in 2006 in Canada (PHAC, 2009a). In my analysis of these numbers, this shows the significantly disproportionate rate of Indigenous people who progress from HIV to having AIDS. To me, the statement in the *Guidelines* attributing healthier and longer lives to HIV-positive MSM clearly articulates the experience of predominantly White, middle-upper class gay men.

While "living longer" is articulated from a privileged position, the emphasis on MSM's sex drive continues to position them as deviant. Khan (2001) speaks to the insatiable male libido in his work regarding men's constructions of their need for sexual "release." Although the *Guidelines* do not explicitly suggest that MSM have uncontrollable sexual desires, it repetitively uses words and phrases such as "*increases* in unsafe sexual practices," "*increase* in number of sex partners," "*increase* in risky sexual practices," "*increasing* proportions of HIV-infected MSM ... having sex *more* often and with *more* partners" (PHAC, 2008, p.1, italics added). This language suggests that because of MSM's insatiable sex drive, they will have sex in unsafe ways regardless of the costs to themselves, others, or society. What is left unsaid is what measures MSM do take to prevent the spread of STIs and HIV.

Women Who Have Sex With Women (WSW) and MSM?

Finally, I want to examine the women who have sex with women (WSW) or sexual contact with MSM in the epidemiology section. While the MSM appendix focuses primarily on men, a small section focuses on WSW. By now, I am sure the fags, dykes, queers, trannies, generally all of us deviants have "them" (concordantly straight and narrow "normal" people) thoroughly confused. I can almost hear them asking: Why are "gay men" having sex with "lesbians?" Deviant discourse requires the reader to draw upon the discourse of unquenchable male libido to make sense of this discordant sexual behaviour. Or perhaps the reader calls into question the authenticity of WSW and MSM's self-identity; after all, there is a conflation of

MSM and gay (and, as an afterthought, WSW and lesbian). However, what is made explicitly clear in the *Guidelines* is that WSW are deviant as well. Through similar deviant-making tactics, WSW are also constructed as disease-infected, promiscuous, drug users and sex workers.

What I am particularly curious about is the comment: "STI risk behaviours among WSW have demonstrated higher rates of sexual contact with homosexual/bisexual men" (PHAC, 2008, p. 2). The positioning of this statement is at the end of the paragraph, but at the beginning of the list of what deviant behaviours WSW engage in. I argue that because MSM have already been well established as deviant, that beginning this catalogue of other deviant behaviours constructs WSW as deviant by their association with MSM. I suggest while the act of WSW and MSM having sex together seems unfathomable to many, it happens; for instance if Califia (2000, p. 159) "had a choice between being shipwrecked on a desert island with a vanilla lesbian and a hot male masochist, [she[1]]'d pick the boy." I would also like to rupture this arbitrary line not only between MSM and WSW, but also between sex and gender. If a trans man has sex with a female-bodied dyke, is that a man having sex with a woman or are two "females" having sex? Or is it a trans guy having sex with a lesbian or is it something else? The intent of my questions is to expose the complexity of sex, gender, and sexuality in addition to how deviants are made.

Conclusion

Unsafe sex practices conclusively construct MSM as deviant in multiply ways. Through the discourses of deviance, risk, and heteronormativity, MSM are expected to be celibate and sequestered. The study of disease in the MSM appendix in the *Canadian Guidelines on STIs* irrefutably depicts MSM as infected deviants who need particular interventions. This epidemiology is about a group of people, MSM in this instance, rather than diseases. It effectively conflates people with a disease, as it was done repeatedly in the early 1980s with the naming of Gay-Related Immune Deficiency syndrome by the US Center for Disease Control (Findlay, 1991). The conflation of people and disease involves the reader in biopower by becoming complicit in controlling and regulating people instead of diseases. My challenge was to resist the implications of the epidemiology section in this appendix. By disrupting deviant discourses, I challenged the complacency and omnipotence of epidemiology to reveal its material effects on MSM. Further research needs to question the work that epidemiology does for other groups as a regulating and controlling practice. The question is whose bodies are marked by disease and what are the consequences of these markings? From a Foucauldian perspective, I am still unsettled by HIV epidemiology as its scientific approach can be taken up as a tool of political control by demarcating people affected by STIs as deviant. Exposing heteronormativity, Whiteness, and classism in health care

policy, especially in sexual health assessments, facilitates our resistance to these pervasive discourses that mold not only clinical interventions, but also Canadian public policy.

Notes

1 This quote is taken from Califia's (2000) anthology; the original piece was written in 1979, when the author identified as a lesbian. I am making this note to convey no disrespect to the author's "change in social gender" by using female pronouns in this quote (Califia, 2000, p. x).

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